

CHAPTER 32
NEW OPPORTUNITY WAIVER SERVICES
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32.0 NEW OPPORTUNITIES WAIVER

32.1 INTRODUCTION AND OVERVIEW

The New Opportunities Waiver (NOW) is a 1915 C Waiver and is designed to provide Home and Community Based Waiver Services to recipients who otherwise would require the level of care of an Intermediate Care for the Mentally Retarded (ICFs/MR).

The mission of the NOW is to utilize the principles of Self Determination to supplement the family and/or community supports while supporting dignity, quality of life, and security in the everyday lives of people while maintaining the Recipient in the community.

Services to be provided are based on the need of the recipient and are developed using a person centered process. The person-centered process coordinated by the case manager will formulate an individualized plan for each recipient. Services identified in this manual are provided under the New Opportunities Waiver (NOW), based on need; and must be specified in the BCSS approved Comprehensive Plan of Care (CPOC). NOW services are provided as a supplement to regular Medicaid State Plan services and natural supports. NOW should not be viewed as a lifetime entitlement or a fixed annual allocation.

All NOW recipient services are accessed through the recipient's case management agency. Agencies are selected through a Freedom of Choice process. Case management is not a NOW service but is required for participation for waiver services. The "continuity of stay" rule states that a waiver service(s) must be received every 30 days. As case management is not a waiver service, it cannot be applied to the "continuity of stay" rule without receiving another NOW service. The average recipient expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF-MR services.

Providers are to follow the regulations and requirements as specified in this manual.

32.2 NOW ELIGIBILITY CRITERIA

To qualify for the NOW, a person must be three years old or older, offered a waiver opportunity slot, and meet **ALL** of the following eligibility criteria to become a NOW waiver recipient:

- MR/DD as defined in L.R.S. 28:380, et. Seq.;

- Be on the MR/DD Request for Services Registry (RFSR);
- Meet financial eligibility for Medicaid;
- Meet the medical certification eligibility;
- Meet the health and welfare requirements;
- Meet the ICF/MR level of care. The ICF/MR level of care requires active treatment of mental retardation or a developmental disability under the supervision of a qualified mental retardation or developmental disability professional;
- A resident of Louisiana and at least three years old; and
- Be a citizen of the United States or qualified alien.

If the recipient fails to meet all the above criteria, they will not be eligible to participate in NOW.

32.3 RIGHTS AND RESPONSIBILITIES FOR APPLICANTS/ RECIPIENTS OF A HOME AND COMMUNITY BASED WAIVER

These are the **rights** of an applicant for or a recipient of a Home and Community Based Waiver:

- To be treated with dignity and respect;
- To participate in and receive person-centered individualized planning of supports and services;
- To receive accurate, complete, and timely information that includes a written explanation of the process of evaluation and participation in a Home and Community Based Waiver, including how they qualify for it and what to do if he/she is not satisfied;
- To work with competent, capable people in the system;
- To file a complaint, a grievance, or an appeal with his/her case management agency, direct service provider, or the Department of Health and Hospitals regarding services provided to them if he/she is dissatisfied. The recipient should call the BCSS Help Line at 1-800-660-0488;
- To have a choice of service/support providers when there is a choice available;

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- To receive services in a person-centered way from trained competent caregivers;
 - To have timely access to all approved services that are identified in their Comprehensive Plan of Care (CPOC);
 - To receive in writing any rules, regulations, or other changes that affect their participation in a Home and Community Based Waiver;
 - To receive information explaining the case manager and the direct service provider's responsibilities and requirements in providing services to the recipient.
 - To have all available Medicaid services explained to him/her and how to access these services **if they are Medicaid recipients.**

These are the **responsibilities** of an applicant for or recipient of a Home and Community Based Waiver:

- To actively participate in planning and making decisions on supports and services he/she needs.
- To cooperate in planning for all the services and supports he/she will be receiving.
- To refuse to sign any paper that he/she does not understand or that is not complete.
- To provide all necessary information about himself/herself. This will help the case manager to develop a Comprehensive Plan of Care (CPOC) that will determine what services and supports he/she need.
- To not ask providers to do things in a way that are against the laws and procedures they are required to follow.
- To cooperate with the Bureau of Community Supports and Services' staff and his/her case manager by allowing BCSS to contact the recipient by telephone and visit him/her at home at least once quarterly. Necessary visits include pre-certification visits to assist the Bureau in providing the best services and support possible, regular home visits to assure the plan of care is sufficient to meet his/her needs, visits resulting from complaints to BCSS, and visits needed to assure the services as reported by his/her provider are being received.
- To immediately notify his/her case manager and direct service provider if their health, medications, service needs, address, phone number, alternate contact number, or their financial situation changes.
- To help the case manager identify any natural and community supports that would be of assistance to him/her in meeting his/her needs.
- To follow the requirements of the program, and if information is not clear, ask the case manager or direct service provider to explain.

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- To verify he/she have received the waiver and medical services the provider says they have received, including the number of hours their direct care provider works, and report any differences to the BCSS Help Line at 1-800-660-0488.
 - To understand as a recipient of the waiver program, if they fail to receive waiver services for thirty- (30) calendar days or more his/her waiver case may be closed.
 - To recognize in the NOW, case management is not a waiver service and does not apply as a service in the thirty- (30) day "continuity of stay rule.
 - To recognize the thirty- (30)-day "continuity of stay rule" does not apply to hospital days.
 - To obtain BHSF Form 90-L "Request for Level of Care Determination" completed by their physician each year. Failure to provide this form at least 35 days prior to their annual Comprehensive Plan of Care may result in the recipient becoming ineligible to receive further waiver services. Applicants and recipients for NOW services must also provide a psychological assessment periodically as requested to continue to be eligible for services.
 - To recognize that all waiver programs have an age requirement and that they will not be offered services in a program that they previously requested if they no longer meet the age requirement for that program.

To request different waiver services if they no longer meet any of the criteria as outlined on the waiver fact sheet that they received.

32.4 NOW DISCHARGE CRITERIA

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

- Loss of Medicaid eligibility as determined by the parish Medicaid Office;
- Loss of eligibility for an ICF-MR level of care as determined by the Regional BCSS office;
- Incarceration or placement under the jurisdiction of penal authorities, courts or state juvenile authorities for more than 30 days;
- Change of residence to another state with the intent to become a resident of that state;

- Admission to an ICF/MR facility or nursing facility with the intent not to 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 ICF/MR or nursing facility;

- The health and welfare of the waiver recipient cannot be assured in the community through the provision of reasonable amounts of waiver services as determined by the Regional BCSS Office, i.e., the waiver recipient presents a danger to himself or to others;
- Failure to cooperate in either the eligibility determination process, or the initial or annual development of the approved Comprehensive Plan of Care (CPOC) or the responsibilities of the NOW recipients;
- Continuity of services is interrupted as a result of the recipient not receiving NOW services during a period of 30 or more consecutive days.
 - This does not apply to interruptions in NOW services because of hospitalization or institutionalization (such as ICFs/MR or nursing facilities. (There is a documented expectation from the treating physician that the recipient will return to NOW services.)
 - Non-routine lapses in services where the family has agreed to provide all needed or paid natural supports as documented in the CPOC. This interruption cannot exceed 90 days. During this 90-day period, the BCSS will not authorize payment for NOW services.
- Acceptance of Hospice Services under the Title XIX Medicaid State Plan. The date the recipient accepts Hospice Services, is the date the recipient is discharged from the NOW.

32.5 ACCESSING NOW SERVICES

The case manager and the case management agency are the resources to assist the recipient in the coordination of all services that are needed by the recipient.

Once his/her eligibility is determined, all NOW services are accessed through the recipient's case management agency. Case managers are selected by the recipient through a Freedom of Choice process provided by BCSS.

The case management agency develops, through a person-centered process, the Comprehensive Plan of Care (CPOC).

Involvement of the direct service provider begins upon notification from the case management agency that the recipient has chosen their agency to deliver New Opportunities Waiver (NOW) services.

Services are based on the needs of the recipient. The recipient should receive what he/she needs. The service provider shall be paid for services provided based on the BCSS approved CPOC.

Services should not be planned for the convenience of the provider. All changes in the CPOC shall be only at the request of the recipient and directed to the case manager.

All services are prior authorized (PA) and until the service provider receives prior authorization, no reimbursable services can begin. If services are provided without approved PAs, the BCSS **cannot** reimburse the provider for services rendered without prior authorization.

32.6 NOW COMPREHENSIVE PLAN OF CARE (CPOC)

The CPOC is a person-centered planning process designed cooperatively by the case manager, the recipient and other persons invited by the recipient, who may include family members, a provider, appropriate professionals, and others who know the recipient best. This NOW waiver should not be viewed as a lifetime entitlement or a fixed annual allocation. The role of the direct service provider at the CPOC meeting is to provide information and agree to the provision of services based on the needs of the recipient as stated at the CPOC meeting. The recipient's BCSS approved CPOC shall reflect only the services needed. Payment shall be made for only those approved services received by the recipient.

The BCSS approved CPOC will contain all paid and unpaid natural support services that are necessary to assist the recipient in his/her residence and promote greater independence. During the CPOC year, the recipient and family, with the assistance of their case manager and circle of support will have the flexibility within the scope of this waiver and Medicaid requirements to select the type and amount of services consistent with the recipient's needs and welfare.

The CPOC year is not defined by calendar year, State or Federal fiscal year, but rather by the specific 12 months during which the BCSS approved CPOC is in effect. If the CPOC is amended during the 12-month period, the original start/end date continues to apply for the duration of the original 12 months.

32.6.1 Now Individual Service Plan (ISP)

The service provider shall develop an individualized service plan (ISP) to meet the needs of the recipient based on the BCSS approved CPOC. This ISP must identify services to be provided to the recipient in accordance with the BCSS approved CPOC.

The ISP should be person-centered focusing on the desired outcomes; the procedures to achieve these outcomes; the person responsible; and the methods used to evaluate progress toward meeting desired personal outcomes. The ISP must be reviewed and updated as necessary to comply with the BCSS approved CPOC.

The ISP should include the following elements:

- Information about recipient's personal choices, vision, preferences, outcomes, and incorporating this into the individual's service plan
- Assessment of the recipient's skills, needed supports, health, safety, and welfare needs.
- Development of strategies to meet the recipient's identified needs, development of strategies to implement supports along with persons responsible for implementing these services, and development of strategies to address the frequency and duration of services.
- Development of a process to document and monitor the ongoing implementation of the ISP so that this information can be used for future planning,
- Submission of required data to BCSS.

32.7 NOW DIRECT SERVICE PROVIDER RESPONSIBILITIES

Recipients choose a provider agency from the Freedom of Choice list of providers offered by the Case Management Agency. Service providers shall not recruit recipients.

The direct service provider must:

- Attend the CPOC planning meeting if the recipient wants the provider in attendance. The case management agency typically gives the provider two (2) weeks notice prior to the CPOC meeting. The provider shall send a representative who has authority to actively participate and make decision regarding service delivery.

- Sign the CPOC budget page to assure that services can be provided in accordance to the proposed CPOC. The BCSS approves the CPOC and authorizes the services to be provided. Original signatures by the service provider on the CPOC budget sheet are not required. If at the time of the CPOC meeting, the service provider is unable or unwilling to sign the budget page, the case manager is still required to obtain the signature of the service provider on the budget page and submit to the BCSS Regional Office. The BCSS Regional Office will accept copied/faxed documents with the service provider signature.
- Request a written revision to the CPOC when a recipient requests a change in the number of hours of services from the service provider. The recipient requests a change in the number of hours by contacting the Case management agency. Written revisions requests must be submitted to BCSS 7 days prior to the request date of the change.
- Request a written revision to the CPOC when an emergency arises and the recipient need a change in the number of hours of services. The request must be sent to the BCSS for approval. These emergency revisions must be initiated by the case manager and sent in to the BCSS within 24 hours.
- Develop an individualized service plan to meet the needs of the recipient based on the BCSS approved CPOC. This service plan must identify services to be provided to the recipient in accordance with the BCSS approved CPOC. The service should be person-centered focusing on the outcomes and the procedures to achieve these outcomes along with the person responsible and methods used to evaluate progress toward meeting personal outcomes.
- Track the services provided for each recipient. The service provider will be held accountable for any service provided over the authorized amount in the BCSS approved CPOC. BCSS will not reimburse for any service(s) provided that were not authorized and on the BCSS approved CPOC.
- Report and document any incidents/complaints/abuse to the case manager/BCSS/ Appropriate law Enforcement Agency within two hours of first knowledge. Refer to the section on Incident/Complaint Reporting for additional instructions.
- Continue to meet all assurances of DHH licensing, DSS licensing, Medicaid enrollment and BCSS policies.
- Keep accurate and timely documentation regarding service delivery. This would include documentation in the form of progress notes, service logs, time sheets and verification of services. The provider shall make available without cost to BCSS all requests by BCSS for required documentation. A simple checklist used alone without individualized documentation will not be considered adequate. See the section on sanctions for more information.

- Keep BCSS and case manager informed on any address, telephone number, or other demographic changes in the agency, including name of person actually delivering the services.
- Communicate and cooperate with the case managers in the planning and coordination of services.
- Provide the case management agency with written documentation of the services provided, documentation of progress toward the individual's goal and outcomes and documentation of authorized services remaining in the BCSS approved CPOC, when a recipient request to change service providers .
- Maintain the required license and be enrolled in Medicaid to provide all services.
- Maintain confidentiality of recipient's records and information based on Medicaid and HIPAA requirements.

32.8 CHANGING DIRECT SERVICE PROVIDERS

The recipient may change direct service provider agencies once every services authorization quarter (3 months) with the effective date being the beginning of the following quarter or for good cause approved by BCSS State Office. Once the recipient has decided to change direct service providers, he/she shall notify his/her case manager.

The case manager will:

- Provide information to the recipient from the current Freedom of Choice (FOC) listing about service provider options.
- Assist in completing the FOC form and release of information form.
- Inform the transferring service provider agency of the pending transfer.
- Will forward the case record to the services provider.
- Obtain the case record from the releasing provider which includes the most current six months of progress notes; time sheets, written documentation of the services provided, documentation of progress toward the individual's goal and outcomes and documentation of authorized services remaining in the BCSS approved CPOC.

Due to the need to coordinate services, it is required that provider changes be made at least seven days prior to the end of the service authorization quarter, unless there is "Good Cause".

“Good Cause” is defined as:

- The recipient moves to a new region; or,
- The recipient and direct service provider agency have unresolved difficulties and mutually agree to a transfer; or,
- Safety, health, and welfare have been compromised and/or the direct service provider has not rendered satisfactory services to the recipient.

32.9 Service Provider Documentation of Services and Prior Authorization

When a recipient changes service providers, the former service provider must provide the case management agency with written documentation of the services provided, time sheets, documentation of progress toward the recipient’s goal and outcomes and documentation of authorized services remaining in the BCSS approved CPOC.

A new PA number will be issued to the new service provider with an effective starting date of the first-day of the new quarter or the first day of the first-full-calendar-month. BCSS or its agent **in no case** will backdate the PA period prior to the first-day of the first-full-calendar-month in which the FOC/Transfer of Records Section is completed. The transferring agencies PA number will expire on the date of transfer of records (first-day of the first-full-calendar-month).

Lack of cooperation in the transfer process must be reported to the BCSS Help Line at 1-800-660-0488. The BCSS NOW Program Manager will review all allegations of failure to cooperate.

32.10 SERVICES FOR THE NEW OPPORTUNITES WAIVER

32.10.1 INDIVIDUALIZED AND FAMILY SUPPORT (IFS) SERVICES – DAY (Attendant Care Services - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Individualized and Family Support (IFS) services are defined as day and/or night direct support and assistance for recipients three years of age and older, or for the relief of the care giver, in or out of the recipient's residence, to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, and inclusion in the community, as outlined in his/her person-centered plan.

Individualized and Family Support services can be shared by related waiver recipients or up to three unrelated waiver recipients who choose to live together. These services can be provided in a variety of settings, and the waiver recipients may share IFS services staff when agreed to by the recipient and health and welfare can be assured for each recipient. Based on an individual-by-individual determination, the sharing staff shall be reflected on each recipient's BCSS approved CPOC as a special billing code and rates are adjusted accordingly. Due to requirements of privacy and confidentiality, recipients who choose to share supports must agree to sign a release of confidentiality form to facilitate the coordination of services.

Transportation is included in the rate paid to the provider for Individual Family Support. Therefore the IFS worker can provide transportation.

32.10.1.1 Description of Services

- 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, bed making, dusting, vacuuming, laundry, cooking, evacuating the home in emergency situations, shopping, and money management. This does not include the cost of the supplies needed or the cost of the meals themselves.
- Personal support and assistance in participating in community, health, and leisure activities. This may include accompanying the recipient to these activities.

- Support and assistance in developing relationships with neighbors and others in the community and in strengthening existing informal, social networks and natural supports.
- Enabling and promoting individualized community supports targeted toward inclusion into meaningful integrated experiences. Volunteer work, community awareness activities and/or teaching.
- Providing orientation and information to acute hospital nursing staff concerning the recipient's specific Activities of Daily Living (ADL's), communication, positioning, and behavioral needs. While the recipient is in the hospital, all decisions regarding medical care will be made by appropriate medical staff. The IFS day worker can perform support functions, such as facilitating communication needs, assistance with eating, assistance with positioning and assistance with behavioral supports. The specific functions must be outlined on the BCSS approved CPOC and cannot be duplicative of personal care services provided by the hospital.
- Individualized and Family Support (IFS) 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 defined as the period of time when the recipient is awake and can be day or night. Direct services shall be those services that would support the recipient with challenging behavior and assist the recipient with his/her daily living skills, positioning, or training, and will not be medical procedures. The cost of transportation is included in the cost of these services.
- Additional hours of IFS day services beyond the 16 hours can be approved based on documented need, which can include medical or behavioral and specified in the BCSS, approved CPOC. Three months of documentation, which would include progress notes, will be necessary to substantiate the request for additional hours of day services beyond the 16 hours. The BCSS Regional Office will determine the decision for request for additional hours of IFS day services.
- Any service outlined in Individualized and Family Support – Day services may be provided by the IFS-N worker

32.10.1.2 Special Limitations

- To bill for IFS-D services, the recipient and family support day worker must be present, awake, alert, and available to respond to the recipient's immediate needs.
- The IFS-D worker may not work more than 16 hours in a 24-hour period of combined IFS-D and IFS-N unless there is a documented emergency or a time limited, non-routine need documented in the BCSS approved CPOC.

Time limited, non-routine could include family vacations, business trips, summer camps, and others. For recipients who live at home with family and the family is going on vacation, or business trip for a time limited non-routine basis, or in an emergency, the recipient could stay at home and the IFS –D worker exceed the 16 hours. Emergencies could include natural acts of God such as flooding, hurricane, tornadoes, or other emergencies.

- In agreement with licensing regulations, services cannot be provided in the IFS-D worker's residence, regardless of relationship, except if the IFS- D worker's home is a certified foster care home.
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as Day Habilitation, Supported Employment Models, Employment Related Training, Transportation for Habilitative Services, Professional Services, Professional Consultation, Transitional Professional Support Services, Center-Based Respite, Skilled Nursing Services, Individualized and Family Support Night, Shared Supports (Day/Night), or Community Integration Development.
- In no instance should a recipient be left alone when IFS-D services are being provided.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen consumer direction.
- IFS-D employees may be members of the recipient's family, provided the recipient does not live in the family member's residence. Payment will not be made for services furnished by a legally responsible relative defined as: parent of a minor child, foster parent, tutor, curator, legal guardian; or the recipient's spouse.
- Family members who provide IFS-D shall meet the same standards as other IFS-D workers who are unrelated to the recipient.
- Supervision of the IFS service worker shall be furnished by the licensed IFS provider agency, licensed Supervised Independent Living (SIL) agency as specified by state licensing. In the Consumer Direction option, the recipient or his/her representative, including the direct service provider, will provide supervision.
- Individualized and Family Support services must be provided in the State of Louisiana. Exceptions to provide IFS-D services outside of Louisiana, but only within the United States or territories of the United States, must be prior approved and for time-limited periods or emergencies
- IFS-D services will not be authorized or provided outside the United States or territories of the United States.

- Must comply with federal wage and hour laws.
- Request for IFS-D services for vacation, can be approved at the current level the recipient receives of IFS-D services. Additional hours of support for vacations may be approved based on the need of the recipient and documentation to support the need of the recipient.

32.10.1.3 Agency Provider Type

Providers must be licensed by Department of Social Services and enrolled Medicaid Home and Community Based Waiver service providers of Personal Care Attendant; or an individual, or a Personal Care Attendant agency providing support under authorized Consumer Directed Services.

32.10.2 Individualized and Family Support Services –Night (Attendant Care Services - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, IFS-N service is the availability of direct support and assistance provided to recipients three years of age and older with disabilities while sleeping. Individualized and Family Supports can be shared by related waiver recipients or up to three unrelated waiver recipients who choose to live together. These services can be provided in a variety of settings and the waiver recipients may share IFS services staff when health and welfare can be assured for each recipient. Based on an individual-by-individual determination, the shared staff shall be reflected on the BCSS approved CPOC as a special billing code. Rates are adjusted. The IFS-N must be awake, alert, immediately available, and in the same residence as the recipient to be able to respond to the recipient's immediate needs. Night hours are the period of time when the recipient is asleep and there is a reduced frequency and intensity of required assistance and are not limited to traditional night time hours.

Documentation must support this level of assistance. Due to requirements of privacy and confidentiality, recipients who choose to share supports must agree to sign a release of confidentiality form to facilitate the coordination of services.

32.10.2.1 Special Limitations

- To bill for this service, the recipient and the IFS-N worker must be present.
- Must be a minimum of 8 hours for recipients who have 24-hour period, but cannot exceed 24 hours combination of day and night.

The number of IFS-N service for recipients who receive less than 24 hours of paid support is based on need and specified in the BCSS approved CPOC.

- The IFS-N worker may not work more than 16 hours in a 24-hour period, of combined support, unless there is a documented emergency or a time limited non-routine need documented in the BCSS approved CPOC.
- Habitual patterns of 16 hour plus work will be investigated.
- In agreement with licensing regulations, services cannot be provided in the IFS-Day or Night worker's residence, regardless of relationship, except if the IFS-N worker's home is a certified foster care home.
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Supported Employment models, Employment Related Training, Transportation for Habilitation Services, Professional Services, Professional Consultation, Transitional Professional Support Services, Center-Based Respite, Skilled Nursing Services, Individualized and Family Supports – Day, Shared supports day or night, or Community Integration Development.
- The provider may not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Family members who provide IFS-N services shall meet the same standards as other IFS-N workers unrelated to the recipient.
- IFS-N employees may be members of the recipient's family, provided the recipient does not live in the family member's residence. Payment will not be made for services furnished by a legally responsible relative defined as a: parent of a minor child, foster parent, curator, tutor, legal guardian or the recipient's spouse.
- Supervision of the IFS-N service worker shall be furnished by the licensed IFS provider agency. In the Consumer Direction option, the recipient or his/her representative, including the direct service provider, will provide supervision.
- IFS-N services will not be authorized or provided outside the United States or territories of the United States.
- Individualized and Family Support-Night services must be provided in the State of Louisiana. Exceptions to provide IFS services outside of Louisiana, but only within the United States and territories of the United States, must be prior approved and for time-limited periods or emergencies.
- Hours for vacation request for IFS-N can be approved at the current level the recipient receives. Additional hours of support for vacations may be approved based on the need of the recipient and documentation to support the need of the recipient.

32.10.2.2 Agency Provider Type

Providers must be licensed, by Department of Social Services, and enrolled as a Medicaid Home and Community Based Waiver service providers of Personal Care Attendant; or an individual, or a Personal Care Attendant agency providing support under authorized Consumer Directed Services.

32.10.3 Shared Supports (SS) – Day and Shared Support – Night (Attendant Care Services - HIPAA Code Name)

Individualized and Family Support services can be shared by related waiver recipients who live together or up to three unrelated waiver recipients who choose to live together.

These services can be provided in a variety of settings and the waiver recipients may share IFS services staff when health and welfare can be assured for each recipient. When recipients share supports, this is known as shared supports services, both day and night.

Based on an individual-by-individual determination, the shared staff shall be reflected on the BCSS approved CPOC as a special billing code. Rates are adjusted. Due to requirements of privacy and confidentiality, recipients who choose to share supports must agree to sign a release of confidentiality form to facilitate the coordination of services.

32.10.3.1 Special Limitations

- To bill for this service, the recipient and the Individual and Family Shared Support day/night worker must be present.
- The Shared Support Worker may not work more than 16 hours, in a 24-hour period, combination IFS-D and IFS-N service unless there is a documented emergency. Habitual patterns of 16 hour plus work will be investigated.
- Must be a minimum of 8 hours of night-shared support for recipient's receiving 24-hour period for shared night support not to exceed 24 hours for day and night combined.
- Cannot include services provided in the shared support worker's residence, regardless of relationship, per licensing regulations, unless the shared support worker's home is a certified foster care home.
- Must be billed in 15-minute increments.
- Cannot be provided for or billed for at the same hours on the same day as; Day Habilitation, Supported Employment models, Employment Related Training, Transportation for Habilitative Services, Professional Services, Professional Consultation, Transitional Professional Support Services, Center-Based Respite,

Skilled Nursing Services, Day-Night Individualized and Family Supports, or Community Integration Development.

- The provider may not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- IFS-SS D/N employees may be members of the recipient's family, provided the shared support worker is not the legally responsible relative. Payment will not be made to legally responsible relative defined as a parent of a minor, foster parent, curator, tutor, legal guardian, or the recipient's spouse.
- Family members who provide IFS-SS services must meet the same standards as IFS-SS workers who are unrelated to the recipient.
- Supervision of the IFS-SS service worker shall be furnished by the licensed IFS provider agency. In the Consumer Direction option, the recipient or his/her representative, including the direct service provider, will provide supervision.
- Individualized and Family Support-Shared Supports services must be provided in the State of Louisiana. Exceptions to provide IFS-SS services outside of Louisiana, but only within the United States or territories of the United States, must be prior approved and for time-limited periods or emergencies.
- IFS-N services will not be authorized or provided outside the United States or territories of the United States.
- Hours for vacation request for IFS-SS can be approved at the current level the recipient receives. Additional hours of support for vacations may be approved based on the need of the recipient and documentation to support the need of the recipient.

32.10.3.2 Agency Provider Type

Providers must be licensed by Department of Social Services and enrolled as a Medicaid Home and Community Based Waiver service providers of Personal Care Attendant; or an individual, or a Personal Care Attendant agency providing support under authorized Consumer Directed Services.

32.10.4 Individual and Family Support Workers Accompanying Recipients to the Hospital

Policy

The NOW policy will allow the Individual and Family Support worker(s) to accompany recipients to the hospital and this service must be on the BCSS approved Comprehensive Plan of Care (CPOC).

- The IFS worker can provide orientation and information to the acute hospital nursing and medical staff concerning the recipient's activities of daily living (ADLs), which includes communication, positioning, and behavioral needs.
- The IFS worker can provide support functions such as facilitating communication needs, assistance with eating, assistance with positioning and assistance with behavioral supports.
- Decisions regarding medical care of the recipient will be made by the appropriate hospital medical staff, the recipient or the recipient's legally responsible representative and not the IFS worker.
- The functions and service of the IFS worker accompanying the recipient to the hospital must be on the BCSS approved CPOC.

Procedure

- When a recipient is to go to the hospital for whatever medical reason, either an emergency or a planned admission, the current BCSS approved CPOC must be revised to reflect the addition of this need.
- The recipient shall, if capable, notify the case management agency of the need for their IFS worker to accompany them to the hospital. In cases of an emergency situation, where the recipient is unable to communicate the need of the emergency, the IFS worker shall immediately notify a family member(s) or the recipient's legally responsible representative regarding the emergency and immediately notify the case manager of the emergency.
- The case management agency must submit the revision to the BCSS Regional Office within the timelines of submitting a revision request. For an emergency revision request, it is within 24 hours and for a non- emergency revision request, it is 7 days prior to the requested date.

- Once the recipient's date of discharge has been determined, the recipient, or recipient's legally responsible representative, or the IFS worker shall notify the case manager of the scheduled date of discharge.
- Once the recipient is discharged from the hospital, the CPOC must be revised to delete the need for the IFS worker at the hospital.
- The case management agency must submit this revision request within 7 days from the recipient's date of discharge.

32.10.5 POLICY FOR EXCEEDING THE 16 HOURS FOR INDIVIDUAL AND FAMILY SUPPORT WORKERS

Policy

The Bureau of Community Supports and Services (BCSS) may approve Individual and Family Support day workers to work more than 16 hours in a 24 hour period, in the following circumstances and must be documented on the BCSS approved Comprehensive Plan of Care (CPOC):

- On a non-routine and time limited basis, that could include vacations, business trips, or other documented need.
- Emergency situations that could include hurricane, tornado, flooding, or other acts of God.

Procedure

- The recipient would notify the case management agency of the need for the worker to work beyond the 16 hours.
- The case management agency would submit a revision request to the BCSS Regional Office with supporting documentation to justify the need.
- The revision request for emergency situations as defined above must be done within 24 hours of the emergency.
- The revision request for the need identified that can be planned in advance, such as vacations, business trip, must be submitted within 7 days of the planned need.
- The BCSS Regional Office will review the documentation notify the case management agency of the decision.

32.10.6 CENTER BASED RESPITE CARE (Respite Care - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Center-Based Respite (CBR) Care is temporary, short-term care provided to recipients three years of age and up when unable to care for himself/herself, to prevent him/her from being institutionalized.

The service is provided for a recipient with developmental disabilities who requires support and/or supervision in his/her day-to-day life, in the absence of his/her primary care giver. Recipient's routine is maintained while receiving Center-Based Respite Care in order to attend school, work, or other community activities/outings. Community outings shall be included in the BCSS approved CPOC and shall include school attendance, other school activities, or other activities the recipient would receive if they were not in a center-based respite center. The respite center is responsible for providing transportation for community outings, as this is included in their reimbursement. This would allow the recipient's routine to be uninterrupted. In accordance with Licensing regulations and BCSS policy, no other NOW services can be authorized while the recipient is in Center Based respite, as Center Based respite services are to meet all the needs of the recipient.

32.10.6.1 Special Limitations

- To bill for this service, the recipient and center-based respite worker must be present.
- Shall not exceed 2,880 1/4 hours units, which equals 720 hours per recipient per CPOC year.
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Supported Employment models, Employment Related Training, Transportation for Habilitative Services, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day or Night, Shared Support- Day or Night, Skilled Nursing Services, or Community Integration Development.
- Transportation for community outings will be provided by the Respite Center.
- Payment to provider does not include cost of room and board.
- The provider may not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.6.2 Agency Provider Type

Providers must be licensed by Department of Social Services and enrolled as a Medicaid Home and Community Based Waiver service provider of Center-Based Respite Care.

32.10.7 COMMUNITY INTEGRATION DEVELOPMENT (Waiver services not otherwise specified - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Community Integration Development (CID) is the development of opportunities to assist recipients 18 years and older in becoming involved in their community with the creation of natural supports. The purpose is to encourage and foster the development of meaningful relationships in the community reflecting the recipient's choices and values, i.e., doing preliminary work toward membership in civic, neighborhood, church, leisure, etc. groups. CID is for the development of community connections and should not to be confused with IFS. Payment for this service includes the development of a service plan. Two recipients may choose to share CID workers with each recipient's CPOC revised accordingly.

32.10.7.1 Special Limitations

- Recipient must be 18 years and older.
- To bill for Community Integration Development (CID), the recipient and CID worker providing this service **shall** be present.
- It will be person-centered, plan-driven, with a cap of 60 hours per recipient per CPOC year, which includes the combination of shared and non-shared CID.
- Must be billed in 15-minute increments.
- Cannot be provided or billed for on the same hours on the same day as; Day Habilitation, Supported Employment models, Employment Related Training, Transportation for Habilitative Services, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support-Day-Night, Shared Support – Day – Night, Skilled Nursing Services, or Center-Based Respite.
- The provider may not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Transportation cost included in the rate paid to the provider.

32.10.7.2 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled Medicaid Home and Community-Based Waiver service providers of Personal Care Attendant; or an individual, or a Personal Care Attendant agency providing support under authorized Consumer Directed Services.

32.10.8 ENVIROMENTAL ACCESSIBILITY ADAPTATIONS

(Environmental Accessibility - ramp - HIPAA Code Name)

(Environmental Accessibility - lift - HIPAA Code Name)

(Environmental Accessibility - bathroom - HIPAA Code Name)

(Environmental Accessibility - other - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Environmental Accessibility Adaptations are physical adaptations to the home and/or vehicle which are necessary to ensure the health, welfare and safety of recipients three years and up, or which enable the recipient to function with greater independence in the home, and without which the recipient would require additional supports or institutionalization. Repairs to environmental accessibility adaptations to the home and/or vehicle provided under NOW will not be authorized by BCSS. Also, BCSS will not authorize repairs or modifications to previously installed lifts or adaptations not provided under NOW.

Such adaptations to the home may include the installation of non-portable ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies for the welfare of the recipient. Modifications may be applied to rental or leased property with the written approval of the landlord and approval of BCSS.

Such 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.

The Environmental Accessibility Adaptation(s), whether from an original claim, a corrected claim, a resubmit or revision CPOC or claim, must be accepted, fully delivered, installed, operational, and reimbursed in the current CPOC year that it was approved.

Three written itemized detailed bids, including drawings with dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted. The lowest bid will be authorized by BCSS. Recipient or family preference for a specific builder/installer is not sufficient justification for approval of a higher bid. Modification may be applied to rental or leased property with the written approval of the landlord.

Three bids may not be required to be submitted if there are no other Environmental Accessibility Adaptations providers in the region. Justification and agreement by the service planning interdisciplinary team for not providing three bids **must** be included with any request for prior approval. BCSS Regional Office will determine whether three bids are required and notify the case manager of its determination. Case managers will contact the BCSS Regional Office before approving modifications for an individual leaving an ICF/MR.

This documentation shall be submitted with all requests. Payment will not be authorized or made until written documentation that the job is completed, and the job has been completed to the satisfaction of the recipient.

When state and local building or housing code standards are applicable, modifications to the home shall meet such standards. The BCSS Regional Office must approve the Environmental Modifications Job Completion Form (Form BCSS-PF-03-010).

32.10.8.1 Special Limitations

- Cap of \$4,000 per recipient for Environmental Accessibility Adaptations. Once 90% (\geq \$3,600) of the cap is reached and no additional expenditures are made for a three-year period, the recipient may again access the \$4,000. Any additional Environmental Accessibility expenditures during this three-year period reset the three-year time frame.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Excluded are those adaptations or improvements to the residence that are of general utility or maintenance and are not of direct medical or remedial benefit to the recipient, such as:
 - Flooring (carpet, wood, vinyl, tile, stone, etc.)
 - Interior/exterior walling not directly affected by a modification
 - Lighting or light fixtures that are for non-medical use
 - Furniture
 - Roofing, initial 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.

- 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.
 - 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, are excluded from this benefit.
- Car seats are not considered as a vehicle adaptation.
 - 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.
 - Vehicle modifications are designed to help the recipient function with greater independence. Excluded are those adaptations, which are of general utility, or for maintenance of the vehicle, or for repairs to adaptations.
 - All providers must meet any state or local requirements for licensure or certification, as well as the person performing the service (such as building contractors, plumbers, electricians, or engineers). When state and local building or housing code standards are applicable, modifications to the home shall meet such standards.
 - Any services covered by Title XIX (Medicaid State Plan Services) are excluded.
 - Any services denied by Title XIX (Medicaid State Plan Services) are not reimbursable.

32.10.8.2 Agency Provider Type

Providers must be enrolled as Medicaid Home and Community-Based Services Waiver Environmental Accessibility Adaptation service provider. When required by state law, the person performing the service must meet applicable requirements for professional licensure. When building code standards are applicable, modifications to the home shall meet such standards.

32.10.9 SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (SES)

(Medical Equipment and Supplies - lifts - HIPAA Code Name)

(Medical Equipment and Supplies - switches - HIPAA Code Name)

(Medical Equipment and Supplies - controls - HIPAA Code Name)

(Medical Equipment and Supplies - other - HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Specialized Equipment and Supplies (SES) are specified devices, controls, or appliances, which enable recipients to increase their ability to perform the activities of daily living, ensure safety, or to perceive and control the environment in which they live.

This service also includes items medically necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and medically necessary durable and non-durable medical equipment not available under the Medicaid State Plan. NOW will not cover or reimburse for Specialized Medical Equipment and Supplies eligible for payment under the Medicaid State Plan. 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 Job Completion Form (BCSS Form BCSS-PF-03-009) and must be approved by the BCSS Regional Office.

Some examples would include sip and puffer switches, other specialized switches, voice activated, light activated, or motion activated devices to access the recipient's environment. Generators could be covered for recipient's whose medical condition(s) warrants it, such as recipients with ventilators.

Case managers shall pursue and document all alternate funding sources that are available to the recipient, and alternate funding sources the recipient may be eligible, before submitting a request for approval to purchase or lease Specialized Medical Equipment and Supplies.

To avoid delays in service provisions/implementation, the case manager should be familiar with the process for obtaining Specialized Medical Equipment and Supplies or durable medical equipment (DME) through the Medicaid State Plan.

32.10.9.1 Special Limitations

- Cap of \$4,000 per recipient for Medical Equipment and Supplies. Once 90% (\geq \$3,600) of the cap is reached and no additional expenditures are made for a three-year period, the recipient may again access the \$4,000. Any additional Medical Equipment and Supplies expenditures during this three-year period resets the three-year time frame.

- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Excluded are those specialized 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.) swimming pool, hot tub, etc. eye exams, athletic and tennis shoes, automobiles, van lifts attached to van other than the recipient's or the recipient's family, adaptive toys, recreation equipment (swing set, etc.)
 - Personal computers and software, daily hygiene products (deodorant, lotions, soap, toothbrush, toothpaste, feminine products, Band-Aids, q-tips, etc.)
- Rent subsidy, food, bed covers, pillows, sheets, etc. exercise equipment, taxi fares, Intra and Interstate transportation services bus passes, pagers including monthly service, telephones including mobile telephones and monthly service, Home Security Systems, including monthly service.

32.10.9.2 Agency Provider Type

The provider must be enrolled as a Home and Community-Based Service Waiver service agency of specialized medical equipment and supplies.

32.10 .10 RESIDENTIAL HABILITATION SUPPORTED INDEPENDENT LIVING (Companion Care, HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Residential Habilitation-Supported Independent Living (SIL) services are provided in the recipient's residence or in the community. The residence of the recipient includes his/her apartment or own home provided the recipient does not live in the residence of any legally responsible relative(s) as defined in Individual and Family Supports.

Family Members who are not legally responsible relatives can be SIL workers provided they meet the same qualifications as any other non-related SIL worker. Exceptions are for recipients living in the residence of his/her spouse or disabled parent, or a parent aged 70 or older. The direct service provider cannot be the homeowner/landlord unless the home is a HUD home. Recipients must be able to choose to receive supports from any provider on the Freedom of Choice list in their region.

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

Residential Habilitation-Supported Independent Living (SIL) is assistance and/or training in the performance of tasks related to maintaining, acquiring, or improving skills, such as, but not limited to, personal grooming, bathing, housekeeping, bed making, dusting, vacuuming, laundry, cooking, shopping, and money management. Minimum direct services include three documented contacts per week, by the SIL provider agency, with at least one contact being face-to-face in addition to the approved direct support hours.

These services will also assist with social, community, and adaptive skills necessary to enable the recipient to reside in the community of their choice and to participate as independently as possible, and to prevent institutionalization and/or divert him/her from becoming institutionalized.

These services will also assist in obtaining financial aid, assistance in accessing other benefits available, advocacy and self-advocacy training as appropriate, and emergency support, providing trained staff and assisting the beneficiary to access other programs for which he/she qualifies.

These services shall be coordinated with any services listed in the BCSS approved CPOC and may serve to reinforce skills or lessons taught in school, therapy, or other settings.

32.10.10.1 Special Limitations

- To bill for this service, the SIL provider must maintain required activities for and with the recipient.
- SIL settings cannot be in a substitute family care setting.
- Cannot exceed 365 days per year.
- Services are limited to once a day, per CPOC year. When a recipient is in SIL and is admitted to a Center-based respite (CBR) facility, the SIL provider cannot bill the SIL per diem beginning with the date of admission to the CBR through the date of discharge from the CBR.
- The recipient must be 18 years or older to receive SIL services.

- No more than 3 people can live together and share an SIL setting unless they are related.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- The provider shall provide 24 hour back up.
- Legally responsible relatives may not be SIL providers.
- SIL per diem payment will not be paid to SIL provider agency for recipient's participating in the Consumer Direction as the recipient will be directing his or her own care.
- The per diem maybe billed when the SIL recipient is in the hospital.
- Cannot include the cost of:
 - Supplies needed or the cost of the meals themselves
 - Room and board
 - Facility maintenance
 - Upkeep and improvement
 - Direct or indirect payment(s) to Legally Responsible Relatives.
 - Routine care and supervision which should be expected to be provided by a family or a group home provider
 - Activities or supervision by a source other than Medicaid (OCDD, etc.) for which a payment is made.

32.10.10.2 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled Home and Community-Based Service Waiver service SIL provider, or an individual providing support under authorized Consumer Directed Services.

32.10.11 DAY HABILITATION

Day Habilitation Waiver - HIPAA Code Name)

Based on need, specified in the BCSS approved Comprehensive Plan of Care, Day Habilitation is provided in a community based setting for the 18-year-old and older recipient that focuses on

socialization with meaningful age-appropriate activities which provide enrichment and promote wellness, as indicated in their person-centered plan. This is not Adult Day Health Care. Day habilitation services begin when both the recipient and the day habilitation worker are present.

The recipient will be given assistance and/or training in the performance of tasks related to maintaining, acquiring, or improving skills such as, but not limited to, personal grooming, housekeeping, bed making, dusting, vacuuming, laundry, cooking, shopping, and money management.

This service will also assist with social and adaptive skills necessary to enable the recipient to reside in a non-residential setting and to participate as independently as possible in the community. Habilitation service shall be coordinated with any therapies listed in the Comprehensive Plan of Care, as well as Employment Related Training, Mobile Crew, or Enclave and may serve to reinforce skills or lessons taught in school, therapy, or other settings. The recipient does not get paid for the activities in which he/she is involved. The provider must develop an individual service plan to address the outcomes for the recipient.

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

- A recipient receives 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.
- A recipient receives personal care skills training at a facility to improve his/her adaptive skills.
- A recipient participates in a community inclusion activity designed to enhance his/her social skills.
- A recipient receives training in basic nutrition and cooking skills at a community center.
- An older recipient is supported in participating 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.
- A recipient is provided with aerobic aquatics in an inclusive setting to maintain his/her range of motion.
- A recipient is taught how to use a vacuum cleaner.
- A recipient learns how to make choices and order from a fast food restaurant.
- A recipient is taught how to observe basic personal safety skills.

- A recipient does non-paid work in the community along side peers without disabilities to improve social skills and establish connections.
- A recipient and, as appropriate, his/her family receive information and counseling on benefits planning and assistance in the process.

32.10.11.1 Agency Provider Type

Providers must be licensed by the Department of Social Services as an Adult Day Care provider and enrolled Medicaid Home and Community Based Services Waiver service provider of day habilitation.

32.10.11.2 Special Limitations

- To bill for day habilitation services, both the recipient and the day habilitation worker must be present.
- The recipient must be 18 years or older
- Can be for 1 or more hours per day but not to exceed 8 hours per day.
- Cannot exceed 8,320 ¼ hour units in a CPOC year.
- Cannot be provided or billed for at the same hours on the same day as; Supported Employment models, Employment Related Training, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day or Night, Shared Supports – Day or Night, Community Integration Development, or Center-Based Respite.
- Must be billed in 15-minute increments.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.11.3 Transportation for Day Habilitation

(Non-emergency transportation - HIPAA Code Name)

(Non-emergency transportation - wheelchair - HIPAA Code Name)

Only round-trip transportation will be reimbursed. The recipient may receive Day Habilitation in more than one place.

This daily round trip rate includes as many trips as necessary for Day Habilitation activities in one day, but must have at least one round trip documented in order for the provider to bill on any given recipient. Round trip is defined as transporting from the recipient's place of residence and returning to the recipient's place of residence. The service provider must only bill transportation for the date(s) on which the recipient has received Day Habilitation services based on the BCSS approved CPOC. This service shall be documented in the recipient's record and the round trip shall be documented in the provider's transportation log. The provider's vehicles used in transporting recipients must be in good repair, have a current Louisiana inspection sticker, first aid kit, and must carry \$1 million dollars liability insurance. Drivers must have a current Louisiana driver's license applicable to the vehicle being used.

32.10.11.4 Agency Provider Type

Providers must be licensed by the Department of Social Services as an Adult Day Care provider and enrolled Home and Community Based Services Waiver service provider for Day Habilitation or an individual providing support under authorized Consumer Directed Services.

32.10.12 SUPPORTED EMPLOYMENT (Supported Employment - HIPAA Code Name)

These are services not available under a program 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 17)). Supported employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the individuals are working toward competitive work, consistent with strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of individuals with ongoing support services for whom competitive employment has not traditionally occurred. These are services provided to recipients who are not served by Louisiana Rehabilitation Services and need more intense, long-term follow along and usually cannot be competitively employed because supports cannot be successfully faded.

Supported employment is conducted in a variety of settings; particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by recipients receiving Waiver services, including supervision and training.

When supported employment services are provided at a work site in which persons without disabilities are employees, 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.

Supported employment 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.

The three Supported employment models are:

- **One On One Intensive (Supported Employment)– HIPAA Code Name**

A supported employment placement strategy in which an employment specialist (job coach) places a person 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. Once the recipient has mastered the job task, then they maybe transitioned to the follow along status of supported employment, if needed. One on one intensive service is time limited and usually six to eight weeks in duration.

A recipient can move from follow along back to one to one intensive if the job changes or a new job has been secured for the recipient and new tasks have to be learned.

Special Limitations for One To One Intensive

- To bill for this service, the recipient and One on One worker must be present.
- Cannot exceed 1,280 ¼ hour units per CPOC year.
- Typically 6-8 weeks in duration.
- Cannot exceed 8 hours a day, and cannot exceed 5 days a week.
- Must be 18 years or older
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Employment Related Training, Mobile/crew enclave, follow along, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Support – Day and Night, Community Integration Development, or Center-Based Respite.

The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

- **Follow Along - (Ongoing Support to maintain Employment-HIPAA Code Name)**

Ongoing follow along services are supports to maintain the recipient in their job and these follow along services must be provided by another entity other than the Louisiana Rehabilitation Services.

The ongoing follow along support services must include at a minimum, twice monthly face-to-face contacts with the recipient at their work site. Ongoing support services can be provided from more than one source.

Special Limitations to Follow Along

- To bill for this service, the recipient and follow along worker must be present.
- Not to exceed 2 follow along contacts per calendar month and cannot exceed 24 days per recipient per CPOC year, without additional documentation.
- The recipient must be 18 years or older
- Must be billed by the daily per diem.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Employment Related Training, One-to-One intensive, Mobile Work Crew/Enclave, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Support – Day and Night, Community Integration Development, or Center-Based Respite.

The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

- **Mobile Work Crew/Enclave (Ongoing support to maintain employment-HIPAA Code Name)**

An employment situation in competitive employment in which a group two or more workers, but fewer than eight workers, with disabilities are working at a particular work setting under the supervision of a permanent employment specialist (job coach/supervisor). The disabled workers may be disbursed throughout the company and among non-disabled workers, or congregated as a group in one part of the business.

Special Limitations to Mobile Crew/Enclave

- To bill for this service, the recipient and Mobile Work Crew/Enclave worker must be present.
- Cannot exceed 8,320 ¼ hour units per CPOC year
- Not to exceed 8 hours a day, 5 days a week.
- The recipient must be 18 years or older
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Employment Related Training, One-to-One intensive, Follow Along, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Support – Day and Night, Community Integration Development, or Center-Based Respite.

The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.12.1 Agency Provider Type for All Three Models Of Supported Employment

Providers must be licensed by the Department of Social Services as an Adult Day Care provider and enrolled Home and Community Based Services Waiver service provider for Supported Employment, or an individual providing support under authorized Consumer Directed Services.

32.10.12.2 Transportation for Supported Employment

(Non-emergency transportation - HIPAA Code Name)

(Non-emergency transportation - wheelchair- HIPAA Code Name)

Only round-trip transportation will be reimbursed when provided between the recipient's place of residence and the site of the supported employment models of service; or between supported employment model sites (cases in which the recipient receives supported employment services in more than one place), is reimbursable.

The round-trip rate includes as many trips as necessary for supported employment model activities in one day, but must have at least one round trip documented in order for the provider to bill on any given recipient. Round trip is defined as transporting from the recipient's place of residence and return transporting to the recipient's place of residence.

The service provider must only bill transportation for the date(s) on which the recipient has received supported employment models based on the BCSS approved CPOC. This service shall be documented in the recipient's record and the round trip shall be documented in the provider's transportation log.

Service provider vehicles used in transporting recipients must be in good repair, have a current Louisiana inspection sticker, first aid kit, and must carry \$1 million dollars liability insurance. Drivers must have a current Louisiana driver's license applicable to the vehicle being used.

32.10.12.3 Agency Provider Type for Transportation For All Supported Employment Models

Providers must be licensed by the Department of Social Services as an Adult Day Care provider and enrolled Home and Community Based Services Waiver service provider for Supported Employment, or an individual providing support under authorized Consumer Directed Services.

32.10.12.4 Policy and Procedure for Transportation for Day Habilitation and Supported Employment Modules (One-to-One, Intensive, Follow Along, Mobile Work Crew/Enclave)

Policy

BCSS NOW pays a flat per diem for transportation when day habilitation and/or supported employment modules have been provided for the recipient. There are two separate rates. One rate is for regular transportation, and the other rate is for wheelchair transportation. The rate(s) is for a one time, round trip per day. Round trip is defined as transportation from the recipient's place of residence and return to the recipient's place of residence. Any transportation provided during the day from job site to job site or other trips is included in the one flat rate per day.

Procedure

- At the time of the development of the CPOC, if the recipient is in need of supported employment modules, and/or day habilitation, the transportation will be added to the CPOC.
- The case manager should check the appropriate transportation box in **Section VI, Identified Services, Needs, and Supports**, on Page 8 of 16 of the NOW CPOC and identify whether the transportation is regular or wheelchair.

- The case manager should identify in **Section VII, Typical Weekly Schedule**, on Page 9 of 16 of the NOW CPOC the times that transportation will be provided.
- The case manager should identify in **Section IX (A) CPOC Requested Waiver Services (Budget Sheet) – Typical Weekly and Alternate Schedule** on Page 11 of 16 of the NOW CPOC the transportation service provider's name, the appropriate transportation service procedure code, the transportation service type, and identify the days of the week the transportation will be provided and identify the total weekly number of transportation units of service.
- The case manager should identify in **Section IX (B) CPOC Requested Waiver Services (Budget Sheet)** on Page 12 of 16 of the NOW CPOC the transportation service provider's name, the transportation provider's number, the transportation service type, the transportation procedure code number, the typical weekly number of units of transportation, the cost/rate per unit for the transportation, total typical weekly costs for transportation, the number of weeks in CPOC year for transportation and the total typical annual weekly costs for the transportation.
- The case manager should complete the other needed services on the CPOC according to the instructions and submit to the BCSS Regional Office for approval.
- BCSS Regional Office will review the CPOC to assure that either a supported employment module and/or day habilitation services are listed on the CPOC prior to approving transportation.
- Once the BCSS Regional Office approves the CPOC the transportation services can begin.

32.10.13 EMPLOYMENT RELATED TRAINING (Habilitation, Support Employment - HIPAA Code Name)

These are services not available under a program 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), and based on need.

Employment Related Training services consists of paid employment for recipients 18 year-old or older for whom competitive employment at or above the minimum wage is unlikely, and who because of their disabilities need intensive ongoing support to perform in a work setting.

Services are aimed at providing recipients with opportunities for employment and related training in work environments in accordance with U.S. Dept. of Labor regulations and guidelines, one to eight hours a day, one to five days a week at a commensurate wage in accordance with applicable regulations and guidelines. Services also include related training designed to improve and/or maintain the recipient's capacity to perform productive work and function adaptively in the work environment. Payment for these services includes transportation in the rate and the requirement the provider develops an individualized service plan.

Employment related training services begin when the recipient arrives at the employment related training site and the employment related training activities contained in the individualized plan of care begin.

Employment Related Training Services include but are not limited to:

- A recipient receives assistance and prompting in the development of employment related skills. This may include assistance with personal hygiene, dressing, grooming, eating, toileting, ambulation or transfers, and behavioral support needs and any medical task, which can be delegated.
- A recipient is employed at a commensurate wage at a provider facility for a set or variable number of hours.
- A recipient observes an employee of an area business to obtain information to make an informed choice regarding vocational interest.
- A recipient is taught to use work related equipment.
- A recipient is taught to observe work-related personal safety skills.
- A recipient is assisted in planning appropriate meals for lunch while at work.
- A recipient learns basic personal finance skills.
- A recipient and, as appropriate, his/her family receive information and counseling on benefits planning and assistance in the process.

32.10.13.1 Special Limitations

- To bill for this service, the recipient and the employment related training worker must be present.
- The recipient must be 18 years of age or older.

- Cannot exceed 8,320 ¼ hour units per recipient per CPOC year.
- Limited to 8 hours a day, 5 days a week.
- Must be billed in 15-minute increments.
- Cannot be provided or billed for at the same hours on the same day as; Day Habilitation, Supported Employment Models (one-to-one, follow along, mobile work crew/enclave), Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Supports – Day and Night, Community Integration Development, or Center-Based Respite.
- The recipient may be paid by the employment related training provider for engaging in this service, according to Federal regulations.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction for his or her own waiver needs.

32.10.13.2 Agency Provider Type

Providers must be licensed by the Department of Social Services as an Adult Day Care Provider and enrolled Medicaid Home and Community Based Services Waiver service provider of employment related training.

32.10.14 PROFESSIONAL SERVICES

These professional services are limited to psychological services, social work services, and nursing services. Professional services are direct services to recipients 21 years-of age and older, based on need, and specified in the BCSS approved Comprehensive Plan of Care.

They are to be used only when the services are not covered under the Medicaid State Plan. The purpose of these services is to increase the recipient's independence, and his/her participation and productivity in the home, work, and community. Service intensity, frequency, and duration will be determined by the recipient's needs. Professional services must be delivered in the recipient's presence and be provided based on the BCSS approved CPOC and under an individualized service plan.

Professionals must possess a valid Louisiana license in the specific area in which they are providing services and have at least one year of experience post licensure.

Professional services are limited to \$1,500 per recipient per CPOC year for the combined range of professional services.

32.10.14.1 Description of Services

Professional services are limited to the following:

- **Psychological Services - (Psychosocial Rehabilitation Services - HIPAA Code Name)**

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 team. Services must be reasonable and necessary to preserve and improve or maintain adaptive behaviors or decrease maladaptive behaviors of a person with Mental Retardation or Developmental Disabilities.

The service must be outlined in the BCSS approved CPOC. Psychology services include:

- Counseling (a variety of techniques and procedures used by the therapist, i.e., structuring and reinforcement, social modeling, functional activities, etc.)
 - Behavior evaluation for the purpose of therapy
 - 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
 - Administering, evaluating, and modifying treatment and consulting within the scope of practice of behavior therapy
 - Adapting environments specifically for the recipient
-
- **Social Worker Services - (Psychosocial Rehabilitation Services – HIPAA Code Name)**

Social worker services are highly specialized direct counseling services furnished by a Licensed Clinical Social Worker (LCSW).

Services are highly specialized and designed to meet the unique counseling needs of recipients with Mental Retardation and Development Disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address those personnel outcomes and goals listed in the BCSS approved CPOC.

- **Nursing Services - (Psychosocial Rehabilitation Services - HIPAA Code Name)**

Nursing services are medically necessary direct services provided by a Licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN). Services will be outlined in the BCSS approved CPOC and as ordered by a physician. Direct services may address health care needs related to prevention and primary care activities, treatment, and diet. Services must comply with the Louisiana Nurse Practice Act.

Reimbursement will be for the direct service provided directly to the recipient performed by a nurse only, and not for the supervision of a nurse performing the hands-on direct service.

Professional services may be performed the same day as professional consultation. They may not be provided or billed for at the same hours on the same day.

32.10.14.2 Requirements for Direct Psychological Services, Social Work Services, and Nursing Services

Providers of these services must:

- Perform an initial evaluation to assess the recipient's needs for services;
- Develop an individual service plan;
- Implement the recipient's therapy plan in accordance with appropriate licensing and certification standards;
- Within 10 working days, complete progress notes for each session, and provide these notes to the designated case manager every three months, or as specified in the BCSS approved CPOC;
- Maintain current and past records and make them available upon request to BCSS, service providers, case management agency, the Centers for Medicare and Medicaid Services (CMS), and/or Legislative Auditors;
- Bill for services based on a BCSS approved CPOC and Prior Authorization, only for services rendered;
- Comply with DHH/BCSS standards for payment, MAPIL, HIPAA, ADA, and licensing requirements.

Non-Billable Activities of the Provider:

- Friendly visiting, attending meetings.

- Time spent on paperwork or travel.
- Time spent writing reports and progress notes.
- Time spent on general staff training not related to training for the natural or paid support regarding the recipient's program plan. Time spent on billing of services.
- Other non-Medicaid reimbursable activities.

32.10.14.3 Special Limitations

- To bill for this service, the recipient must be present when the professional rendered the service.
- The recipient must be 21 years or older.
- \$1,500 cap per recipient per CPOC year for all professional services.
- Must be billed in 15-minute increments.
- A recipient could receive two or more professional services on the same day; however, these two professional services will not be authorized at the same time.
- Professional services and professional consultations may be performed on the same day but shall not be provided or billed for at the same hours on the same day.
- Cannot be provided or billed for at 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, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Supports – Day and Night, Community Integration Development, Skilled Nursing Services, or Center-Based Respite.

The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.14.4 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled Medicaid Home and Community Based Services Waiver service providers of Personal Care Attendant, Supervised Independent Living, or Home Health Services as licensed by the Department of Health and Hospitals.

Each professional rendering service(s) must possess a valid Louisiana and have one-year experience in their field of expertise post licensure.

The professional could either be employed or contracted with the SIL, PCA or Home Health agency to provide this service

Agencies enrolled as both SIL and PCA provider types shall bill these professional services. Under there PCA number in accordance with the fiscal intermediary requirements. Agencies enrolled, as only SIL or Home Health would bill under their SIL or Home Health provider number.

32.10.15 PROFESSIONAL CONSULTATION

These professional consultation services are limited to psychological consultation services, social work consultation services, and nursing consultation services.

Professional consultation services are consultative services to recipients 21 years-of age and older, based on need, and specified in the BCSS approved Comprehensive Plan of Care. They are to be used only when the services are not covered under the Medicaid State Plan.

The purpose of these services is to evaluate, develop programs, and train natural and formal supporters to implement training or therapy programs, which will increase the recipient's independence, participation, and productivity in his/her home, work, and community.

These services are not meant to be long-term, on-going services, but instead are normally meant to be short-term or intermittent to develop critical skills which may be self-managed by the recipient or maintained by natural and formal supporters.

The recipient must be present during all aspects of the consultation in order for the professional to bill and receive payment for this service. Service intensity, frequency, and duration will be determined by recipient need. These services may include assessments and periodic reassessments.

Professional consultations services are limited to \$750 per recipient per CPOC year for combined range of professional consultation services. All professionals must possess a valid Louisiana license to practice in their area of expertise and have one-year minimum experience post licensure and be contracted or employed by the PCA, SIL, or Home Health Agency.

32.10.15.1 Description of Services

Providers must be licensed in the specific area in which training or consultation is being offered. Professional consultation services will include the following:

- **Nursing Consultation - (Skilled training and development - HIPAA Code Name)**

Nursing consultation services are provided by a licensed registered nurse regarding those medically necessary nursing services ordered by a physician that exceed the service limits for home health services under the Medicaid State Plan and do not meet the skilled nursing criteria for NOW. Nursing consultation services must be on the BCSS-approved CPOC. Services must comply with the Louisiana Nurse Practice Act. Consultation services may address health care needs related to prevention and primary care activities.

- **Psychological Consultation - (Skilled training and development - HIPAA Code Name)**

Psychology consultation is evaluation and education 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/her team.

Services must be reasonable and necessary to preserve and improve or maintain adaptive behaviors or decrease maladaptive behaviors of a person with Mental Retardation or Developmental Disabilities.

Consultation provides the recipient family, care givers, and team with information necessary to plan and implement plans for the recipient. This services must be outlined in the BCSS approved CPOC.

- **Social Worker Consultation (Skilled training and development - HIPAA Code Name)**

Social Worker consultation services are highly specialized consultation services furnished by a Licensed Clinical Social Worker (LCSW). These services are highly specialized and designed to meet the unique counseling needs of recipients with Mental Retardation and Development Disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address those personal outcomes and goals listed in the BCSS approved CPOC.

32.10.15.2 Requirements for Direct Psychological Consultation, Social Work Services, Nursing Services

These providers shall:

- Perform an initial evaluation to assess the recipient's needs for environmental services that can be carried out by a paraprofessional or family member;
- Develop an individual service plan;
- Educate the care giver on the recipient's therapy plan, in accordance with appropriate licensing and certification standards;
- Within 10 working days, complete progress notes for each consultation session, and provide these notes to the designated case manager every three months, or as specified in the CPOC;
- Maintain current and past records and make them available to BCSS, agency representatives, CMS, or legislative auditors;
- Bill for consultation based on a BCSS approved CPOC and Prior Authorization only for services rendered (all other activities are built into the rate and are identified as non-contractual activities);
- Comply with DHH/BCSS standards for payment, MAPIL, HIPAA, ADA, and licensing requirements
- A formal Behavioral Support plan is needed when the recipients' behavior creates problems/concerns with daily life situations; when the recipient's behavior puts himself or herself or others at risk; when other restrictive methods are utilized; when psychotropic medications are used for behavioral concerns; and/or when less restrictive methods of behavioral support have proved ineffective.

Non-Billable Activities of a Provider:

- Friendly visiting, attending meetings,
- Time spent on paperwork or travel,
- Time spent writing reports and progress notes,
- Time spent on staff/provider training,
- Time spent on billing of services, and
- Other non-Medicaid reimbursable activities.

32.10.15.3 Special Limitations

- To bill for this service, the recipient and the professional rendering consultation the service must be present.
- The recipient must be 21 years or older.
- \$750 cap per recipient per CPOC year, for all professional consultation.
- Must be billed in 15-minute increments.
- Two or more professional consultations could be received by a recipient on one day; however, these two professional consultations will not be authorized at the same time.
- Professional services and professional consultations may be performed on the same day but shall not be provided or billed for at the same hours on the same day.
- Cannot be provided or billed for at 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, Transportation for Habilitative Services, Professional Services, Transitional Professional Support Services, Individualized and Family Support – Day and Night, Shared Supports – Day and Night, Skilled Nursing Services, Community Integration Development, or Center-based Respite.

The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.15.4 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled in Medicaid Home and Community Based Services Waiver service providers of Personal Care Attendant, Supervised Independent Living, or Home Health Services as licensed by the Department of Health and Hospitals. Each professional rendering consultation service(s) must possess a valid Louisiana license and have one-year experience in their field of expertise post licensure.

The professional could either be employed or contracted with the SIL, PCA or Home Health agency to provide this service.

Agencies enrolled as both SIL and PCA provider types would bill this service under their PCA number. Agencies enrolled as only SIL or Home Health would bill under their SIL or home health provider number.

32.10.16 PERSONAL EMERGENCY RESPONSE SYSTEMS

(Emergency Response System, Installation and Testing Only - HIPAA Code Name)

(Emergency Response System, Maintenance, HIPAA Code Name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, a Personal Emergency Response System (PERS) is a rented electronic device connected to the recipient's phone, which enables a recipient to secure help in an emergency. The recipient may wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center.

Personal Emergency Response Systems (PERS) services are limited to those persons who:

- Live alone, or
- Live alone without the benefit of a natural emergency backup system, which would include care givers (paid and non-paid), and who would otherwise require extensive routine IFS services or other NOW services and due to cognitive limitations, need support until educated on the use of PERS and the direct support is phased-out. This phase out plan must be addressed in the BCSS approved CPOC, or
- Have older or disabled care givers, or
- Are not equipped with other communication systems to summon emergency assistance.

32.10.16.1 Special Limitations

- Coverage of the PERS is limited to the rental of the electronic device.
- The monthly rental fee, regardless of the number of units in the household, must include the cost of maintenance and training the recipient how to use the equipment.
- Reimbursement will be made for a one-time installation fee for the PERS unit.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.

32.10.16.2 Agency Provider Type

Providers must be enrolled in Medicaid Home and Community Based Services Waiver program as a service provider of PERS.

32.10.17 SKILLED NURSING SERVICES

(RN services - HIPAA Code name) - (LPN/LVN services - HIPAA Code Name)

Based on need and specified in the BCSS approved CPOC, Skilled Nursing Services are medically necessary nursing services ordered by a physician and provided to a medically fragile recipient in or outside of the recipient's home. Skilled Nursing Services will not be paid for in hospitals and/or other institutional settings. Skilled Nursing Services are 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. All Medicaid State Plan Services available to the recipient must be utilized before accessing this service. Skilled nursing services will be provided by a licensed, enrolled home health agency using Licensed Nurses, to 21 year-old or older recipients who require skilled nursing services and who meet the medically fragile criteria as defined below.

32.10.17.1 Skilled Nursing Services Medical Criteria

- Recipients diagnosed with a chronic disease which the disease requires added vigilance by a licensed nurse to provide prevention, monitoring and assessment in order to management the acuity of the disease and reduce the frequency of acute and emergency services. Chronic conditions requiring skilled nursing services include: insulin dependence; unstable or uncontrolled diabetes; insufficient respiratory capacity requiring use of oxygen therapy, a ventilator and/or tracheotomy; hydration, nutrition, and/or medication via a gastronomy tube; severe muscular-skeletal conditions/non-ambulatory status that require increased monitoring and/or the treatment of decubitus; kidney failure requiring dialysis; cancer requiring radiation/chemotherapy; and end-of-life care not covered by hospice services.

OR

- Recipients with chronic disease process who require life-sustaining equipment necessary to sustain, monitor, and treat a recipient to ensure sufficient body function. Such medical equipment may include: a ventilator, a suction machine, pulse oximeters, apnea monitors, or nebulizers.
- This category may also include recipients who require the admission of medications, which by law must be administered by a licensed nurse via mediports/central lines/intravenous therapy. The use of the equipment referenced does not have to be continuous, but must be medically necessary and life sustaining as documented by the primary care physician.

AND

- Skilled Nursing services must be included in the recipient's BCSS approved CPOC, have a physician's order, a physician's letter of medical necessity, 90-L and 485, an individual nursing service plan, a summary of medical history, and the skilled nursing checklist.

32.10.17.2 Requirements for Skilled Nursing Services

Provider agencies of Skilled Nursing Services shall:

- Assure that services are delivered by Licensed Nurses licensed by the State of Louisiana, and who have at least one year of Medical-Surgical experience managing the chronic condition the recipient has.
- Inform the case manager immediately of the providers' inability to staff according to the Recipients Nursing Service Plan.
- Develop and implement an Individual Nursing Service Plan as noted in the BCSS approved Comprehensive Plan of Care (CPOC) in conjunction with the recipient's physician, planning team and the case manager in a manner identifying and fulfilling the Waiver recipient's specific needs in a cost-effective manner.
- Provide the case management agency with physician-ordered changes every 60 days regarding the NOW Waiver recipient's health status and health needs.
- Follow all NOW Waiver requirements and State and Federal rules and regulations for licensed home health agencies and nursing care. Must obtain authorization; follow Home Health Agency requirements for assessment, supervision, documentation, and physician authorization.
- Complete progress notes for each treatment, assessment, intervention, and critical incident, and report any NOW Waiver recipient's non-compliance with or refusal of the established Individual Nursing Service Plan, and provide these notes to the designated case manager every three months, or as specified in the BCSS approved CPOC.
- Maintain current and past records and make them available to BCSS, agency representatives, CMS, or legislative auditors.
- Bill for prior authorized services rendered based on a BCSS approved CPOC.
- Comply with DHH/BCSS standards for payment, MAPIL, HIPPA, ADA, and licensing requirements.
- The home health nurse and the case manager **shall** communicate frequently. Monthly telephone contact is required to allow the case manager to determine if further planning is required.

32.10.17.3 Special Limitations

- To bill for this service, the recipient and the nurse providing the skilled nursing service must be present.
- The recipient must be 21 years or older.
- Providers must be bill in 15-minute increments.
- All Medicaid State Plan services must be utilized before accessing this service.
- Skilled Nursing Services cannot be provided or billed for at the same hours on the same day as; Transportation for day habilitation, transportation for supported employment models, Professional Services, Professional Consultation, Transitional Professional Support Services, Individualized and Family Support- Day and Night, Shared Supports- Day and Night, Community Integration Development, or Center-Based Respite.
- The provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Request for 12 hours or less per day can be approved at the BCSS Regional Office.
- Requests for 13 hours or greater per day or more must be forwarded to the BCSS State Office for review of the Medical Review Panel. The Medical Review Panel consists of at a minimum, a Medical Doctor and a Registered Nurse.
- A request to increase the number of skilled nursing hours per day above the number of hours already approved requires the primary care physician to document the medical change(s) of the client necessitating the increase in the request for skilled nursing services.
- When there is more than one recipient in the home receiving skilled nursing services, services maybe shared and payment must be coordinated with the Service Authorization system and each recipient's CPOC.

32.10.17.4 Agency Provider Type

Providers must be licensed by the Department of Health and Hospitals and enrolled Medicaid home and community based services Waiver service provider of Home Health.

32.10.17.5 Home Health Agency Standards and Procedures

The Bureau of Community Supports and Services requires certain standards to be maintained by Home Health agencies providing skilled nursing services:

- The Home Health agency must be licensed and enrolled to provide Home Health services in the State of Louisiana and meet all Minimum Standards for Home Health Agencies. The agency must also be an enrolled provider of Medicaid-reimbursed skilled nursing services.
- It is the responsibility of the Home Health agency to ensure that all nurses employed to provide skilled nursing services are either registered nurses or licensed practical nurses holding 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 who meet the medically fragile criteria.
- The agency must render services to the recipient as ordered by the primary care physician as reflected the recipient's BCSS approved Comprehensive Plan of Care and 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 are consistent with CMS Forms 484, 485, 486, and OASIS and shall be used by the Home Health Agencies providing skilled nursing services.

Documents to be collected and submitted to the case management agency include:

- Primary Care Physician's Order for Skilled Nursing Services must be signed, dated, and contains the number of hours per day of skilled nursing services and the duration of the skilled nursing services necessary. This must be updated at least every 60 days. A copy of the physician's approval shall be sent to the case management agency prior to expiration of the previous approval to ensure continuation of services. This letter must be included at the time of the recipient's annual CPOC.
- Primary Care Physician's Letter of Necessity for Skilled Nursing Services must be on the Physician's letterhead, listing and identifying all nursing duties to be performed by the nurse, and stating the current medical condition of the recipient warranting skilled nursing services.
- Primary Care Physician's 90-L.
- Summary of the recipient's Medical History - must include a recent (within one year) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) extended home health approvals and other specific service needs which must be based on documented record review.
- Form 485 completed by the Home Health Agency identifying the skilled nursing service needs.
- Prior Authorization will not be released if the physician's orders are not submitted as required.

- Any changes in the recipient's nursing service needs must be reported to the case manager. If necessary, the case manager will call an ID Team meeting for CPOC review planning and any needed revision. (This includes changes, which increase skilled nursing services in excess of 12 hours per day). The Home Health Agency, in accordance with their regulations, must revise their Individual Nursing Services Plan every 60 days. However, it is not necessary to revise the CPOC every 60 days unless there is a change in the recipient's medical condition, which requires 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.
- Communication between the case manager and the home health agency nurse should be no less than monthly.
- The Home Health agency must provide an orientation to waiver services and assure that the licensed nurse adheres to the BCSS Critical Incident Reporting policy.
- The Individual Nursing Service Plan must be current and available in the recipient's home at all times.

32.10.17.6 Case Management Agency Procedures

- The case manager convenes the Interdisciplinary Team (ID Team) for a recipient who is medically fragile. This ID Team meeting must include the licensed home health nurse who is responsible for the development of the Individual Nursing Service Plan. The case management agency will not need to verify if the recipient has exhausted his/her home health services under the Medicaid State Plan as skilled nursing services through the NOW waiver are in addition to these home health services.
- The CPOC must be developed and include strategies and interventions necessary to assure the medically fragile recipient's health and safety. Skilled Nursing Services must meet the following requirements:
 - Ordered by the recipient's primary care physician
 - Approved by the primary care physician
 - Medically necessary to support the recipient in the community; and
 - Set forth the coordination of all services including the skilled nursing service included in the CPOC

- Set forth the use of natural supports, when available, to compliment the skilled nursing service
- The CPOC is submitted to the BCSS Regional Office for approval following the requirements outlined in the Case Management Services Provider Manual.
- Submit all documents collected by the home health agency, along with the CPOC, to the BCSS Regional Office.
- When changes in the recipient's nursing service needs are reported to the case manager, the case manager may call an ID Team meeting for CPOC revision and planning. This includes changes, which increase skilled nursing services in excess of 12 hours per day. However, it is not necessary to revise the CPOC every 60 days unless there is a change in the recipient's medical condition, which requires the need for additional skilled nursing services or the recipient requests, a change. The physician's order for skilled nursing services must be updated every 60 days in accordance with home health agency requirements and a copy submitted to the case management agency.
- Quarterly Face to Face monitoring includes: Observing delivery of skilled nursing services, the recipient's health and safety needs, related skilled nursing needs and the recipient's progress towards personal outcomes.

32.10.17.7 BCSS State Office Responsibilities

- When a request for more than 13 hours per day or greater of skilled nursing services is received from the BCSS Regional Office, the NOW Waivers Manager will convene with the DHH/BCSS Designated Physician & Medical Review Team.
- When a request for consultation for 13 hours or more per day is received from the BCSS Regional Office, the NOW Waivers Manager will request review by the Medical Review Team.
- After the Medical Review Team reviews the documentation for skilled nursing services for 13 or more hours per day, the NOW Waivers Manager will notify the BCSS Regional Office of the decision.

32.10.17.8 Appeals

- Any recipient who disagrees with the decision reached concerning his/her request for skilled nursing services has the right to request a fair hearing/appeal.

- An appeal request may be submitted verbally or in writing specifically stating the reason(s) of disagreement with the BCSS decision to the BCSS Regional Office, BCSS State Office, or directly to the DHH Bureau of Appeals within 30 days from notification of denial of services must be within 10 days of denial to continue the existing approved services. The requested changes will not be in effect until the administrative law judge makes a decision.

32.10.18 SUBSTITUTE FAMILY CARE (Foster Care/Adult, HIPAA Code Name)

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

This service provides for day programming, transportation, independent living training, community integration, homemaker, chore, attendant care and companion services, medication oversight (to the extent permitted under State law) provided in a licensed Substitute Family Care Home.

The total number of recipients (including persons served in the waiver) living in the home who are unrelated to the principal care provider cannot exceed three.

Payment for rendered services is dependent upon the prior authorization of the SFC services on the BCSS-approved CPOC and includes the development of an individual service plan.

32.10.18.1 Special Limitations

- To bill for this service, the recipient must be in the substitute family setting.
- Services cannot exceed 365 days a year.
- Payment does not include room and board.
- The SFC provider shall not bill the fiscal intermediary for this service if the recipient has chosen Consumer Direction.
- Immediate family members, who include mother, father, brother, sister, spouse or curator cannot be a substitute family care parent.
- SFC homes shall not be SIL living settings.

32.10.18.2 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled in Medicaid Home and Community Based Services Waiver service provider of Substitute Family Care, or an individual providing support under authorized Consumer Directed Service.

32.10.19 ONE TIME TRANSITIONAL EXPENSES; Life Time Limits (Community Transition waiver HIPAA Code name)

Based on need and specified in the BCSS approved Comprehensive Plan of Care, Transitional Expenses are set-up expenses capped at \$3,000 over an recipient's life time. The expenses cannot constitute payment for housing, rent or refundable security deposits.

The expenses are for recipients 18 years of age and up who make the transition from an ICF/MR to his/her own home or apartment in the community of their choice.

Own home shall mean the recipient's own place of residence and does not include any family members home or substitute family care home(s).

32.10.19.1 Description of Services

- Essential furnishings such as bedroom and living room furniture, table and chairs, window blinds, eating utensils, and food preparation items such as pots and pans;
- 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.
- Can be used for non-refundable security deposits.

32.10.19.2 Services Exclusion

- Cannot be used for payment for housing or rent.
- Cannot be used for refundable security deposits.

32.10.19.3 Service Limitations

- Life time limit of \$3,000 per recipient.
- Service authorization and transitional expenses are time limited

- Once a recipient has been approved for one time transitional expenses, and made purchases any additions must be requested by the recipient and must be submitted on a new TEPA form and authorized by the case manager and the BCSS Regional Office.

Additional request may be submitted up to 30 calendar days after the stamped date the BCSS Regional Office receives the 18-W in the event “last minute needs” are identified.

All billing is based on the BCSS approved TEPA authorization for which payment is being requested. The BCSS approved TEPA authorization must be completed within 60 calendar days after the BCSS Regional Office receives the 18-W in order for the reimbursements to be paid.

32.10.19.4 Procedure

When an individual has been offered an opportunity to participate in the NOW, it is the responsibility of the case manager that has been selected by the recipient transitioning from an ICF/MR into the community, to include as a part of the person centered planning process, a plan that shall include the transition expenses the individual will have as he/she moves into his/her own community residence. No TEPA funds will be disbursed without prior authorization of expenditures.

- The Transitional Expenses Planning and Approval (TEPA) form is the form the case manager will complete with input from the recipient and their circle of support reflecting the need for transitional expenses.
- The case manager will complete the TEPA form and forward it to the BCSS Regional Office along with the Comprehensive Plan of Care (CPOC) packet for review and pre-approval. The CPOC must have the one time transitional expenses included and the budget sheet reflecting the estimated TEPA cost. This is part of the pre-142 approval process for those transitioning out of an ICF/MR facility into the community. The purchasing process cannot begin until the TEPA is given pre-142 approval.
- Once pre-approval of the request is obtained from the BCSS Regional Office, the BCSS Regional Office will fax the pre-approved TEPA form to the Office for Citizens with Developmental Disability (OCDD) and the case manager. In no instance, will the date OCDD receive the pre-approved TEPA form be less than 10 working days from actual move date.

The case manager shall contact the transition expense coordinator at the Office for Citizens with Developmental Disabilities (OCDD) Office in Baton Rouge at:

Office for Citizens with Developmental Disabilities
P.O. Box 3117, Bin #21
Baton Rouge, Louisiana 70821-3117
Attention: Fiscal Section
Telephone 225-342-0095
Fax 225-342-8823

- OCDD will set up a transition expense record for each recipient.
- OCDD will utilize the pre-approved TEPA form to ensure that only the item/services listed are reimbursed to the designated purchaser. The recipient will identify the designated purchaser(s). The designated purchaser may be the participant, their authorized representative, the SIL provider, or the case manager. The case manager or their designee will work with the designated purchaser to obtain items pre-approved by BCSS on the TEPA form. The designated purchaser(s) are responsible for submitting the original receipts to the case manager within the allotted time frame. After purchases are made, the case manager will be responsible to:
 - Collect original receipts from the designated purchaser(s) and identify the designated purchaser(s) of the pre-approved item(s) to be reimbursed.
 - If the person or entity to be reimbursed is not already established as a state vendor, then a Form W-9 (Request for Taxpayer Identification Number and certification) must be completed.
 - Summarize all items purchased by the designated purchaser(s) on the NOW TEPA invoice form.
 - Inform the designated purchaser/entity to be reimbursed that the service authorization for purchase of pre approved/approved TEPA transitional expenses items is time-limited.
- BCSS Regional Office will review the purchased items with the recipient at the Pre-Certification Home Visit for approval.

Payment will not be authorized until the BCSS Regional Office gives final CPOC approval upon receipt of the 18W. Upon receipt of the 18-W, the BCSS Regional Office will fax to OCDD Fiscal at 225-342-8823.

- If there are any differences between the approved estimated TEPA cost and the actual TEPA cost, then the case manager must submit a revised CPOC budget sheet to BCSS Regional Office with the actual cost for each item previously approved item noting the cost difference.
- The case manager will send the completed TEPA form with the actual costs to OCDD for verification after the pre-certification home visit. OCDD will review documents for completeness and compliance with the BCSS approved TEPA request.
- OCDD will send BCSS Regional Office the verified TEPA for Service Authorization.
- BCSS Regional Office will give final approval based on OCDD's verification of the actual expenditures on the approved TEPA form. BCSS Regional Office will fax back to the OCDD State Office the final approved TEPA form for maintenance in the OCDD payment record. BCSS Regional Office will fax the approved TEPA form to the BCSS PA contractor.
- Service authorization will be issued to OCDD for the actual cost of items as identified on the BCSS approved TEPA form. Any new items not on the original approved TEPA form will not be reimbursed.
- OCDD will bill the Medicaid fiscal intermediary under Procedure Code Z0636.
- Once payment is received from Medicaid for these expenses, OCDD will forward the reimbursement to the designated purchaser.
- Additional items not on the original request, must be requested by submitting a new TEPA form for authorization by the case manager up to 30 calendar days after the date the BCSS Regional Office receives the 18-W in the event "last minute needs" are identified. The same procedure outlined in steps 5 and 7 through 12 above will be followed for any additional requests.
- All billing based on the BCSS approved TEPA authorization for which payment is being requested must be completed within 60 calendar days after the stamped date the BCSS Regional Office receives the 18-W in order for the reimbursement to be paid. The case manager would follow the same steps outlined above regarding submitting of invoices for reimbursement.
- OCDD will maintain documentation including each recipient's individual TEPA form with original receipts and record of payments to the authorized purchaser for the recipient. This documentation is for accounting and monitoring purposes.

32.10.19.5 Agency Provider Type

The Department of Health and Hospitals, Office for Citizens with Developmental Disabilities (OCDD) will coordinate the appropriate entities for the provision of these services.

32.10.20 TRANSITIONAL PROFESSIONAL SUPPORT SERVICES (Crisis Intervention Services - HIPAA Code Name)

Based on need and specified in the BCSS approved CPOC, Transitional Professional Support services is a system using specialized staff and resources to intervene and stabilize a situation caused by any severe behavioral or medical circumstance that could result in loss of a current community-based living arrangement.

32.10.20.1 Description of Services

These services are available for recipients 3 years of age and up who have met all of the following criteria:

- A developmental disability or one or more concurrent diagnosis:
 - Mental health diagnosis of Autism or other pervasive developmental disorder
 - Transitioned or who are in the process of transitioning out of public Developmental Centers
 - A history of recurrent challenging behaviors that risk injury to self or others, or result in significant property damage
 - A documented need for Professional Services and/or Professional Consultation above the limits of Professional Services and/or Professional Consultations, or services available in the Medicaid State Plan, with a statement of necessity by the treating psychiatrist/psychologist and an individual service plan in the recipient's BCSS approved CPOC.
 - All Medicaid State Plan services must be utilized before accessing this service.

OR

- An recipient with an acute illness or injury in which the acute condition process requires an added vigilance by a licensed nurse to provide surveillance, early identification and treatment of disease symptoms to avert and/or delay the

consequence of advanced complications of the acute condition, thereby limiting the likelihood of a permanent debilitation state (such acute conditions may include trauma resulting in amputation of a limb, or care required after major surgeries)

AND

- The need exists with supporting documentation from a medical doctor, including:
 - A letter of medical necessity,
 - A physician's order, and
 - An individual nursing service plan.
- All Medicaid State Plan services must be utilized before accessing this service.

32.10.20.2 Special Limitations

- This service is limited to recipients who have transitioned out of state-operated Developmental Centers, and who have reached the \$750 CPOC year cap for Professional Services and the \$1,500 CPOC year cap Professional.
- Cannot be provided or billed for at 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, Transportation for Habilitative Services, Professional Services, Professional Consultation, Individualized and Family Support – Day and Night, Shared Supports – Day and Night, Community Integration Development, Skilled Nursing Services, or Center-based Respite.
- The provider shall not bill the fiscal intermediary for this service if the recipients have chosen Consumer Direction for their own waiver needs.

32.10.20.3 Agency Provider Type

Providers must be licensed by the Department of Social Services and enrolled in Medicaid Home and Community Based Waiver service provider of Personal Care Attendant, Supervised Independent Living, or Home Health Services.

Home health agencies are licensed by the Department of Health and Hospitals. Each professional rendering service must possess a valid Louisiana license to practice in their field and a minimum of one-year experience in their field post licensure. The professional can either be on contracted or employed by the PCA, SIL or home health agency.

Agencies enrolled as both SIL and PCA provider types would bill this service under their PCA number. Agencies enrolled, as only SIL or Home Health would bill under their SIL or Home Health provider number.

An agency that fulfills this role must possess specialized staff and resources to intervene in and stabilize a situation caused by any severe behavioral or medical circumstance that could result in loss of a current community-based living arrangement.

32.10.20.4 Process to Access Transitional Professional Support Services

- The process to access transitional professional services would begin with the recipient or family making a request to the case management agency regarding the type service that is needed once professional Support or Consultation Services is exhausted or is expected to be exhausted within the quarter.
- The case management agency would submit a revision to the CPOC that reflects the need for the transitional professional support services.
- The request should be based on recipient's needs and reflected in the results of the support team meeting
- Should be based on the recipient's needs and the result of the support team meeting.
- Necessary documentation of the need for these services as outlined in the description of services for Transitional Professional Support Services must be attached to the CPOC Revision.
- Documentation should include:
 - A full description of need.
 - A history leading up to the need
 - A summary of the progress or lack of progress or regression related to the professional service consultation received.
 - A statement of medical necessity by treating Psychiatrist, Psychologist or Medical Doctor; Individual Service Plan with plan for review no less than every 90 days.

- The case management agency would send the CPOC revision and supporting documentation to the BCSS Regional Office.
- The BCSS Regional Office would review the revision request and act on it, by either approving, requesting additional information or disapproving.’
- The BCSS Regional Office would notify the case manager of the final determination of the CPOC revision request.
- In order for Transitional professional support services to be reimbursed by Medicaid, services cannot begin before the revision to the CPOC has been approved and prior authorization received.

32.11

GENERAL RECORD KEEPING

In accordance with Standards for Participation, published, September 20, 2003, in the *Louisiana Register*. The service provider shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as defined by Centers for Medicare and Medicaid Services regarding records and documentation. The service provider shall maintain all records required by Medicaid, BCSS, and Department of Social Services – Licensing Bureau.

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

The service provider shall:

- Maintain a complete and separate record for each recipient served and shall include the following:
 - Planning meeting minutes;
 - CPOCs;
 - Service logs;
 - Billing records;
 - Progress notes;
 - Eligibility records; and
 - All other pertinent documents.
- Provide all case records and billing documents to BCSS as required for monitoring activities and investigations upon request on site or within two hours if records are stored off site.

- Maintain the following documents and provide them to the BCSS upon request:
 - Copies of the current approved CPOC, the current service plan and all CPOC revisions in the recipient's case record and in the recipient's home. The documents must be current and available;
 - Documentation of payroll and services delivered within a time period must agree. Documentation of services delivered within a pay period will be recorded in the recipient's home record;
 - Updated and implemented service plan, to meet the service changes warranted by CPOC revisions within five calendar days of receiving a copy of the approved CPOC revision;
 - A copy of the behavior support plan, if one is required, in the recipient's home.

- Maintain documentation to support that services were rendered as per the BCSS approved and service plan. The provider shall:
 - Maintain documentation of the day-to-day activities of the recipient via service logs and progress notes;
 - Maintain documentation detailing the recipient's progress towards his/her personal outcomes;
 - Maintain documentation of all interventions used to ensure the recipient's health, safety and welfare. Interventions may include, but are not limited to, medical, consultations, and environmental and adaptive interventions.

- Develop written policies and procedures relative to the protections of recipient's rights which include, but not limited to:
 - Human dignity/respectful communication;
 - Person-centered planning/personal outcomes;
 - Community/cultural access;
 - Right to personally manage his/her financial affairs, unless legally determined otherwise or he/she gives informed consent;
 - Right to refuse service treatment;
 - Civil rights, such as right to vote.

32.11.1 Components of Record Keeping

All provider records must be maintained in an accessible, standardized order and format at each Regional Office. The agency must have sufficient space, facilities, and supplies to ensure effective record keeping.

- The provider must keep sufficient recipient records to document provision of services and compliance with Medicaid requirements.
- A separate record must be maintained on each recipient that fully documents services provided and receipt of remittance advice indicating payment for services.

The provider must maintain sufficient documentation to enable DHH to verify that prior to payment each charge is due and proper as identified in the section of this manual. Re: Components of Recipient Records.

- 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. Records must be maintained and present and available upon request.
- Records shall document the date; time period (for services) and each authorized service provided. Records shall include progress notes concerning observation of the client's condition, progress or other pertinent information. A checklist is insufficient.

32.11.2 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.

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

32.11.3 Confidentiality and Protection of Records

Records, including administrative and recipient, must be secured against loss tampering destruction or unauthorized use. Must follow HIPAA, Medicaid's or Division of Administration's confidentiality regulations whichever are most stringent in each area of confidentiality or protection of records.

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 DHH/BCSS of whatever sanctions are available pursuant to Medicaid certification authority] or the imposition of a monetary fine and/or imprisonment by the U. S. Government pursuant to the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The information may be released only under the following conditions:

- By court order, or;
- By the recipient's written, informed consent for release of information;
- When the recipient has been declared legally incompetent, the recipient to whom the recipient's rights have devolved provides written consent;
- When the recipient is a minor, the parent or legal guardian provides written consent;
- In compliance with the Federal Confidentiality Law of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2);
- A provider must, upon request, furnish a copy of information in a recipient's case record to the recipient or the recipient's personal representative.

However, the provider may deny access to the record if a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the recipient or another person;

- The provider may charge a reasonable fee (not to exceed the usual and/or customary fee for copying) for providing the above records to the recipient.
- 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 security, maintenance, control, and location of all recipient records. Recipient records must be located at the enrolled site.

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

32.11.4 Review by State and Federal Agencies

Service providers must make all administrative, personnel, and recipient records available to BHSF/BCSS and appropriate state and federal personnel at all times of office operation.

Providers must always safeguard the confidentiality of recipient information and follow the HIPAA requirements and where more stringent, the Medicaid confidentiality regulation.

32.11.5 Administrative Files

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

- Documents identifying the governing body as required and defined by Department of Social Services - Licensing Bureau requirements,
- List of members and officers of the governing body, their addresses, and terms of membership,
- Minutes of formal meetings and bylaws of the governing body, if applicable,
- Documentation of the service provider's authority to operate under state law,
- Functional organizational chart which depicts lines of authority,
- All leases, contracts, and purchase-of-service agreements to which the service provider is a party,
- Insurance policies,
- Annual budgets, audit reports, and accounting records,
- Provider's policies and procedures,
- Documentation of corrective action taken as a result of external or internal reviews,
- Plan for recruitment, screening orientation, ongoing training, development and supervision, and performance evaluation of staff,

- Procedures for the maintenance, security, and confidentiality of records that specify who supervises the maintenance of records and who has custody of records,
- Quality Improvement Plan,
- A clear, concise program description, which is made available to the public, detailing:
 - Overall philosophy of the services
 - Long-term and short-term goals of the services
 - Target and/or waiver group(s) of recipients served
 - Intake and closure criteria
 - Written eligibility criteria for each service provided
 - Services to be provided
 - Schedules of fees for services, including a sliding scale, which will be charged to non-Medicaid recipients, if applicable
 - Method of obtaining opinion from the recipient regarding recipient satisfaction with services
- A current comprehensive resource directory of existing formal and informal services that addresses the unique needs of recipients with developmental disabilities and communities served which must be updated at least annually.
- Accounting records maintained according to generally accepted accounting principles, as well as, state and federal regulations and all accounting records.
- All fiscal and other records concerning services as they are subject at all times to inspection and audit by the Department of Health and Hospitals, the Legislative Auditor, and auditors of appropriate federal funding agencies.

32.11.5.1 Personnel Files

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

- Job descriptions for all positions, including volunteers and students that specify duties, qualifications, and competencies.
- Description of hiring practices that includes a policy against discrimination based on race, color, religion, sex, age, national origin, disability, political beliefs, disabled veteran, veteran status or any other non merit factor.

- Description of procedures for:
 - Employee evaluation
 - Promotion
 - Disciplinary action
 - Termination
 - Hearing of employee grievances

There must be written grievance procedures that allow employees to make complaints without retaliation. Grievances must be periodically reviewed by the service provider's governing body in an effort to promote improvement in these areas.

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

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

An employee must have access to his/her personnel file and must be allowed to add any written statement he/she wishes to make to the file at any time. A provider must not release a personnel file without the employee's written permission except according to state law.

32.11.5.2 Recipient Records

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

Progress notes must be of sufficient content:

- To reflect descriptions of activities, procedures, and incidents,
- To give a picture of the services and,
- To show progress, if any, toward outcomes and goals.

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

- “Called the recipient(s)” or
- “Supported recipient(s)” or
- “Assisted recipient(s)” or
- “Recipient is doing fine” or
- “Recipient had a good day” or
- “Prepared meals”

Checklists alone are not adequate documentation for progress notes.

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

32.11.5.3 Organization of Records, Record Entries, and Corrections

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

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

- The name of the person making the entry,
- A legible signature of the person making the entry,
- A functional title of the person making the entry,
- The full date of documentation,
- Must be legible,
- In ink,
- Reviewed by the supervisor, if required, and
- If necessary, corrected using the legal method only

The legal method of correcting a document or entry 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.**

32.11.5.4 Components of Recipient Records

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

32.11.5.4.1 Active Record

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

- Identifying information on the recipient recorded on a standardized form including the following:
 - Name,
 - Home address,
 - Home telephone number,
 - Date of birth,
 - Sex,
 - Race or ethnic origin (optional),

- Closest living relative,
- Education,
- Marital status,
- Name and address of current employment, school, or day program, as appropriate,
- Date of initial contact,
- Court and/or legal status, including relevant legal documents,
Names, addresses, and telephone numbers of other recipients or providers involved with the recipient's CPOC including the recipient's primary or attending physician.
- Date this information was gathered, and
- Signature of the staff member gathering the information.
- Documentation of the need for ongoing services.
- Medicaid eligibility information for Medicaid eligible recipients.
- A copy of Freedom of Choice of providers, recipient rights and responsibilities, confidentiality, and grievance procedures, etc., signed by the recipient.
- Complete individual service plan as specified in the *Services Section* of this manual signed and dated by the recipient and copies of all pertinent correspondence.
- Progress notes written at least monthly summarizing services and interventions provided and progress toward service objectives, as specified below.
- Reason for case closure and any agreements with the recipient at closure.
- Records should reflect the most current utilization of services up to six months. Records older than six (6) months may be kept in storage files or folders, but must be available for review.
- Any threatening medical condition of the recipient including a description of any current treatment or medication necessary for the treatment of any serious or life threatening medical condition or known allergies.
- Monitoring reports of waiver service providers to ensure that the services outlined in the Comprehensive Plan of Care are delivered as specified.
- Service logs describing 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 relationship of the contact to the CPOC.

- Any additional documentation required for other services identified in service definition section.

32.12.5.4.2 Service Logs

Service logs are a chronology of events and contacts which supports justification for service authorization or payment of services. Service logs must reflect services delivered and are the "paper trail" for services delivered.

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

- Name of recipient,
- Name of service provider and employee providing the service,
- Service provider 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, and
- Content and outcome of service contact

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

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

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

32.11.5.4.3 Progress Notes

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

- Indicate the name of the recipient that was contacted, the location where the contact occurred, and what services rendered and/or activities occurred.
- Record activities and actions taken, by whom, and progress made; and indicate how the recipient is progressing toward the Personal Outcomes in the CPOC.
- Document delivery of each service identified on the CPOC.
- Record any changes in the recipient's medical condition, behavior or home situation, which may indicate a need for a reassessment and CPOC change.
- Be readable (including signature) and include the job title of the person making the entry and date.
- Be completed and signed at least monthly, preferably weekly, by the person providing the services or direct service agency staff.
- Be recorded more often, either daily or weekly, if there is either frequent activity or significant changes occurring in the recipient's service needs and progress.

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

When a case is transferred to another service provider or closed, a summary must also be entered in the recipient's record.

32.11.5.4.4 Table of Documentation of Documentation Schedule

SERVICE PROVIDERS				
WAIVER	SERVICE LOG/PAYROLL SHEET	PROGRESS NOTES	PROGRESS SUMMARY	CASE CLOSURE/ TRANSFER
NOW	At time of every activity	At time of every activity and at least monthly	At least every 90 days	Within 14 days of discharge

32.12 PROGRAM MONITORING

32.12.1 INTRODUCTION

The Department of Health and Hospitals has instituted a procedure in which the Bureau of Community Supports and Services will provide management, direction, and supervision of waiver services delivered to waiver recipients by case management agencies and direct service providers. Services offered through Louisiana’s New Opportunities Waiver (NOW) are monitored to assure compliance with DHH policy as well as applicable state and federal regulations.

BCSS regional staff conducts on-site reviews of each provider agency contracted with DHH and/or enrolled as a provider of waiver services. These reviews are conducted to monitor the provider agency's compliance with DHH Provider Enrollment’s participation requirements, Standards for Participation, continued capacity for service delivery, quality and appropriateness of service provision to the waiver group, and the presence of the Personal Outcomes as defined and prioritized by the recipients served.

In addition to licensing and reviewing enrollments, BCSS conducts bi-annual monitoring for 5% of waiver recipients plus recipient identified as High Risk. Bi-annual 5% monitoring focuses on the quality of services and supports provided by the case management agency and direct service provider.

Program monitoring reviews may include but are not limited to the following areas:

- Recipient's health, safety, and welfare.
- Services provided in accordance with approved CPOC.
- 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/guardian.
- Internal quality assurance/quality improvement activities.
- Billing practices.
- Compliance with Standards for Participation for Waiver Service Providers.

A service provider's failure to follow DHH/Medicaid policies and practices could result in administrative sanctions such as the provider's removal from Medicaid participation, a federal investigation, and possible prosecution in suspected cases of fraud.

32.12.2 Types of Review Conducted by BCSS

Types of reviews conducted by BCSS include the following:

- Annual licensure for case management agencies,
- Enrollment of waiver direct service providers,
- Annual 5% Sample plus High risk recipients (Quality Focus),
- Complaint investigations,
- Critical incident investigations,
- Mortality case reviews, and
- Consumer satisfaction interviews.

32.12.2.1 On-Site Reviews

On-site reviews are conducted by BCSS regional staff on no less than a semi-annual basis but may be more frequent as a result of complaint investigation, critical incident investigations, and/or consumer satisfaction surveys.

An on site review is scheduled with the case management agency, the direct service provider and the recipient. The on-site reviews are conducted by BCSS Regional Monitor Teams.

In some instances, other state agencies may participate as part of the Monitoring Team (such as representatives from Louisiana's Adult, Child or Elderly Protection Services, representatives from the Office for the Citizens with Developmental Disabilities, and/or representatives from the Department of Education.

32.12.2.2 Case Management Agency Review

Licensure reviews are performed for initial licensing and annually thereafter. Licensing reviews are done in conjunction with the monitoring activities to the extent possible.

(Refer to Case Management Manual for additional information related to licensing of case management agencies by BCSS.)

Licensure Reviews include:

- A review of administrative records,
- Personnel Records,
- Training Records, and
- Other agency documents.

All attempts at scheduling annual re-licensing reviews will be made at the same time of the monitoring site visit prior to the expiration of the license. Administrative and personal record reviews will be conducted on initial licensing and license renewal, but may be included in the 5% monitoring if needed to substantiate findings of deficient practices.

In addition, administrative procedures, and record reviews, personnel and training records reviews may be required during complaint or critical incident investigations.

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

32.12.2.3 Service Provider Reviews

Service providers are reviewed for initial enrollment as a waiver service provider and annual re-enrollment thereafter. Enrollment reviews include administrative procedures and records review, personnel records review, training records review, quality assurance activities, and recipient records review. Re-enrollment reviews are conducted in conjunction with the semi-annual monitoring review to the extent possible. Service providers may also be reviewed in conjunction with complaint investigations and/or critical incidents investigations.

32.12.2.4 Personnel Record Review

The personnel records review includes review of employees' file for driver's license (if driving is part of the job description), proof of age, criminal background checks, and orientation/training records for compliance with minimum Standards for Participation (Rule, September 20, 2003).

32.12.2.5 Service Provider Staff Interviews

Service provider agency staff interviews are conducted to ensure that case managers, direct service providers, and all supervisors meet the following staff qualifications:

- Experience
- Skills
- Staff coverage
- Supervisor-case manager ratio
- Caseload/recipient assignments
- Supervision documentation and,
- Other requirements as stated in the Standards for Participation.

32.12.2.6 Recipient/Guardian/Authorized Representative Interviews

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

- A representative sample (2% sample of the total number recipients served) by each provider agency;
- Members of the recipient's circle or network of support, which may include family and friends;
- Service providers; and,
- Other members of the recipient's community. This may include case managers, case manager supervisors and other employees of the case management provider.

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

32.12.2.7 Recipient Record Review

Record reviews are performed at the case management agency and service provider agency to evaluate the quality of services and supports delivered to waiver recipients and to assure services are rendered according to the recipient's CPOC. The primary focus is placed on the outcomes to the waiver recipient.

Recipient's records will be reviewed to ensure that the activities of the provider agency are associated with the appropriate services of intake, ongoing assessment, planning (development of the CPOC), transition/closure, and that these activities are effective in assisting the recipient to attain or maintain the desired personal outcomes. The case record must indicate how these activities are designed to accomplish desired personal outcomes or how these activities are associated with personal outcome measures leading to the desired personal outcomes of the recipients served.

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

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

32.12.2.8 Monitoring Protocol

BCSS Regional Monitoring Team will monitor service providers for compliance with the Standards for Participation (Rule, *Louisiana Register*, September 20, 2003) with the option to expand/extend the survey if substantial non-compliance or the suspicion that substantial non-compliance exists.

32.12.2.9 Focus Review for Core Standards/Case Management Requirements

Core provider standards or core case management requirements are those determined to be the minimum compliance requirements that must be met by all waiver provider agencies. The core requirements for case management agencies are found in the licensing rule, September 20, 1994.

- The monitor reviews the clinical records and interviews agency staff to determine compliance with core standards or core case management requirements.

- If the provider agency is determined to be out of compliance with the core standards/core requirements, the monitors shall decide to extend the review to include all the standards for participation by waiver direct service providers, or conduct a full survey of the case management agency.
- The monitor may decide to expand the sample to identify a pattern of repeated deficiencies, if necessary to determine if an extended review is needed.

32.12.2.10 Partial Extended Review

The Partial Extended Review is primarily used in investigations of complaint and/or critical incident investigations. This review focuses on the provider standards or case management requirements relative to the allegations or the type of incident. This review shall include core standards or core case management requirements and may include any one or all-pertinent standards/requirements.

32.12.2.11 Full Reviews

Initial enrollment of direct service providers and initial licensure of case managers require a full review. Also, a full review shall be conducted as a result of the monitoring team's decision to extend the survey when significant number of deficiencies or deficiencies impacting the health, safety, or welfare of waiver recipients is identified.

32.13 QUALITY IMPROVEMENT PLAN

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

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

32.13.1 Provider Self-Evaluation

The purpose of the self-evaluation is to assess the presence of personal outcomes, as defined and prioritized by the recipient/guardian, as well as the presence of required case record documentation in a representative sample of recipients served by each employee. The self-evaluation is also used for the agency to otherwise prepare for the on-site review by the BCSS Quality Management staff and representatives of DHH Research and Development Section. The self-evaluation must be based on the process for interviewing people and determining the presence of personal outcomes in accordance with the recognized national standard model on outcome measures approved by BCSS.

32.13.1.1 Components of the Provider Self –Evaluation

- The self-evaluation must include:
- Interviews by the case management agency or direct service provider agency with the recipients in the representative sample,
- Interviews by the case management agency and direct service provider agency with others who know the recipient best (family, friends, service and support providers, professionals, other members of the recipient’s network of support), and
- A review of the case records of the recipients in the representative sample.

32.13.1.2 Self Evaluation Requirements

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

32.13.1.3 Report of Self-Evaluation Findings

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

DHH-Office of the Secretary
Bureau of Community Supports and Services
446 N. 12th Street
Baton Rouge, LA 70802

- The initial self-evaluation is completed six (6) months after approval of the initial plan and then once a year after the first report.
- This report must include:
 - A description of the personal outcomes defined and prioritized by each of the recipients in the representative sample;
 - Assessment of the existence of required case record documentation in the representative sample; and
 - Written request or plan to acquire any needed technical assistance, training and/or support.

A sample of recipients included in the case record review is also surveyed to determine their satisfaction with the case management agencies and direct service providers. This part of the monitoring of the agency is to determine if the case management or direct service provider is meeting the needs of its recipients.

If the findings of the case management or direct service provider agency self-evaluation indicate that the agency is not working toward personal outcome requirements and/or case record documentation requirements, the self-evaluation report must also include a Quality Improvement Plan describing how the agency will address issues with individual case managers or direct service staff to make systematic efforts to meet the personal outcome and case record documentation requirements.

32.13.1.4 Monitoring Report

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

The monitoring report includes:

- Identifying information includes demographics of the agency,
- Specific strengths and deficiencies identified in the review, including the presence of personal outcomes in the representative sample of recipients interviewed by the BCSS Quality Management staff,
- Recommended corrective action, and
- Deficiencies requiring corrective action by the case management or direct service provider agency listed in order of severity in the report.

- Although the monitoring report has an educational component, any inappropriate reimbursement for possible recoupment action is identified in the report.
- The BCSS Quality Management staff will review the reports and assess any sanctions or liquidated damages as appropriate.

32.13.1.5 Corrective Action Report

The case management or direct service provider agency is required to submit a Plan of Correction (POC) to BCSS within **30 working days of the receipt of the report**. The Plan of Correction must address the following:

- What corrective actions will be accomplished for each citation, time lines for making the correction, and who within the agency is responsible for assuring the corrective action is taken;
- How other recipients, being served by the agency, who may have the potential to be affected by the deficient practice will be identified and correction action taken on their behalf;
- The measures that will be put into place or the systemic changes that will be made to ensure that the deficient practice does not recur; and
- How the corrective action will be monitored to ensure the deficient practice will not recur, such as addition to the agency's Quality Assurance/Quality Improvement Criteria.
- The provider agency is afforded an opportunity to rebut the BCSS monitoring findings through informal mediation.
- Upon receipt of the written Plan of Correction (POC), the BCSS Quality Management staff reviews the agency's plan within **90 days** to assure that all findings of deficiency have been adequately addressed. If all deficiencies have not been addressed, the BCSS Quality Management staff responds to the provider requesting immediate resolution of those deficiencies in question.
- A follow-up monitoring visit may be conducted when serious deficiencies have been found to ensure that the provider has fully implemented the plan of correction.

32.13.1.6 Mediation (Optional)

In the course of monitoring duties, an informal hearing process may be requested. The case management agency or service provider agency is notified of the right to an informal hearing in correspondence that details the cited deficiencies.

The informal hearing is optional on the part of the case management agency or service provider agency and does not limit the right of the case management agency or service provider agency to a formal appeal hearing. In order to request the informal hearing, the case management agency or service provider agency should contact the Quality Management Administrator at

BCSS Quality Management Section
ATTN.: Informal Discussion
446 N. 12th Street
Baton Rouge, LA 70802
(225) 219 – 0643

Every effort will be made to schedule a hearing at the convenience of the case management agency or service provider agency. However, the request must be made within the time limit given for the corrective action recommended by the BCSS.

The case management agency or service provider agency is notified of time and place where the informal hearing will be held. The agency should be prepared to present all documentation supporting their position.

The BCSS Quality Management Program Manager solicits representation from other sections within the BCSS as well as other persons within BHSF to participate in the informal hearing process.

The BCSS Quality Management Program Manager facilitates the informal hearing. The case management agency or service provider agency is given an opportunity to present its case and to explain its disagreement with the monitoring findings, and/or to present new information. .

The case is discussed and the decision will be sent to the case management agency or service provider agency in a written response. There is no appeal of the informal hearing decision; however, the agency may appeal the original findings to the DHH Bureau of Appeals.

32.13.2 Fraud and Abuse

When BCSS Quality Management staff suspects patterns of abusive or fraudulent Medicaid billing, the service provider will be referred to the Program Integrity Section of the Medicaid Program for investigation. Specific information regarding fraud, abuse is found in Section 10 of this manual.

DHH has an agreement with the Attorney General's Office, which provides for the Attorney General's office to investigate Medicaid fraud. The Office of the Inspector General, Federal Bureau of Investigation (FBI), and Postal Inspectors also conduct investigations of Medicaid fraud.

32.13.3 Immediate Jeopardy

Immediate jeopardy is a situation in which the provider's non-compliance with one or more standards of care and/or provider regulations has caused or is likely to cause serious injury, harm, impairment or death to the recipient.

These situations include physical abuse, sexual abuse, neglect and failure to protect the recipient from psychological harm, failure to protect the recipient from undue adverse medication consequences, failure to ensure adequate nutrition and hydration to the recipient, failure to practice standard precautions to protect from infection, and failure to plan for medical emergencies for recipients with known high risk medical conditions.

32.14 CONSUMER DIRECTION INITIATIVE SERVICE DESCRIPTION

32.14.1 Services Description

For many citizens with developmental disabilities and their families, a new approach for increasing their quality of life while addressing financial considerations will be offered as a waiver payment option in the Consumer Direction Initiative of the New Opportunities Waiver (NOW). This new initiative will be implemented through a three-year phase-in process with 250 participants. The data collected through the first three years of the phase-in will be used to create a basis for systems changes in Louisiana's Home and Community-Based Waivers. The DHH Regions involved in this initiative are 1, 2, and 9.

Participation in Consumer Direction is voluntary for the individual or his/her authorized representative. This initiative enables the participant and/or authorized representative the right to choose what services and/or supports best fit their individual needs through the person-centered planning process and where those services will be delivered. In addition, participating waiver recipients will have the right to hire, fire, train and schedule workers who are expected to provide the necessary direct services (e.g., personal assistant, home-health skilled nurse, contractor, social worker, psychologist, broker, etc). A required component of this option will be the use of fiscal agents to provide financial services and supports to participants who opt for the Consumer Direction Initiative. Fiscal agents will be contracted to provide functions on behalf of the participants, such as: training for participants and direct service providers regarding Consumer Direction; disbursement of public and private funds; monthly financial statements; audit reports; fiscal conduit; and generally be accountable for the individual's budget.

Case management services are utilized for supports brokerage; plan of care and individual budget development, advocacy, organizing the unique resources that the person needs, and for ongoing evaluation of the supports and services.

32.14.2 Service Authorization

BCSS Regional Office sends all approvals on Initial/Annual CPOCs and Revisions for prior authorization as follows:

- For initial CPOCs the cover page, budget pages, approval signature page, 18W, and 51NH are sent for authorization.
- For Revisions the approved budget sheets are to be sent for authorization.
- For Annual CPOCs the cover page, budget pages, approval signature page are to be sent for authorization.

Direct services will be authorized on the CPOC year begin date unless a later date is indicated on the CPOC budget page but will never be prior to the vendor payment begin date on the 51NH. Only those services in the BCSS approved CPOC shall be authorized.

**Services shall not be reimbursed prior to the
Vendor Payment Begin Date on the 51NH.**

Authorizations will be issued in quarterly intervals directly to the provider and the last authorization will end on the CPOC end date.

Authorizations for annual CPOCs will be issued upon receipt of the annual CPOC.

32.15 BILLING RESPONSIBILITIES OF THE PROVIDER

The service provider should:

- Ensure all data provided to the case manager that is in the CPOC is correct.
- Immediately check their prior authorizations to see that all prior authorization for services match the approved services in the CPOC. Any mistakes that either under authorize or over authorize services shall be corrected to match the CPOC approved services. ONLY services in the BCSS approved CPOC shall be authorized.
- If there is an error in the CPOC, the service provider must go through the case manager to correct the CPOC and BCSS Regional Office must approve all changes.

Then the forms will go through the authorization process again.

- Before billing:
 - Review the Direct Service Worker timesheet to ensure the services delivered are in the BCSS approved CPOC and/or revisions
 - Bill only the amount of services that were documented as provided (as evidenced by the timesheets and case record notes) and **ONLY** if they are within the approved services in the CPOC make sure you bill with the correct span dates, authorization number, provider number, recipient # as indicated on the authorization
 - Reconcile all Remittance Advice's issued by Unisys with each payment.
 - Check each recipient billing to see that payment was given.

Service Providers have a one-year timely filing requirement under Medicaid regulations. This means that the service provider has up to one year to bill for prior authorized services delivered in accordance with the BCSS approved CPOC.

32.16

GLOSSARY

Abuse¹ - Inappropriate use of public funds by either providers or recipients, including practices which are not criminal acts and which may even be technically legal but still represents the inappropriate use of public funds.

Abuse² - Is the infliction of physical or mental injury on a recipient by other parties, including, but not limited to, such means as sexual abuse, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well being is endangered. (La. R.S. 14:403.2)

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

Agency -The legal entity enrolled to provide services under the approved Louisiana NOW. Both public and private agencies are eligible to provide waiver services.

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

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

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

APS - Adult Protective Services.

Assessment¹: A comprehensive process to collect, analyze and interpret information about an individual for the purpose of making decisions concerning the services and supports to address then person's needs.

Assessment²: - For purposes of case management, the process of gathering and integrating formal/professional and informal information concerning a recipient's goals, strengths, and needs necessary to develop a service plan.

Authorized Representative - The Consumer may select a representative (advocate) to speak on his/her behalf and who enters into the Consumer Direction Agreements on behalf of the waiver consumer.

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

Bureau of Community Supports and Services (BCSS) - The BCSS is responsible for directing the coordination and approval of all services and supports necessary for the planning development, and evaluation of all Home and Community Based supports and service offered through the Waivers and targeted populations approved by Centers for Medicare and Medicaid Services (formerly known as HCFA).

Case Management - Services provided to eligible recipients to help them gain access to the full range of needed services including medical, social, educational, and the other support services. This definition adapted from P.L. 100-203 (g)(2) and Section 4302A of the *State Medicaid Manual*. Case management is a necessary component in the management of services under this waiver, and provider agencies are licensed by BCSS. Case management, how ever, is not a waiver service.

Case Management-Supports Brokerage - Encompasses assessment, service planning, referral and monitoring services for the individual receiving waiver services.

Case Manager - Individual meeting qualifications as required by DHH who is employed by a qualified provider agency that provides case management services.

Centers for Medicare and Medicaid Services (CMS)-The Federal agency in DHHS responsible for administering the Medicaid Program and overseeing and monitoring the State's Medicaid Program. Previously named Health Care Financing Administration (HCFA).

Change of Ownership (CHOW) - Any change in the legal entity responsible for the operation of a provider agency.

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)

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

Consumer Direction - A voluntary waiver recipient or his/her authorized (appointed) representative has the right to choose services and/or supports which best fit their individual needs through the person-centered planning process. A fiscal agent must be contracted to provide certain functions on behalf of the consumer such as budget preparation and management.

Consumer - For the purposes of this policy, a consumer means the individual receiving waiver services and supports.

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

Corrective Action Plan - Written description of action a case management provider agency plans to take to correct deficiencies identified by the provider's Quality Improvement Planning Committee or by BCSS Regional staff.

Comprehensive Plan of Care (CPOC)- The CPOC is a person-centered planning process designed cooperatively by the case manager, the recipient and other persons invited by the recipient, who may include family members, a provider, appropriate professionals, and others who know the recipient best. The recipient's BCSS approved CPOC shall reflect only the services needed. The BCSS approved CPOC will contain all paid and unpaid natural support services that are necessary to assist the recipient in his/her residence and promote greater independence. Payment shall be made for only those approved services received by the recipient.

Crossover Medicare/Medicaid Claims - Claims received on a Medicaid-eligible recipient who has both Medicare and Medicaid coverage. (Medicare does not pay for case management services.)

Diagnosis and Evaluation (D&E) - A process conducted by an appropriate professional to determine the level of disability of the recipient and make recommendations for remediation.

De-certification - Removal from the waiver by BCSS subsequent to review by the Service/Peer Review Panel.

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

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

Department of Social Services (DSS) - The state agency responsible for administering social services including Family Independence Temporary Assistance Program (FITAP), Food Stamps, children's protective services, foster care and vocational rehabilitation services.

Developmental Disability (DD) -

Defined in La. R.S. 28:380 as amended in 1983 as a severe chronic disability of a person which is attributable to:

- Mental retardation, cerebral palsy, epilepsy; or autism OR,
- Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, or requires treatment or services similar to those required for these persons; AND,
- Which is manifested before the person reaches age 22; AND,
- Which is likely to continue indefinitely; AND,
- Which results in substantial functional limitations in three or more of the following areas of major life activity: Self-care, Understanding and use of language, Learning, Mobility, Self-direction, Capacity for independent living?

Direct Service Provider (DSP) - Medicaid enrolled agency that provides needed services including medical, social, educational and other support services to eligible recipients.

Direct Support - An individual who provides hands -on services and active supports to a recipients.

Discharge - Removal from the waiver for reasons established by BCSS.

Durable Medical Equipment (DME) – Covered durable medical equipment covered under the Medicaid State Plan.

Eligibility - The determination of whether or not a recipient qualifies to receive case management services based on meeting established criteria for the target or waiver group set by DHH.

Enrollment - The process of executing a contract with a potential provider for participation in the Medicaid program if the agency meets the necessary requirements. Also referred to as provider enrollment or certification.

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

Fiscal Agent (FA) - An organization or entity that assists a recipient or the recipient's family to manage and distribute funds allocated for services.

Fiscal Intermediary (FI) - The entity that DHH contracts with to pay the Medicaid claims. Refer to MMIS.

Freedom of Choice (FOC) - The process that allows an individual to review all case management agencies and provider agencies and to select their case management agency and provider agency.

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

HIPAA - Health Insurance Portability and Accountability Act

Home and Community-Based Services (HOME AND COMMUNITY BASED SERVICES) - A collection of waiver services available in a community setting to enable recipients who qualify for institutional care to remain in their own home or community based setting. These are administered under a special Medicaid program and provided by BCSS.

ICF/MR - Intermediate Care Facility/Mentally Retarded

Individual Budget - An amount of dollars over which the recipient or his/her family (as appropriate) exercised decision-making authority concerning the selection of services, service providers, and the amount of services.

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

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

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

Licensure¹ - A determination by the DHH/BCSS that a case management provider agency meets the state requirements to provide client care services, specifically, case management/service coordination services.

Licensure² - A determination made by the Division of Licensing and Certification, Department of Social Services that a service provider meets the requirements of State law to provide services.

Linkage - A core element of case management defined as implementation of the service plan and arranging of a continuum of formal/professional and informal services to be provided to the recipient.

LOC - Level of Care - The level of care for the NOW is an ICF/MR, which is Intermediate Care Facility for the Mentally Retarded.

LTC - Long Term Care.

MD - Medical Doctor

Medicaid/Medicaid Program - Medical assistance provided under the State Plan approved by the Center for Medicare and Medicaid Services (CMS) under Title XIX of the Social Security Act, and under approved waivers of the provisions of that law.

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.

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

New Opportunities Waiver (NOW) - Mental Retardation/Development Disability Waiver program providing 10 services not available to other Medicaid recipients in lieu of providing institutional care to individuals of any age meeting the federal definition for mental retardation or a developmental disability and who meet certain financial criteria.

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)

Monitoring - The ongoing oversight of the provision of home and community-based services and other services in order to determine that they are furnished according to the recipient's plan of care and effectively meet his/her needs, including health and welfare. It is also an element of case management, which refers to the follow-up mechanism to assure applicability of the service plan. BCSS Regional staff is responsible for performing on-site reviews of case management providers to determine compliance with Medicaid policies and procedures

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

Multi-disciplinary Evaluation (MDE) - The testing of an infant or toddler by a group of professionals including infant development specialists, speech therapists, physical therapists, occupational therapists, social workers, nurses, etc.

Neglect - Is the failure, by a caregiver responsible for an adult's care or by other parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 14:403.2).

NOW - New Opportunities Waiver

OCDD - Office for Citizens with Developmental Disabilities (previously the Office of Mental Retardation/ Developmental Disabilities). The Office in DHH responsible for services to developmentally disabled citizens in Louisiana.

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

PA - Prior Authorization is the authorization for service delivery, based on the BCSS approved CPOC and sent to providers and must be obtained before any services can be provided.

Recipient/Participant - An individual who is eligible for Medicaid and waiver services and supports through the Bureau of Community Supports and Services.

Person-Centered Assessment - The process of gathering and integrating formal and informal information relevant to the individual personal outcomes for the development of an individualized CPOC.

Person-Centered Planning Team - A team comprised of the recipient, recipient's family, case manager, direct service providers, medical and social work professionals as necessary, and advocates, who determine needed supports and services to meet the recipient's identified personal outcomes. For medical and social work professionals, participation may be by report.

Person-Centered Planning - A process directed by the recipient or the recipient's family (when appropriate) that is intended to identify the strengths, capacities, preferences, needs and desired outcomes of the recipient.

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

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 lives.

Plans of Correction - (POC) are developed by a provider in response to deficient practice citations. Required components of the POC include the following:

- What corrective actions will be accomplished for those waiver recipients found to have been affected by the deficient practice;
- How other individuals 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-cert Home Visit – The visit the Regional BCSS office makes to an individual’s home prior to certifying them for NOW services.

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

Provider Agreement - A contract between the provider of services and the Bureau of Health Services Financing that specifies responsibilities with respect to the provision of services and payment under the Title XIX Medicaid Program.

Provider - Any individual or entity furnishing Medicaid services under a provider agreement with DHH.

Provider Enrollment - Another term for enrollment.

QA/QE - Quality Assurance/Quality Enhancement Program - 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, special studies and peer reviews.

QI - Quality Improvement.

Quality Management - The section of BCSS whose responsibilities include the constellation of activities undertaken 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.

Recipient/Participant - Any individual who has been determined eligible for Medicaid. See definition on page 32-101.

Recipient/ Legal Guardian - The individual receiving services, or the responsible party, or a parent. All references to recipient include the parent or Legal guardian if the recipient has been interdicted or is a minor.

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

Request for Services Registry (RFSR) - The process by which an individual verifies their desire to participate in the NOW program.

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

RN - Registered Nurse.

Secretary - The Secretary of the Department of Health and Hospitals.

Self-Neglect - Is the failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 14:403.2)

Self-Determination:

Principles of Self-Determination:

Freedom to live a meaningful life in the community

Authority over dollars needed for support

Support to organize resources in ways that are life enhancing and meaningful

Responsibility for the wise use of public dollars

Confirmation of the important leadership that self advocates must hold in a newly designed system.

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

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.

SOE - Statement of Eligibility or Summary of Evidence

SPOE - Single Point of Entry.

SSA - Social Security Administration.

SSN - Social Security Number.

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

Title XIX - The section of the Social Security Act, which is applicable to Medicaid services.

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

UR - Utilization Review.

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.

APPENDIX A-Now CPOC Forms

Instruction for CPOC Forms

CPOC Revision Request

Sensitive Information Forms

Consent for Authorized Representation

Transition “Walk Over” Forms

Now Transitional Expense and Planning

Replacement PA Request Environmental

Documentation For Authorization of Shared Staff

Accessibility Modification Job Completion Form

People First Language

**APPENDIX B-
Procedure Codes and Rates**

