

Office of Aging and Adult Services
--Community Choices Waiver Services--

Support Coordination

A service designed to assist participants in accessing and coordinating all needed services, regardless of the funding source. Services to be accessed and coordinated include but are not limited to: waiver services; state plan services; medical services; educational services; and housing. The support coordinator is also responsible for linking waiver participants to other federal, state and local programs; evaluation and re-evaluation of level of care eligibility; assessment and reassessment of the need for waiver services; development and/or review of the service plan; monitoring the participant's health and welfare; monitoring the provision of services included in the recipient's plan of care; addressing problems in service provision; responding to participant crises; and determining the cost neutrality of waiver services for an individual.

+ Provider Enrollment Requirements

- Obtain initial certification from Health Standards
- Contact OAAS and complete the following OAAS requirements in the order listed below prior to enrolling with Medicaid:
 1. Provide to OAAS a copy of Health Standards Certification.
 2. Provide to OAAS the "OAAS Support Coordination Performance Agreement Signature Form" (*i.e.*, the original signed form)
 3. Purchase a Citrix Account at a cost of \$385.15 (price subject to change without notice). This account allows access to client assessment information. Initially, the agency will have access to a test site only. Full access will be made available after the agency has been approved as an enrolled provider. Call (225)342-6491 to purchase.
 4. One support coordinator supervisor and one support coordinator must complete and pass the Assessment and Care Planning Certification Training and attend orientation by the OAAS regional office. Information about the Assessment and Care Planning Training can be found at the OAAS website: <http://new.dhh.louisiana.gov/index.cfm/page/463>
 5. Submit support coordination agency brochure to OAAS for approval.
 6. Provide to OAAS the completed "OAAS Support Coordination Agency Key Personnel/Contact Information" form
- Obtain approval letter from OAAS indicating all requirements met
- Complete Medicaid enrollment process by completing both the basic and specific (Provider type 08: OAAS Case Management [Support Coordination) provider enrollment packets posted to the LA Medicaid website: <http://www.lamedicaid.com>
- Once OAAS is notified that the agency has completed the Medicaid provider enrollment process, the agency will be added to the freedom of choice list
- Once the newly enrolled agency has received first linkage (referral) the agency shall contact Statistical Resources, Inc. (SRI) at 225/767-0501 to complete Case Management Information System (CMIS) training.
- Prior & Post Authorization
- Unit of service – one (1) month
- Provisional or comprehensive POC is sent to SRI
- For the POC year, SRI issues two (2) PAs each for five (5) to seven (7) months.

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- One (1) unit is released for the previous month once requirements are met and documented in CMIS

Transition Intensive Support Coordination

A service designed to assist nursing facility residents in accessing and coordinating all services necessary for moving out of the nursing home, regardless of the funding source. This service can be provided for a maximum of six months prior to transition from the nursing facility. See the description of Support Coordination above for additional details on the support coordinator's responsibilities to participants transitioning from nursing facilities.

+ Provider Enrollment Requirements

Same as for Support Coordination

+ Prior and Post Authorization

- Unit of service – one (1) month
- Provisional or initial POC indicating the participant currently resides in a nursing home is sent to SRI
- SRI issues one (1) PA for a maximum of 6 months prior to transition from the nursing facility based on what is included in the POC
- One (1) unit is released for the previous month once requirements are met and documented in CMIS

Transition Services

These are time limited, non-recurring set-up expenses available for participants transitioning from nursing facilities. Allowable expenses are those necessary to enable the participant to establish a basic household and include the following: housing security deposits; specific set-up fees for telephone, electricity, gas, water and other such housing start-up fees or deposits; essential furnishings for the living room, dining room, kitchen and bedroom; and health and welfare assurances including pest control/eradication, fire extinguisher, smoke detector, and first aid supplies/kit. There is a \$1,500.00 lifetime maximum for these services.

+ Provider Enrollment Requirements

Same as for Support Coordination

+ Prior and Post Authorization

- After purchases are made, the “*Transition Service Expense and Planning Approval (TSEPA) Form*”, the Provisional POC, POC or revised POC that includes Transition Services, and receipts are sent to SRI
- If information is complete, accurate, and everything matches, SRI simultaneously issues and releases one (1) PA to the authorizing Support Coordination agency
- Upon receipt of reimbursement, the Support Coordination agency is responsible for reimbursing the purchaser (family, provider, own agency, self...)

Environmental Accessibility Adaptations

These services are adaptations to the participant's home to reasonably assure health and welfare and to enable the participant to function with greater independence in the home.

+ Provider Enrollment Requirements for EAA Assessor/Inspector/Approver

- Affirm and attest to the following (via notarized statement):
 - All statements made on the enrollment application and attachments are true and correct

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- All EAA Assessor/Inspector/Approver services provided to Community Choice Waiver participants are prior authorized before services are rendered
- Have the following professionals on staff or under contract: licensed and registered Occupational Therapist, licensed Physical Therapist, and Rehabilitation Engineer credentialed as either an Assistive Technology Professional or a Registered Environmental Technician
- That professionals on staff or under contract have completed a minimum of 25 assessments in their particular area of service
- That professionals on staff or under contract have knowledge and experience to assess waiver participants and their home environments to determine whether or not there is a need for environmental adaptations to the home, provide a written report and recommendations, develop specifications for needed environmental adaptations, and perform mid-term and final inspections for environmental adaptations to the home.
- That violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid
- Enroll as Medicaid provider type 15 (Environmental Accessibility Adaptation – Waiver) with provider sub-specialty of 8Q (EAA Assessor, Inspector, Approver)
- Provider Enrollment packet checklist instructions contain the following statement:
“Agencies enrolled to provide EAA Assessor/Inspector/Approver services for Community Choices Waiver recipients cannot enroll to perform Environmental Accessibility Adaptations for Community Choices Waiver recipients.”

OR

+ Provider Enrollment Requirements for EAA contractors

- Have license for one of the following building trade classifications: General Contractor, Home Improvement, Residential Building

OR

If currently enrolled in Louisiana Medicaid as a Durable Medical Equipment (DME) provider, documentation from the manufacturing company (on their company letterhead) that confirms this DME provider is an authorized distributor of a specific product that attaches to a building. The letter must specify the product and must state that this DME provider has been trained on its installation.

- Enroll as Medicaid provider type 15 (Environmental Accessibility Adaptation – Waiver) without a provider sub-specialty
- Provider Enrollment packet checklist instructions contain the following statement:
“Agencies enrolled to perform Environmental Accessibility Adaptations for Community Choices Waiver program recipients cannot enroll to provide EAA Assessor/Inspector/Approver services for OAS Community Choices Waiver recipients.”

+ Service Specifications & Limits

- Enrolled EAA Assessor/Inspector/Approver may not bill for providing environmental accessibility adaptations (ramps, lifts, bathroom modifications, other adaptations).
- Enrolled EAA contractors may not bill for EAA assessment, inspection and approval services.
- There is no longer a lifetime maximum
- **This service cannot be used for basic home construction and repairs.**

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✚ Prior Approval

- Until have enrolled EAA Assessor/Inspector/Approver, regional office retains responsibility for approval of EAA jobs.
- Once have enrolled EAA Assessor/Inspector/Approver this process is to be similar to the currently utilized process as authorized by the support coordination agency instead of regional office.
- An EAA job shall be authorized only if health and welfare can be reasonably assured for the duration of the POC year.

✚ Prior and Post Authorization

- A provisional POC or POC or revised POC including EAA assessment is sent to SRI
- SRI issues PA for the basic assessment and approval upon receipt of POC or revised POC
- Upon receipt of authorization that the assessment has been completed, SRI will release the PA for the basic assessment and approval service
- If EAA assessment indicates need for completion of EAA job, a revised POC is sent to SRI. The revised POC will include the complex assessment and approval service, and the EAA job
- SRI issues a PA for the complex assessment and approval service and a PA for the EAA job upon receipt of the revised POC
- SRI releases the PAs for the complex assessment and approval, and for the EAA job upon receipt of documentation that these tasks have been completed

✚ New Procedure Codes and Rates

- Environmental Accessibility Adaptation – Basic Assessment and Approval (Z0640)
\$600.00 per service
- Environmental Accessibility Adaptation – Complex Assessment and Approval (Z0642)
\$150.00 per service

Personal Assistance Services

These services include supervision or assistance with activities of daily living, instrumental activities of daily living and health related tasks; and protective supervision necessary for participants with functional limitations to remain safely in the community. Other services include escort assistance with community tasks and extension of therapy services.

✚ Provider Enrollment Requirements

- Waiver Personal Care Attendant agencies (provider type 82) must have PCA license from Health Standards
- Home Health Agencies (provider type 44) must have home health agency license from Health Standards
- Fiscal Agent (provider type 01) is used for participant directed services

✚ Service Specifications & Limits

- Additional/New delivery method:-PAS – a.m./p.m.:
 - Provided up to two (2) times per day at the beginning of the participant's day (e.g., the a.m. session) and/or at the end of the participant's day (e.g., the p.m. session)
 - The duration of each session is to be a minimum of one (1) hour and a maximum of two (2) hours
 - If both an a.m. and a p.m. session are provided, there is to be a minimum of a four (4) hour break between the two (2) sessions
 - The a.m. session is used to assist the participant to begin his/her day

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- The p.m. session is used to assist the participant to end his/her day
- It is permissible for a participant to receive only one session (either at the beginning of his/her day or at the end of his/her day)
- It is permissible for this method of delivery to be self directed
- This method of delivery is not intended to be shared
- Unit of reimbursement for PAS – a.m./p.m. is per visit (as opposed to 15 minute unit of reimbursement for regular PAS)
- PAS a.m./p.m. and regular PAS in 15 minute increments (shared and unshared) cannot be provided/received on the same day of service
- Home Health agency's PAS direct service worker must be a qualified Home Health Aide as specified in Louisiana's Minimum Licensing Standards for Home Health Agencies
- Home Health agency is limited to providing services within a 50 mile radius of its parent agency
- PAS cannot be received at the same time of day as Caregiver Temporary Support or ADHC
- ✚ Prior and Post Authorization
 - Annual PA is issued based on what is included in the approved POC
 - Once the services are provided and documented in LAST, the PA is released on daily basis with weekly cap based on prior authorized week that begins on Sunday at 12:00 a.m. and ends on the following Sunday at 12:00 a.m.
 - Unused portions of the prior authorized weekly allotment may not be saved or borrowed from one week for use in another week
- ✚ New Procedure Codes and Modifiers and Rates
 - Personal Assistance Services – a.m.-p.m. provided in the morning (S5126 – UF)
 - Personal Assistance Services – a.m.-p.m. provided in the evening (S5126 – UH)
 - \$30.00 per visit for each session

Adult Day Health Care

These services are provided at an Adult Day Health Care center, in a non-institutional, community-based setting and include health/medical and social services needed to ensure optimal functioning. Services include assistance with activities of daily living; health and nutrition counseling; individualized exercise program, individualized, goal-directed recreation program; health education classes; transportation to and from the ADHC; individualized health/nursing services; and meals to include 2 snacks or breakfast and 1 snack and a hot nutritious lunch.

✚ Provider Enrollment Requirements

- Obtain Adult Day Health Care license from Health Standards
- Enroll as Medicaid provider type 85 (Adult Day Health Care)

✚ Service Specifications & Limits

- Unit of reimbursement is 15 minutes
- Daily service maximum is 40 units (10 hours)
- Weekly service maximum is 200 units (50 hours)
- ADHC cannot be received at same time of day as PAS or Caregiver Temporary Support

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✚ Prior & Post Authorization

- Depending on the number of prior approved units of service, two (2) or more PAs will be issued for the POC year. Multiple PAs have to be issued because Molina's system limits each PA to a maximum of 9,999 units.
- PA is released for reimbursement once the services are provided and documented in LAST

Skilled Maintenance Therapies (SMTs) – Physical Therapy, Occupational Therapy, Speech/Language Therapy (Respiratory Therapy is pending further development)

These therapy services focus primarily on maintaining, improving, reducing decline in the participant's ability to perform activities of daily living. These services are not necessarily acute event focused as are Medicaid state plan services. These services may also be used for assessing a participant's need for assistive devices or home modifications; training the participant and caregivers in the use of purchased devices; performing in-home fall prevention assessments; and participation on the care planning team.

Physical Therapy services promote the maintenance of or reduction in the loss of gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities.

Occupational Therapy services promote the maintenance of or reduction in the loss of fine motor skills, coordination, sensory integration and/or facilitate the use of adaptive equipment or other assistive technology.

Speech/Language Therapy services preserve abilities for independent function in communication, eating and swallowing; facilitate use of assistive technology; and/or prevent progressive disabilities.

✚ Provider Enrollment Requirements

- Individual therapists must have professional license and enroll as applicable Medicaid provider type (PT) with applicable provider sub-specialty:
 - Physical Therapist – PT 35
 - Occupational Therapist – PT 37
 - Speech/Language Therapist – PT 39
- Home Health Agencies must have home health agency license from Health Standards and enroll as Medicaid provider type 44 (HH Agency) with applicable provider sub-specialty
- Rehabilitation Centers must have rehabilitation center license from Health Standards and enroll as Medicaid–provider type 65 (Rehab Center) with applicable provider sub-specialty
- All must affirm and attest to the following (via notarized statement):
 - All statements made on the enrollment application and attachments are true and correct
 - That reimbursement can be received for services provided only to Community Choices Waiver participants
 - that Medicaid Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare
 - that failure to exhaust these above referenced third party payer sources may subject the Medicaid enrolled agency to recoupment of funds previously paid by Medicaid

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- that all Professional Services provided to Community Choices Waiver participants must be prior authorized before services are rendered
- that as a provider of services to Community Choices Waiver participants, any licensed therapist used will have one full year of verifiable experience working with the elderly
- That violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid

✚ Service Specifications & Limits

- For physical therapy and occupational therapy: home care training for family and home care training for non-family are two separate services paid under two separate procedure codes so they are not payable on the same day of service. Training can be delivered to both at the same time, but the therapist will need to choose which code to use. This is not applicable to speech/language therapy because training is a part of the treatment service.
- Home Health agency is limited to providing services within a 50 mile radius of its parent agency

✚ Prior Approval

- If the support coordinator's assessment indicates a possible need for services, referral is made for an assessment to be completed by the participant's provider of choice
- If it is determined that therapy is needed, this will be included in the Provisional POC, POC or revised POC

✚ Prior & Post Authorization

- SRI will issue PA(s) for assessment and/or therapy upon receipt of a Provisional POC, POC or revised POC that includes these services
- These PAs are auto released at the time of issuance
- PAs will be issued for no more than 6 months
- If it is later determined that another source will pay for the services, a revised POC to remove the service will be sent to SRI. If SRI finds that the PA has not been used, the PA will be voided making the funds available for use by the participant.

✚ New Procedure Codes and Modifiers and Rates

- In-home Physical Therapy
 - Evaluation (97001 – GP) \$77.50 per service
 - Re-Evaluation (97002 – GP) \$77.50 per service
 - Physical Therapy (S9131) \$77.50 per visit
 - Home Care Training for Family (S5111 – GP) \$77.50 per visit
 - Home Care Training for Non-Family (S5116 – GP) \$77.50 per visit
- In-home Occupational Therapy
 - Evaluation (97003 – GO) \$77.50 per service
 - Re-Evaluation (97004 – GO) \$77.50 per service
 - Occupational Therapy (S9129) \$77.50 per visit
 - Home Care Training for Family (S5111 – GO) \$77.50 per visit
 - Home Care Training for Non-Family (S5116 – GO) \$77.50 per visit
- In-home Speech/Language Therapy
 - Speech/Language Hearing Evaluation (92506 – GN) \$77.50 per service
 - Swallowing Functioning Evaluation (92610 – GN) \$77.50 per service
 - Speech/Language Hearing Therapy (92507 – GN) \$77.50 per visit
 - Oral Function Therapy (92526 – GN) \$77.50 per visit

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Nursing Services

These are medically necessary services provided by a nurse practitioner, registered nurse or a licensed nurse within the scope of the Louisiana Statutes governing the practice of nursing. These services include periodic assessment of the participant's medical condition; evaluation of the need for medical intervention; monitoring and/or modifying medical treatment services provided by non-professional care providers; regular, ongoing monitoring of a participant's fragile or complex medical condition; monitoring of a participant with a history of non-compliance with medication or other medical treatment; assessing a participant's need for assistive devices or home modifications; training the participant and family in the use of purchased devices; and training the direct service workers in tasks necessary to carry out the plan of care.

✚ Provider Enrollment Requirements

- Nurse Practitioner must have professional license and enroll as Medicaid provider type 78 (Nurse Practitioner – Individual)
- Home Health Agencies must have home health agency license from Health Standards and enroll as Medicaid provider type 44 (HH Agency)
- Adult Day Health Care center must have Adult Day Health Care license from Health Standards and enroll as Medicaid provider type AL (Community Choices Waiver Nursing) with provider sub-specialty of 8K (ADHC HCBS)
- All must affirm and attest to the following (via notarized statement):
 - All statements made on the enrollment application and attachments are true and correct
 - That reimbursement can be received for services provided only to Community Choices Waiver participants
 - that Medicaid Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare
 - that failure to exhaust these above referenced third party payer sources may subject the Medicaid enrolled agency to recoupment of funds previously paid by Medicaid
 - that all Professional Services provided to Community Choices Waiver participants must be prior authorized before services are rendered
 - That violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid

✚ Service Specifications & Limits

- Home Health agency is limited to providing services within a 50 mile radius of its parent agency

✚ Prior Approval

- If the support coordinator's assessment indicates a possible need for services, referral is made for an assessment to be completed by the participant's provider of choice
- If it is determined that nursing services are needed, this will be included in the Provisional POC or POC or revised POC

✚ Prior & Post Authorization

- SRI will issue PA(s) for assessment and/or therapy upon receipt of a Provisional POC or POC or revised POC that includes these services

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- These PAs are auto released at the time of issuance
- PAs will be issued for no more than 6 months
- If it is later determined that another source will pay for the services, a revised POC to remove the service will be sent to SRI. If SRI finds that the PA has not been used, the PA will be voided making the funds available for use by the participant.

✚ New Procedure Codes and Modifiers and Rates for In-home Nursing:

- Nursing assessment by Nurse Practitioner (T1001) \$65.22 per service
- Nurse Practitioner visit(S0274) \$65.22 per visit
- Nursing Assessment by RN (T1001 – TD) \$65.22 per service
- Nursing Assessment by LPN (T1001 – TE) \$58.00 per service
- Nursing Care by RN (T1030) \$65.22 per visit
- Nursing Care by LPN (T1031) \$58.00 per visit

Home Delivered Meals

This service includes a maximum of two (2) nutritionally balanced home delivered meals per day. An eligible participant is unable to leave his/her home without assistance; unable to prepare his/her own meals, and/or has no responsible caregiver in the home.

✚ Provider Enrollment Requirements

- In-state providers must meet all Louisiana Public Health certification, permit and inspection requirements for retail food preparation, processing, packaging, storage and distribution
- Out-of-state providers must meet all USDA food preparation, processing, packaging, storage and out-of-state distribution requirements
- All must enroll as Home Delivered Meals provider type AM (Home Delivered Meals) with provider subspecialty of 8M (Community Choices Waiver – Home Delivered Meals)

✚ Service Specifications and Limits

- Each participant may receive a maximum of two (2) home delivered meals per day
- Meals may be shipped in bulk
- It is permissible for participants to have some meals delivered daily and others delivered in bulk by different providers as long as the two (2) meals per day maximum is not exceeded.
- Delivery of meals are to be suspended while the participant is hospitalized or temporarily in a nursing facility making it important for this information to be reported and acted upon immediately.
- Span date billing is allowed

✚ Prior & Post Authorization

- Unit of reimbursement is one (1) meal
- SRI will issue an annual PA for a maximum of two (2) meals per day and for a maximum of 14 meals per week according to what is on the POC
- These PAs are auto released at the time of issuance

✚ New Procedure Code and Rate

- Home Delivered Meals (S5170) maximum of \$7.00 per meal

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Personal Emergency Response System (PERS) – traditional

This service is a rented electronic device that enables the participant to secure help in an emergency. The unit is connected to the telephone line and is programmed to send an electronic message to a community-based 24-hour emergency response center when a “help” button is activated. This service is limited to participants who live alone, or are alone for significant parts of the day; who have no regular care giver for extended periods of time; who would otherwise require extensive, routine supervision; and who are cognitively and/or physically able to operate the system.

✚ Provider Enrollment Requirements

- Must be enrolled as provider type 16 (PERS-Waiver)

✚ Service Specifications & Limits

- A participant will not be able to simultaneously receive traditional PERS services and TeleCare Activity and Sensor Monitoring services

✚ Prior & Post Authorization

- One (1) PA is issued for one-time installation according to information on the POC
- An annual PA is issued for one (1) unit per month for a 13 month period for ongoing monitoring according to information on the POC
- These PAs are auto released at the time of issuance
- PAs are mailed to these providers rather than being issued electronically because these providers do not use LAST

Assistive Technology – TeleCare Activity & Sensor Monitoring

This service is a computerized system that monitors the participant’s in-home movement and activity for health, welfare and safety purposes. The system is individually set based on the participant’s typical in-home movements and activities. The provider agency is responsible for monitoring electronically generated information, for responding as needed, and for upkeep of the equipment. At a minimum, the system shall monitor the home’s points of egress and entrance; detect falls; detect movement or the lack of movement; detect whether doors are opened or closed; and provide a push-button emergency alert system. Some systems may also monitor the home’s temperature.

✚ Provider Enrollment Requirements

- Must be a home health agency with home health license from Health Standards and enroll as a Medicaid provider type 17 (Assistive Devices Waiver) with provider sub-specialty of 3U (Community Choices Waiver – Assistive Devices – Home Health)

✚ Service Specifications & Limits

- A participant will not be able to simultaneously receive TeleCare Activity and Sensor Monitoring services and traditional PERS services
- Home Health agency is limited to providing services within a 50 mile radius of its parent agency

✚ Prior & Post Authorization

- Same as for traditional PERS

✚ New Procedure Codes and Rates

- TeleCare – Activity & Sensor Monitoring – Equipment Installation & Removal (S5160) one (1) time \$200.00 at installation
- TeleCare – Activity & Sensor Monitoring – Monitoring, Routine Maintenance & Rental (S5161) \$130.00 monthly

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Caregiver Temporary Support

These services are provided on a short-term basis because of the absence or need for relief of caregivers during the time they would normally provide unpaid care for the participant. The purpose of caregiver temporary support is to provide relief to unpaid caregivers to maintain the participant's informal support system. This service is provided in the participant's place of residence, an adult day health care center, an assisted living center, a nursing facility or a respite care center.

+ Provider Enrollment Requirements

- Enroll as one of the following Medicaid provider types:
 - Personal Care Attendant – Waiver (provider type 82) with provider sub-specialty of 8D (Community Choices Waiver – Caregiver Temporary Support) to provide in-home services
 - Caregiver Temporary Support (provider type AN) with provider specialty of 8D (Community Choices Waiver – Caregiver Temporary Support) for:
 - Home Health agency with Home Health license from Health Standards with provider sub-specialty of 8F (Community Choices Waiver – Caregiver Temporary Support – Home Health) to provide in-home services
 - ADHC center with ADHC license from Health Standards with provider sub-specialty of 8H (Community Choices Waiver – Caregiver Temporary Support – ADHC) to provide center-based, non-overnight services
 - Assisted Living center with Assisted Living license from Health Standards with provider sub-specialty of 8G (Community Choices Waiver – Caregiver Temporary Support – Assisted Living) to provide center-based, overnight services
 - Nursing Facility with Nursing Facility license from Health Standards with provider sub-specialty of 8J (Community Choices Waiver – Caregiver Temporary Support – Nursing Facility) to provide center-based, overnight services
 - Respite Care Center (provider type 83) with provider sub-specialty of 8D (Community Choices Waiver – Caregiver Temporary Support) to provide center-based, overnight services

+ Service Specifications & Limits

- PCA and Home Health agencies will provide in-home services
 - Unit of reimbursement is 15 minutes
- ADHC centers will provide center-based, non-overnight services
 - Unit of reimbursement is 15 minutes
 - Daily service maximum is 40 units (10 hours)
- Assisted Living Centers, Nursing Facilities and Respite Care Centers will provide center-based, overnight services
 - Unit of reimbursement is daily
- Home Health agency is limited to providing services within a 50 mile radius of its parent agency
- Caregiver Temporary Support cannot be received at the same time of day as PAS or ADHC
- POC year service maximum is 30 calendar days or 29 overnight stays
- Consecutive days of services/episodes maximum is 14 days or 13 overnight stays

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✚ Prior & Post Authorization

- SRI will issue PAs for no more than 30 calendar days or 29 overnight stays per POC year
- Each PA issued will be capped at 14 calendar days or 13 overnight stays
- No contiguous PAs will be issued
- PCA agencies, ADHC centers and Home Health agencies will use LAST to bill for Caregiver Temporary Support
 - PAs for these type agencies will be released for reimbursement once the services are provided and documented in LAST
- Assisted Living Centers, Nursing Facilities and Respite Care Centers will not use LAST to bill for Caregiver Temporary Support
 - PAs for these type providers are auto released at the time of issuance

✚ New Procedure Codes and Modifiers and Rates

- In-Home by PCA agency or Home Health agency (T1005) \$2.83 per 15 minute unit
- Center-Based, Not Overnight at ADHC ((T1005 – HQ) \$2.66 per 15 minute unit for maximum of 40 units or 10 hours per day
- Center-Based with Overnight stay:
 - at Assisted Living Center (H0045) \$95.00 per diem
 - at Nursing Facility (H0045 – HQ) \$148.31 per diem
 - at Respite Care Center (H0045 – HQ & UJ) \$148.31 per diem

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Community Choices Waiver Services Payable during Transition from a Nursing Facility

- + Transition Intensive Support Coordination
- + Transition Services
- + Environmental Accessibility Adaptation – Ramp
- + Environmental Accessibility Adaptation – Lift
- + Environmental Accessibility Adaptation – Bathroom
- + Environmental Accessibility Adaptation – Other Adaptations
- + Environmental Accessibility Adaptation – Basic Assessment & Approval (Effective 10-1-11 in Molina’s system with description: “EAA Assessment”)
- + Environmental Accessibility Adaptation – Complex Assessment and Approval (Effective 10-1-11 in Molina’s system with description: “EAA - Inspection and Final Approval”)
- + Physical Therapy Evaluation
- + Occupational Therapy Evaluation
- + Speech Language Hearing Evaluation
- + Swallowing Function Evaluation
- + Nursing Service Assessment (by Nurse Practitioner, RN or LPN)

INTEND TO ADD:

- + PERS Initial Installation
- + TeleCare Activity and Sensor Monitoring – Equipment Installation

Community Choices Waiver Services Payable during Temporary stay in a Nursing Facility

- + Support Coordination
- + PERS Initial Installation
- + PERS Monthly Maintenance
- + Environmental Accessibility Adaptation – Ramp
- + Environmental Accessibility Adaptation – Lift
- + Environmental Accessibility Adaptation – Bathroom
- + Environmental Accessibility Adaptation – Other Adaptations
- + Environmental Accessibility Adaptation – Basic Assessment & Approval (Effective 10-1-11 in Molina’s system with description: “EAA Assessment”)
- + Environmental Accessibility Adaptation – Complex Assessment and Approval (Effective 10-1-11 in Molina’s system with description: “EAA - Inspection and Final Approval”)
- + Physical Therapy Evaluation
- + Occupational Therapy Evaluation
- + Speech Language Hearing Evaluation
- + Swallowing Function Evaluation
- + Nursing Service Assessment (by Nurse Practitioner, RN or LPN)

INTEND TO ADD:

- + TeleCare Activity and Sensor Monitoring – Equipment Installation
- + TeleCare Activity and Sensor Monitoring – (Monitoring,) Routine Maintenance & Rental