



PERSONAL CARE SERVICES PROVIDER MANUAL

Chapter Thirty of the Medicaid Services Manual

Issued November 1, 2009

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

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

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SECTION 30.1: LT-PCS – OVERVIEW**PAGE(S) 2**

OVERVIEW

Long Term-Personal Care Services (LT-PCS) is an optional home and community- based service (HCBS) under the Medicaid State Plan. This program is designed for Medicaid recipients who require assistance with the activities of daily living (ADLs) and are either in a nursing facility or at imminent risk of nursing facility placement.

The purpose of LT-PCS is to assist individuals with functional impairments with their ADLs. Assistance with instrumental activities of daily living (IADLs) may also be provided if necessary as indicated in the Plan of Care (POC). LT-PCS must be prior authorized and provided in accordance with an approved POC. In addition, the POC must consider the coordination of services including Medicaid services, community services and informal supports being provided to the recipient without any duplication of services. LT-PCS does not replace current support or other assistance, it is meant to supplement other sources. Medicaid is the payer of last resort for any services rendered.

Each individual requesting LT-PCS will undergo a functional eligibility screening, known as the Level of Care Eligibility Tool (LOCET), to determine if the following criteria are met:

- Nursing facility level of care; and
- Nursing facility admission is imminent.

LT-PCS applicants who have been determined to meet the requirements listed above are assessed using a face-to-face interRAI assessment. This assessment is utilized to:

- Verify eligibility qualifications;
- Determine if program requirements are met;
- Determine resource allocation; and
- Identify the individual's need for support in performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

The services offered under the LT-PCS program are provided by a Medicaid enrolled provider that has a valid HCBS license issued by the Department's Health Standards Section (HSS).

This provider manual chapter specifies the requirements for reimbursement for services provided through this program. This document is a combination of federal and state laws and Louisiana

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Department of Health (LDH) policy which provides direction for provision of these services to eligible individuals in the State of Louisiana.

These regulations are established to assure minimum compliance under the law, equity among those served, provision of authorized services and proper fund disbursement. Should a conflict exist between manual chapter material and pertinent laws or regulations governing the Louisiana Medicaid Program, the latter will take precedence.

This manual chapter is intended to provide LT-PCS providers with the information necessary to fulfill their vendor contract with the State of Louisiana. Full implementation of these regulations is necessary for a provider to remain in compliance with federal and state laws and department rules.

Providers should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website (below) for general information concerning topics relative to Medicaid provider enrollment and administration.

<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>

The LDH Bureau of Health Services Financing (BHSF), Office of Aging and Adult Services (OAAS), and Health Standards Section (HSS) are responsible for assuring oversight of the provision of services, licensure compliance, program monitoring, and overall compliance with the rules and regulations.

Services to be provided are specified in the Plan of Care (POC) which is written by the OAAS designee. The planning team is comprised of the recipient, the assessor, and in accordance with the recipient's preferences, members of the family/natural support system, appropriate professionals and others whom the recipient chooses. The POC contains all services and activities involving the recipient. Notification of approved services is forwarded to the provider by the LTC Access contractor. The data contractor issues prior authorization (PA) to the providers based on the approved POC.

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COVERED SERVICES

This section provides information about the services that are covered in the Long Term-Personal Care Services (LT-PCS) program. For the purpose of this policy, when reference is made to “individual” or “recipient”, this includes that person’s responsible representative, legal guardian(s) and/or family member(s), as applicable, who are assisting that person in obtaining services.

LT-PCS may be received through the Medicaid State Plan, in conjunction with the Adult Day Health Care (ADHC) Waiver or Supports Waiver.

NOTE: For these ADHC Waiver recipients, support coordinators work with recipients to coordinate their waiver services and LT-PCS. For these Supports Waiver recipients, the support coordinators will coordinate LT-PCS in terms of their daily schedule; however, LT-PCS is accessed separately through the Medicaid State Plan.

Service Definitions

ADLs are personal functions or basic self-care tasks which are performed by an individual in a typical day. They include the following tasks:

- Bathing
 - Verbal reminder to take a bath;
 - Preparation of the bath;
 - Assistance transferring in and out of the bath/shower; and/or
 - Physical assistance with bathing and/or drying off.

- Grooming
 - Verbal reminder to do the task;
 - Assistance with shaving;
 - Application of make-up and/or body lotion or cream;
 - Brushing or combing hair;
 - Brushing teeth; and/or
 - Other grooming activities.

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- Dressing
 - Verbal reminder to dress;
 - Physical assistance with putting on/taking off clothing; and/or
 - Assistance with prosthetic devices.

- Ambulation
 - Supervision or assistance with walking; and/or
 - Supervision or assistance with assistive devices. (e.g. wheelchair, walker, etc.).

- Eating
 - Verbal reminder to eat;
 - Cutting up food;
 - Assistance with feeding; and/or
 - Assistance with adaptive feeding devices.

- Transferring
 - Assistance with moving body weight from one surface to another; and/or
 - Assistance with moving from a wheel chair to a standing position.

NOTE: Assistance provided to get on/off commode is a subtask of toileting. Assistance getting into/out of tub or shower is a subtask of bathing.

- Toileting
 - Verbal reminder to toilet; and/or
 - Assistance with bladder and/or bowel requirements, including bedpan routines and changing pads or adult briefs (if required).

- Bed Mobility
 - Assistance with repositioning while in bed;
 - Moving to and from a laying position; and/or
 - Turning in bed.

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IADLs are routine tasks that are considered essential but may not require performance on a daily basis. **The purpose of providing assistance or support with these tasks is to meet the needs of the recipient, NOT the needs of the recipient's household.**

IADL tasks include:

- Laundry
 - Recipient's clothing and bedding
- Meal preparation and storage for the recipient
- Shopping with or without the recipient (for items specifically for the recipient)
 - Groceries;
 - Personal hygiene items;
 - Medications; and/or
 - Other personal items.
- Light housekeeping
 - Vacuuming;
 - Mopping floors;
 - Cleaning bathroom and kitchen;
 - Making the recipient's bed; and/or
 - Making sure that pathways are free from obstructions.
- Assistance with scheduling (making contacts and coordinating) medical appointments including but not limited to the following:
 - Physicians;
 - Physical Therapists;
 - Occupational Therapists; and/or
 - Speech Therapists.
- Accompanying the recipient to medical appointments and providing assistance throughout the appointments
- Assistance in arranging medical transportation depending on the needs and

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preferences of the recipient with:

- Medicaid emergency medical transportation;
 - Medicaid non-emergency medical transportation;
 - Public transportation; and/or
 - Private transportation.
- Medication reminders with self-administered prescription and non-prescription medication that is limited to:
 - Verbal reminders;
 - Assistance with opening the bottle or bubble pack;
 - Reading the directions from the label;
 - Checking the dosage according to the label directions; and/or
 - Assistance with ordering medication from the drug store.

NOTE: The worker is NOT allowed to give medication to the recipient. This includes taking medicine out of a bottle to set up pill organizers.

- Medically non-complex tasks where the direct service worker (DSW) has received the proper training pursuant to Louisiana Revised Statutes 37:1031-1034.

NOTE: Emergency and non-emergency medical transportation is a covered Medicaid service and is available to all recipients. Non-medical transportation is NOT a required component of LT-PCS. However, providers MAY CHOOSE to furnish transportation for recipients during the course of providing LT-PCS. If transportation is furnished, the provider must accept all liability for their employee transporting a recipient. It is the responsibility of the provider to ensure that the employee has a current, valid driver's license and automobile liability insurance. Refer to HCBS Provider Licensing Standards for complete details.

Service Limitations

Recipients are limited to the weekly approved amount of LT-PCS hours indicated in the POC and based on the results of the assessment. In no case may the amount of services exceed 32 hours per week.

Under no circumstances may LT-PCS units (hours) be “banked,” “borrowed” or “saved” from one prior authorized week to the next. **Service must be given in the week for which it was intended**, based upon the POC.

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NOTE: A prior authorized week begins at 12:00 a.m. on Sunday and ends at 11:59 p.m. the following Saturday.

For tasks that a recipient can complete without difficulty or the need for physical assistance, the assistance should be limited to prompting or reminding the recipient to complete the task. IADLs may not be performed in the recipient's home when the recipient is absent from the home.

There shall be no duplication of services. LT-PCS may not be provided while the recipient is attending or admitted to a program or setting that provides in-home assistance with ADLs or IADLs, or while attending or admitted to a program or setting where such assistance is provided. In cases where a recipient goes to the Emergency Room department, the LT-PCS worker may provide assistance up until the time the recipient is admitted to the hospital.

Service Exclusions

LT-PCS providers may not bill for this service until after the individual has been approved by OAAS or its designee.

The following individuals are **prohibited from being reimbursed** for providing services to a recipient:

- The recipient's spouse;
- The recipient's curator;
- The recipient's tutor;
- The recipient's legal guardian;
- The recipient's designated responsible representative; or
- The person to whom the recipient has given representative and mandate authority (also known as "power of attorney").

LT-PCS recipients are not permitted to receive LT-PCS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed LT-PCS provider and providers are prohibited from providing and billing for services under these circumstances. Recipients may not live in the home of their DSW unless their direct service worker is related by blood or marriage to the recipient. (See link for "*Who Can Be a Direct Support Worker (DSW*

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Flowchart) for PAS and LT-PCS?" in Appendix A of this manual chapter.) These provisions may be waived with prior written approval by OAAS or its designee on a case by case basis.

LT-PCS **does not** include:

- Administration of medication;
- Insertion and sterile irrigation of catheters;
- Irrigation of any body cavities which require sterile procedures;
- Complex wound care;
- Skilled nursing services as defined in State Nurse Practices Act, including administration of medications/injections, or other non-delegable nursing tasks;
- Teaching a family member or friend how to care for a recipient who requires assistance with ADL;
- Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process;
- Specialized aide procedures such as rehabilitation of the patient (exercise or performance of simple procedures as an extension of physical therapy services), specimen collection, special skin care, decubitus ulcer care, cast care, testing urine for sugar and acetone;
- Rehabilitative services such as those performed by an occupational therapist, speech therapist, audiologist or respiratory therapist;
- Companionship; and/or
- Continuous or intermittent supervision.

NOTE: LT-PCS is not designed to provide continuous or intermittent supervision to a recipient while informal caregivers work or are otherwise unavailable. LT-PCS is a task-oriented service tied to ADLs and IADLs. It is not a time-oriented sitting or supervision service.

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For a list of non-complex tasks that are delegable, see Appendix A *Health Standards Section DSW Guidelines*.

LT-PCS and Hospice

Recipients who elect hospice services may choose to elect LT-PCS and hospice services concurrently. The hospice provider and the long term care access services contractor must coordinate LT-PCS and hospice services when developing the recipient's POC. All core hospice services must be provided in conjunction with LT-PCS. When electing both services, the hospice provider must develop the POC with the recipient, the recipient's caregiver and the LT-PCS provider. The POC must clearly and specifically detail the LT-PCS and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the recipient's daily needs are being met. This will involve coordinating tasks where the recipient may receive services each day of the week.

The hospice provider must be licensed by LDH-HSS and must provide all hospice services as defined in 42CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies and counseling in accordance with Hospice licensing regulations.

Once the hospice program requirements are met, then LT-PCS can be utilized for those personal care tasks with which the recipient requires assistance.

Shared LT-PCS

LT-PCS may be provided by one DSW for up to three (3) recipients with LT-PCS being provided as part of their Adult Day Health Care (ADHC) Waiver Services. The ADHC Waiver LT-PCS recipients must:

- Live together; and
- Have a common direct service provider.

Sharing of the DSW must be agreed upon by each recipient and only when the health and welfare of each recipient can be reasonably assured. Shared LT-PCS must be identified in the approved POC for each recipient. Reimbursement rates are adjusted accordingly. Due to the requirements of privacy and confidentiality, recipients who choose to share these services must agree to sign a confidentiality consent form to facilitate the coordination of services. (See Appendix A for information on accessing the *Release of Confidentiality for Shared Personal Assistance Services (PAS) or Long Term-Personal Care Services (LT-PCS) form*.)

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SECTION 30.3: LT-PCS - RECIPIENT REQUIREMENTS**PAGE(S) 1**

RECIPIENT REQUIREMENTS

LT-PCS are available to recipients who meet the following criteria:

- Meets Medicaid financial eligibility;
- Age 65 years or older, or 21 years of age or older and have a disability that meets Medicaid standards or the Social Security Administration's disability criteria;
- Meets Nursing Facility Level of Care requirements as determined by the Level of Care Eligibility Tool (LOCET) AND verified by the interRAI assessment;
- Requires at least limited assistance with one or more ADLs. The interRAI assessment defines Limited Assistance for most ADLs as the receipt of physical help or a combination of physical help and weight-bearing assistance during the assessment's look-back period;
- Able to participate in his/her care and be able to direct their care independently, or through a responsible representative;
- At imminent risk of nursing facility placement according to the following criteria:
 - In a nursing facility and could be discharged if community-based services were available;
 - Be likely to require nursing facility admission within the next 120 calendar days as determined by the assessment or supporting documentation; or
 - Has a primary caregiver who has a disability or is age 70 or older.

Failure of an individual to meet or maintain any of the above listed criteria will result in denial of admission to/discharge from LT-PCS program.

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RECIPIENT RIGHTS AND RESPONSIBILITIES

Recipients have specific rights and responsibilities that accompany eligibility and participation in the Medicaid programs. OAAS, or its designee, and 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. Providers are bound by their provider agreement with Medicaid to adhere to the following policies on recipient rights.

Each individual who requests LT-PCS has the option to designate a responsible representative to assist or act on his/her behalf in the process of accessing and/or maintaining LT-PCS. The recipient has the right to change his/her responsible representative at any time. The responsible representative may not concurrently serve as a responsible representative for more than two recipients in a Medicaid Home and Community-Based Services program that is operated by the Office of Aging and Adult Services (unless an exception is granted by OAAS) which includes, but is not limited to:

- Program of All-Inclusive Care for the Elderly (PACE);
- Long Term-Personal Care Services (LT-PCS);
- Community Choices Waiver (CCW); and
- Adult Day Health Care (ADHC) Waiver.

Rights and Responsibilities Form

OAAS, or its designee, is responsible for reviewing the recipient's rights and responsibilities with the recipient and/or his/her personal representative as part of the initial intake process and at least annually thereafter. (See Appendix A for information on accessing the *Office of Aging and Adult Services (OAAS) Rights and Responsibilities for LT-PCS Applicants/Participants* form.)

Freedom of Choice of Providers

Recipients have the freedom of choice to select their providers. A list of enrolled providers is given to the recipient at every assessment visit. When the recipient chooses a provider, or chooses to change his/her provider, the recipient must contact OAAS or its designee.

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Recipients may make provider changes based on the following schedule:

Type of Service	Without Good Cause	With Good Cause
LT-PCS	Every 3 months based on a calendar quarter	Any time

Good cause is defined as:

- A recipient moving to another region in the state where the current provider does not provide services;
- The recipient and the provider have unresolved difficulties and mutually agree to a transfer;
- The recipient’s health or welfare has been compromised; or
- The provider has not rendered services in a manner satisfactory to the recipient.

OAAS, or its designee, will provide recipients with their choice of providers and help arrange and coordinate all the services on the Plan of Care (POC).

Changing Providers

All requests for change of provider must be submitted in writing to the LTC Access contractor. Providers will receive written notification when approval has been given for recipients to change providers.

Adequacy of Care

Recipients have the responsibility to request only those services that are necessary and not request excess services, or services for the convenience of employees or providers. Units of service are not “saved up”. The services are certified as medically necessary for the recipient to be able to stay in the community and are revised on the POC as each recipient’s needs change. OAAS, or its designee, must be informed any time there is a change in the recipient’s health, medication, physical conditions, caregiver status, and/or living situation.

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Participation in Care

Each recipient must participate in the assessment and person-centered planning meetings and any other meeting involving decisions about services and supports to be provided. Each recipient may choose whether or not providers attend assessment and planning meetings. 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. The recipient is expected to participate in the planning process to the best of the recipient's ability so that services can be delivered according to the approved person-centered POC. Changes in the amount of services may be requested by the recipient or by a provider on behalf of the recipient. OAAS, or its designee, will verify ALL requests with the recipient.

Voluntary Participation

Recipients have the right to refuse services and to know the consequences of their decisions. Therefore, a recipient will not be required to receive services or participate in activities that they do not want, even if they are eligible for these services. The intent of LT-PCS is to provide community-based services to individuals who would otherwise require care in a nursing facility.

Quality of Care

Each LT-PCS recipient has the right to be treated with dignity and respect and receive services from providers and their employees who have been trained and are qualified to provide them. In addition, providers are required to maintain privacy and confidentiality in all interactions related to the recipient's services.

Recipients have the right to be free from abuse (mental, physical, emotional, coercion, restraints, seclusion, and any other forms of restrictive interventions).

In cases where services are not delivered according to the approved POC, or there are allegations of abuse, neglect, exploitation, or extortion, the recipient must follow the reporting procedures and inform the provider and appropriate authorities.

Recipients and providers must cooperate in the investigation and resolution of reported incidents/complaints.

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Civil Rights

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

Notification of Changes

The Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for LT-PCS recipients. In order to maintain eligibility, recipients and providers have the responsibility to inform BHSF of changes in the recipient's income, resources, address, and living situation.

OAAS or its designee is responsible for approving level of care and medical certification. Recipients and their providers have the responsibility to inform OAAS, or its designee, of any changes which affect programmatic eligibility requirements, including changes in level of care.

Grievances/Complaints

The recipient has a responsibility to bring problems to the attention of providers or OAAS, or its designee, and to file a grievance/complaint without fear of retribution, retaliation, or discharge.

All direct service providers must have grievance procedures through which recipients may voice complaints regarding the supports or services they receive. Recipients must be provided a copy of the grievance procedures upon admission to a direct service provider and complaint/grievance forms shall be given to recipients thereafter upon request. It is the recipient's right to contact any advocacy resource as needed, especially during grievance procedures.

If recipients need assistance, clarification, or to report a complaint, toll-free numbers are available (*See Appendix B for contact information*).

Fair Hearings

Recipients must be advised of their rights to appeal any action or decision resulting in an adverse action or determination. This include denials, suspension, reduction, discontinuance, or termination of services. Recipients have the right to an appeal/fair hearing through the Division

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of Administrative Law (DAL). In the event of a fair hearing, a representative of the direct service provider (DSP) must participate by telephone, or in person, if requested.

An appeal by the recipient may be filed with DAL via fax, mail, online request, by telephone, or in person (See Appendix B for contact information). Instructions for submitting appeal requests are also included in all adverse action notices.

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SECTION 30.5: LT-PCS – SERVICE ACCESS AND AUTHORIZATION

SERVICE ACCESS AND AUTHORIZATION

Once the assessment and any other documentation are reviewed to determine if the recipient meets nursing facility level of care and other program requirements, the Plan of Care (POC) will be developed based on the results. The POC includes the:

- Type of supports needed; and
- Amount of services needed.

Provider Selection

At the in-home assessment visit, the Long-Term Care (LTC) Access contractor provides a current list of enrolled Medicaid LT-PCS providers in the region. The recipient is instructed to contact providers in order to make their selection. This enables the recipient to have Freedom of Choice (FOC) for the provider who will administer services, if he/she is eligible for LT-PCS. It is the recipient’s responsibility to inform the LTC Access contractor of their decision.

The contractor will send the selected provider the “Agreement to Provide Services” form. Providers will need to meet with the recipient to review the POC and discuss provision of the services.

If the provider agrees to provide the services, the “*Agreement to Provide Services*” form must be signed and returned to the LTC Access contractor within 14 calendar days. If approved for services, an approval notice is mailed to the recipient along with a copy of the POC and the approved interRAI assessment. (Refer to Appendix B for contractor information)

If the chosen provider declines to serve an individual, the provider must provide to OAAS or its designee, written documentation that supports an inability to meet the individual’s needs, or documentation that all previous efforts to provide services and supports have failed and there is no option but to refuse services. The individual will then be asked to choose another provider.

Prior Authorization

All services under LT-PCS must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid recipient by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and that it meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent

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upon the passing of all edits contained within the claims payment process, the recipient's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

PA is performed by the Medicaid data contractor and is specific to a recipient, provider, service code, established quantity of units, and for specific dates of service.

PA revolves around the POC document, which means that only the amount of services specified in the approved POC will be prior authorized. A PA number is assigned, and approved units of service are released on a weekly basis to the provider. The approved units of service must be used for the specified week. Units of service approved for one week cannot be combined with units of service for another week. For PA purposes, a week is defined as beginning midnight Sunday and ending at 11:59 pm the following Saturday.

A PA number will be issued to providers for the service authorization period, unless the recipient changes providers.

Services provided without a current PA are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current PA.

The provider is responsible for the following activities:

- Checking prior authorizations by accessing MEVS/REVS at the beginning of each month to verify that all prior authorizations for services match the approved services in the recipient's POC. Any mistakes must be immediately corrected;
- Verifying that services were documented as specified in Section 30.8 – Record Keeping and are within the approved service limits as identified in the recipient's POC prior to billing for the service;
- Verifying that services were delivered according to the recipient's approved POC prior to billing for the service;
- Proper use of the Electronic Visit Verification (EVV) system;
- Inputting the correct date(s) of service, authorization numbers, provider number, and recipient number in the billing system;
- Billing only for the services that were delivered to the recipient and approved in the recipient's POC;
- Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary with each payment; and

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- Checking billing records to ensure that the appropriate payment was received.

NOTE: Providers have one-year timely filing billing requirement under Medicaid regulations. See section 1.4, Timely Filing Guidelines in Chapter General Information and Administration of the Medicaid Services Manual at: <http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>

All requests for changes in services and/or service hours must be made by the recipient or his/her responsible representative. A status change assessment will be performed for all requests where a change in the recipient’s level of functioning is reported and verified.

Re-assessments will be conducted at least once every 18 months to determine ongoing qualification for services.

Post Authorization

LT-PCS requires post authorization before the provider is able to bill for services rendered. Post authorization is verified through EVV.

The data contractor checks the information reported against the prior authorized units of service. Once post authorization is granted, the provider may bill the LDH fiscal intermediary for the appropriate units of service.

Changing Providers

All requests for changes in providers require a new FOC by the recipient or his/her responsible representative. (Refer to 30.4-Recipient Rights and Responsibilities, Freedom of Choice of Providers, for details on “good cause” criteria and timelines.)

OAAS, or its designee, will provide the recipient with the current FOC provider list for his/her region. Once a new provider has been selected, OAAS or its designee will ensure the new provider is notified of the request. Both the transferring provider and the receiving provider share responsibility for ensuring the exchange of medical and program information which includes:

- 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;
- Current Individualized Service Plan, current assessments upon which the Individualized Service Plan is based (if applicable);
- Documentation of the amount of authorized services remaining in the POC including direct service case record documentation; and

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- Documentation of exit interview.

OAAS or its designee will facilitate the transfer of the above referenced information to the receiving provider and forward copies of the following to the new provider:

- Most current POC;
- Current assessments on which the POC is based;
- Number of services used in the calendar year; and
- All documents necessary for the new provider to begin providing services.

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

Prior Authorization for New Providers

OAAS or its designee will complete a POC revision that includes the start date for the new provider and the end date for the transferring provider. A new PA will be issued to the new provider with an effective starting date as indicated on the POC revision. The transferring provider's PA number will expire on the end date as indicated on the POC revision.

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PROVIDER REQUIREMENTS

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

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

Providers should refer to the General Information and Administration manual chapter of the *Medicaid Services Manual* located on the Louisiana Medicaid website. Section 1.1 - Provider Requirements contains detailed information concerning topics relative to Medicaid provider enrollment. (<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>)

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

Providers must document that criminal record history checks have been obtained and that employees and the employees of subcontractors do not have a criminal record as defined in R.S. 40:1203.1 et seq. Providers are not to employ individuals who have been convicted of abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual. Providers must take all reasonable steps to determine whether applicants for employment have histories indicating involvement in abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual.

Failure to comply with all regulations may result in any or all of the following:

- Recoupment;
- Sanctions;
- Loss of enrollment; or
- Loss of licensure.

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Providers must also check the Certified Nursing Assistant (CNA) and Direct Service Worker (DSW) Registries for placement of findings of abuse, neglect, or misappropriation and shall be in accordance with licensing regulations.

Providers must attend all mandated meetings and training sessions as directed by LDH and/or its designee as a condition of enrollment and continued participation as a waiver provider. A Provider Enrollment Packet must be completed by the provider for each provider type and for each LDH administrative region in which the agency or provider will deliver services. Providers will not be added to the Freedom of Choice (FOC) list of available providers until they have been issued a Medicaid provider number for that provider type.

LT-PCS is to be provided strictly in accordance with the provisions of the approved POC. All providers and/or contractors are obligated to immediately report any changes to LDH that could affect the recipient's eligibility.

Providers are responsible for documenting the occurrence of incidents or accidents according to their company's policy.

Providers must:

- Participate in all training for prior authorization (PA) and data collection. Initial training is provided at no cost to the provider. Any repeat training must be paid for by the requesting provide; and
- Have available computer equipment software, and internet connectivity necessary to participate in prior authorization, data collection, and Electronic Visit Verification (EVV).

Licensure and Specific Provider Requirements

Providers must meet licensure and other additional requirements as outlined in the table below:

Personal Care Services
<p>Provided by a PCS provider that:</p> <ul style="list-style-type: none"> • Is licensed by the LDH Health Standards Section (HSS) as a PCS provider; • Has enrolled in Medicaid as a PCS provider; and • Is listed on the Freedom of Choice form.

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Provider Responsibilities

LT-PCS providers must abide by all staffing and training requirements and ensure that staff and supervisors possess the minimum requisite education, skills, qualifications, training, supervision, and coverage as set forth by their respective licensing authorities and in accordance with all applicable LDH and OAAS rules and policies.

Providers shall not refuse to serve any recipient who chooses their agency, unless there is documentation to support an inability to meet the recipient's needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services. OAAS, or its designee, must be notified immediately of the circumstances surrounding the refusal. The refusal request must be made in writing by the provider to OAAS, or its designee, and to the recipient detailing why the provider is unable to serve the recipient. This requirement can only be waived by OAAS or its designee.

Providers shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

If the provider proposes **involuntary transfer, discharge of a recipient, or if a provider closes** in accordance with licensing standards, the following steps must be taken:

- The provider shall give written notice to the recipient, a family member and/or the responsible representative, if known, at least 30 calendar days prior to the transfer or the discharge;
- Written notice shall be made via certified mail, return receipt requested and shall be in a language and manner that the recipient understands;
- A copy of the written discharge/transfer notice shall be put in the recipient's record;
- When the safety or health of recipients or provider staff is endangered, written notice shall be given as soon as possible before the transfer or discharge;
- The written notice shall include the following:
 - A reason for the transfer or discharge;
 - The effective date of the transfer or discharge;
 - An explanation of a recipient's right to personal and/or third party representation at all stages of the transfer or discharge process;
 - Contact information for the Advocacy Center;
 - Names of provider personnel available to assist the recipient and family in decision making and transfer arrangements;

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- The date, time and place for the discharge planning conference;
- A statement regarding the recipient’s appeal rights;
- The name of the director, current address and telephone number of the Division of Administrative Law (DAL); and
- A statement regarding the recipient’s right to remain with the provider and not be transferred or discharged if an appeal is timely filed.

Provider transfer or discharge responsibilities shall include:

- Holding a transfer or discharge planning conference with the recipient, family, support coordinator, legal representative and advocate, if such is known;
- Developing discharge options that will provide reasonable assurance that the recipient will be transferred or discharge to a setting that can be expected to meet his/her needs;
- Preparing an updated service plan, as applicable, and preparing a written discharge summary that shall include, at a minimum, a summary of the health, behavioral issues, social issues and nutritional status of the recipient; and
- Providing all services required prior to discharge that are contained in the final update of the service plan, as applicable, and in the transfer or discharge plan.

NOTE: The requirements above do not apply when the recipient is being discharged from the LT-PCS program by LDH or OAAS.

Failure of the provider to meet the minimum standards shall result in a range of required corrective actions including, but not limited to, the following:

- Removal from the Freedom of Choice listing;
- A citation of deficient practice;
- A request for corrective action plan; and/or
- Administrative sanctions.

Continued failure to meet the minimum standards may result in disenrollment as an LT-PCS provider.

LT-PCS providers must complete and submit the LDH approved cost report(s) to the LDH designated contractor no later than five months after the state fiscal year ends (June 30). (See

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Appendix B to obtain web address for additional information.)

Back-up Staffing Plan

Providers must have a written back-up plan for each LT-PCS recipient in the event the assigned worker is unable to provide support due to unplanned circumstances or emergencies which may arise. This plan must be developed and maintained in accordance with licensing standards and include:

- Person or persons responsible for back up coverage (including names, relationships, and contact phone numbers);
- A toll-free telephone number with 24 hour availability manned by an answering service that allows the recipient to contact the provider if the worker fails to show up for work; and
- Signatures and dates.

If providers use a pool of on-call or substitute workers to ensure that services to the recipient will not be interrupted, those workers must meet the same qualifications as the regular LT-PCS workers.

In all instances when a worker is unable to provide support, he/she must contact the provider and family/recipient immediately.

Back-up Staffing Plans **must** be provided to recipients and/or their personal representative before services begin.

Emergency Plan

Providers must also ensure that each recipient has a documented individualized emergency plan in preparation for, and response to, emergencies and disasters that may arise. This plan must identify specific resources available through family, friends, the neighborhood and the community.

Worker Qualifications

All staff providing direct care to the recipient must meet the qualifications set forth in the licensing regulations found in the Louisiana Administrative Code (LAC Title 48, Chapter 50 and Chapter 92).

Family members who provide LT-PCS must meet the same standards for employment as caregivers who are unrelated to the recipient. (Refer to the link in Appendix A for further clarification.)

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Changes

Changes in the following areas are to be reported in writing to HSS, OAAS and the fiscal intermediary's Provider Enrollment Section, within the time specified in the Health Standards Section (HSS) licensing rule:

- Provider's entity name ("doing business as" name);
- Key administrative personnel;
- Ownership;
- Physical location;
- Mailing address;
- Telephone number; and
- Account information affecting electronic funds transfer (EFT).

When a provider closes or decides to no longer participate in the Medicaid program, the provider must give at least a 30 calendar day written advance notice to all recipients served and their responsible representatives, and LDH (OAAS and HSS) prior to discontinuing service.

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SERVICE DELIVERY**Plan of Care/Plan of Care Revisions**

The Office of Aging and Adult Services (OAAS) or its designee will develop the Plan of Care (POC) to correlate with the beneficiary's needs identified in the interRAI assessment. Those tasks/activities covered under long-term personal care services (LT-PCS) will be outlined in the POC and includes the following:

- The specific activities of daily living (ADLs) and instrumental activities of daily living (IADLs) tasks in which the individual requires assistance;
- How the LT-PCS worker is to perform the ADL and/or IADL tasks (e.g. assist or cue the beneficiary, etc.); and
- The frequency of service for each task/activity:
 - The number of days per week each task/activity will be performed; and
 - The preferred time of day to accomplish each task/activity (when the time is pertinent, such as when to prepare meals).

This POC will be sent by the Long-Term Care (LTC) Access contractor to the chosen provider in the provider notice packet.

Even though the beneficiary's POC shows an amount of time per task/activity, and the system captures the data in this format, LT-PCS approvals are **NOT** based on the time per task/activity.

Following the identified time per task/activity is **NOT** a requirement and it is not necessary to document any deviation from the time per task/activity. **The focus is on documenting that the task/activity required in the POC is actually performed.**

Weekly units of service must not be more than the units specified in the POC. Beneficiaries have the flexibility to use the weekly LT-PCS units (hours) according to their preferences and personal schedule within the prior authorized week.

During brief periods (less than 30 calendar days duration), the provider may deviate from the POC.

If POC deviations extend beyond 30 calendar days **or** there are continuous deviations from the POC **or** when an apparently permanent change in the beneficiary's level of functioning and/or an availability of other supports is noted, the beneficiary or responsible representative should request

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a status change assessment to determine if the POC needs to be revised. Status change assessments may result in the number of hours approved being decreased, increased, or remaining the same.

Location of Service

LT-PCS must be provided in the beneficiary's home or can be provided in another location outside of the beneficiary's home if the provision of these services allows the beneficiary to participate in normal life activities as they pertain to ADLs and IADLs cited in the POC. Services that are provided in the beneficiary's home must be provided while the beneficiary is present. The beneficiary's home is defined as the place where the beneficiary resides such as a house, apartment, a boarding house, or the house or apartment of a family member or unpaid primary caregiver.

The provision of LT-PCS outside of the beneficiary's home does not include trips outside of the borders of the state without written prior approval of OAAS or its designee, through the POC or otherwise.

Interruption of Services

A beneficiary may go without services up to **30 calendar days** being discharged from the program.

Interruption of services is permissible under the following circumstances:

- An acute care hospital admission;
- Temporary stay in another type of care facility (e.g. nursing facility, rehabilitation hospital, etc.); or
- A temporary stay outside the home (e.g., a vacation, etc.).

Reimbursement is not available during service interruption periods.

Discontinuation of Services

A provider must give written notification to the beneficiary or the responsible representative when discontinuing services for a good cause (Refer to Section 30.6 – Provider Requirements of this manual chapter). This notice must be written and delivered in accordance with all LDH rules.

A provider may discontinue services to a beneficiary without a 30 calendar day notice under the following circumstances:

- Upon the beneficiary's request;

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- If the beneficiary's hospitalization is expected to last more than 30 calendar days, the provider may terminate services because of the unavailability of the beneficiary to receive services. When the beneficiary is discharged and returns home, he/she may choose the same provider or another provider to continue receipt of services;
- Unsafe working conditions prevent the worker from performing his/her duties or threaten the worker's personal safety (e.g., unsanitary conditions, illegal activities in the home, etc.). The provider must make a documented, reasonable effort to notify the beneficiary and/or the personal representative of the unsafe working conditions in the home and attempt to resolve the problem. At the same time, OAAS, or its designee, should be notified of the provider's concerns for staff's safety;
- The beneficiary no longer meets the Medicaid financial eligibility criteria;
- The beneficiary no longer meets LT-PCS program requirements;
- The beneficiary is incarcerated or placed under the supervision of the judicial system;
- The beneficiary is admitted to a long-term care facility; or
- The beneficiary moves out of the service area (permanently or for a period over 30 calendar days).

If services are to be discontinued, the provider must notify the LTC Access contractor **within 24 hours prior to action being taken**. (See Appendix F of this manual chapter for contact information).

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SECTION 30.8: LT-PCS - RECORD KEEPING**PAGE(S) 7**

RECORD KEEPING

Providers should refer to the Medicaid Services Manual, Chapter 1 General Information and Administration, Section 1.1 - Provider Requirements for additional information of record keeping. <http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>.

Components of Record Keeping

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

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

Retention of Records

The provider must retain administrative, personnel and beneficiary records for a minimum of six years from the date of the last payment period. If records are under review as part of a departmental or government audit, the records must be retained until all audit questions are answered and the audit is completed (even if that time period exceeds six years).

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

Confidentiality and Protection of Records

Records, including administrative and beneficiary, must be the property of the provider and secured against loss, tampering, destruction or unauthorized use.

Employees of the provider must not disclose or knowingly permit the disclosure of any information concerning the provider, the beneficiaries or their families, directly or indirectly to any

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unauthorized person. The provider must safeguard the confidentiality of any information that might identify the beneficiary or their family.

The information may be released only under the following conditions:

- Court order;
- Beneficiary's written informed consent for release of information;
- Written consent of the individual to whom the beneficiary's rights have been devolved when the beneficiary has been declared legally incompetent; or
- Compliance with the Federal Law, Confidentiality of Alcohol and Drug Abuse Patients Records (42 CFR, Part 2).

A provider must, upon request, make available information in the case records to the beneficiary or legally responsible representative. If, in the professional judgment of the administration of the provider, it is felt that the information contained in the record would be damaging to the beneficiary, that information may be withheld from the beneficiary except under court order.

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

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

Any electronic communication containing beneficiary specific identifying information sent by the provider to another agency, or to LDH, must comply with regulations of the Health Insurance Portability and Accountability Act (HIPAA) and be sent securely via an encrypted messaging system.

Beneficiary records must be located at the enrolled site.

NOTE: Under no circumstances should providers allow staff to remove beneficiary records from the provider site.

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Review by State and Federal Agencies

Providers must make all administrative, personnel, and beneficiary records available to LDH, or its designee, and appropriate state and federal personnel within the specified timeframe given by LDH or its designee. Providers must always safeguard the confidentiality of beneficiary information. The provider is responsible for incurring the cost of copying records.

Beneficiary Records

Providers must have a separate written record for each beneficiary. To ensure continuity of care, the record must have on-going, adequate chronological documentation of activities/services offered and provided. Services provided must be clearly related to the services documented in the beneficiary's Plan of Care (POC).

Records at the Beneficiary's Home

Providers must maintain the following documents at the beneficiary's home:

- A **current** copy of the beneficiary's POC and POC revision (if applicable); and
- Copies of the beneficiary's service logs for the current prior authorized week. (A prior authorized week begins on Sunday at 12:00 a.m. and ends on the following Saturday at 11:59 p.m.).

Example: If LDH staff or designee goes into the home on a Wednesday, service logs for that day, along with the applicable documentation (if services were performed) from that Sunday, Monday, and Tuesday (the current prior authorized week) are required.

NOTE: A copy of the "Long-Term Personal Care Services (LT-PCS) Log", along with instructions for using and completing this form, can be found in Appendix D.

LDH or its designee may request copies of these records and, at its discretion, may also request additional records from the provider. Records should be made available to the requestor in accordance with LDH policy.

See below for specific information regarding documentation for LT-PCS:

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SECTION 30.8: LT-PCS - RECORD KEEPING

Long Term-Personal Care Services (LT-PCS)	
Service Log	Complete the task checklist after each activity has been performed and/or supports have been provided. Page 2 of the service log (progress notes) is to be completed as applicable to reflect observed changes and other important information about the beneficiary. (Refer to Appendix A for form/instructions).
Case Closure/Transfer	Complete within 14 calendar days of discharge.

Organization of Records, Record Entries and Corrections

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

All entries and forms completed by staff in beneficiary records must be legible, written in ink (if not completed electronically) and include the following:

- The name of the person making the entry;
- The signature of the person making the entry;
- The functional title of the person making the entry;
- The full date of documentation; and
- Reviewed by the supervisor, if required.

Any error made in a beneficiary's record must be corrected using the legal method which is to draw a line through the incorrect information, write "error" by it and initial the correction. **Correction fluid must NEVER be used in a beneficiary's records.** The provider's office staff may not change any of the documentation entered by the LT-PCS worker.

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Service Logs

Service logs document the services provided and billed. These service logs are the “paper trail” for services delivered by the worker.

Service logs contain the following information:

- Name of beneficiary;
- Name of provider and employee providing the service;
- Date of service contact; and
- Content of service contact.

NOTE: The start and stop time of service contacts, as well as the location where check in/check out occurs, are captured through the use of an Electronic Visit Verification (EVV) System.

A separate service log must be kept for each beneficiary. Reimbursement is only payable for services documented in the service log and captured through EVV. Providers are required to use the LT-PCS log issued by OAAS. *(See Appendix D for information on accessing this form and the associated instructions.)*

All portions of the service log must be completed each week. Photocopies of previously completed service logs will not be accepted.

Service logs must be:

- Completed **daily as tasks are performed** (Service logs may not be completed prior to the performance of a task.); and
- Signed and dated by the worker and by the beneficiary or responsible representative **after the work has been completed at the end of the week.**

Progress notes are located on the second page of the service log and are the means of documenting:

- Observed changes in the beneficiary's mental and/or medical condition(s), behavior or home situation that may indicate a need for a reassessment and POC, and/or ISP change (as applicable); and

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- Other information important to ensure continuity of care.

Examples of when to document in a narrative progress note include but are not limited to:

- Provided more assistance than what is indicated in the POC due to the beneficiary's request or his/her increased need.
- Assistance not provided with a particular task/subtask as indicated in the POC due to beneficiary's request or his/her lack of need.

NOTE: If a beneficiary, for any reason, did not use all or part of his/her LT-PCS hours on a particular day but the unused LT-PCS hours were used in other days throughout that week, it MUST be clearly documented how the hours were used and the justification or need for the hours on that day. When hours are not used, they CANNOT be used later in the week just to "make up" the hours; therefore, workers CANNOT do the same task/activity twice in one (1) day just to "make up" the unused hours. There MUST be an ACTUAL need for the unused hours on the day that they are actually used.

When progress notes are written/entered, they must:

- Be legible;
- Include the date of the entry;
- Include the name of the person/worker making the entry; and
- Be completed and updated in the record in the time specified.

Each provider's documentation should support justification for prior authorization or payment of services. Services billed must clearly be related to the current approved POC and Individualized Service Plan (ISP), if applicable.

NOTE: Service logs (including the progress notes section) can be completed, signed, initialed and/or dated electronically, as long as the provider complies with the requirements stated above.

Transfers and Closures

A progress note **MUST** be entered in the beneficiary's record when a case is transferred or closed.

A discharge summary must also be entered in the beneficiary's record and detail the beneficiary's progress prior to a transfer or closure. This summary must be completed within 14 calendar days following a beneficiary's discharge.

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SECTION 30.9: LT-PCS - INCIDENTS/ACCIDENTS/COMPLAINTS

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INCIDENTS, ACCIDENTS AND COMPLAINTS

LT-PCS 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 entity (APS or EPS). Any illegal activities **MUST** be reported to law enforcement. Reporting to a supervisor only **does not** satisfy the legal requirement to report. The supervisor is responsible for ensuring that a report or referral is made in a timely manner to the appropriate entity.

Incident/Accident Reports

Providers are responsible for documenting and maintaining records of all incidents and accidents involving the recipient that occurred during the course of delivering services. The incident/accident report must be maintained in the recipient's record. The report must include:

- Recipient identifying information;
- Event information (including date, time, location, etc.) of the incident/accident;
- Circumstances surrounding the incident/accident;
- Description of incident/accident (including any medical attention or law enforcement involvement, witnesses, etc.);
- Action taken to correct or prevent future occurrences of the incident/accident; and
- Name of person completing the report.

Imminent Danger and Serious Harm

Providers must report all suspected cases of abuse (physical, mental, emotional, and/or sexual), neglect, exploitation or extortion to the appropriate authority. In addition, any other circumstances that place the recipient's health and well-being at risk should be reported to the appropriate authorities. (See Appendix F of this manual chapter for contact information.)

For recipients ages 18 through 59 and emancipated minors, Adult Protective Services (APS) must be contacted. APS investigates and arranges for services to protect adults with disabilities at risk of abuse, neglect, exploitation or extortion. (See Appendix B of this manual chapter for contact information.)

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For recipients age 60 or older, Elderly Protective Services (EPS) must be contacted. EPS investigates situations of abuse, neglect and/or exploitation of individuals age 60 or older. (See Appendix B of this manual chapter for contact information.)

If the recipient needs emergency assistance, the worker must call 911 or the local law enforcement agency before contacting the supervisor.

Internal Complaint Policy

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

- Each provider must designate an employee to act as a complaint coordinator to investigate complaints. The complaint coordinator must maintain a log of all complaints received. The complaint log must include the date the complaint was made, the name and telephone number of the complainant, nature of the complaint and resolution of the complaint.
- All written complaints should be forwarded to the complaint coordinator. If the complaint is verbal, the staff member receiving the complaint must document all pertinent information in writing and forward it to the complaint coordinator.
- The complaint coordinator must send a letter to the complainant acknowledging receipt of the complaint **within five (5) 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. The provider is encouraged to use all available resources to resolve the complaint internally. The LT-PCS supervisor must be informed of the complaint and the resolution.
- The provider must inform the recipient, the complainant, and/or the responsible representative in writing **within ten (10) working days** of receipt of the complaint, the results of the internal investigation.

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- If the recipient is dissatisfied with the results of the provider's internal investigation, he/she may continue the complaint resolution process by contacting the Health Standards Section. (See Appendix B of this manual chapter for contact information.)

REIMBURSEMENT

Providers must utilize the Health Insurance Portability and Accountability (HIPAA) compliant billing procedure code and modifier. (Refer to Appendix E in this manual chapter for information about procedure code, unit of service and current reimbursement rate.)

Reimbursement must not be made for services provided prior to approval of Plan of Care (POC) and release of prior authorization (PA) for these services.

Medicaid is the payer of last resort in accordance with federal regulation 42 CFR-433.139. Failure by the provider to exhaust all third party payer sources may subject the enrolled provider to recoupment of funds previously paid by Medicaid. Third parties include, but are not limited to:

- Private health insurance;
- Casualty insurance;
- Worker’s compensation;
- Estates;
- Trusts;
- Tort proceeds; and
- Medicare.

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

LT-PCS providers are reimbursed at a per quarter-hour-rate for services provided under a Prospective Payment System (PPS) that recognizes and reflects the cost of direct care services provided.

Release of PA for LT-PCS is contingent on post authorization. Post authorization occurs through the Electronic Visit Verification (EVV) system. EVV is mandatory for LT-PCS. The EVV system requires use of the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and Office of Aging and Adult Services (OAAS). The system is to be used to electronically “check in” and “check out” when the LT-PCS worker begins and when they end service delivery for a participant.

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SECTION 30.10: LT-PCS – REIMBURSEMENT**PAGE(S) 2**

While there may be some circumstances that require manual edits by the provider's designee, these should only be occasional. In the event that there is a billing overlap, the provider that uses the EVV system correctly (i.e. data has not been manually added or edited) will have priority for payment.

Providers who are approved to provide services to more than one recipient under shared LT-PCS (through the ADHC Waiver) must bill separately for each recipient based on his/her POC. Each recipient must be present to receive the shared service in order for the provider to bill for the service.

Span Date Billing

Claims cannot be span-dated for a specified time-period. Each line on the claim form must represent billing for a single date of service.

Details about when claims can be filed for LT-PCS can be found in Section 30.5 – *Service Authorization Process* of this manual chapter.

FRAUD AND ABUSE

General

Federal regulations require that the Louisiana Medicaid Program establish criteria that are consistent with principles recognized as affording due process of law for identifying situations where there may be fraud or abuse, for arranging prompt referral to authorities, and for developing methods of investigation or review that ascertain the facts without infringing on the legal rights of the individuals involved.

Fraud

Fraud, in all aspects, is a matter of law rather than of ethics or abuse of privilege. The definition of fraud that governs between citizens and government agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.01. Legal action may be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142 (HR-3). Prosecution for fraud and the imposition of a penalty, if the individual is found guilty, are prescribed by law and are the responsibility of the law enforcement officials and the courts. All such legal action is subject to due process of law and to the protection of the rights of the individual under the law.

Provider Fraud

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

- Billing for services that are not rendered to, or used for, Medicaid recipients;
- Claiming costs for non-covered or non-chargeable services disguised as covered items;
- Materially misrepresenting dates and descriptions of services rendered, the identity of the individual who rendered the services, or of the recipient of the services;
- Submitting duplicate billing to the Medicaid Program or to the recipient, which appears to be a deliberate attempt to obtain additional reimbursement;
- Arrangements by providers with employees, independent contractors, suppliers, and others, and various devices such as commissions and fee splitting, which appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from Medicaid; and

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SECTION 30.11: LT-PCS - FRAUD AND ABUSE

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- Coaching applicant/recipient on how to respond to assessment questions in order to appear eligible for services.

Recipient Fraud

Providers should refer to the *Medicaid Services Manual*, Chapter 1 General Information and Administration for a description of recipient fraud.

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PROGRAM OVERSIGHT AND REVIEW

Services offered through the LT-PCS program are closely monitored to assure compliance with Medicaid's policy as well as applicable state and federal rules and regulations. Oversight is conducted through licensure and regulatory compliance and by program monitoring. The Louisiana Department of Health's (LDH) Health Standards Section (HSS) staff conducts on-site surveys to assure state licensure and regulatory compliance for the providers they license.

Pursuant to R.S. 40:2120.2, LDH established minimum licensing standards for Home and Community-Based Services (HCBS) providers. These licensing provisions contain the core requirements for HCBS providers as well as the module-specific requirements, depending upon the services rendered by the HCBS provider. These regulations are separate and apart from Medicaid standards of participation or any other requirements established by the Medicaid program for reimbursement purposes. HCBS providers must be licensed to provide LT-PCS.

Health Standards Section Surveys

HSS conducts surveys on-site or through administrative desk review to assess for provider compliance with licensing regulations, and other applicable statutes, rules, and regulations via record review, interviews, and observation.

A provider's failure to be in compliance with State licensing standards could result in sanctions, loss of licensure and other department actions, such as the provider's removal from Medicaid participation, federal investigation, and prosecution in suspected cases of fraud.

On-Site Reviews

The HSS on-site survey of a provider is unannounced to ensure continuing licensure and regulatory compliance.

Personnel Record Review

The Personnel Record Review may include:

- A review of personnel files;
- Review of time sheets;

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- Review of the current organizational chart; and
- Provider staff interviews to ensure that direct service workers and supervisors meet staff qualifications in accordance with licensing regulations.

Interviews

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

- A representative sample of the recipients served by the provider;
- Members of the recipient's network of support, which may include family and friends;
- Direct care staff; and
- Other members of the recipient's community. This may include other employees of the HCBS provider.

This interview process is to assess the overall satisfaction of recipients regarding the provider's performance and to determine the presence of the personal outcomes of the recipient in accordance with the Plan of Care (POC).

Recipient Record Review

Following the interviews, HSS staff may review the case records of a representative sample of recipients served. The records will be reviewed to ensure that the activities of the provider are associated with the appropriate services of intake, ongoing assessment, care planning, and transition/closure.

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

- Identified in the POC and ISP (if applicable);
- Provided to the recipient; and
- Documented properly.

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HSS staff may review the support coordination and professional assessments/re-assessment documentation, service plans, progress notes and other pertinent information in the recipient record necessary and required for the survey process.

Report of Survey Findings

Upon completion of the on-site survey, HSS staff discusses the preliminary findings of the survey in an exit interview with appropriate provider staff. HSS staff compiles and analyzes all data collected in the survey, and a written report summarizing the survey findings and a notice for required corrective action, if applicable, is sent to the provider.

The review report includes:

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

HSS program managers may review the survey findings 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 survey findings.

This plan must address how each cited deficiency has been corrected and how recurrences will be prevented. The provider is afforded one opportunity to dispute the HSS survey 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 resolution of those deficiencies in question.

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

Informal Dispute Resolution (IDR)

Providers are afforded one opportunity to dispute the deficiencies cited as a result of a survey. The provider is notified of the right to an informal hearing in correspondence that details the cited

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deficiencies. The informal hearing is optional on the part of the provider. In order to request the informal hearing, the provider may contact the IDR program manager at HSS. (See Appendix A for contact information.)

The provider is notified of time and place where the informal hearing will be held. The provider may bring any supporting documentation that is to be submitted for consideration.

The HSS staff conducts the informal hearing in a non-formal atmosphere. The provider is given the opportunity to present its case and to explain its disagreement with the survey findings. The provider representatives are advised of the date that a written response will be sent and are reminded of the right to a formal appeal, if applicable.

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SECTION 30.13: EPSDT-PCS – OVERVIEW**PAGE(S) 1**

EPSDT – PCS OVERVIEW

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) established a program that provides Personal Care Services (PCS) to beneficiaries up to age 21 years meeting the medically necessary criteria for these services. For purposes of this manual hereafter, the services offered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) PCS program are provided by a Medicaid enrolled agency that has a valid Home and Community Based Services - Personal Care Attendant Module License issued by LDH.

The EPSDT – PCS program, by definition, does not include any medical tasks such as medication administration, tracheostomy care, feeding tubes, or catheters. If such tasks are necessary, they must be requested under either the Home Health Program or, if the beneficiary is certified for home and community based waiver services, through the waiver program. BHSF will not accept the physician's delegation for EPSDT – PCS providers to perform such medical tasks.

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SECTION 30.14: EPSDT – PCS COVERED SERVICES**PAGE(S) 5**

EPSDT – PCS COVERED SERVICES

Personal care services are defined as tasks that are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with eating, toileting, bathing, bed mobility, transferring, dressing, locomotion, personal hygiene, and bladder or bowel requirements.

Service Definitions

EPSDT – Personal Care Services include the following tasks:

- Basic personal care, including toileting, grooming, bathing, and assistance with dressing.
- Assistance with bladder and/or bowel requirements or problems, including helping the beneficiary to and from the bathroom or assisting the beneficiary with bedpan routines, but excluding catheterization.
- Assistance with eating and food, nutrition, and diet activities, including preparation of meals for the beneficiary only.
- Performance of incidental household services, only for the beneficiary, not the entire household, which are essential to the beneficiary's health and comfort in his/her home. This does not include routine household chores such as regular laundry, ironing, mopping, dusting, etc., but instead arises as the result of providing assistance with personal care to the beneficiary.

Examples of such activities are:

- Changing and washing the beneficiary's soiled bed linens.
- Rearranging furniture to enable the beneficiary to move about more easily in his/her own home.
- Cleaning the beneficiary's eating area after completion of the meal and/or cleaning items used in preparing the meal, for the beneficiary only.

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- Accompanying, not transporting, the beneficiary to and from his/her physician and/or medical appointments for necessary medical services.
- Assisting the beneficiary with locomotion in their place of service, while in bed or from one surface to another. Assisting the beneficiary with transferring and bed mobility.

Intent of Services:

- EPSDT PCS shall not be provided to meet childcare needs nor as a substitute for the parent or guardian in the absence of the parent or guardian.
- EPSDT PCS shall not be used to provide respite care for the primary caregiver.
- EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services that are provided by or shall be provided by the Department of Education.

Location of Service

EPSDT – PCS shall be provided in the beneficiary’s home, or if medically necessary, in another location outside of the beneficiary’s home. The beneficiary’s own home includes the following: an apartment, a custodial relative’s home, a boarding home, a foster home, or a supervised living facility.

Institutions such as hospitals, institutions for mental disease, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, or residential treatment centers are not considered a beneficiary’s home.

Service Limitations

EPSDT – PCS are not subject to service limits. The units of service approved shall be based on the physical requirements of the beneficiary and medical necessity for the covered services.

Hours may not be “saved” to be used later or in excess of the number of hours specified according to the approval letter.

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SECTION 30.14: EPSDT – PCS COVERED SERVICES**PAGE(S) 5**

Excluded Services

The following services are not appropriate for personal care and are not reimbursable as EPSDT – PCS:

- Insertion and sterile irrigation of catheters (although changing of a catheter bag is allowed);
- Irrigation of any body cavities which require sterile procedures;
- Application of dressing, involving prescription medication and aseptic techniques; including care of mild, moderate or severe skin problems;
- Administration of injections of fluid into veins, muscles or skin;
- Administration of medicine (an EPSDT PCS worker may only remind/prompt about self-administered medication to an EPSDT eligible beneficiary who is over the age of 18),
 - Cleaning of the home in an area not occupied by the beneficiary;
 - Laundry, other than that incidental to the care of the beneficiary;
Example: Laundering of clothing and bedding for the entire household as opposed to simple laundering of the beneficiary's clothing or bedding;
 - Skilled nursing services as defined in the state Nurse Practices Act, including medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks;
 - Teaching a family member or friend how to care for a beneficiary who requires frequent changes of clothing or linens due to total or partial incontinence for which no bowel or bladder training program for the patient is possible;
- Specialized nursing procedures such as:
 - Insertion of nasogastric feeding tube

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- In-dwelling catheter
 - Tracheotomy care
 - Colostomy care
 - Ileostomy care
 - Venipuncture
 - Injections
-
- Rehabilitative services such as those administered by a physical therapist,
 - Teaching a family member or friend techniques for providing specific care,
 - Palliative skin care with medicated creams and ointments and/or required routine changes of surgical dressings and/or dressing changes due to chronic conditions,
 - Teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process,
 - Specialized aide procedures such as:
 - Rehabilitation of the beneficiary (exercise or performance of simple procedures as an extension of physical therapy services).
 - Measuring/recording the beneficiary's vital signs (temperature, pulse, respiration and/or blood pressure, etc.), or intake/output of fluids
 - Specimen collection.
 - Special procedures such as non-sterile dressings, special skin care (non-medicated), decubitus ulcers, cast care, assisting with ostomy care, assisting with catheter care, testing urine for sugar and acetone, breathing exercises, weight measurement, enemas
 - Home IV therapy,
 - Custodial care or provision of only instrumental activities of daily living tasks or provision of only one activity of daily living task,
 - Occupational therapy,

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- Speech pathology services,
- Audiology services,
- Respiratory therapy,
- Personal comfort items,
- Durable medical equipment,
- Oxygen;
- Orthotic appliances or prosthetic devices;
- Drugs provided through the Louisiana Medicaid pharmacy program;
- Laboratory services; and
- Social work visits.

RECIPIENT CRITERIA

Conditions for provisions of EPSDT – Personal Care Services are as follows:

- Medicaid Eligibility

The person must be a categorically eligible Medicaid beneficiary birth through 20 years of age (EPSDT eligible) and have been prescribed medically necessary, age appropriate EPSDT-PCS by a practitioner (physician, advance practice nurse, or physician assistant). The practitioner shall specify the health/medical condition which necessitates EPSDT – Personal Care Services.

- Medical Necessity

An EPSDT eligible shall meet medical necessity criteria as established by the Bureau of Health Services Financing (BHSF) which shall be based on functional and medical eligibility and impairment in at least two activities of daily living (ADL), as determined by BHSF or its designee.

To establish medical necessity, the EPSDT eligible must be of an age at which the tasks to be performed by the PCS provider would ordinarily be performed by the individual, if he/she was not disabled due to illness or injury.

- Physician Referral

EPSDT – PCS shall be prescribed by the recipient’s attending practitioner initially and every 180 days after that (or rolling six months), and when changes in the Plan of Care occur.

The Plan of Care shall be acceptable for submission to BHSF only after the practitioner signs and dates the completed form.

The practitioner’s signature must be an original signature and not a rubber stamp.

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SECTION 30.16: EPSDT – PCS RIGHTS AND RESPONSIBILITIES

EPSDT – PCS RIGHTS AND RESPONSIBILITIES

The beneficiary shall be allowed the freedom of choice to select an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Personal Care Services (PCS) provider. This freedom also extends to the beneficiary’s right to change providers at any time should he or she finds it necessary to cease the relationship with the current provider.

Beneficiaries may contact the Bureau of Health Services Financing directly for assistance in locating an EPSDT – PCS provider to submit a prior authorization request for medically necessary personal care services. (See Appendix H for contact information.)

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SECTION 30.17: EPSDT – PCS PRIOR AUTHORIZATION PAGE(S) 5

EPSDT – PCS PRIOR AUTHORIZATION

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – Personal Care Services are subject to prior authorization (PA) by BHSF or its designee. Services shall not be authorized for more than a six-month period. A face-to-face medical assessment shall be completed by the practitioner. The beneficiary's choice of a personal care services provider may assist the practitioner in developing a plan of care which shall be submitted for review/approval by BHSF or its designee. Beneficiaries may contact the BHSF directly for assistance in locating a provider to submit a prior authorization request for medically necessary personal care services. (See Appendix H for contact information.)

Initial and Subsequent Prior Authorization Requests

All initial and subsequent prior authorization requests for EPSDT – PCS shall be accompanied by the following documents:

- Copy of the beneficiary's Medicaid Eligibility Card;
- Practitioner's referral for PCS;
 - EPSDT – PCS **shall be prescribed** by the beneficiary's attending practitioner initially and every 180 days after that (or rolling six months), and when changes in the Plan of Care occur. The prescription does not have to specify the number of hours being requested, but shall specify PCS and not PCA.
 - The practitioner's signature shall be an original signature or a computer generated electronic signature. Rubber stamped signatures will not be accepted.
 - Signatures by registered nurses on the referrals are not acceptable.
- Plan of Care prepared by the PCS agency with practitioner's approval;

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SECTION 30.17: EPSDT – PCS PRIOR AUTHORIZATION PAGE(S) 5

- The provider may not initiate services or changes in services under the Plan of Care prior to approval by BHSF.

- EPSDT – PCS Form 90;
 - Completed by the attending practitioner;
 - Completed within the last 90 days;
 - Documents the beneficiary requires assistance with at least two activities of daily living (ADL); and
 - Documents a face-to-face medical assessment was completed.

- EPSDT – PCS Daily Schedule Form;

- EPSDT Personal Care Services - Social Assessment Form;

- Request for Prior Authorization Form (PA-14); and

- Other documentation that would support medical necessity (i.e., other independent evaluations).

NOTE: Information about forms used with a prior authorization request can be found in Appendix I.

Requests for prior approval of EPSDT – Personal Care Services should be submitted by fax or electronically (e-PA) to the Prior Authorization Unit. (See Appendix H for contact information.)

The request shall be reviewed by BHSF’s physician consultant and a decision rendered as to the approval of the service. A letter will be sent to the beneficiary, the provider and the support coordination agency, if available, advising of the decision.

Chronic Needs Case

Beneficiaries who have been designated by BHSF as a “Chronic Needs Case” are exempt from the standard prior authorization process. A new request for prior authorization shall still be submitted every 180 days; however, the EPSDT PCS provider shall only be required to submit a PA-14 form accompanied by a statement from the beneficiary’s primary practitioner verifying that the beneficiary’s condition has not improved and the services currently approved must be continued.

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The provider shall indicate “Chronic Needs Case” on the top of the PA-14 form. This determination only applies to the services approved where requested services remain at the approved level.

Requests for an increase in these services will be subject to a full review requiring all documentation used for a traditional PA request.

NOTE: Only BHSF or its designee will be allowed to grant the designation of a “chronic needs case” to a beneficiary.

Plan of Care

The Plan of Care shall be written on the current version of the EPSDT PCS POC – 1 Form which can be downloaded from the Louisiana Medicaid website. (See Appendix I) The form shall be completed in its entirety and shall specify the personal care task(s) to be provided (i.e., activities of daily living for which assistance is needed) and the frequency and duration required to complete each of these tasks.

Dates of service not included in the Plan of Care or services provided before approval of the Plan of Care by BHSF or its designee are not reimbursable.

The beneficiary’s attending practitioner shall review and/or modify the Plan of Care and sign and date it prior to the Plan of Care being submitted to BHSF or its designee.

The Plan of Care shall include the following information:

- Beneficiary name, Medicaid ID number, date of birth and address, phone number;
- Date EPSDT personal care services are requested to start;
- Provider name, Medicaid provider number and address of personal care agency;
- Name and phone number of someone from the provider agency that may be contacted, if necessary for additional information;
- Medical reasons supporting the beneficiary’s need for PCS;
- Other in-home services the beneficiary is receiving;
- Specific personal care tasks (bathing, dressing, eating, etc.) with which PCS provider is to assist the beneficiary;

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SECTION 30.17: EPSDT – PCS PRIOR AUTHORIZATION **PAGE(S) 5**

- Goals for each activity;
- Number of days services are required each week;
- Time requested to complete each activity;
- Total time requested to complete each activity each week,
- Signature of parent/primary caregiver, provider representative and the beneficiary's primary practitioner.

Changes in Plan of Care

Amendments or changes in the Plan of Care shall be submitted as they occur and shall be treated as a new Plan of Care which begins a new six-month service period. Revisions of the Plan of Care may be necessary because of changes that occur in the beneficiary's medical condition which warrant an additional type of service, change in frequency of service or an increase or decrease in duration of service.

Documentation for a revised Plan of Care is the same as for a new Plan of Care. Both a new "start date" and "reassessment date" shall be established at the time of reassessment. The EPSDT PCS provider may not initiate services or changes in services under the Plan of Care prior to approval by BHSF or its designee.

Subsequent Plans of Care

A new Plan of Care shall be submitted at least every 180 days (rolling six months). The subsequent Plan of Care shall:

- Be approved by the beneficiary's attending practitioner;
- Reassess the beneficiary's need for EPSDT – PCS;
- Include any updates to information which has changed since the previous assessment was conducted; and
- Explain when and why the change(s) occurred.

The plan of care shall be acceptable only after the practitioner signs and dates the completed form. The practitioner's signature shall be an original signature and not a rubber stamp.

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SECTION 30.17: EPSDT – PCS PRIOR AUTHORIZATION PAGE(S) 5

Reconsideration Requests

If the prior authorization request is not approved as requested, the provider may submit a request for a reconsideration of the previous decision. When submitting a reconsideration request, providers should include the following:

- A copy of the prior authorization notice with the word “Recon” written across the top and include the reason the reconsideration is being requested written across the bottom;
- All original documentation submitted from the original request; and
- Any additional information or documentation which supports medical necessity.

The reconsideration request packet should be sent to the Prior Authorization Unit via fax or e-PA. After the reconsideration request has been reviewed, a new notification letter with the same prior authorization number will be generated and mailed to the provider, beneficiary, and support coordinator, if the beneficiary has a case manager.

Changing PCS Providers

Beneficiaries have the right to change providers at any time; however, approved authorizations are not transferred between agencies. If a beneficiary elects to change providers within an authorization period, the current agency shall notify the Prior Authorization Unit of the beneficiary’s discharge, and the new agency shall obtain their own authorization through the usual authorization process.

NOTE: Beneficiaries may contact the Bureau of Health Services Financing directly for assistance in locating another provider.

Prior Authorization Liaison

The Prior Authorization Liaison (PAL) was established to facilitate the authorization process for EPSDT beneficiaries who are part of the Request for Services Registry. The PAL assists by contacting the provider, beneficiary, and support coordinator (if the beneficiary has one) when a request cannot be approved by the Prior Authorization Unit because of a lack of documentation or a technical error.

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SECTION 30.18: EPSDT – PCS PROVIDER REQUIREMENTS PAGE(S) 2

EPSDT – PCS PROVIDER REQUIREMENTS

Standards of Participation

Personal care services must be provided by a licensed personal care services agency which is duly enrolled as a Medicaid provider. Agencies providing EPSDT – PCS shall conform to all applicable Medicaid regulations as well as all applicable laws and regulations by federal, state and local governmental entities regarding wages, working conditions, benefits, Social Security deductions, Occupational Safety and Health Administration requirements, liability insurance, Worker’s Compensation, occupational licenses, etc. Agencies shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

EPSDT – PCS shall only be provided to EPSDT beneficiaries and only by a staff member of a licensed Personal Care Attendant (PCA) agency enrolled as a Medicaid personal care services provider.

A copy of the current PCA license must accompany the Medicaid application for enrollment as a PCS provider.

Copies of current licenses shall be submitted to Provider Enrollment thereafter as they are issued for inclusion in the enrollment record. The provider’s enrollment record shall include a current PCA license at all times.

Medicaid enrollment is limited to providers located in Louisiana and certain out-of-state providers located only in the trade areas of Arkansas, Mississippi, and Texas.

Provider agencies shall comply with the policies and procedures contained in the Personal Care Services provider manual for the EPSDT – PCS program.

Electronic Visit Verification

The agency shall use an electronic visit verification (EVV) system for time and attendance tracking and billing for EPSDT PCS.

EPSDT PCS providers identified by BHSF shall use:

- the (EVV) system designated by the department; or
- an alternate system that has successfully passed the data integration process to connect to the designated EVV system, and is approved by the department.

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SECTION 30.18: EPSDT – PCS PROVIDER REQUIREMENTS PAGE(S) 2

Reimbursement for services may be withheld or denied if an EPSDT PCS provider fails to use the EVV system, or uses the system not in compliance with Medicaid’s policies and procedures for EVV.

Staffing

The licensed PCS agency is responsible for ensuring that all direct service workers providing EPSDT PCS meet all training requirements applicable under state law and regulations. Individuals who provide coverage in the PCS worker’s absence must meet all staffing requirements for the PCS worker or supervisor.

Providers must conduct criminal background checks on the direct care and supervisory staff. A worker may be assigned to provide services to a beneficiary prior to the results of the criminal background check under the direct supervision of a permanent employee or in the presence of a member of the immediate family of the beneficiary or a caregiver designated by the immediate family of the beneficiary as outlined in R.S. 40:1300.52(C)(2). If the results of any criminal background check reveal that the employee was convicted of any offenses as described in R.S. 40:1300.53, pursuant to the statutory revision authority of the Louisiana State law institute, the employer shall not hire or may terminate the employment of such person.

Staff assigned to provide personal care services to a beneficiary shall not be a member of the beneficiary’s immediate family. Immediate family is defined as father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the beneficiary. Personal care services may be provided by a person of a degree of relationship to the beneficiary other than immediate family, only if the relative is not living in the beneficiary’s home, or, if he/she is living in the beneficiary’s home solely because his/her presence in the home is necessitated by the amount of care required by the beneficiary.

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SECTION 30.19: EPSDT – PCS SERVICE DELIVERY

EPSDT – PCS SERVICE DELIVERY

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – Personal Care Services providers may not provide services at the same time as other covered services, unless medically necessary.

Medicaid prohibits multiple professional disciplines from being present in the beneficiary’s residential setting at the same time. However, multiple professionals may provide services to multiple beneficiaries in the same residential setting when it is medically necessary. This includes but is not limited to nurses, home health aides, and therapists. BHSF or its designee will determine medical necessity for fee-for-service beneficiaries.

Children’s Choice waiver services and PCS may be performed on the same date, but not at the same time. If the recipient is receiving home health, respite, and/or any other related service, the PCS provider cannot provide service at the same time as the other Medicaid covered service provider.

Recipients who receive EPSDT – PCS may also receive hospice services on the same date, but not at the same time. The hospice provider and the PCS provider must coordinate services and develop the patient’s plan of care.

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SECTION 30.20: EPSDT – PCS RECORD KEEPING**PAGE(S) 2**

EPSDT – PCS RECORD KEEPING

Providers must maintain case records for all EPSDT – PCS beneficiaries and personnel records on all supervisory and direct care staff. Records must be complete, accurately documented, readily accessible, and organized. All records must be retained for a period of five years. Billing records must be maintained for a period of five years from the date of payment.

Any error made in a beneficiary’s or employee’s record must be corrected using the legal method which is to draw a line through the incorrect information, write “error” by it and initial the correction. Correction fluid must never be used in a beneficiary’s or employee’s record.

There shall be a clear audit trail between:

- The prescribing practitioner;
- The personal care services provider agency;
- The person providing the personal care services to the beneficiary; and
- The services provided and reimbursed by Medicaid.

Beneficiary Records

Providers must provide reasonable protection for beneficiary records against loss, damage, destruction, and unauthorized use. A provider must have a separate written record for each beneficiary that includes:

- Copies of all Plans of Care, Social Assessments, EPSDT PCS Form 90, EPSDT – PCS Daily Schedule Forms, and Practitioner’s Order/Prescription for EPSDT Personal Care Services;

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SECTION 30.20: EPSDT – PCS RECORD KEEPING**PAGE(S) 2**

- Dates and results of all evaluation/diagnosis provided in the interest of establishing or modifying the Plan of Care including the tests performed and results, copies of evaluation and diagnostic assessment reports signed by the individual performing the test and/or interpreting the results;

- Documentation of approval of services by BHSF or its designee; and

- Documentation of the provision of services by the Personal Care Services worker including signed daily notes by the worker, and supervisor if appropriate, that include:
 - Date of service;
 - Services provided (checklist is adequate);
 - Total number of hours worked;
 - Time period worked;
 - Condition of beneficiary;
 - Service provision difficulties;
 - Justification for not providing scheduled services; and
 - Any other pertinent information.

Availability of Records

Providers must make beneficiary and personnel records available to LDH, its designee and/or other state and federal agencies upon request. The provider shall be responsible for incurring the cost of copying records for LDH or its designee.

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SECTION 30.21: EPSDT – PCS REIMBURSEMENT**PAGE(S) 1**

EPSDT – PCS REIMBURSEMENT

All claims for EPSDT – PCS shall be filed by electronic claims submission 837P or on the CMS 1500 claim form. Providers must utilize the HIPAA compliant billing procedure code and modifier. Refer to Appendix E for information about procedure code, unit of service and the current reimbursement rate. EPSDT – PCS shall be paid the lesser of billed charges or the maximum unit rate set by BHSF.

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

If the claim for EPSDT – PCS is submitted without the prior authorization number, the claim will automatically deny with the error code “191” (Procedure Requires Prior Authorization).

If the dates of services on the claim are not within the dates in the prior authorization, the claim will be denied with error code “193” (Date on Claim Not Covered by PA).

If an incorrect number of units are billed, the claim will be denied with error code “194” (Claim Exceeds Prior Authorized Limits).

Hours may not be “saved” to be used later or in excess of the number of hours specified in the approval letter.

Hardcopy claims must be mailed to the Fiscal Intermediary. (See Appendix H for contact information.)

LT-PCS FORMS AND LINKS

The following documents, forms, links and manuals are available on the following website addresses:

Form/Document/Website Name	Website Address
Health Standards Section DSW Guidelines	http://www.ldh.la.gov/index.cfm/page/3779
Long Term-Personal Care Services (LT-PCS) Service Log	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/Forms/LT-PCSServiceLogAndInstructions.pdf
Release of Confidentiality for Shared Personal Assistance Services (PAS) or Long Term-Personal Care Services (LT-PCS)	http://new.dhh.louisiana.gov/assets/docs/OAAS/publications/Forms/Confidentiality-Consent-Shared-Services.pdf
Who Can Be A Direct Support Worker (DSW) for PAS & LT-PCS?	http://dhh.louisiana.gov/assets/docs/OAAS/Manuals/dswflowchart.pdf
Rights and Responsibilities for LT-PCS Applicants/Participants	http://www.ldh.la.gov/assets/docs/OAAS/publications/RightsRespon_LTPCS.pdf
Louisiana State Adverse Actions List Search and Office of the Inspector General	https://adverseactions.ldh.la.gov/SelSearch https://exclusions.oig.hhs.gov/

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APPENDIX A – LT-PCS FORMS AND LINKS

Federal System Award Management	https://www.sam.gov/SAM/pages/public/searchRecords/search.jsf
Medicaid Services Chart	http://www.ldh.la.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf

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APPENDIX B: LT-PCS – CONTACT INFORMATION

LT-PCS CONTACT INFORMATION

Office Name	Type of Assistance	Contact Information
<p>Conduent (Access Contractor)</p>	<p>Office to send signed “Agreement to Provide Services” and who to contact when requesting LT-PCS</p>	<p>Long Term Care (LTC) Access Services 2900 Westfork Drive, Suite 540 Baton Rouge, LA 70827 Phone #: 877-456-1146 TDD #: 877-544-9544 Fax #: 866-246-8511</p>
<p>OAAS State Office</p>	<p>Provides LT-PCS policy clarification and receives complaints regarding the long-term care services access contractor</p>	<p>Office of Aging and Adult Services P. O. Box 2031 Baton Rouge, LA 70821-2031 Phone #: 1-866-758-5035 Fax #: 225-219-0202</p>
<p>OAAS Regional Offices</p>	<p>Reviews and provides approval of waiver services (including ADHC Waiver with LT-PCS) and offers providers technical assistance</p>	<p>http://new.dhh.louisiana.gov/index.cfm/directory/category/141</p>
<p>Gainwell Provider Enrollment Unit</p>	<p>Office to contact to report changes in provider ownership, address, telephone number or account information affection electronic funds transfer</p>	<p>Gainwell Provider Enrollment Unit P.O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 or (225) 924-5040 http://www.lamedicaid.com/provweb1/Provider_Enrollment/ProviderEnrollmentIndex.htm</p>
<p>Gainwell Provider Relations Unit</p>	<p>Office to contact to obtain assistance with questions regarding billing information and billing issues</p>	<p>Gainwell Provider Relations Unit P.O. Box 91024 Baton Rouge, LA 70821 1-800-473-2783 or (225) 924-5040 http://www.lamedicaid.com/provweb1/Provider_Support/provider_supportindex.htm</p>

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APPENDIX B: LT-PCS – CONTACT INFORMATON

<p>Statistical Resources, Inc.</p>	<p>Agency to contact regarding LaSRS, EVV, and PA Billing Issues</p>	<p>11505 Perkins Road Suite #H Baton Rouge, LA 70810 (225) 767-0501 Fax#: (225) 767-0502</p>
<p>Division of Administrative Law - Louisiana Department of Health Section</p>	<p>Office to contact to request an appeal hearing</p>	<p>Division of Administrative Law – LDH Section Post Office Box 4189 Baton Rouge, LA 70821-4189 Physical: 1020 Florida Street Baton Rouge, LA 70802 Phone #: (225) 342-5800 Fax #: (225) 219-9823 https://www.adminlaw.state.la.us/</p>
<p>LDH - Health Standards Section</p>	<p>Office to contact to report changes that affect provider license (e.g. address change, change of ownership, etc.) Office to contact when providers wish to request an informal hearing as the result of a provider’s receipt of a statement of deficient practice or file a complaint against a provider by a recipient</p>	<p>Health Standards Section P. O. Box 3767 Baton Rouge, LA 70821 Phone #: 1-800-660-0488</p>
<p>Medicaid Program Integrity</p>	<p>Office to contact to report Medicaid fraud</p>	<p>Provider Fraud Hotline #: 1-800-488-2917 Recipient Fraud Hotline #: 1-888-342-6207 Provider Fraud Fax #: (225) 216-6129 Recipient Fraud Fax #: (225) 389-2610 http://new.dhh.louisiana.gov/index.cfm/page/219</p>
<p>Adult Protective Services</p>	<p>Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of adults ages 18-59 and emancipated minors</p>	<p>1-800-898-4910</p>

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APPENDIX B: LT-PCS – CONTACT INFORMATION

Elderly Protective Services	Office to contact to report suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older	1-833-577-6532
Myers and Stauffer LC	Information about filing cost reports	http://www.mslc.com/Louisiana/HCBS.aspx

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APPENDIX C – BILLING CODES

BILLING CODES

All personal care services must be prior authorized and billed using the appropriate provider number that was issued for personal care services.

EPSDT:

Procedure Code	Modifier	Description	Unit Size	Reimbursement Rate
T1019	EP	EPSDT – Personal Care Services	15 min	\$3.50

LT-PCS:

Information on procedure codes and the current rates is available at:

Program	Website Address
LT-PCS	https://www.lamedicaid.com/provweb1/fee_schedules/LTPCSServiceCodeRateChart.pdf

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APPENDIX D – RESERVED

GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Personal Care Services (PCS) Manual Chapter for long-term personal care services (LT)-PCS and Early and Periodic Screening Diagnosis and Treatment (EPSDT)-PCS.

Abuse - The infliction of physical and mental injury or actions which may reasonably be expected to inflict physical 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. (La R.S. 15:1503)

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

Activities of Daily Living (ADLs) - The functions or basic self-care tasks which an individual performs in a typical day, either independently or with supervision/assistance. Activities of daily living include bathing, dressing, eating, grooming, walking, transferring and/or toileting. The extent to which a person requires assistance to perform one or more of these activities often is a level of care criterion.

Adult Day Health Care (ADHC) Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 22-64 and have a physical disability, and meet nursing facility level of care requirements.

Adult Protective Services (APS) - the office within Office of Aging and Adult Services (OAAS) that handles reports of suspected cases of abuse, neglect, exploitation or extortion of adults ages 18-59 and emancipated minors.

Advocacy – The process of assuring that beneficiaries receive appropriate high quality supports and services and locating additional services needed by beneficiaries which are not readily available in the community.

Agreement to Provide Services - An agreement between the long-term personal care services (LT-PCS) provider and the LT-PCS beneficiary. The agreement specifies responsibilities with respect to the provision of services.

Appeal – A request for a fair hearing concerning a proposed agency action, a completed agency action, or failure of the agency to make a timely determination; a legal proceeding in which the applicant/enrollee and OAAS representative, or designee, presents the case being appealed in front

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of an impartial hearing officer. (See Fair Hearing).

Approval Date – The date the plan of care is approved.

Applicant – An individual who is requesting Medicaid services (LT-PCS or EPSDT-PCS).

Assessment – One or more processes that are used to obtain information about a person, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that a person meets nursing facility level of care and requirements of the LT-PCS program. The results are used to develop the Plan of Care (POC) and an Individualized Service Plan (ISP).

Beneficiary – An individual who has been certified for PCS through the Medicaid Program. A beneficiary may also be referred to as a recipient and/or participant.

Bureau of Health Services Financing - The bureau within the Louisiana Department of Health (LDH) that is responsible for the administration of the Medicaid Program.

Centers for Medicare and Medicaid (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

Certification Period – The time period that a Long Term-Personal Care Service beneficiary is qualified to receive services.

Chronic Needs Case – A designation granted to some EPSDT – Personal Care Service beneficiaries by the Prior Authorization Unit when the beneficiary’s medical condition is such that services are expected to be continuous and remain at the level currently approved.

Community Choices Waiver (CCW) – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 21 – 64 and have a physical disability and meet the nursing facility level of care requirements.

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

Corrective Action Plan – Written description of action a provider plans to take to correct identified deficiencies.

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

Direct Care Staff – Unlicensed staff paid to provide personal care and other direct service and support to persons qualified beneficiaries to enhance their well-being, and who are involved in face-to-face direct contact with the beneficiary.

Elderly Protective Services (EPS) - The office within the Governor’s Office of Elderly Affairs that handles reports of suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older.

Electronic Visit Verification (EVV) – A web-based system that electronically records and documents the precise date, start and end times that services are provided to beneficiaries. The EVV system will ensure that LT-PCS beneficiaries are receiving services authorized in their POCs, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight.

Eligibility – The determination of whether or not a beneficiary qualifies to receive services based on meeting established criteria as set by LDH.

Enrollment – A determination made by LDH that a provider meets the necessary requirements to participate as a Medicaid provider. This is also referred to as provider enrollment or certification.

Exploitation – The illegal or improper use or management of the funds, assets or property, of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one’s own profit or advantage. (La. R.S. 15:1503)

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. R.S. 15:1503)

Early and Periodic Screening Diagnosis and Treatment (EPSDT) – Medicaid’s comprehensive and preventive child health program for individuals who are under the age of 21.

Fair Hearing – A legal proceeding in which the beneficiary and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer.

Fiscal Intermediary – The contractor, managed by the Medicaid Management Information System, which processes claims, issues payments to providers, handles provider inquiries and complaints, and provides training for providers.

Formal Services – Another term for professional and paid services.

Good Cause – An acceptable reason to change providers outside of the designated circumstances and timelines.

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Health Standards Section (HSS) – A section of the LDH responsible for the licensure and enforcement of compliance of those health care providers licensed by the Health Standards Section (HSS).

Hospice – An alternative treatment approach for a terminally ill patient that focuses on palliative care and support for his/her family.

Individualized Service Plan (ISP) – An individualized written plan of action to be completed and followed by providers to address the beneficiary’s difficulties, health care needs, and services based upon his/her assessment. A comprehensive POC prepared in accordance with policies, procedures, and timelines established by Medicaid or by an LDH program office for reimbursement purposes may be substituted or used for the individual service plan for in-home providers.

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

Institutionalization – The placement of a beneficiary in an inpatient facility including, but not limited to a hospital, nursing facility, or psychiatric hospital.

Instrumental Activities of Daily Living (IADLs) – Those routine household tasks that are considered essential for sustaining the individual’s health and safety, but may not require performance on a daily basis.

Intake – The LT-PCS screening process consisting of activities necessary to determine the need and qualifications for personal care services.

Level of Care Eligibility Tool (LOCET) – An algorithm-based screening tool that is used by OAAS and/or its designee during the initial intake screening process to determine whether an applicant “presumptively” meets Nursing Facility Level of Care (NFLOC) eligibility criteria.

Licensure – A determination by the HSS that a provider meets the requirements of State law to provide health care and services.

Linkage – Act of connecting a beneficiary to a specific provider.

Long-Term Care (LTC) Access Contractor – The contractor who is responsible for managing the authorization of services for beneficiaries in the LT-PCS program.

Long Term-Personal Care Services (LT-PCS) – An optional Medicaid State Plan service which provides assistance with the ADL and IADL as an alternative to institutional care to qualified Medicaid beneficiaries who are age 21 or older and meet specific program requirements.

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Louisiana Department of Health (LDH) – The state agency responsible for administering the state’s Medicaid Program and other health and related services including aging and adult services, public health, mental health, developmental disabilities, and behavioral health services.

Louisiana Service Reporting System (LaSRS) – A secure modular web application developed by an LDH contractor to issue prior authorizations (Pas) for LT-PCS and confirm post authorizations through EVV.

Medicaid – A federal-state financed medical assistance program that is provided under approved State Plan under Title XIX of the Social Security Act.

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

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

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

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

Non-allowable costs – Costs that are not based on the reasonable cost of services covered under Medicare/Medicaid and are not related to the care of beneficiaries.

Nursing Facility (NF) – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides intermediate, skilled nursing, and/or long-term care for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within the LDH that is responsible for the management and oversight of certain Medicaid home and community-based services waiver programs, state plan programs, including LT-PCS, adult protective services for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

OAAS Regional Office – One of nine administrative offices within the Office of Aging and Adult

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Services.

Office for Citizens with Developmental Disabilities (OCDD) – The office in LDH responsible for services to individuals with developmental disabilities.

Program of All-Inclusive Care for the Elderly (PACE) – A program under the Medicaid State Plan that is a capitated, managed care program that coordinates and provides all needed preventative, primary health, acute and long-term care services for enrolled beneficiaries.

Person-Centered – An approach used in the assessment and planning processes that considers a beneficiary’s personal experiences and preferences.

Personal Outcome – Result achieved by or for the beneficiary through the provision of services and supports that make a meaningful difference in the quality of the individual’s life.

Personal Representative – An individual designated by a Medicaid beneficiary to act on his/her behalf when applying for and/or receiving Medicaid services.

Plan of Care (POC) – A written person-centered plan developed by the beneficiary, his/her authorized representative and based on assessment results. This document identifies each service area and outlines how services will be delivered to a beneficiary based on his/her preferences.

Prior Authorization Liaison (PAL) – Facilitates the prior authorization approval process for EPSDT-PCS beneficiaries who are part of the Request for Services Registry.

Progress Notes – Documentation of the delivery of services, activities, and/or observations of a beneficiary.

Provider – A licensed provider that delivers Medicaid personal care services under a provider agreement with the LDH.

Provider Agreement – A contract between the provider of services and the Medicaid program or other LDH office. The agreement specifies responsibilities with respect to the provision of services and payment under Medicaid or other LDH office.

Provider Enrollment – See “Enrollment”.

Re-assessment – See “Assessment”. The re-assessment is completed at least once every 18 months for LT-PCS beneficiaries and when status changes occurs in order to update the POC and/or ISP.

Responsible/Personal Representative – An adult who has been designated by the beneficiary to act

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on his/her behalf with respect to his/her services. The written designation of a responsible representative does not give legal authority for that individual to independently handle the beneficiary’s business without the beneficiary’s involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction.

Self-neglect – The failure, either by the adult’s action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 15:1503)

Service Area – A designated region where services are provided.

Service Period Authorization – The period that a provider is authorized to provide services.

Sexual Abuse – Any non-consensual sexual activity between a beneficiary and another individual. 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 beneficiary to perform sex with any other person when beneficiary is not capable of or competent to refuse.

Supports Waiver - A 1915(c) waiver designed 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.

Transition – A shift from a beneficiary’s current services to another appropriate level of services, including discharge from all services.

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

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**EPSDT-PCS
 CONTACT INFORMATION**

Common Questions	Who to Contact	Contact Information
Who can beneficiaries call to request assistance in locating an EPSDT-PCS provider?	Bureau of Health Services Financing	1-888-758-2220
Where do providers send their prior authorization requests?	DXC Technology – Prior Authorization Unit	Fax: (225) 216-6481 Electronic: www.lamedicaid.com
Where do providers send their claims?	DXC Technology	DXC Technology Electronically at www.lamedicaid.com or P. O. Box 91020 Baton Rouge, LA 70821
Who do providers contact regarding billing problems?	DXC Technology	1-800-473-2783 or (225) 924-5040

EPSDT – PCS FORMS

The following forms are used in the EPSDT Personal Care Services program and can be downloaded from www.lamedicaid.com at the “Forms/Files/Surveys/User Manuals” link:

- Request for Prior Authorization (PA – 14)
- Request for Medicaid EPSDT – Personal Care Services (EPSDT PCS Form 90)
- EPSDT Personal Care Services – Plan of Care (EPSDT PCS POC – 1)
- EPSDT Personal Care Services – Social Assessment Form (EPSDT PCS Social Assessment – 2)
- EPSDT PCS Daily Schedule (EPSDT PCS Daily Schedule – 3)

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CLAIMS RELATED INFORMATION

Hard copy billing of Personal Care Services (PCS) are billed on the CMS-1500 (02/12) claim form or electronically in the 837P 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:

Gainwell 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, directory link "HIPAA Information Center, sub-link "5010v of the Electronic Transactions" – 837P Professional Guide.)

This appendix includes the following:

- Instructions for completing the CMS 1500 claim form and samples of completed CMS-1500 claim forms; and

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

CMS 1500 (02/12) Billing Instructions for Personal Care Services

Locator #	Description	Instructions	Alerts
1	Medicare / Medicaid / Tricare Champus / Champva / Group Health Plan / Feca Blk Lung	Required -- Enter an “X” in the box marked Medicaid (Medicaid #).	
1a	Insured’s I.D. Number	Required – Enter the recipient/beneficiary’s 13-digit Medicaid I.D. number exactly as it appears when checking recipient/beneficiary eligibility through MEVS, eMEVS, or REVS. NOTE: The recipient/beneficiary’s 13-digit Medicaid ID number <u>must</u> be used to bill claims. The CCN number from the plastic ID card is NOT acceptable. The ID number must match the recipient/beneficiary’s name in Block 2.	
2	Patient’s Name	Required – Enter the recipient/beneficiary’s last name, first name, middle initial.	
3	Patient’s Birth Date Sex	Required – Enter the recipient/beneficiary’s date of birth using six digits (MM DD YY). If there is only one digit in this field, precede that digit with a zero (for example, 01 02 07). Enter an “X” in the appropriate box to show the sex of the recipient/beneficiary.	

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Locator #	Description	Instructions	Alerts
4	Insured’s Name	Situational – Complete correctly if the recipient/beneficiary has other insurance; otherwise, leave blank.	
5	Patient’s Address	Optional – Print the recipient/beneficiary’s permanent address.	
6	Patient Relationship to Insured	Situational – Complete if appropriate or leave blank.	
7	Insured’s Address	Situational – Complete if appropriate or leave blank.	
8	RESERVED FOR NUCC USE	Leave Blank.	
9	Other Insured’s Name	Situational – Complete if appropriate or leave blank.	
9a	Other Insured’s Policy or Group Number	Leave Blank.	
9b	RESERVED FOR NUCC USE	Leave Blank.	
9c	RESERVED FOR NUCC USE	Leave Blank.	
9d	Insurance Plan Name or Program Name	Situational – Complete if appropriate or leave blank.	
10	Is Patient’s Condition Related To:	Situational – Complete if appropriate or leave blank.	
11	Insured’s Policy Group or FECA Number	Situational – Complete if appropriate or leave blank.	
11a	Insured’s Date of Birth Sex	Situational – Complete if appropriate or leave blank.	
11b	OTHER CLAIM ID (Designated by NUCC)	Leave Blank.	

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Locator #	Description	Instructions	Alerts
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	Patient’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	Leave Blank.	
17	Name of Referring Provider or Other Source	<p>Situational – Complete if applicable. Enter the applicable qualifier to the left of the vertical, dotted line to Identify which provider is being reported.</p> <p>o DK Ordering Provider</p> <p>In the following circumstances, entering the name (First Name, Middle Initial, Last Name) followed by the credentials of the ordering physician or non-physician practitioner and appropriate qualifier is required:</p> <ul style="list-style-type: none"> • EPSDT - PCS Services always require an ordering 	<p>For LA Medicaid other source is defined as the ordering provider.</p> <p>Any provider entered as an ordering provider must be enrolled with LA Medicaid.</p> <p>Note: LTPCS does not require an ordering provider but if no one is</p>

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Locator #	Description	Instructions	Alerts
		provider	listed on the claim, it must be valid.
17a	Other ID #	Situational Complete if applicable. Enter the 7-digit Medicaid ID number of the ordering provider.	Enter the 7- digit Medicaid ID Number here.
17b	NPI#	Situational – Complete if applicable. Enter the NPI number of the ordering provider.	The 10-digit NPI Number is <u>required</u> .
18	Hospitalization Dates Related to Current Services	Optional.	
19	Additional Claim Information (Designated by NUCC)	Leave Blank.	
20	Outside Lab? \$Charges	Leave Blank.	

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Locator #	Description	Instructions	Alerts
21	ICD Indicator Diagnosis or Nature of Illness or Injury	<p>Required -- Enter the applicable ICD indicator to identify which version of ICD coding is being reported between the vertical, dotted lines in the upper right-hand portion of the field. 0 ICD-10-CM</p> <p>Required -- Enter the most current ICD diagnosis code.</p> <p>NOTE: ICD-10 external cause of injury diagnosis codes V, W, X and Y will be accepted as <u>non-primary</u> diagnosis codes</p>	<p>The most specific diagnosis codes must be used. General codes are not acceptable.</p>

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Locator #	Description	Instructions	Alerts
22	Resubmission Code and/or Original Reference Number	<p>Situational – If filing an adjustment or void, enter an “A” for an adjustment or a “V” for a void as appropriate AND one of the appropriate reason codes for the adjustment or void in the “Code” portion of this field.</p> <p>Enter the internal control number from the paid claim line as it appears on the remittance advice in the “Original Ref. No.” portion of this field.</p> <p>Appropriate reason codes follow:</p> <p><u>Adjustments</u> 01 = Third Party Liability Recovery 02 = Provider Correction 03 = Fiscal Agent Error 90 = State Office Use Only – Recovery 99 = Other</p> <p><u>Voids</u> 10 = Claim Paid for Wrong Recipient/Beneficiary 11 = Claim Paid for Wrong Provider 00 = Other</p>	<p>To adjust or void more than one claim line on a claim, a separate form is required for each claim line since each line has a different internal control number.</p>
23	Prior Authorization (PA) Number	<p>Required – Enter the 9-digit prior authorization number for the authorized services.</p>	
24	Supplemental Information	<p>Situational.</p>	
24A	Date(s) of Service	<p>Required -- Enter the date of service for each procedure.</p> <p>Either six-digit (MM DD YY) or eight-digit (MM DD YYYY) format is acceptable.</p>	
24B	Place of Service	<p>Required -- Enter the appropriate place of service code for the services rendered.</p>	

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

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Locator #	Description	Instructions	Alerts
24C	EMG	Leave Blank.	
24D	Procedures, Services, or Supplies	<p>Required -- Enter the procedure code(s) for services rendered in the unshaded area(s).</p> <p>Enter appropriate modifier with procedure code:</p> <p>UB = LT-PCS EP = EPSDT-PCS</p>	
24E	Diagnosis Pointer	<p>Required – Indicate the most appropriate diagnosis for each procedure by entering the appropriate reference number letter (“A”, “B”, etc.) in this block.</p> <p>More than one diagnosis/reference number may be related to a single procedure code.</p>	
24F	\$Charges	Required -- Enter usual and customary charges for the service rendered.	
24G	Days or Units	Required -- Enter the number of units billed for the procedure code entered on the same line in 24D.	
24H	EPSDT Family Plan	Situational – Leave blank or enter a “Y” if services were performed as a result of an EPSDT referral.	
24I	I.D. Qual.	Optional. If possible, leave blank for Louisiana Medicaid billing.	
24J	Rendering Provider I.D. #	Leave Blank.	
25	Federal Tax I.D. Number	Optional.	
26	Patient’s Account No.	Situational – Enter the provider specific identifier assigned to the recipient/beneficiary. This number will appear on the Remittance Advice (RA). It may consist of letters and/or numbers	

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Locator #	Description	Instructions	Alerts
		and may be a maximum of 20 characters.	
27	Accept Assignment?	Optional. Claim filing acknowledges acceptance of Medicaid assignment.	
28	Total Charge	Required – Enter the total of all charges listed on the claim.	
29	Amount Paid	Leave Blank.	
30	Reserved for NUCC use	Leave Blank.	
31	Signature of Practitioner or Supplier Including Degrees or Credentials Date	Optional – For the PCS CMS 1500, the practitioner or the practitioner’s authorized representative’s original signature is no longer required. Required -- Enter the date of the signature.	
32	Service Facility Location Information	Situational – Complete as appropriate or leave blank.	
32a	NPI	Optional.	
32b	Unlabeled	Situational – Complete if appropriate or leave blank.	
33	Billing Provider Info & Phone #	Required -- Enter the provider name, address including zip code and telephone number.	
33a	NPI	Required – Enter the billing provider’s 10-digit NPI number.	The 10-digit NPI Number must appear on paper claims.

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APPENDIX J: CLAIMS RELATED INFORMATION

Locator #	Description	Instructions	Alerts
33b	Other ID #	<p>Required – Enter the billing provider’s 7-digit Medicaid ID number.</p> <p>ID Qualifier - Optional. If possible, leave blank for Louisiana Medicaid billing.</p>	<p>The 7-digit Medicaid Provider Number <u>must</u> appear on paper claims.</p>

Sample PCS Claim Form – See below.

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION



HEALTH INSURANCE CLAIM FORM

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

Mail completed forms to:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

PICA PICA

1. MEDICAID <input checked="" type="checkbox"/> (Medicaid) <input type="checkbox"/> (Medicare) <input type="checkbox"/> (TRICARE) <input type="checkbox"/> (CHAMPVA) <input type="checkbox"/> (GROUP HEALTH PLAN) <input type="checkbox"/> (ECCA/SEKELUNG) <input type="checkbox"/> (OTHER)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE		3. PATIENT'S BIRTH DATE MM DD YY 06 11 05 SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M	
5. PATIENT'S ADDRESS (No., Street) 1234 ANYLANE		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY: MYTOWN STATE: LA		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 999-7777		CITY: STATE:	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. RESERVED FOR NUCC USE d. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. INSURED'S POLICY OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, complete items 9, 9a, and 9d.	
13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED: DATE:		14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED: DATE:	
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 DK JOHN DOE, MD		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Please A-L to service line below (24E) ICD Ind: 0		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. Days of URS H. EPST/Primary PIA I. ID QUAL J. REFERRING PROVIDER ID.#		23. PRIOR AUTHORIZATION NUMBER 123456789	
1 03 01 19 03 01 19 12 T1019 EP A 48.00 16 NPI			
2 03 02 19 03 02 19 12 T1019 EP A 45.00 15 NPI			
3 03 05 19 03 05 19 12 T1019 EP A 48.00 16 NPI			
4 03 06 19 03 06 19 12 T1019 EP A 24.00 8 NPI			
5			
6			
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 1234	
27. ACCEPT ASSIGNMENT? (For great claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 165.00	
29. AMOUNT PAID \$		30. Res'd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials) (certify that the statements on the reverse apply to this bill and are made a part hereof) IMMA BILLER		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	
SIGNED: 03/08/19 DATE		33. BILLING PROVIDER INFO & PH# (800) 233-3333 PCS AGENCY 700 MAIN ST ANY TOWN, LA 70000	
		c. 1326547895 d. 1987654	

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APPROVED CMB-0935-1197 FORM 1500 (02-12)

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Adjustments and Voids

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

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

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

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

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

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

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

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

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

CHAPTER 30: PERSONAL CARE SERVICES

APPENDIX J: CLAIMS RELATED INFORMATION

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.

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

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

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

Sample PCS Claim Form Adjustment Form – See below.

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APPENDIX J: CLAIMS RELATED INFORMATION



HEALTH INSURANCE CLAIM FORM

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

Mail completed forms to:

Gainwell Technologies
P.O. Box 91020
Baton Rouge, LA 70821

<input type="checkbox"/> PICA <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRI-CARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA EXCLUDING <input type="checkbox"/> OTHER		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 1234567890123	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LOU, JANNIE		3. PATIENT'S BIRTH DATE 06 11 05 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) 1234 ANYLANE		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY: MYTOWN STATE: LA		7. INSURED'S ADDRESS (No., Street) CITY: STATE:	
ZIP CODE: 70000 TELEPHONE (Include Area Code): (225) 999-7777		ZIP CODE: TELEPHONE (Include Area Code):	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. RESERVED FOR NUCC USE		b. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> #yes, complete items 9, 9a, and 9d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			
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.		18. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
SIGNED: DATE:		SIGNED:	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DK JOHN DOE, MD		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below. (I4E)		22. SUBMISSION CODE A 02 ORIGINAL REF. NO. 9070123456002	
A: G808 B: C: D: E: F: G: H: I: J: K: L:		23. PRIOR AUTHORIZATION NUMBER PA # IF APPLICABLE	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY E. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) ICD ICDPCS MODIFIER E. DIAGNOSIS POINTER		F. \$ CHARGES G. PAID IN UNITS H. SPOT TENDY PLAN I. ID. QUAL J. RENDERING PROVIDER ID. #	
1 03 01 19 03 01 19 12 T1019 EP A 42,00 14 NPI		25. FEDERAL TAX I.D. NUMBER SSN/EIN 26. PATIENT'S ACCOUNT NO. 1234 27. ACCEPT ASSIGNMENT? (For opt. claims, see 1033) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 28. TOTAL CHARGE \$ 42,00 29. AMOUNT PAID \$ 30. Rev'd for NUCC Use	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS. (I certify that the statements on the reverse apply to this bill and are made a part hereof.) IMMA BILLER		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	
SIGNED: 03/29/19 DATE:		33. BILLING PROVIDER INFO & PH# (800) 233-3333 PCS AGENCY 700 MAIN ST ANY TOWN, LA 70000 a. 1326547895 b. 1987654	

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APPENDIX J: CLAIMS RELATED INFORMATION



HEALTH INSURANCE CLAIM FORM

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

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

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