



# **SUPPORTS WAIVER**

*Chapter Forty-three of the Medicaid Services Manual*

**Issued June 10, 2011**

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

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## OVERVIEW

The Supports Waiver (SW) is a 1915(c) waiver designed to enhance the home and community-based supports and services available to recipients with developmental disabilities who require the level of care of an Intermediate Care Facility for the Developmentally Disabled (ICF/DD). The SW is funded by the Centers for Medicare and Medicaid Services (CMS), a federal agency, and matching state dollars. The waiver is operated by the Office for Citizens with Developmental Disabilities (OCDD) under the authorization of the Bureau of Health Services Financing (BHSF), both of which are under the Louisiana Department of Health and Hospitals (DHH).

The mission of the SW is to create options and provide meaningful opportunities for those individuals, 18 years of age and older who have a developmental disability, through vocational and community inclusion. The SW is available to provide the supports necessary in order for individuals to achieve their desired community living and work experience by providing the services needed to acquire, retain, and/or improve self-help, socialization and adaptive skills as well as providing the recipient an opportunity to contribute to his/her community.

The objectives of the SW are to:

- Promote independence for recipients through the provision of services, which meet the highest standard of quality and are based on national best practices, while ensuring their health and welfare through a comprehensive system of safeguards;
- Offer an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing (not replacing) existing informal networks;
- Support recipients and their families to exercise their rights and share responsibility for their programs, regardless of the service delivery method;
- Offer access to services on a short-term basis that would protect the health and welfare of recipients if their families or caregivers are unable to continue to provide care and supervision; and
- Increase high school to community transition resources by offering supports and services to those 18 years and older.

The SW includes the following services: Supported Employment, Day Habilitation, Prevocational, Habilitation, Respite, Housing Stabilization Transition, Housing Stabilization, Personal Emergency Response System, and Support Coordination. These services are further defined in this chapter. Recipients have a choice of available Support Coordination (SC) agencies and provider agencies and are able to select enrolled qualified agencies through the Freedom of Choice (FOC) process. The Plan of Care (POC) is developed using a person-centered planning process and identifies all of a recipient's needs, both non-funded and funded.

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All natural supports, available community resources, and applicable Medicaid State Plan services must be exhausted prior to utilization of waiver funding. Also, the recipient must apply for, and exhaust any similar services available through Louisiana Rehabilitation Services (LRS) or the Individuals with Disabilities Education Act (IDEA) if the recipient meets the criteria for the programs.

Providers are required to follow the regulations and requirements as specified in this chapter, the Supports Waiver Rule (Louisiana Register, Volume 32, Number 09), the Standards for Participation Rule for home and community-based waiver providers (Louisiana Register, Volume 29 Number 09) and all applicable licensure and/or certification requirements.

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**RECIPIENT REQUIREMENTS**

To qualify for the Supports Waiver (SW), a person must be 18 years of age or older, be offered a waiver opportunity slot and meet all of the following eligibility criteria:

- Be a citizen of the United States or qualified alien, and be able to provide original or certified copies of documents as evidence;
- Be a resident of Louisiana;
- Meet the Developmental Disability Law criteria as defined in Appendix A,
- Have his/her name on the Developmental Disabilities Request for Services Registry (DDRFSR) for the SW;
- Meet financial eligibility for the Medicaid program as defined in the home and community-based waiver group, which includes individuals whose income level equals 300% of the Supplemental Security Income (SSI) Federal Benefit Rate (FBR);
- Meet the medical requirements;
- Meet the requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) level of care, which requires active treatment of developmental disabilities under the supervision of a qualified developmental disability professional; and
- Meet the health and welfare requirements.

To remain eligible for waiver services, a recipient must receive one or more waiver services every 30 days.

**Request for Services Registry**

Enrollment in the waiver is dependent upon the number of approved and available funded waiver slots.

Individuals who request waiver services are placed on a statewide Developmental Disabilities Request for Services Registry (DDRFSR) and are selected for a waiver opportunity in the date order in which they applied. Requests for waiver services must be made from the applicant or his/her authorized representative by contacting the applicant's local Human Services Authority or District, hereafter referred to as the local governing entity (LGE).

**Note:** Exceptions include people who qualify for the SW program through emergency placements or other designated placements.

Once it has been determined by the LGE that the applicant meets the definition of a developmental disability as defined by the Louisiana Developmental Disability Law (see

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

**Inactive Status**

An applicant may choose to be placed in an inactive status on the DDRFSR by notifying the LGE. When the applicant determines that he/she is ready to begin the SW evaluation process, he/she must request in writing to the LGE that his/her name be removed from inactive status. The applicant's original request date will be reinstated and he/she will be notified when the next SW opportunity becomes available.

**Verifying Request Date**

Applicants or their authorized representatives may verify their request date by calling their LGE.

**Level of Care**

The SW program is an alternative to institutional care. All waiver applicants must meet the definition of developmental disability (DD) as defined in Appendix A. The LGE will issue either a Statement of Approval (SOA) or a Statement of Denial (SOD).

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

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



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**RIGHTS AND RESPONSIBILITIES**

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

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

**Freedom of Choice**

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

**Notification of Changes**

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

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

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

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**Participation in Care**

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

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

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

**Freedom of Choice of Support Coordination and Service Providers**

Support coordinators should be aware that at the time of admission to the waiver and every six months thereafter, recipients have the opportunity to change support coordination providers, if one is available. Recipients may request a change by contacting the local Human Services Authority or District hereafter referred to as the local governing entity (LGE).

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

**Voluntary Participation**

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

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**Compliance with Civil Rights**

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

**Quality of Care**

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

**Grievances/Fair Hearings**

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

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

**Rights and Responsibilities Form**

For a complete list of the recipient's rights and responsibilities, refer to Appendix D. The support coordinator must review these rights and responsibilities with the recipient and his/her authorized representative as part of the initial intake process into waiver services.

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**SERVICE ACCESS AND AUTHORIZATION**

When funding is appropriated for a new Supports Waiver opportunity or an existing opportunity is vacated, the next individual on the Request for Services Registry (RFSR) will receive a written notice indicating that a waiver opportunity is available. That individual will be evaluated for a possible Children's Choice Waiver opportunity assignment.

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

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

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

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

**Provider Selection**

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

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The support coordinator is responsible for:

- Notifying the provider that the recipient has selected their agency to provide the necessary service,
- Requesting the provider sign and return the
  - Provider Agreement form,
  - Emergency plan, and
  - Individualized staffing back-up plan.
- Forwarding the POC packet to the local Human Services Authority or District hereafter referred to as the local governing entity (LGE) for review and approval.

**NOTE:** The authorization to provide service is contingent upon approval by the LGE.

**Prior Authorization**

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

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

PA revolves around the POC document and any subsequent revision, which means that only the service codes and units specified in the approved POC will be considered for PA. Services provided without prior authorization are not eligible for reimbursement.

The service provider is responsible for the following activities:

- Checking PAs to ensure all PAs for services match the approved services in the recipient's POC. Any mistakes must be immediately corrected to match the approved services in the POC.

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

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

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

**Post Authorization**

To receive post authorization, a service provider must enter the required information into the billing system maintained by the Medicaid data contractor. The Medicaid data contractor checks the information entered into the billing system by the service provider against the prior authorized unit(s) of service. Once post authorization is granted, the service provider may bill the DHH FI for the appropriate unit(s) of service. Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

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**Changing Direct Service Providers**

Recipients/families may change direct service providers once every twelve months. All requests for changes in services and/or service hours must be made by the recipient/family.

Direct service providers may be changed for good cause at any time as approved by the LGE.

Good cause is defined as:

- A recipient/family moving to another region in the state where the current direct service provider does not or cannot provide services,
- The recipient/family and the direct service provider have unresolved difficulties and mutually agree to a transfer,
- The recipient's health, safety or welfare have been compromised, or
- The direct service provider has not rendered services in a manner satisfactory to the recipient/family.

The recipients/families must contact their support coordinator to change direct service providers. The support coordinator will assist in facilitating a team meeting involving the current direct service provider(s) if agreed to by the recipient/family. This meeting will address the reason for wanting to terminate services with the current service provider(s). Whenever possible, the current service provider will have the opportunity to submit a corrective action plan with specific time lines, not to exceed 30 days to attempt to meet the needs of the recipient.

If the recipient/family refuses a team meeting, the support coordinator and the LGE determines that a meeting is not possible or appropriate, or the corrective action plan and timelines are not met, the support coordinator will:

- Provide the recipient/family with the current FOC list of service providers in his/her region,
- Assist the recipient/family in completing the FOC and release of information form,
- Ensure the current provider is notified immediately upon knowledge of the request and prior to the transfer,
- Obtain the case record from the releasing provider which must include:

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- Progress notes from the last six months, or if the recipient has received services from the provider for less than six months, all progress notes from date of admission,
- Written documentation of services provided, including monthly and quarterly progress summaries,
- Current POC,
- Records tracking recipient’s progress towards POC goals and objectives,
- Behavior management plans, current and past if applicable,
- Documentation of the amount of authorized services remaining in the POC, including applicable time sheets, and
- Documentation of exit interview.

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

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

**NOTE:** Transfers must be made at least seven days prior to the end of the service authorization quarter. The start date should be effective the first day of the new quarter in order to coordinate services and billing. The LGE may waive this requirement in writing due to good cause, at which time the start date will be the first day of the first full calendar month.

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

**Prior Authorization for New Service Providers**

The support coordinator will complete the POC revision form with the start date for the new provider and the end date for the transferring provider and submit the revision request to the LGE for approval.

Upon approval, a new PA number will be issued to the new provider with the effective starting date. The transferring agency’s PA number will expire on the date immediately preceding the PA date for the new provider.



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

Exceptions to the existing service provider end date and the new service provider begin date may be approved by the LGE when the reason for the change is due to good cause.

**Changing Support Coordination Agencies**

A recipient may change support coordination agencies after a 12-month period or at any time for good cause if the new agency has not met their maximum number of recipients. Thereafter, a recipient may request a change in support coordination agencies every 12 months. Good cause is defined as:

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

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

**Changes in Authorized Services**

Any change or revision to the POC must be prior approved by the LGE. Requests for changes to the POC must be made by the recipient/family to the support coordinator. Changes will not be made solely on the request of the service provider.

The recipient/family may not authorize services or authorize direct service workers to work hours or services not included in the approved POC.

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**COVERED SERVICES**

Support Waiver services are designed to enhance the recipient's independence through involvement with employment and other community activities. All services must be based on need documented in the approved Plan of Care (POC), and provided within the state of Louisiana. The services that are available include: Supported Employment, Day Habilitation, Prevocational, Respite, Habilitation, Personal Emergency Response System (PERS) and Support Coordination. The services are described in detail below.

**Supported Employment**

Supported Employment (SE) is intensive, ongoing supports and services necessary for a recipient to achieve the desired outcome of employment in a community setting where the majority of the persons employed do not have disabilities. Recipients utilizing SE services may need long-term supports for the life of their employment due to the nature of their disability and where natural supports would not meet their needs.

SE services are available for Individual, Self-Employment or Microenterprise, or Group Employment in the following areas:

- Job assessment, discovery and development; and
- Initial job support and job retention.

Job assessment, discovery and development is the process of:

- Identifying specific career interests of a recipient;
- Identifying appropriate community employment options that match information gained from a recipient's assessment, profile and/or plan;
- Ensuring the identified position will meet the occupational, physical and financial requirements of the recipient; and
- Assisting the recipient and employer in achieving a successful job match, placement, and sustaining employment.

**Job Assessment**

Job assessment is the evaluation of a recipient's skills and interests, and consists of one or more of the following activities:

- Vocational assessments to determine a person's career interests
- Job analysis
- Community-based situational assessments

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- Facility-based situational assessments
- Recipient profile
- Placement plan
- Assisting with personal care in activities of daily living

**NOTE:** Work activity training and work hardening skills training are prevocational services.

Job assessment will not be authorized for services that prepare a recipient for paid or unpaid employment in the community. This includes teaching concepts such as compliance, attendance, task completion, problem-solving and safety that are associated with performing compensated work, as well as, activities aimed at a generalized outcome.

**Documentation Requirements**

To receive post-authorization for job assessment, one or more of the following documents must be submitted to the recipient's support coordinator for approval:

- Completed vocational assessment
- Completed job analysis
- Notes from community-based/facility-based situational assessments
- Recipient profile
- Placement plan

Approval of job assessment documents submitted will be based on the following information:

- The objectives and time lines outlined in the Individualized Service Plan (ISP) were met timely;
- Basic requirements of the job are identified in the document. These requirements must include, but are not limited to:
  - Identification of specific career interest(s)
  - Maximum hours per week and times of day recipient will consider working
  - Minimum rate of pay recipient will accept
  - Benefits recipient receives that might impact earnings, in particular SSI and/or Social Security Disability Insurance (SSDI) benefits
  - Areas of town, city or parish(s) recipient will consider working
  - Transportation currently available to recipient
  - Current work strengths/skills that will help recipient obtain job of his/her choosing
  - Current barriers to recipient obtaining job of his/her choosing; and

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- The staff ratio needed to support the recipient, group employment is the career outcome.

**Job Discovery and Development**

Job discovery and development consists of one or more of the following activities:

- Marketing agency services to employers that match the recipient's interest in order to establish business relationships that could result in job opportunities for the recipient
- Assisting the recipient to make use of all available job services through one-stop career centers
- Contacting specific employers whose business matches the recipient's career interests, or who are advertising for open positions through newspaper advertisements, websites, or word of mouth
- Assisting the recipient in creating a resume
- Assisting the recipient in preparing for a job interview
- Transporting the recipient to a job interview
- Accompanying the recipient to a job interview if requested to do so
- Referring recipient to work incentives, planning and assistance representatives when necessary, or as requested
- Reconfiguring an existing position to fit the employer and recipient's needs, also known as job restructuring
- Consulting and/or negotiating as needed and/or requested with employer on rate of pay, benefits, and employment contracts
- Restructuring a work site to maximize a recipient's ability to perform the job, also known as job accommodations
- Training to enable a recipient to independently travel from his/her home to place of employment
- Providing employee education and training as requested by employer on disability issues
- Providing employers with information on benefits available when hiring a person with a developmental disability such as on the job training (OJT) or Work Opportunities Tax Credit (WOTC)
- Assisting with personal care activities of daily living.

The following activities in addition to the activities listed above may be included for self-employment/microenterprise:

- Coordinating access to grants and other resources needed to begin and/or sustain the enterprise

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- Identifying equipment and supplies needed
- Facilitating consultation with groups able to offer guidance such as Louisiana Economic Development and the Small Business Administration
- Assisting with creation of a business plan
- Facilitating interactions with required legal entities such as necessary business licensing agencies, fire marshals and building inspectors; and
- Assisting with hiring, training and retaining appropriate employees.

**NOTE:** Funds for self-employment may not be used to defray any expenses associated with setting up or operating a business.

**Documentation Requirements**

The following documentation reflecting the recipient's choice of occupation as documented on the ISP must be submitted to the recipient's support coordinator for approval. **These elements can be listed or contained in a narrative report:**

- All objectives and timelines related to job discovery and development outlined in the ISP were met timely. If changes were made, the revised ISP and new signature page with dates must be attached;
- Dates, times, names and addresses of companies contacted and method of contact (e.g. in-person, by phone, letter, e-mail or through employer's website);
- Job restructuring activities, including meetings specific to an identified position in a community business including date, time, and names and job titles of community business staff in attendance. If meeting(s) occurred, meeting minutes must be submitted;
- Community business education and/or trainings specific to an identified job in a community business, including date, time, names and job titles of community business staff in attendance, and content of education and/or training session(s);
- Job accommodation, travel training, and any other employment related activities specific to an identified job in a community business;
- Amount of time spent in discovery and development per day; and
- Confidentiality release forms in the recipient's native language, if applicable, that he/she approved contacts, meetings, education or training to occur in his/her absence.

The recipient may **or** may not be present during job discovery and development activities. If the recipient is not present, a signed and dated confidentiality release form must be completed.

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**Staffing Ratios for Job Assessment, Discovery and Development****Job Assessment**

The recipient **must be** present in order to receive individual, self-employment/microenterprise or group employment **job assessment services**. Job assessments must be done on a one staff to one recipient ratio. For group employment, rates for job assessment are **paid per recipient, not per group**.

**Job Discovery and Development**

Individual and group employment job discovery and development may be billed on a one staff to multiple recipient ratios. The staff ratio needed to support the recipient must be documented on the POC.

When individual job discovery and development is billed on one staff to multiple recipient ratios, post authorization documentation must show individual outcomes. For example, if an employer bills for two recipients on the same day for the same time period, post authorization documentation must show that job development efforts were made for each individual according to his/her identified specific career interests. If more than one recipient's identified career interest is childcare then billing could reflect a visit to one childcare facility on behalf of both recipients. However, if one recipient's identified career interest is childcare and the other recipient wishes to work in a medical setting, documentation must show visits to the specific type of business for each recipient.

**Service Limits for Job Assessment, Discovery and Development**

Activities will be authorized for a maximum of **120 standard units in a service year** for individual job assessment, discovery and development, and 20 standard units in a service year for group employment job assessment, discovery and development.

A standard unit of service is six or more hours per day in job assessment, discovery, and development.

Utilization of job assessment units will be counted towards the total available units for job assessment, discovery and development for a service year. Therefore, if 120 (individual job/self-employment/microenterprise) or 20 (group employment) standard units are utilized in a service year, job discovery and development could not begin until the next service year. If all available units in job assessment, discovery and development are used only for job assessment for a recipient in one service year, only job discovery and development activities and not job assessment will be authorized for the next service year.

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**Authorization of Services**

To receive prior-authorization for Job Assessment, Discovery and Development services, the portion of the ISP covering these services must be submitted to the recipient's support coordinator with measurable goals, objectives and time lines that address these services. The ISP must be signed and dated by the recipient, his/her responsible representatives and support team members indicating agreement with the goals, objectives and time lines. **The Job Assessment, Job Discovery, Job Development form must be completed** (see Appendix D).

Specific documentation that shows evidence that the goals, objectives and time lines on the ISP related to those activities have been met must be submitted to the recipient's support coordinator for post-authorization. If an objective or time line cannot be met timely, the provider must facilitate changes prior to the end date of the objectives and timelines on the ISP and obtain team members' dated signatures indicating agreement with the changes. Partial completion of job assessment, discovery and/or development of ISP objectives and timelines will **not** qualify for post authorization and payment.

**Initial Job Support and Retention**

Initial Job Support is provided to the recipient on or off the job site by provider staff. It may be intensive, intermittent, short-term and/or ongoing.

Initial job support and retention consists of one or more of the following activities:

- Provision of support at a job site by provider staff that ensures the recipient can maintain and meet the expectations of the employer;
- Assisting with personal care activities of daily living in the employment setting by provider staff;
- Face-to-face support off the job site by provider staff that is necessary for the recipient to maintain gainful employment. Examples of this kind of contact include, but are not limited to:
  - A recipient needing travel re-training to the work site due to changes in transportation;
  - A recipient needing assistance in setting up an alarm clock system at home in order to be at work on time; The recipient wishing to discuss a problem that involves personal issues that could affect his/her ability to retain the job at a place other than the work site;

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- The recipient needing assistance with completing documentation required by the employer or by an agency providing benefits that are affected by work income, such as SSI.
- Communications with the recipient by telephone, e-mail or fax that is necessary for the recipient to maintain gainful employment.
- Meetings with the community employer without the recipient present are limited to five days per service year; which are counted as part of the total maximum number of standard units available. Examples of when such a meeting might occur include, but are not limited to:
  - Explanation and/or demonstration of significant change in job duties which the employer feels may require re-training for the recipient to remain successfully employed; or
  - Discussion of a behavioral issue that may adversely impact the recipient's ability to remain successfully employed.

If the recipient is not present at a meeting with the community employer, the provider will be expected to have the following documentation available upon request of the support coordinator, OCDD/WSS or HSS staff:

- Date, time, names of persons in attendance at meeting;
- Location and method of meeting (i.e. face-to-face with employer, by phone, or internet/videoconference);
- Reason for meeting without recipient and results of meeting; and
- Written documentation through applicable confidentiality release forms in the recipient's native language that the recipient approved contacts and/or meetings to occur in his/her absence.
- Transportation to or from a community business site by provider staff in a staff or provider-owned vehicle. However, the provider must produce documentation upon request of the support coordinator or OCDD, WSS or HSS staff that all other possible sources of transportation, including those incurring a charge or without charge, have been exhausted.

**NOTE: Under no circumstances can a provider charge a recipient, his/her responsible representative(s), family members or other support team members a separate transportation fee.**



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In addition to the list above, these activities can be considered initial job support and retention activities for self-employment/microenterprise:

- Assisting the recipient in acquisition of skills necessary for operation of the business including clerical, payroll, tax functions, and inventory tracking system;
- Assisting with interviewing, hiring or terminating employees;
- Assisting with communications with vendors and customers; and
- Assisting with all functions of business operations.

Initial job support and retention will be authorized for an individual job a recipient holds in a provider-owned facility when:

- The recipient is paid the same wage as a regular employee of that provider, but at least minimum wage;
- There is a job description for the position that would be utilized by the provider for a person without a disability; and
- The recipient is paid all benefits, including holidays, absentee and vacation time that other employees without disabilities would receive in a comparable position.

Initial job support and retention may be authorized for group employment in a provider-owned or leased facility when:

- The building in which business is conducted is in a separate physical location from the rest of the provider facility.
- Members of the public are the primary customers who utilize the services of the business.

Examples of this include but are not limited to laundry/ironing services, restaurants and retail shops.

Initial job support and retention will only be authorized for individual job, self-employment/microenterprise or group employment for which the recipient is paid in accordance with the United States Fair Labor Standards Act of 1985 as amended.

**Restrictions with Other Services**

Recipients receiving Supported Employment services may also receive Day Habilitation or Prevocational Services, but these services cannot be billed for the same service day.

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**Service Limits**

Individual job, microenterprise/self-employment or group employment initial job support and retention activities may be authorized for **240 standard units in a service year**. Rates are paid per recipient, not per group. **A standard unit of service is one hour or more per day.**

Post authorization for initial job support and retention for units above 240 standard units per POC year will be granted when the support coordinator receives and approves documentation generated by the community business or host company where the recipient(s) performs job duties. Post authorization for excess units will occur after 240 standard units have been utilized.

When a recipient(s) perform job duties at more than one community business or host company, there must be documentation from each employer. Acceptable documentation for post authorization from community businesses or host companies for units in excess of 240 units per POC year are the following:

- Recipient payroll records; or
- Statement signed by the employer or host company that the recipient(s) is required to work in excess of 240 days per calendar year; or
- A formal agreement or contract signed by the employer and provider that outline the recipient's and provider's responsibility to be present in excess of 240 days per POC year to accomplish a job task; and
- Progress notes or other documentation from the provider that show initial job support and retention activities occurred for one or more hours per day in excess of 240 standard units in the POC year.
- A written or oral statement from the provider will not be accepted for approval of post authorization for units in excess of 240 standard units per POC year.

**Staffing Ratios**

Individual job, self-employment and microenterprise initial job support and retention must be provided with a one staff to one recipient ratio.

Group employment initial job support and retention must have one of the following staff to recipient ratios in order to receive payment:

- One-staff to one recipient. This option is only available if the staff providing one-to-one support is in addition to a crew supervisor and is in attendance for the entire shift;
- One staff to two recipients;

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- One staff to three to four recipients; or
- One staff to five to eight recipients.

The maximum ratio for group employment is one staff to eight recipients.

**Additional Provider Responsibilities**

Prior to receiving SE services, the recipient must apply for, and exhaust any similar services available through Louisiana Rehabilitation Services (LRS) or the Individuals with Disabilities Education Act (IDEA) if the recipient is still attending high school. Services will be considered unavailable if a recipient applies, is eligible and qualifies for LRS services but is put on a waiting list. However, if there is no waiting list, the recipient must utilize LRS services prior to receiving initial job support and retention through the waiver, regardless of the amount of time it takes for the recipient to begin receiving job assessment, discovery and development services through LRS.

There must be documentation in the recipient's file that these services are not available from programs funded under the Rehabilitation Act of 1973, the IDEA or Medicaid State Plan.

**Place of Service**

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

**Transportation**

Transportation is included in supported employment, but whenever possible, family, neighbors, friends, co-workers or community resources that can provide transportation without charge should be utilized. **Under no circumstances can a provider charge a recipient, his/her responsible representative(s), family members or other support team members a separate transportation fee.**

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**Provider Qualifications**

Providers of Supported Employment services must meet the following requirements:

- Possess a certificate of compliance from Louisiana Rehabilitation Services as a community rehabilitation provider and maintain this certificate
- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

**OR**

- Be licensed as an Adult Day Care provider by the Department of Health and Hospitals (DHH);
- At least one vocational supervisor receives 15 hours of vocational training annually;
- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

**Day Habilitation**

Day habilitation is services that provide recipients with assistance in developing social and adaptive skills necessary to enable them to participate as independently as possible in the community.

Day Habilitation services allows for peer interaction, meaningful and age-appropriate activities, community and social integration, which provide enrichment and promote wellness.

Day habilitation includes the assistance and/or training in the performance of tasks related to acquiring, maintaining, or improving skills including but not limited to: personal grooming, housekeeping, laundry, cooking, shopping, and money management.

Day Habilitation services:

- Shall be coordinated with any physical, occupational, or speech therapies or employment listed in the recipient’s approved POC.
- May serve to reinforce skills or lessons taught in school, therapy, or other settings.
- Shall be provided in a setting separate from the recipient’s private residence and focus on enabling the recipient to attain or maintain his or her maximum functional level.
- Shall be used to increase the recipient’s self-sufficiency in their home and community.

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- Shall include activities of his or her choice in the community such as trips to museums, parks, libraries, sporting events and other activities that non-disabled peers enjoy.

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

- 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. However, personal care assistance may not comprise the entirety of this service.
- 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.
- A recipient is provided with aerobic aquatics in an inclusive setting to maintain his/her range of motion.
- 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 volunteer work in the community alongside 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.
- A recipient participates in inclusive sports activities in their community.
- A recipient participates in town hall meetings and other community meetings to gather a better understanding of his community.
- A recipient receives a basic understanding of his right to vote and how to vote.
- A recipient receives information on current events.

**Place of Service**

Day habilitation is provided in a setting separate from the recipient's private residence. Activities and environments are structured and designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice which will increase the recipient's self-sufficiency and maximize his/her use of the community.

Community inclusion activities occur in any community setting alongside peers without disabilities and may be educational and/or recreational in nature and cover a wide range of opportunities to allow the recipient to be a part of the community and allow the recipient to contribute to his or her community.

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Volunteer activities must follow the guidelines of the United States Fair Labor Standards Act of 1985 as amended and occur in a business or organization where people without disabilities typically volunteer. These activities may be done individually or in a group.

**NOTE: Volunteer activities cannot occur in a provider-owned business or facility.**

Facility-based activities that occur in a provider owned facility, are recreational, educational or clinical in nature and cover a wide range of opportunities. Facility-based activities include but are not limited to sensory motor development, social, communication and behavioral skills, crafts, computers, gardening, self-advocacy, music and art appreciation.

**Restrictions with Other Services**

Recipients receiving Day Habilitation services may also receive Prevocational or SE services, but these services cannot be billed in the same service day.

Work activity training and work hardening skills training are prevocational services. Day habilitation will not be authorized for services that prepare a recipient for paid or unpaid employment in the community. This includes teaching concepts such as compliance, attendance, task completion, problem-solving and safety that are associated with performing compensated work, as well as, activities aimed at a generalized outcome.

Vocational related services begin when the recipient arrives at the training site and the training activities begin.

**Staffing Ratios**

Day habilitation activities may occur with one of the following staff ratios:

- One staff to one recipient;
- One staff to two to four recipients; or
- One staff to five to eight recipients.

The maximum ratio for day habilitation is one staff to eight recipients.

**Transportation**

All transportation costs are included in the reimbursement for Day Habilitation services. If a recipient needs transportation, the provider must provide, arrange or pay for appropriate transport to and from a central location convenient for the recipient agreed upon by the team. The need for transportation and the location must be documented on the ISP. Recipient must be present to

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receive this service. Under no circumstances can a provider charge a recipient, his/her responsible representative(s), family members or other support team members a separate transportation fee.

**Service Limits**

Day habilitation must be scheduled on the service plan for one or more days per week and may be prior authorized for 240 up to a maximum of 254 standard units of service in a POC year. **A standard unit of service is five or more hours per day.**

Day habilitation may be prior authorized for a maximum of 254 units in a POC year if the support coordinator determines through the assessment process and information from the support team that the recipient has a need for more than 240 standard units per POC year. PA will be granted based on information including, but not limited to:

- Behavior plans that specify supports in excess of 240 days per POC year;
- Goals on the POC that require in excess of 240 standard units for the service year;
- Requests from the recipient, family, support team members or providers for units in excess of 240 without programmatic justification that the recipient will benefit from excess units will not qualify for PA.
- The fact that a provider agency is open for more than 240 days per calendar year will not qualify for PA of units in excess of 240 standard units per POC year.

Post authorization will be granted for a maximum of 254 standard units in a POC year when the support coordinator receives and approves attendance records from the provider showing the number of days the recipient received services.

**Authorization of Services**

In order to receive prior authorization when Day Habilitation and Habilitation services are chosen in conjunction with one another, the provider must submit specific educational strategies and time lines for each service that will be used to achieve the goals and time lines as outlined on the POC and on the ISP. This documentation must be submitted to the support coordinator within five working days after receiving the completed POC. This process must occur regardless of whether the same provider is chosen by the recipient for both services, or different providers are chosen for each service.

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The support coordinator will:

- Facilitate development of a POC that specifies but does not duplicate the training, supports and staff ratio, and time lines for Day Habilitation and Habilitation services;
- Cross reference the POC and the provider(s) ISP to ensure that no duplication of services will occur;
- Approve PA; and
- Forward the approved provider(s) ISP to the OCDD/WSS Regional Office the same or next business day after completing the cross checks.

**Provider Qualifications**

Day habilitation providers must meet the following requirements:

- Be licensed as an Adult Day Care provider by the DHH;
- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

**Prevocational Services**

Prevocational services prepare a recipient for paid or unpaid employment in the community and include teaching concepts such as compliance, attendance, task completion, problem solving and safety that are associated with performing compensated work.

Prevocational services are not job task oriented but instead are aimed at a generalized result and are directed to habilitative rather than explicit employment objectives. These services are provided to persons not expected to join the general work force within one year of service initiation.

Prevocational services may 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. However, personal care assistance may not comprise the entirety of this service.
- A recipient is employed at a commensurate wage at a provider facility for a set or variable number of hours.



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- 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 his/her family, as appropriate, receive information and counseling on benefits planning and assistance in the process.

In the event recipients are compensated, pay must be in accordance with the United States Fair Labor Standards Act of 1985 as amended. If recipients are paid in excess of 50% of minimum wage, the provider must:

- Conduct productivity time studies on the recipient every six months;
- Do six month formal reviews of the recipient's ISP to determine the appropriateness of continued prevocational services as opposed to supported employment; and
- Provide the support coordinator with documentation of both the productivity time studies and ISP reviews at the recipient's annual POC meeting.

**Place of Service**

Prevocational services are provided in a supervised facility-based setting operated through the provider agency where more than 25% of the recipients are individuals with a developmental disability.

**Staffing Ratios**

Prevocational activities may occur with one of the following staff ratios:

- One staff to one recipient;
- One staff to two to four recipients; or
- One staff to five to eight recipients;

The maximum ratio for prevocational services is one staff to eight recipients.

**Transportation**

All transportation costs are included in the reimbursement for Prevocational services. Transportation needed by the recipient must be documented on the POC. The recipient must be

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present to receive this service. If the recipient needs transportation, the provider must physically provide, arrange, or pay for appropriate transport to and from a central location convenient for the recipient agreed upon by the team. This location shall be documented in the service plan.

**NOTE: Under no circumstances can a provider charge a recipient, his/her responsible representative(s), family members or other support team members a separate transportation fee.**

**Restrictions with Other Services**

Recipients receiving Prevocational services may also receive Day Habilitation or Supported Employment services, but these services cannot be billed in the same service day.

There must be documentation in the recipient’s file that this service is not available from programs funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602 (16) or (17) of the Individuals with Disabilities Education Act (230 U.S.C. 1401) (16 and 71) and those covered under the State Plan.

**Service Limits**

Prevocational services must be scheduled on the service plan for one or more days per week and may be prior authorized for 240 up to a maximum of 254 standard units of service in a POC year. **A standard unit of service is five or more hours per day.**

Prevocational services may be prior authorized for a maximum of 254 units in a POC year if the support coordinator determines through the assessment process and information from the support team that the recipient has a need for more than 240 standard units per POC year.

PA will be granted based on information including, but not limited to:

- Behavior plans that specify supports in excess of 240 days per POC year;
- Goals on the POC that require in excess of 240 standard units for the service year;

PA will **NOT** be granted based on information including, but not limited to:

- Requests from the recipient, family, support team members or providers for units in excess of 240 without programmatic justification that the recipient will benefit from excess units. .

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- The fact that a provider agency is open for more than 240 days per calendar year will not qualify for PA of units in excess of 240 standard units per POC year.

Post authorization will be granted for a maximum of 254 standard units in a POC year when the support coordinator receives and approves attendance records from the provider showing the number of days the recipient received services.

Choice of this service and staff ratio needed to support the recipient must be documented on the POC.

**Provider Qualifications**

Providers of Prevocational services must meet the following requirements:

- Possess a certificate of compliance from Louisiana Rehabilitation Services as a Community Rehabilitation Provider and maintain this certificate;
  - Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services;
- OR**
- Be licensed as an Adult Day Care provider by the DHH;
  - At least one vocational supervisor receive 15 hours of vocational training annually; and
  - Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

**Respite**

Respite is a service provided on a short-term basis to a recipient unable to care for him/herself because of the absence of or need for relief of those unpaid caregivers/persons normally providing care for the recipient. Services may be provided in the recipient's home or private residence, the direct service worker's home, or in a licensed respite care facility determined appropriate by the recipient or responsible party.

Respite services may be preplanned on the POC. However, if a recipient anticipates needing respite in the POC year, but does not know when this will occur; he/she and his/her responsible party should receive a FOC list of respite providers and interview these providers. In this manner, the recipient and his/her responsible party(ies) and the provider chosen will be familiar with each other. When a situation occurs during the POC year in which respite will be needed, a revision to the POC will be done by the support coordinator; and the recipient will be able to access the service in a timely manner.

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**Restrictions with Other Services**

Recipients receiving respite may use this service in conjunction with other SW services as long as services are not provided during the same period in a day.

**Service Limits**

The need for respite must be documented in the POC. Respite shall not exceed 428 standard units of service in a plan year. A standard unit of service is 15 minutes (1/4 hour).

**Provider Qualifications**

Respite service providers must meet the following requirements:

- Be licensed as a respite care service provider and/or a personal care attendant service provider by the DHH;
- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

**Habilitation**

Habilitation services are designed to assist recipients in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and/or in community settings.

These services are educational in nature and focus on achieving a goal utilizing specific teaching strategies. Goals may cover a wide range of opportunities including but not limited to learning how to clean house, do laundry, wash dishes, grocery shop, bank, cook meals, shop for clothing and personal items, become involved in community recreational and leisure activities, do personal yard work, and utilize transportation to access community resources.

Habilitation services include but are not limited to the following:

- A recipient receives assistance in learning how to maintain their home including, washing dishes, laundry, vacuuming, mopping and other household tasks.
- A recipient acquires skills needed to cook/prepare nutritional meals in their home.
- A recipient receives assistance in learning how to grocery shop in the community as well as other community activities such as going to the bank, library and other places in the community.

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- A recipient learns travel training to community sites other than work sites.
- 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. However, personal care assistance may not comprise the entirety of this service.
- A recipient participates in a community inclusion activity designed to enhance his/her social skills.
- 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.

Habilitation services may be provided at any time of day or night on any day of the week as needed by the recipient to achieve a specified goal.

Recipients in Habilitation services are reasonably expected to independently achieve the goal(s) identified on their service plan within measurable time lines, as evidenced by information from their standardized assessment, personal outcome interviews and information from their support team members.

**Place of Service**

Habilitation services are provided in the home or community with the recipient's place of residence as the primary setting, and include the necessary transportation.

**Staffing Ratio**

Habilitation services may **only** be provided on a one staff to one recipient ratio.

**Restrictions with Other Services**

Recipients receiving habilitation may use this service in conjunction with other Supports Waiver services as long as services are not provided during the same time period in a day.

Travel training to places in the community, where the recipient's life activities take place, is considered a service. However, travel training to the recipient's Supported Employment, Day Habilitation, or Prevocational sites is **not** considered a Habilitation service.

**Authorization of Services**

To receive PA when Day Habilitation and Habilitation services are chosen in conjunction with one another, the provider must submit specific educational strategies and time lines for each

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service that will be used to achieve the goals and time lines as outlined on the POC. This documentation must be submitted to the support coordinator within five working days after receiving the completed POC. This process must occur regardless of whether the same provider is chosen by the recipient for both services or different providers are chosen for each service.

Day habilitation ISP recreational goals, strategies and time lines should not be submitted. If the day habilitation ISP contains only recreational goals, the habilitation portion of the ISP is the only document that needs to be submitted to the support coordinator.

The support coordinator will:

- Facilitate development of a POC that specifies but does not duplicate the training, supports and staff ratio, and time lines for Day Habilitation and Habilitation services;
- Cross reference the POC and the provider(s) ISP(s) to ensure that no duplication of services will occur;
- Approve prior authorization; and
- Forward the approved provider(s)' ISP(s) to the OCDD/WSS Regional Office the same or next business day after completing the cross checks.

**Service Limits**

Habilitation shall not exceed 285 standard units of service in a plan year. A standard unit of service is 15 minutes (¼ hour).

**Provider Qualifications**

Providers of Habilitation services shall meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services and one of the following two requirements:

- Be licensed as a respite care service provider and/or a personal care attendant service provider by the DHH;

**OR**

- Be a licensed occupational therapist in the State of Louisiana, or a licensed physical therapist in the State of Louisiana or certified through the National Council for Therapeutic recreation as a therapeutic recreational specialist and be an employee of an agency holding a personal care attendant and/or adult day care license through the DHH Health Standards Section.

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**Housing Stabilization Transition Services**

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

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

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

**Standards**

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

**Service Exclusions**

No more than 165 units of combined **housing stabilization transition services** and **housing stabilization services (see definition)** can be used per POC year without written approval from the OCDD State Office.

**Service Limitations**

This service is only available upon referral from the support coordinator and is not duplicative of other waiver services, including support coordination. This service is only available to persons who are residing in or who are linked for the selection process of a State of Louisiana permanent supportive housing unit.

No more than 72 units of housing stabilization services can be used per POC year without approval from the OCDD State Office.

**Reimbursement**

Payment will not be authorized until the local governing entity gives final POC approval.

The OCDD State Office reviews and ensures that all requirements are met. If all requirements are met, the POC is approved and the payment is authorized. The permanent supportive housing provider (PSH) is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

Housing stabilization transition services will be reimbursed at a prospective flat rate for each approved unit of service provided to the recipient. **A standard unit of service is equal to 15 minutes.**



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**Housing Stabilization Services**

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

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

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- Providing ongoing communication with the landlord or property manager regarding:
  - The recipient's disability,
  - Accommodations needed, and
  - Components of emergency procedures involving the landlord or property manager.
  
- Updating the housing support plan annually or as needed due to changes in the recipient's situation or status; and

If at any time the recipient's housing is placed at risk (eviction, loss of roommate or income), housing stabilization services will provide supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing, sources of income, etc.

**Standards**

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

**Service Exclusions**

No more than 165 units of combined housing stabilization transition or housing stabilization services (see definition) can be used per POC year without written approval from the OCDD State Office.

**Service Limitations**

This service is only available upon referral from the support coordinator. This service is not duplicative of the other waiver services including support coordination. This service is only available to persons who are residing in a state of Louisiana permanent supportive housing unit.

No more than 93 units of housing stabilization services can be used per year without written approval from the support coordinator.

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**Reimbursement**

Payments will not be authorized until the OCDD state office gives final Plan of Care approval.

OCDD state office reviews all documents to ensure all requirements are met. If all requirements are met, the LGE approves the POC and authorizes the payment.

The PSH provider is notified of the release of the PA and can bill the Medicaid fiscal intermediary for services provided.

Housing stabilization services will be reimbursed at a prospective flat rate for each approved unit of service provided to the recipient. **A standard unit of service is equal to 15 minutes.**

**Personal Emergency Response Systems**

A Personal Emergency Response System (PERS) is a rented electronic device that enables recipients to secure help in an emergency.

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

**Service Limits**

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 on how to use the equipment.

Reimbursement will be made for a one-time installation fee for the PERS unit.

**Agency Provider Type**

Providers must be enrolled as a Medicaid Home and Community Based Services Waiver service provider of Personal Emergency Response System. The provider shall install and support PERS equipment in compliance with all applicable federal, state, parish and local laws and meet manufacturer's specifications, response requirements, maintenance records and recipient education requirements.

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**Support Coordination**

Support Coordination is a service that will assist recipients in gaining access to all of their needed support services, including medical, social, educational and other services, regardless of the funding source for the services.

**Support Coordination activities include but are not limited to the following:**

- Convening the person-centered planning team comprised of the recipient, recipient's family, direct service providers, medical and social work professionals, as necessary, and advocates, who assist in determining the appropriate supports and strategies needed in order to meet the recipient's needs and preferences.
- On-going coordination and monitoring of supports and services included in the recipient's approved POC.
- Building and implementing the supports and services as described in the POC.
- Assisting the recipient to use the findings of formal and informal assessments to develop and implement support strategies to achieve the personal outcomes defined and prioritized by the recipient in the POC.
- Providing information to the recipient on potential community resources, including formal resources and informal/natural resources, which may be useful in developing strategies to support the recipient in attaining his/her desired personal outcomes.
- Assisting with problem solving with the recipient, supports, and services providers.
- Assisting the recipient to initiate, develop and maintain informal and natural support networks and to obtain the services identified in the POC assuring that they meet their individual needs.
- Advocacy on behalf of the recipient to assist them in obtaining benefits, supports or services, i.e. to help establish, expand, maintain and strengthen the recipient's information and natural support networks. This may involve calling and/or visiting recipients, community groups, organizations, or agencies with or on behalf of the recipient.
- Training and supporting the recipient in self-advocacy, i.e. the selection of providers and utilization of community resources to achieve and maintain his/her desired outcomes.
- Oversight of the service providers to ensure that their recipient receives appropriate services and outcomes as designated in the POC.
- Assisting the recipient to overcome obstacles, recognize potential opportunities and developing creative opportunities.

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- Meeting with the recipient in a face-to-face meetings as well as phone contact as specified.
- Must report and document any incidents/complaints/abuse/neglect according to the OCDD policy.
- Must arrange any necessary professional/clinical evaluations needed and ensure recipient choice.
- Must identify, gather and review the array of formal assessments and other documents that are relevant to the recipient’s needs, interests, strengths, preferences and desired personal outcomes.
- Prepare the annual social summary.
- Develop an action plan in conjunction with the recipient to monitor and evaluate strategies to ensure continued progress toward the recipient’s personal outcomes.

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

**Service Limits**

Support Coordination shall not exceed 12 units. A unit is considered a month.

**Provider Qualifications**

Support Coordination providers must meet the following requirements:

- Be licensed as a support coordination provider;
- Meet all requirements in the Standards for Participation for Medicaid Home and Community-Based Waiver Services.

**NOTE: Please refer to the Case Management manual for additional information.**

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### **PROGRAM MONITORING**

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

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

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

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

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

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

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

#### **Administrative Review**

The Administrative Review includes:

- A review of administrative records,
- A review of other agency documentation, and

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- Provider agency staff interviews as well as interviews with a sampling of recipients to determine continued compliance with provider participation requirements.

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

**Interviews**

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

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

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

**Personnel Record Review**

The Personnel Record Review includes a review of the following records:

- Personnel files that include
  - Criminal background checks,
  - Proof of age,
  - Orientation/training records, and
  - Driver's license, if driving is part of the employees' job description,
- Payroll records, and
- Time sheets.

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**Recipient Record Review**

A representative sample of recipient records are reviewed to ensure the services and supports delivered to recipients are rendered according to the recipient's approved Plan of Care. The case record must indicate how these activities are designed to lead to the desired personal outcomes, or how these activities are associated with organizational processes leading to the desired personal outcomes of the recipients served.

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

Documentation is reviewed to ensure that the services reimbursed were

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

**Provider Staff Interviews**

Provider agency staff interviews are conducted to ensure that support coordinators, direct service providers, and all supervisors meet the following staff qualifications:

- Experience,
- Education,
- Skills,
- Employment status,
- Hours worked,
- Staff coverage,
- Supervisor to staff ratio,
- Caseload/recipient assignments,
- Supervision documentation, and
- Other applicable requirements.



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**Monitoring Report**

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

The monitoring report includes:

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

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

**Corrective Action Report**

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

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

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

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

**Informal Dispute Resolution (Optional)**

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

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

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

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

There is no appeal of the informal hearing decision; however, the agency may appeal the original findings to the DHH Bureau of Appeals.

**Fraud and Abuse**

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

**Quality Management**

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

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

Agency quality enhancement activities must be reviewed and approved by the OCDD regional office as described in the *Quality Enhancement Provider Handbook*. Refer to Appendix D for information on this handbook.

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SECTION 43.6: INCIDENTS, ACCIDENTS AND COMPLAINTS

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**INCIDENTS, ACCIDENTS AND COMPLAINTS**

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

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

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

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

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

**Internal Complaint Policy**

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

- Each provider shall designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator shall maintain a log of all complaints received. The complaint log shall include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint and resolution of the complaint.

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- If the complaint is verbal, the provider staff member receiving the complaint must obtain and send all pertinent information in writing to the provider complaint coordinator. If the recipient completes the complaint form, he/she will be responsible for sending the form to the provider complaint coordinator.
- The complaint coordinator shall send a letter to the complainant acknowledging receipt of the complaint **within five working days**.
- The complaint coordinator must thoroughly investigate each complaint. The investigation includes, but is not limited to, gathering pertinent facts from the recipient, the personal representative, the worker, and other interested parties. These contacts may be either in person or by telephone. The provider is encouraged to use all available resources to resolve the complaint at this level and shall include the on-site program manager. For issues involving medical or quality of care issues, the on-site program manager must sign the resolution.
- The provider's administrator or designee must inform the recipient and/or the authorized representative in writing **within 10 working days** of receipt of the complaint, the results of the internal investigation.
- If the recipient is dissatisfied with the results of the internal investigation regarding the complaint, he/she may continue the complaint resolution process by contacting the appropriate local governing entity (LGE) in writing, or by telephone.

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

**Complaint Disclosure Statement**

La. R.S. 40:2009.13 - .21 sets standards for identifying complainants during investigations in nursing homes. The Bureau is mandated to use these standards for use within the Home and Community-Based Services waiver programs. When the substance of the complaint is furnished to the service provider, it shall not identify the complainant or the recipient unless he/she consents in writing to the disclosure. If the disclosure is considered essential to the investigation or if the investigation results in judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.

The OCDD may determine when the complaint is initiated that a disclosure statement is

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necessary. If a Complainant Disclosure Statement is necessary, the complainant must be contacted and given an opportunity to withdraw the complaint.

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

**Definition of Related Terms Regarding Incidents and Complaints**

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

- Complaint - an allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a consumer or consumers (La. R.S. 40:2009.14)
- Minimal harm - is an incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the consumer's activities of daily living. (La. R.S. 40:2009.14)
- Trivial report - is an account of an allegation that an incident has occurred to a recipient or recipients that causes no physical or emotional harm and has no potential for causing harm to the recipient or recipients. (La. R.S. 40:2009.14)
- Allegation of noncompliance - is an accusation that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a consumer or consumers. (La. R.S. 40:2009.14)
- Abuse - is the infliction of physical or mental injury on an adult by other parties, including, but not limited to, such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds, or other things of value, to such an extent that his health, self-determination, or emotional well being is endangered. (La. R.S. 15:1503)
- Exploitation - is the illegal or improper use or management of an aged person's or disabled adult's funds, assets or property, or the use of an aged persons or disabled adult's power of attorney or guardianship for one's own profit or advantage. (La. R.S. 14:403.2)
- Extortion - is the acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. R.S. 15:1503)
- Neglect - is the failure, by a caregiver responsible for an adult's care or by other

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parties, to provide the proper or necessary support or medical, surgical, or any other care necessary for his well being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 15:1503)

- Self-neglect - is the failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 15:1503)
- Sexual abuse - is any sexual activity between a recipient and staff without regard to consent or injury; any non-consensual sexual activity between a recipient and another person; or any sexual activity between a recipient and another recipient or any other person when the recipient is not competent to give consent. Sexual activity includes, but is not limited to kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent; request, suggestion, or encouragement by another person for the recipient to perform sex with any other person when recipient is not competent to refuse.
- Disabled person - is a person with a mental, physical, or developmental disability that substantially impairs the person's ability to provide adequately for his/her own care or protection.
- Incident - any situation involving a recipient that is classified in one of the categories listed in this section, or any category of event or occurrence defined by OCDD as a critical event, and has the potential to impact the recipient or affect delivery of waiver services.

## **DEVELOPMENTAL DISABILITY LAW**

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

- A severe chronic disability of a person that:
    - Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments.
    - Is manifested before the person reaches age twenty-two.
    - Is likely to continue indefinitely.
    - Results in substantial functional limitations in three or more of the following areas of major life activity:
      - Self-care.
      - Receptive and expressive language.
      - Learning.
      - Mobility.
      - Self-direction.
      - Capacity for independent living.
      - Economic self-sufficiency.
    - Is not attributed solely to mental illness.
    - Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.
- or**
- A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in criteria that later in life may be considered to be a developmental disability.

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**APPENDIX B: SERVICE PROCEDURE CODES/RATES**

**The following chart describes the codes and rates that are to be used with the Supports Waiver. Providers must bill the appropriate procedure code for the service performed.**

HIPPA CODE NAME	SERVICE DESCRIPTION	HIPAA CODE	MODIFIER	RATE	STANDARD UNIT OF SERVICE	HOURS PER UNIT	ANNUAL SERVICE LIMITS
Supported Employment	Individual Job Self-Employment or Microenterprise Job Assessment, Discovery and Development	H2024	UK	\$96.47	1 DAY	6 plus	120
Supported Employment	Group Employment Job Assessment, Discovery and Development	H2024	NO MOD	\$80.70	1 DAY	6 plus	20
Supported Employment	Individual Job, Self-Employment or Microenterprise Initial Job Support and Retention	H2026	TS	\$48.24	1 DAY	1 plus	240
Supported Employment	Group Employment Initial Job Support and Retention One staff to one-two participant ratio	H2026	TT	\$71.42	1 DAY	1 plus	240
Supported Employment	Group Employment Initial Job Support and Retention One staff to one to three-four participant ratio	H2026	UQ	\$58.13	1 DAY	1 plus	240
Supported Employment	Group Employment Initial Job Support and Retention One staff to one to five-eight participant ratio	H2026	NO MOD	\$43.50	1 DAY	1 plus	240
Day Habilitation	Day Habilitation One staff to one participant	T2020	TT	\$76.53	1 DAY (must be scheduled a minimum of 1 day each week)	5 plus	240-254
Day Habilitation	Day Habilitation One staff to two-four participant ratio	T2020	UQ	\$60.29	1 DAY (must be scheduled a minimum of 1 day each week)	5 plus	240-254
Day Habilitation	Day Habilitation One staff to five to eight participant ratio	T2020	NO MOD	\$43.60	1 DAY (must be scheduled a minimum of 1 day each week)	5 plus	240-254
Prevocational Habilitation	Prevocational services one staff to one participant ration	T2014	TT	\$76.53	1 DAY (must be scheduled a minimum of 1 day each week)	5 plus	240 +
Prevocational Habilitation	Prevocational services one staff to two to four participant ration	T2014	UQ	\$51.02	1 DAY (must be scheduled a minimum of 1 day each week)	5 plus	240 +
Prevocational Habilitation	Prevocational services one staff to five to eight participant ratio	T2014	NO MOD	\$34.32	1 DAY (must be scheduled a minimum of 1 day each week)	5 plus	240 +
Respite	Center Based Respite	T1005	HQ				
Attendant Care Services	In-home Respite	S5125	NO MOD	\$3.71	15 MINUTES		428



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**APPENDIX B: SERVICE PROCEDURE CODES/RATES**

HIPPA CODE NAME	SERVICE DESCRIPTION	HIPAA CODE	MODIFIER	RATE	STANDARD UNIT OF SERVICE	HOURS PER UNIT	ANNUAL SERVICE LIMITS
Habilitation Supported Employment	Habilitation	T2019	NO MOD	\$3.71	15 MINUTES		285
Personal Emergency Response System	PERS Installation	Z0058	NO MOD	\$30.00	One Time		1 in current residence and 1 each time participant moves to new residence
Case Management	Support Coordination	T2023	NO MOD	\$155.00	Monthly		12
Personal Emergency Response System	PERS Monthly maintenance	Z0059	NO MOD	\$28.00	Monthly		12
Permanent Supportive Housing	Housing Stabilization	Z0648	NO MOD	\$15.11	15 MINUTES		93
	Housing Stabilization Transition	Z0649					72

## CHAPTER 43: SUPPORTS WAIVER

## APPENDIX C: CONTACT/REFERRAL INFORMATION

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## CONTACT/REFERRAL INFORMATION

Name of Contact	Address/Telephone/Website
<b>Fiscal Intermediary: Molina Medicaid Solutions</b> (formerly UNISYS Corporation)	
<b>Electronic Data Interchange (EDI)</b> Electronic claims testing and assistance	P.O. Box 91025 Baton Rouge, LA 70898 Phone: 225-216-6303 Fax: 225-216-6335
<b>Pharmacy Point of Sale (POS)</b>	P.O. Box 91019 Baton Rouge, LA 70821 Phone: 800-648-0790 (Toll Free) Phone: 225-216-6381 (Local) <i>*After hours please call REVS line</i>
<b>Pre-Certification Unit (Hospital)</b> Pre-certification issues and forms	P.O. Box 14849 Baton Rouge, LA 70809-4849 Phone: 800-877-0666 Fax: 800-717-4329
<b>Prior Authorization Unit (PAU)</b> Prior authorization issues, forms, requests and forms	P.O. Box 14919 Baton Rouge, LA 70898-4919 Phone: 800-807-1320 ( <i>Home Health</i> ) Phone: 866-263-6534 ( <i>Dental</i> ) Phone: 800-488-6334 ( <i>DME &amp; All Other</i> )
<b>Provider Enrollment Unit (PEU)</b> Provider Enrollment, direct deposit problems, reporting of provider file changes and ownership changes, NPI, and EDI submitter enrollment	P.O. Box 80159 Baton Rouge, LA 70898 Phone: 225-216-6370 Fax: 225-216-6392
<b>Provider Relations (PR)</b> Billing and training questions	P.O. Box 91024 Baton Rouge, LA 70821 Toll Free: 800-473-2783 Phone: 225-924-5040 (Local) Fax: 225-216-6334
<b>Recipient Eligibility Verification (REVS)</b>	Toll Free: 800-776-6323 Phone: 225-216-7387 (Local)
<b>Web Technical Support</b> e-CDI technical support	Phone: 877-598-8753 (Toll Free)

## CHAPTER 43: SUPPORTS WAIVER

## APPENDIX C: CONTACT/REFERRAL INFORMATION

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Name of Contact	Address/Telephone/Website
<b>Department of Health and Hospitals (DHH)</b>	
<b>Division of Administrative Law (DAL)</b> <b>Health and Hospitals Section</b> Appeals	P.O. Box 4189 Baton Rouge, LA 70821-4189 Phone: 225-342-0263 Fax: 225-219-9823 <a href="http://new.dhh.louisiana.gov/index.cfm/page/323">http://new.dhh.louisiana.gov/index.cfm/page/323</a>
<b>Health Standards Section (HHS)</b> Licensing Standards	P.O. Box 3767 Baton Rouge, LA 70821 Phone: 225-342-0138 Fax: 225-342-5073 Email: <a href="mailto:hss.mail@la.gov">hss.mail@la.gov</a> <a href="http://dhh.louisiana.gov/index.cfm/subhome/32">http://dhh.louisiana.gov/index.cfm/subhome/32</a>
<b>Louisiana Medicaid Website</b> Provider Web Portal	General Medicaid Hotline: 888-342-6207 <a href="http://www.lamedicaid.com">www.lamedicaid.com</a>
<b>Louisiana Children's Health Insurance Program (LaCHIP)</b> General Medicaid and card questions	General Medicaid Hotline: 888-342-6207  LaCHIP: 225-342-0555 (Local) LaCHIP: 877-252-2447 (Toll Free) <a href="http://bhsfweb.dhh.louisiana.gov/LaCHIP/">http://bhsfweb.dhh.louisiana.gov/LaCHIP/</a>
<b>Office of Aging and Adult Services (OAAS)</b> Waiver clarification, assistance and complaints	P.O. Box 2031 Baton Rouge, LA 70821-2031 Phone: 866-758-5035 Fax: 225-219-0202 E-mail: <a href="mailto:OAAS.Inquiries@la.gov">OAAS.Inquiries@la.gov</a> <a href="http://www.dhh.louisiana.gov/offices/?ID=105">http://www.dhh.louisiana.gov/offices/?ID=105</a>
<b>Office for Citizens with Developmental Disabilities (OCDD)</b> State Office	P.O. Box 3117 Baton Rouge, LA 70821 Phone: 866-783-5553 (Toll Free) Phone: 225-342-0095 (Local) Fax: 225-342-8823 E-mail: <a href="mailto:ocddinfo@la.gov">ocddinfo@la.gov</a> <a href="http://www.dhh.louisiana.gov/offices/?ID=191">http://www.dhh.louisiana.gov/offices/?ID=191</a>
<b>Office of Management and Finance (Bureau of Health Services Financing) – MEDICAID</b>	P.O. Box 91030 Baton Rouge, LA 70810 <a href="http://www.dhh.louisiana.gov/offices/?ID=92">http://www.dhh.louisiana.gov/offices/?ID=92</a>

## CHAPTER 43: SUPPORTS WAIVER

## APPENDIX C: CONTACT/REFERRAL INFORMATION

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Name of Contact	Address/Telephone/Website
<b>Department of Health and Hospitals (DHH)</b>	
<b>Office of Management and Finance (Bureau of Health Services Financing) – MEDICAID</b>	P.O. Box 91030 Baton Rouge, LA 70810 <a href="http://www.dhh.louisiana.gov/offices/?ID=92">http://www.dhh.louisiana.gov/offices/?ID=92</a>
<b>Program Integrity (PI) Section</b> Report Fraud	P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: 800-488-2917 Phone: 225-219-4149 Fax: 225-219-4155 <a href="http://www.dhh.louisiana.gov">http://www.dhh.louisiana.gov</a>
<b>Supplemental Payments Section/Rate and Audit (R&amp;A) Unit</b>	P.O. Box 91030 Baton Rouge, LA 70821-9030 Phone: 225-342-6116 Fax: 225-342-1834 <a href="http://www.dhh.louisiana.gov/offices/?ID=111">http://www.dhh.louisiana.gov/offices/?ID=111</a>
<b>Recipient Assistance for Authorized Services</b>	1-888-758-2220
<b>Take Charge (Family Planning Waiver)</b>	P.O. Box 91278 Baton Rouge, LA 70821 Phone: 888-342-6207 Fax: 877-523-2987 <a href="mailto:medweb@la.gov">medweb@la.gov</a> <a href="http://www.takecharge.dhh.louisiana.gov">www.takecharge.dhh.louisiana.gov</a>
<b>Recovery and Premium Assistance</b> <b>Third Party Liability (TPL)</b> TPL Recovery, Trauma	P.O. Box 3558 Baton Rouge, LA 70821 Phone: 225-342-8662 Fax 225-342-1376

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**CHAPTER 43: SUPPORTS WAIVER**

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**APPENDIX C: CONTACT/REFERRAL INFORMATION** **PAGE(S) 4**

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<b>Other Helpful Contact Information</b>	
<b>Centers for Medicare and Medicaid Services (CMS) OASIS, CMS-485 Form</b>	<a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a>
<b>Governor's Office of Homeland Security and Emergency Preparedness (GOSHEP) Home Health Emergency Model Plan</b>	<a href="http://gohsep.la.gov/plans/modelhmlthpln.htm">http://gohsep.la.gov/plans/modelhmlthpln.htm</a>

**FORMS AND LINKS**

This section contains a list of the forms, handbooks and other documents that are used in the Supports Waiver program and the associated web links where the information can be obtained. Providers are required to follow the procedures that are outlined in the documents identified below.

<b>Form/Document Name</b>	<b>Web Address</b>
Job Assessment, Job Discovery, and Job Development Completion Form	<a href="http://new.dhh.louisiana.gov/assets/docs/OCDD/publications/OCDDWSSPF07001SWAJDJDForm032707.pdf">http://new.dhh.louisiana.gov/assets/docs/OCDD/publications/OCDDWSSPF07001SWAJDJDForm032707.pdf</a>
Rights and Responsibilities Form	<a href="http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1564">http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1564</a>
OCDD Critical Incident Reporting for Waiver Services	<a href="http://new.dhh.louisiana.gov/index.cfm/page/137/n/140">http://new.dhh.louisiana.gov/index.cfm/page/137/n/140</a>
Quality Enhancement Provider Handbook	<a href="http://www.dhh.la.gov/assets/docs/OCDD/waiver/QEProviderHandbook080108.pdf">http://www.dhh.la.gov/assets/docs/OCDD/waiver/QEProviderHandbook080108.pdf</a>

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CHAPTER 43: SUPPORTS WAIVER

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## APPENDIX E – CLAIMS FILING

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**CLAIMS FILING**

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

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

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

Paper claims should be submitted to:

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

Services may be billed using:

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

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

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**CHAPTER 43: SUPPORTS WAIVER**

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**APPENDIX E – CLAIMS FILING**

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This appendix includes the following:

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



**CHAPTER 43: SUPPORTS WAIVER**

**APPENDIX E – CLAIMS FILING**

**CMS 1500 (02/12) INSTRUCTIONS FOR SUPPORTS WAIVER SERVICES**

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	<b>Required</b> -- Enter an "X" in the box marked Medicaid (Medicaid #).	<b>You must write "WAIVER" at the top center of the Louisiana Medicaid claim form.</b>
1a	Insured's I.D. Number	<b>Required</b> – Enter the recipient's 13 digit Medicaid ID number exactly as it appears when checking recipient eligibility through MEVS, eMEVS, or REVS.  <b>NOTE:</b> The recipients' 13-digit Medicaid ID number must be used to bill claims. The CCN number from the plastic ID card is <b>NOT</b> acceptable. The ID number must match the recipient's name in Block 2.	
2	Patient's Name	<b>Required</b> – Enter the recipient's last name, first name, middle initial.	
3	Patient's Birth Date  Sex	<b>Situational</b> – Enter the recipient's date of birth using six (6) digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07).  Enter an "X" in the appropriate box to show the sex of the recipient.	
4	Insured's Name	<b>Situational</b> – Complete correctly if the recipient has other insurance; otherwise, leave blank.	
5	Patient's Address	<b>Optional</b> – Print the recipient's permanent address.	
6	Patient Relationship to Insured	<b>Situational</b> – Complete if appropriate or leave blank.	
7	Insured's Address	<b>Situational</b> – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE		
9	Other Insured's Name	<b>Situational</b> – Complete if appropriate or leave blank.	
9a	Other Insured's Policy or Group Number	<b>Situational</b> – If recipient has no other coverage, leave blank.  If there is other commercial insurance coverage, the state assigned 6-digit TPL carrier code is <b>required</b> in this block. The carrier code is indicated on the Medicaid Eligibility verification (MEVS) response as the Network Provider Identification Number.  Make sure the EOB or EOBs from other insurance(s) are attached to the claim.	<b>ONLY the 6-digit code should be entered in this field. DO NOT enter dashes, hyphens, or the word TPL in the field.</b>
9b	RESERVED FOR NUCC USE	<b>Leave Blank.</b>	

**CHAPTER 43: SUPPORTS WAIVER**

**APPENDIX E – CLAIMS FILING**

Locator #	Description	Instructions	Alerts
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient's Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured's Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured's Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	
11c	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
11d	Is There Another Health Benefit Plan?	Situational – Complete if appropriate or leave blank.	
12	Patient's or Authorized Person's Signature (Release of Records)	Situational – Complete if appropriate or leave blank.	
13	Insured's or Authorized Person's Signature (Payment)	Situational – Obtain signature if appropriate or leave blank.	
14	Date of Current Illness / Injury / Pregnancy	Optional.	
15	OTHER DATE	Leave Blank.	
16	Dates Patient Unable to Work in Current Occupation	Optional.	
17	Name of Referring Provider or Other Source	Situational – Complete if applicable.	
17a	Unlabelled	Situational – Complete if applicable.	
17b	NPI	Situational – Complete if applicable.	
18	Hospitalization Dates Related to Current Services	Optional.	
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Leave Blank.	
20	Outside Lab?	Optional.	

**CHAPTER 43: SUPPORTS WAIVER**

**APPENDIX E – CLAIMS FILING**

Locator #	Description	Instructions	Alerts
21	<p>ICD Ind.</p> <p>Diagnosis or Nature of Illness or Injury</p>	<p><b>Required</b> – Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>9 ICD-9-CM 0 ICD-10-CM</p> <p><b>Required</b> – Enter the most current ICD diagnosis code.</p> <p><b>NOTE:</b> The ICD-9-CM "E" and "M" series diagnosis codes are not part of the current diagnosis file and should not be used when completing claims to be submitted to Medicaid.</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p> <p>Louisiana Medicaid currently accepts ICD-9-CM codes. The acceptance of ICD-10-CM codes will be announced at a later date.</p>
22	Resubmission Code	<p><b>Situational.</b> If filing an adjustment or void, enter an "A" for an adjustment or a "V" for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the "Code" portion of this field.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in the "Original Ref. No." portion of this field.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>VOIDS</u> 10 = Claim Paid for Wrong Recipient 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>Effective with date of processing 5/19/14 providers currently using the proprietary 213 Adjustment/Void forms will be required to use the CMS 1500 (02/12).</p> <p>To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.</p>
23	Prior Authorization Number	<b>Required</b> – Enter the 9-Digit PA number in this field.	
24	Supplemental Information	<b>Situational</b>	
24A	Date(s) of Service	<b>Required</b> -- Enter the date of service for each procedure. Either six-digit (MM DD YY) or eight digit (MM DD YYYY) format is acceptable.	
24B	Place of Service	<b>Required</b> -- Enter the appropriate place of service code for the services rendered.	

**CHAPTER 43: SUPPORTS WAIVER**

**APPENDIX E – CLAIMS FILING**

Locator #	Description	Instructions	Alerts
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	<b>Required</b> -- Enter the procedure code(s) for services rendered in the un-shaded area(s).  If a modifier(s) is required, enter the appropriate modifier in the correct field.	
24E	Diagnosis Pointer	<b>Required</b> – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference letter ("A", "B", etc.) in this block.  More than one diagnosis/reference number may be related to a single procedure code.	
24F	\$Charges	<b>Required</b> -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	<b>Required</b> -- Enter the number of units billed for the procedure code entered on the same line in 24D	
24H	EPSDT Family Plan	<b>Situational</b> – Leave blank or enter a "Y" if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	<b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	<b>Situational</b> – If appropriate, entering the Rendering Provider's 7-digit Medicaid Provider Number in the shaded portion of the block is <b>required</b> . Entering the Rendering Provider's NPI in the non-shaded portion of the block is <b>optional</b> .	In instances where the billing provider is required to link attending providers of services, entering the attending provider Medicaid ID number is required.
25	Federal Tax I.D. Number	<b>Optional.</b>	
26	Patient's Account No.	<b>Situational</b> – Enter the provider specific identifier assigned to the recipient. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers and may be a maximum of 20 characters.	
27	Accept Assignment?	<b>Optional.</b> Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	<b>Required</b> – Enter the total of all charges listed on the claim.	

**CHAPTER 43: SUPPORTS WAIVER**

**APPENDIX E – CLAIMS FILING**

Locator #	Description	Instructions	Alerts
29	Amount Paid	<b>Situational</b> – If TPL applies and block 9A is completed, enter the amount paid by the primary payor (including any contracted adjustments). Enter '0' if the third party did not pay.  If TPL does not apply to the claim, leave blank.	
30	RESERVED FOR NUCC USE	<b>Leave Blank.</b>	
31	Signature of Physician or Supplier Including Degrees or Credentials  Date	<b>Optional</b> -- The practitioner or the practitioner's authorized representative's original signature is no longer required.  <b>Required</b> -- Enter the date of the signature.	
32	Service Facility Location Information	<b>Situational</b> – Complete as appropriate or leave blank.	
32a	NPI	<b>Optional.</b>	
32b	Unlabelled	<b>Situational</b> – Complete if appropriate or leave blank.	
33	Billing Provider Info & Ph #	<b>Required</b> -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	<b>Optional.</b>	
33b	Unlabelled	<b>Required</b> – Enter the billing provider's 7-digit Medicaid ID number.  ID Qualifier - <b>Optional.</b> If possible, leave blank for Louisiana Medicaid billing.	<b>The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.</b>

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

**A sample form is on the following page**

CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM



WAIVER

HEALTH INSURANCE CLAIM FORM

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

PICA [ ] [ ] [ ] [ ] PICA [ ] [ ] [ ] [ ]

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 9876543210123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS		3. PATIENT'S BIRTH DATE MM DD YY 07 31 72 SEX M X F	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE MM DD YY QUAL	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD TO MM DD	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD To MM DD B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) EPT/HPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. (9307) PLAN I. ID. QUAL J. RENDERING PROVIDER ID. #		23. PRIOR AUTHORIZATION NUMBER 4123123123	
1 03 31 14 03 31 14 12 S5125 UN A 90 00 30 NPI			
2 04 02 14 04 02 14 12 S5125 UN A 75 00 25 NPI			
3			
4			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For gov't claims, see back) X YES NO		28. TOTAL CHARGE \$ 165 00	
29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Jane Doe DATE 4/5/14		32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH# (225) 555-4957 Here For You Waiver 200 Main St Any Town, LA 70000	
a. 1239876543		b. 1239876	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM CMS-1500 (02-12)

**ADJUSTING/VOIDING CLAIMS**

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

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

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

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

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

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

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

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

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

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

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

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**CHAPTER 43: SUPPORTS WAIVER**

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**APPENDIX E – CLAIMS FILING**

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

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

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

**A sample form is on the following page**



CHAPTER 43: SUPPORTS WAIVER

APPENDIX E – CLAIMS FILING

SAMPLE WAIVER CLAIM FORM ADJUSTMENT



WAIVER

HEALTH INSURANCE CLAIM FORM

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

PICA		PICA	
1. MEDICARE (Medicare #) <input checked="" type="checkbox"/>	MEDICAID (Medicaid #) <input type="checkbox"/>	TRICARE (ID#DoD#) <input type="checkbox"/>	CHAMPVA (Member ID#) <input type="checkbox"/>
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) JAYCO, TRAVIS		3. PATIENT'S BIRTH DATE MM DD YY 07 31 72	SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) CITY STATE		6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street) CITY STATE
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES NO b. AUTO ACCIDENT? PLACE (State) YES NO c. OTHER ACCIDENT? YES NO	11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE SIGNED		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY		15. OTHER DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 71a. QUAL 71b. NPI		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY A. 3510 B. C. D. E. F. G. H. I. J. K. L.		20. OUTSIDE LAB? YES NO \$ CHARGES	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 03 31 14 03 31 14		22. RESUBMISSION CODE A 00 ORIGINAL REF. NO. 4094198765400	
25. FEDERAL TAX I.D. NUMBER SSN EIN		23. PRIOR AUTHORIZATION NUMBER 4123123123	
26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims use box) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
28. TOTAL CHARGE \$ 75 00		29. AMOUNT PAID \$	
30. BALANCE DUE \$		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Jane Doe DATE 4/9/14	
32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH# (225) 555-4957 Here For You Waiver 200 Main St Any Town, LA 70000 a. 1239876543 b. 1239876	

NUCC Instruction Manual available at: www.nucc.org

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CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE FORM FOR EXAMPLE ONLY