

PART II – Chapters 600 to 1000

POLICIES AND PROCEDURES for CCSP GENERAL SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

Revised: July 1, 2016

Policy Revisions included in the July 2016 Edition of the CCSP Policy Manuals

Revision Date	Section	Description of Revision	Revision Type	Citation
7/1/2016	602 of the CCSP General Services Manual	The section on corrective action has been updated to reflect the transfer of administrative authority for CCSP from the Department of Human Services' Division of Aging to the Department of Community Health's Medicaid Division. As of July 2016, all corrective action at the state level will be initiated and monitored by the CCSP Unit in the Division of Medicaid at the Department of Community Health.	Update	Legislative Action
7/1/2016	Chapters 600 through 1900	Any reference to administrative authority for CCSP by the Division of Aging, also referenced as DAS, have been changed to "the CCSP Unit" to designate the transfer of administrative authority for CCSP to the newly created CCSP Unit in the Division of Medicaid at the Department of Community Health.	Update	Legislative Action
7/1/2016				
7/1/2016				
7/1/2016				

Policy Revisions included in the April 2016 Edition of the CCSP Policy Manuals

Revision Date	Section	Description of Revision	Revision Type	Citation
4/1/2016	600.1 F of the CCSP General Services Manual	F. The Healthcare Facility Regulation Division (HFRD) of the Georgia Department of Community Health licenses and monitors personal care homes, private home care providers, adult day health providers and home health agencies.	Add	State Regulations
4/1/2016	601.3 B of the CCSP General Services Manual	f. A private home care provider must submit a copy of the letter issued by DCH's Healthcare Facility Regulation Division that approves the addition of the counties in the service area expansion request to the service area associated with the provider's state license. g. Requests for expansion of a provider's service area are limited to no more than 2 per calendar year.	Add	DCH Medicaid Policy
4/1/2016	Appendix	Adult day health providers must now	Replace	DCH

Revision Date	Section	Description of Revision	Revision Type	Citation
	B of the CCSP General Services Manual	attach a copy of their state license (permit) when completing the service area expansion application.		Regulations and DCH Medicaid Policy
4/1/2016	Section 1102 of the CCSP Adult Day Health Manual	Adult day health facilities must be licensed (permitted) by the Healthcare Facility Regulation Division of the GA Department of Community Health as an adult day center that is approved to provide adult day health services. Facility owners who wish to enroll as a CCSP adult day health provider must be permitted without restriction and be in full compliance with the Rules of the GA Department of Community Health, Chapter 111-8-1, Rules and Regulations for Adult Day Centers.	Replace	DCH Regulations and DCH Medicaid Policy
4/1/2016	Appendix CC of the CCSP General Services Manual	The chart on reporting of abuse, neglect or exploitation has been updated to include the requirement to notify DCH's Healthcare Facility Regulation Division for any incident that occurs for a service that is subject to state licensing, which now includes adult day health.	Update	DCH Regulations and DCH Medicaid Policy
4/1/2016	Section 1902 B of CCSP Skilled Nursing Services by Private Home Care Providers Manual	B. The specific service and frequency for skilled nursing services will be determined by the care coordinator and ordered by the physician, subject to certain limits. The National Correct Coding Initiative, as required by the Affordable Care Act, limits the payment of skilled nursing visits by a private home care provider under Medicaid to no more than one per day. The use of a proxy caregiver to provide care for the member can be utilized in most of these situations unless expressly prohibited by the Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities, Chapter 111-8-100 of the Rules of the GA Department of Community Health. See also Section 606.9 B of the CCSP General Services Manual for more information.	Update	CMS Policy and DCH Medicaid Policy

Policy Revisions included in the October 2015 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION (October 2015)
Section 602.4 B 6 of the CCSP General Services Manual	The section on provisional licensure has been removed, as provisional licenses are no longer accepted for enrollment as a CCSP provider.
Section 606.7 A of the CCSP General Services Manual	<u>NOTE:</u> CCSP service providers may discharge a member who fails to pay cost share. However, a member cannot be discharged from CCSP for failure to pay cost share. Discharge from CCSP occurs when there is no provider who is willing to serve the member.
Appendix GG of the CCSP General Services Manual	The requirement to provide a \$200 application fee has been removed from the Pre-Qualification Checklist. Submission of the application fee is now part of the application packet, which is the second phase of the application process. See Section 601.2 of the CCSP General Services Manual for pre-qualification and application procedures.

Policy Revisions included in the July 2015 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION (July 2015)
Section 600.1 of the CCSP General Services Manual	<p>J. The Georgia Medical Care Foundation (GMCF) reviews the member’s assessment documents and validates or denies the member’s need for a nursing home level of care. If the level of care is approved, GMCF issues a Level of Care Prior Authorization (LOC PA) for a length of stay of up to 365 days.</p> <p>K. The member's physician, familiar with the specific health and service needs of the member, provides the required medical information, approves the plan of care and attests to the member’s need for a nursing home level of care, and consults with the care coordinator as requested.</p>
Section 605.1 B of the CCSP General Services Manual	<p>A CCSP member must meet the level of care criteria for intermediate nursing home placement. The Georgia Medical Care Foundation (GMCF) must validate the member’s level of care (LOC) and assign a length of stay (LOS) not to exceed a maximum of 365 days. The member’s physician signs the Form 5588 (CCSP Level of Care Placement Instrument) to attest to the member’s need for a nursing home LOC, after which the CCSP care coordinator RN signs the 5588 to certify the LOC. CCSP services may not begin under the LOS indicated on the Form 5588 until the RN signs the form to certify the LOC.</p>
Section 605.1 D of the CCSP General Services Manual	<p>If a member needs a change in service within 60 days from the beginning date of the LOS, the care coordinator will document and date the added services on the Comprehensive Care Plan and provide a copy to the member’s physician and the service provider(s). No face to face visit or physician letter is required in this situation unless the client is returning to the community from a nursing/rehabilitation facility. See Appendix G of the CCSP General Manual.</p>

MANUAL SECTION	REVISION (July 2015)
Section 605.1 E of the CCSP General Services Manual	<p>If a member with a current LOS under an LOC experiences a change in condition or change in status that requires the addition of new services and/or a change in the level of services, and the change occurs more than 60 days after the beginning date of the LOS, a new LOC assessment (reassessment) is not required. However, approval of the new comprehensive care plan by the member's physician is required. The CCSP nurse care coordinator must make a home visit to assess the member's condition and service needs. Changes must be documented on the comprehensive care plan, and the comprehensive care plan must be submitted to the member's physician by way of the Physician Change in Services Letter (Appendix EE) to request his/her approval of the new plan of care. Copies of the Appendix EE with the physician's signature and the updated comprehensive care plan must be sent to the provider for the member's file. The following are examples of changes or new services for which physician approval is required:</p> <ul style="list-style-type: none"> <i>*The new service to be added is a skilled service.</i> <i>*The member needs a change in their level of Adult Day Health (ADH) services.</i> <i>*The change in service is from one category to another, such as from personal support services (PSS) to alternative living services (ALS).</i> <i>*A change in service or new service is required for a member after their discharge from a facility that requires a LOC on a DMA-6, such as a nursing or rehabilitation facility.</i> <i>*A member transfers from one planning and service area to another and requires new services.</i>
Section 605.1 F of the CCSP General Services Manual	<p>ADH therapies, HDS and SNS (skilled services) additions require physicians orders before specific medical procedures can be provided. Orders for therapy services must include specific procedure and modalities used frequency and duration of services.</p>
Section 606.1 of the CCSP General Services Manual	<p>R. Schedule and complete an annual level of care (LOC) reassessment within 60 days of the expiration of the current length of stay (LOS)</p> <p>S. Arrange and complete a face to face nursing visit with the member when the member experiences a change in condition</p> <p>T. Coordinate transfer to other services when the member needs changes or other services (discharge or transfer to a hospital, nursing home, or other community-based care).</p> <p>U. If the member requests, assist the member with request for a hearing to appeal an adverse action affecting the member's level of services.</p>
Section 606.4 of the CCSP General Services Manual (Note after 606.4 C 1)	<p>If the level of care is not consistent with the comprehensive care plan, an addendum must be noted on the service order, and a copy of the Physician Change in Services Letter (Appendix EE) must be attached.</p>

MANUAL SECTION	REVISION (July 2015)
Section 606.13 of the CCSP General Services Manual	The reference to the provider’s private pay rate has been removed. A CCSP service provider’s private pay rate does not have to be related to Georgia Medicaid’s reimbursement rate for CCSP services.
Section 606.16 of the CCSP General Services Manual	<p>A licensed physician, nurse practitioner or physician assistant must approve the member services listed on the Form 5588 (CCSP Level of Care and Placement Instrument) <u>except in the following situations:</u></p> <ul style="list-style-type: none"> o The member experiences a change in condition that requires a new service, additional services (such as additional personal support service hours) or a change in the level of Adult Day Health services and the change occurs more than 60 days after the beginning date of the member’s current length of stay (LOS) under a nursing home level of care (LOC). The physician’s approval for new services or a change in the level of ADH services must be communicated through the physician’s signature on the Physician Change in Services Letter (Appendix EE). o The care coordinator adds other CCSP services within 60 days of the beginning date of the current LOS under a nursing home LOC.
Section 606.20 C of the CCSP General Services Manual	<p>The second bullet of the section, “Once a member is placed in a nursing facility, the CCSP Level of Care is invalid,” has been removed. The length of stay (LOS) under an approved nursing home level of care (LOC) is now valid for the entire LOS, regardless of any nursing home stays the member may have during the LOS.</p> <p>If a nursing facility discharges a member who needs CCSP services reinstated, the nurse care coordinator must complete a face to face review of the member, within 48 hours of having received notice of the discharge, to assess the need for services not currently included on Form 5588 (CCSP Level of Care and Placement Instrument). If new services are indicated, the nurse care coordinator must document the new services on the member care plan and submit a request for approval to the member’s physician on the Physician Change in Services Letter (Appendix EE).</p>
Section 901 F of the CCSP General Services Manual (Exception following 901 F)	EXCEPTION: An individual who is receiving hospice services and is admitted to ALS (a personal care home) as a hospice client may not receive CCSP services. A CCSP client who is living in ALS at the time hospice services are ordered may continue living in ALS as a CCSP member. A member who begins hospice services after already in ALS, and they were not placed in ALS by the hospice agency, may receive concurrent hospice and CCSP services.
Appendix DD	The Critical Incident Report has been “renumbered” from Appendix EE to Appendix DD.

MANUAL SECTION	REVISION (July 2015)
Appendix EE	This appendix is to accommodate the addition of the new Physician Change in Services Letter, which will be used to request the physician's approval for new services or a change in the level of ADH services during a current length of stay under a nursing home level of care.

Policy Revisions included in the April 2015 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
Section 605.1 D of the CCSP General Services Manual	The manual was updated to make it clear that OUT OF HOME RESPITE is one of the services that can be added within 2 months of the assessment or reassessment by updating the care plan. The addition of IN-HOME RESPITE , aka extended personal support services, does require a new assessment.
Section 606.11 of the CCSP General Services Manual	NOTE: The Elderly and Disabled Waiver 1915 (c) does not include transportation in the rate for personal support or extended personal support services. NET is available to all Medicaid participants under the State Plan to provide transportation to medical appointments and for waiver services such as adult day health. A provider who allows an aide to make use of a member's or aide's car for transport needs to be sure the member's or aide's auto insurance assumes liability in case of an accident. Consider having the member or their family sign an agreement that discusses the assumption of liability in case of an accident. The provider should also carry adequate liability and worker's comp insurance to cover any accidents. Any such transportation activities are at the risk of those who engage in them. Providers should consult their legal team to determine the extent of liability to which the agency may be exposed through such transportation activities, particularly if an aide assumes that this is part of their normal duties.
Appendix E of the CCSP General Services Manual	The Level of Care form, also known as Form 5588, was updated to reflect the new requirement not to exceed 365 days for a length of stay. See the instructions for Item 44 of the form.
Preface of the CCSP Adult Day Health Services Manual	A reference to Chapter 111-8 Healthcare Facility Regulation, Chapter 111-8-1 Rules and Regulations for Adult Day Centers has been added to the Preface of this manual, as Adult Day Health providers must now maintain a state license and must follow all the Adult Day Center licensing regulations in addition to the CCSP Adult Day Health Services Manual and the Medicaid Part I and Part II Manuals cited in the Preface.
Section 1101 of the CCSP Adult Day Health Services Manual	This section was updated to make it clear that Health-Related Services includes nursing, health monitoring and medication administration, and that Food Services includes nutrition management.
Section 1103.1 A of the CCSP Adult Day Health Services Manual	Item 18 was added to the physical environment requirements for an adult day health center to require an operational washer and dryer for standard precautions, including soiled/dirty items and infection control.
Section 1406 of the CCSP Personal Support Services Manual	The section on the role of the fiscal intermediary was updated to add the responsibility of ensuring that potential employees are at least eighteen years of age, certified in Cardiac Pulmonary Resuscitation (CPR) and basic first aid and are free of tuberculous (TB).

Policy Revisions included in the January 2015 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
Section 601.2 of the CCSP General Services Manual	Several updates were made to this section, including new licensing requirements for Adult Day Health and new pre-qualifying requirements for Alternative Living Services – Family Model and Emergency Response Service. New applicant should read this section carefully before beginning the application process.
Section 601.3 of the CCSP General Services Manual	Updates to this section include procedures for adding an additional services location for an existing service and conditions under which the \$200 application fee is waived. Please read this section carefully before submitting any request to expand services or add an additional service location.
Section 601.1 Q of the CCSP General Services Manual	The minimum network meeting attendance requirement for CCSP providers can consist of participation via Webinar, when available, for one meeting, and attendance in person at another meeting.
Section 601.5 A 1 of the CCSP General Services Manual	The reference to the Part I Policies and Procedures Manual that concerns record retention has been updated to make reference to the correct section of the manual.
Section 605.1 of the CCSP General Services Manual	<p>Beginning January 2015, A level of care (LOC) certification is approved for no more than a 365 day length of stay. If a CCSP member receives no waived service within two months of the beginning date of the length of stay authorized under the Georgia Medical Care Foundation’s level of care prior authorization (PA) <u>or</u> the assessment date, whichever date is later, a new LOC certification is required.</p> <p>Section 605.1 has also been reordered to make it easier to follow and understand, so please review it carefully.</p>
Section 606.4 C 1 b of the CCSP General Services Manual	The documents that must be included in the referral packet have changed. The assessment detail and triggers have been taken off the list, and the Care Plan has been expanded to include the CAPs, Service Order and Task Lists.
Appendix G of the CCSP General Services Manual	<p>A revision to the instructions for completion of the Comprehensive Care Plan has been added, as follows:</p> <p><u>NOTE on instruction 23:</u> The signature of the collaborating team member is only required when the assessment is performed by an LPN or the service addition is made by a staff member other than an RN. (Rev 1/2015)</p>
Appendix S of the CCSP General Services Manual	All the new rates effective October 2014 for personal support services and alternative living services have now been updated, including the new rates for consumer directed personal support services.

Policy Revisions included in the October 2014 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
<p>Section 601.1 O of the CCSP General Services Manual</p>	<p>NOTE: ALS and ADH providers will complete an incident report of any event/situation that has placed the client’s health, safety, and/or welfare in jeopardy or at risk. If an incident that occurs in an ADH involves a member who resides in an ALS, the provider must also notify the ALS. (Rev. 10/14) All other service providers will complete an incident report of such events/situations if any of their staff were present at the time of the incident or were a part of the incident. Interventions must be specific to the client’s cognitive, physical or mental impairment and target reduction of risk for client injury and reduce risk of recurrent incidents.</p>
<p>Section 606.1 O of the CCSP General Services Manual</p>	<p>The SAF is created from the Service Order and reflects the number of days in the month. SAFs are generated initially and when there is a change in services. A copy of the initial SAF and any revised SAFs will be forwarded to the provider(s). Rev 10/14</p>
<p>Section 603 B of the CCSP General Services Manual</p>	<p>NOTE: The member must be informed in writing in advance of running any credit checks. Rev 10/14</p>
<p>Section 606.17 of the CCSP General Services Manual, last NOTE at the end of this section</p>	<p>The RN or LPN who makes the supervisory visit must sign and date the documentation of the visit. If the supervisory visit was made by an LPN, the supervising RN must review and co-sign the documentation of the LPN’s visit within 10 days <u>unless otherwise stated in the provider manual for the particular service.</u> (Rev. 12/10; 10/14).</p>
<p>Section 1002.1 of the CCSP General Services Manual (textbox at the end of this section)</p>	<p>“Relative” is defined as a person who is related by blood or legal adoption within the third degree of consanguinity or by marriage. Third degree of consanguinity means mother, father, grandmother, grandfather, sister, brother, daughter, son, granddaughter, grandson, aunt, uncle, great aunt, great uncle, niece, nephew, grandniece, grandnephew, 1st cousins, 1st cousins once removed and 2nd cousins. Rev 10/14</p>
<p>Sections 1203.5 E and 1253.7 E of the CCSP Alternative Living Services Manual</p>	<p>The supervisory nurse (LPN or RN) must review, sign and date the completed medication administration record (MAR) for the previous month by the first supervisory visit of each month. If the LPN signs the MAR, the RN must review the MAR and sign off after the LPN by no later than the next supervisory visit. Rev. 7/2014, 10/2014</p>

Policy Revisions included in the July 2014 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION				
Section 601.2 B 1 and Appendix FF	The Letter of Intent is now the Notice of Intent to Become a CCSP Services Provider (Appendix FF).				
Section 601.2 C 1 b and Appendix Y of the CCSP General Services Manual	The AAA Consult Form has been added back to the manual as part of the provider application process.				
Appendices GG and HH of the CCSP General Services Manual	Appendix GG is revised to reflect the new Letter of Intent to Become and CCSP Service Provider, and Appendix HH is now the revised Application Checklist.				
Section 1203.5 E and Section 1257.7 E of the CCSP ALS Manual	The RN reviews, signs and dates the completed medication administration record (MAR) for the previous month at the first supervisory visit of each month.				
Section 1203.6 of the ALS Manual	<u>Disaster Preparedness</u> - The home adheres to the <u>Rules and Regulations for Disaster Preparedness Plans, Chapter 111-8-16.</u> (Chapter reference updated.)				
Section 1253.7 G 3 of the CCSP ALS Manual	A copy of the current care plan, including any revisions, must also be maintained at the home at which the member resides.				
Section 1501 of the CCSP Out of Home Respite Manual	<p>1501. <u>Out-of-Home Respite Visits</u></p> <table border="1" data-bbox="769 1104 1412 1839"> <thead> <tr> <th data-bbox="776 1113 1104 1205">Out-of-home Overnight Respite</th> <th data-bbox="1104 1113 1406 1205">Out-of-Home Hourly Respite</th> </tr> </thead> <tbody> <tr> <td data-bbox="776 1205 1104 1831">This Respite Care requires an out-of-home stay of twelve (12) hours or more (overnight). A visit begins at the time the client enters an out-of-home facility for Respite Care and ends 24 hours later. As for ALS Services, bill for the date of admission but not the date of discharge. Rev 7/2014</td> <td data-bbox="1104 1205 1406 1831">Out-of-Home Respite is provided for a stay of from three hours to twelve hours. NOTE: Overnight respite and hourly respite can't be billed for the same date. Rev 7/2014</td> </tr> </tbody> </table>	Out-of-home Overnight Respite	Out-of-Home Hourly Respite	This Respite Care requires an out-of-home stay of twelve (12) hours or more (overnight) . A visit begins at the time the client enters an out-of-home facility for Respite Care and ends 24 hours later. As for ALS Services, bill for the date of admission but not the date of discharge. Rev 7/2014	Out-of-Home Respite is provided for a stay of from three hours to twelve hours. NOTE: Overnight respite and hourly respite can't be billed for the same date. Rev 7/2014
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Policy Revisions included in the April 2014 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
Section 601.1 V and X of the CCSP General Services Manual	These sections were updated to refer the reader to their new requirements in the updated new provider enrollment process in 601.2.
Section 601.2 of the CCSP General Services Manual	This section has been completely revised to include the new procedures for enrolling new CCSP service providers and for service expansions for existing providers. Please read the entire section carefully.
Section 1007 of the CCSP General Services Manual	The ordering, prescribing and referring information has been updated. Georgia Medicaid will begin editing CCSP claims for an NPI number on file if an ordering, prescribing or referring provider is entered in the header or detail section of a claim.
Section 606.1 J of the CCSP General Services Manual	Determine if services are appropriate and effective, monitor changes in member's health and review the comprehensive care plan at least every 90 days.
Section 606.1 Q of the CCSP General Services Manual	Providers enrolled in the CCSP are required to attend at least two of four quarterly AAA Network Meetings during the state fiscal year (July 1 – June 30) in the Planning and Service Areas (PSA) in which services are being rendered.
Appendix A of the CCSP General Services Manual, Requested Counties Form	The AAA consult form has been removed as obsolete and replaced with the Requested Counties Form that will be used when providers make service area expansion requests.
Appendix B of the CCSP General Services Manual, Service Expansion Application	This appendix has been revised due to the changes in new provider enrollment included in this manual update.
Appendix I of the CCSP General Services Manual, Community Care Notification, Form 6500	The CCNF has been revised to add a space for the e-mail address of the sender and recipient of the form.
Appendix AA of the CCSP General Services Manual, Georgia Families and Georgia Families 360	This appendix has been updated to reflect changes to the CMOs, including the addition of Georgia Families 360 in March 2014.
Appendix FF of the CCSP General Services Manual, Letter of Intent.	This appendix has been developed due to the changes in new provider enrollment included in this manual update.
Appendix GG of the CCSP General Services Manual, Pre-Qualification and Application Checklists	This appendix has been developed due to the changes in new provider enrollment included in this manual update.

MANUAL SECTION	REVISION
<p>Section 1006 L of the CCSP General Services Manual</p>	<p>The paper version of the CMS-1500 claim form has been revised. Please use the new version if submitting paper claims.</p>
<p>Note following Section 1253.2 A of the CCSP ALS Family Model Manual</p>	<p>IMPORTANT NOTES on Registrations:</p> <p>If a family model personal care home relocates, the provider agency must submit new documentation to register the home at its new location <u>prior to</u> the relocation. The only exception to this policy is emergency relocation due to fire or natural disaster.</p> <p>Rev. 4/2014</p>
<p>Section 1702 of the CCSP Home Delivered Meals Manual</p>	<p>The requirement that the member live alone or lack a support system has been removed. Members who receive services from a personal support aide may also receive home delivered meals.</p>

Policy Revisions included in the January 2014 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
<p>Section 601.1 B of the CCSP General Services Manual</p>	<p><u>Authorization Document</u>- The provider agency, if incorporated, must submit to the CCSP and DCH a copy of its Good Standing - Certificate of Existence from the Office of the Secretary of State. The provider agency must also submit its current business license and/ or other proof of legal authorization to conduct business in the State of Georgia. Rev. 7/1/13, 1/1/14</p>
<p>Section 601.1 C of the CCSP General Services Manual</p>	<p><u>Licensure</u> - If state or local law requires licensure of the agency, organization, facility or staff for the service the agency wishes to provide, the provider agency must submit proof of licensure to the Division of Aging Services, upon application and by request thereafter. The provider agency must post current licensure and permits (if applicable) in a conspicuous location open to public view. Licensure requirements for each service are included in each specific service provider manual. Rev. 1/1/14</p>
<p>Note after Section 606.1.C of the CCSP General Services Manual</p>	<p align="center">NOTE:</p> <p>In accordance with Section 105 of <u>Part I Policies and Procedures For Medicaid/Peachcare for Kids</u>, providers must be fully licensed without restriction. Provisional licenses are not acceptable. Rev. 1/1/14</p>
<p>Section 601.1 D of the CCSP General Services Manual</p>	<p><u>Compliance</u> - Neither the provider agency nor its owner(s) or management may be currently under suspension from accepting CCSP referrals or delivering services in any Medicaid program.</p> <p>In addition, the provider agency must have had no deficiencies within the past three years from any licensing, funding or regulatory entity associated with enrollment in any Medicaid, Private Home Care, or Title III-funded services or with the provision of any related business, unless all such deficiencies have been corrected to the satisfaction of the imposing entity and the Division of Aging Services. Rev. 1/1/14</p>
<p>Section 601.1 H of the CCSP General Services Manual</p>	<p><u>Organizational Structure</u> - The provider must diagram a readable organizational structure, administrative control, and lines of authority for the delegation of responsibility and supervision from the administrative level to the member care level, to include names and position titles. Rev. 1/1/14</p>

MANUAL SECTION	REVISION
Section 606.1.I, item 23, of the CCSP General Services Manual	Critical Incident Reporting policies and procedures are now required as part of the application package.
Section 601.1 V of the CCSP General Services Manual	<u>Enrollment Training</u> - Pre-Enrollment Training – All applicants must attend pre-enrollment training. Providers currently enrolled in CCSP will be required to attend training at the discretion of the Division. <i>New Provider Training</i> - Attendance at new provider training is by official invitation only at the discretion of the Division. Rev. 1/1/14
Section 601.1 X of the CCSP General Services Manual	<u>Business Experience</u> – All applicants must have been in the business for which application is being made for a minimum of twelve (12) consecutive months prior to making application for enrollment in the CCSP. This means actively serving clients at the time of registration and throughout the application process. CCSP will not recommend approval for a business to be a Medicaid provider in CCSP unless they are currently serving clients and have been serving clients for the past 12 months. Rev. 4/2011, 1/1/14
Section 601.1 Y of the CCSP General Services Manual	<u>Insurance Coverage-</u> The applicant must submit proof that the provider agency has at least \$1,000,000 in general liability insurance coverage. Private home care providers must submit proof of their agency’s worker’s compensation insurance coverage. Rev. 1/1/14
Section 601.2 B of the CCSP General Services Manual	Prospective CCSP providers receive pre-enrollment information and registration by: <ul style="list-style-type: none"> • Downloading the packet from http://aging.DHS.georgia.us ▪ Clicking on the “Publications” tab ▪ Scrolling down to “Pre-Enrollment Provider Technical Assistance and Registration Form” • Faxing a request to 404-657-5251 • Sending a written request to: Georgia Department of Human Services Division of Aging Services Community Care Services Program Two Peachtree Street, NW 33rd Floor Atlanta, GA 30303-3142 Rev. 1/1/14

MANUAL SECTION	REVISION
<p>Section 601.2 D of the CCSP General Services Manual</p>	<p>The DCH Provider Application and CCSP Provider Enrollment Application must be submitted to the CCSP within 60 days of attending Pre-Enrollment CCSP Technical Assistance Training. The CCSP Provider Application must be typed or computer generated. Applications must be sent via postal mail. Faxed applications will not be accepted. Rev. 1/1/14</p>
<p>Section 601.2 D of the CCSP General Services Manual</p>	<p>The Division of Aging Services will conduct site visits, if applicable. If the Division's site visit results in an unsatisfactory review, the Division will recommend denial of the enrollment application to the GA Department of Community Health. Rev. 1/1/14</p>
<p>Section 601.2 H of the CCSP General Services Manual</p>	<p>When the entire application is completed to the satisfaction of the Division of Aging, the applicant will receive notification of the next scheduled New Provider Training. Rev. 1/1/14</p>
<p>Sections 601.3 B and 601.4 D of the CCSP General Services Manual</p>	<p>Address update for DAS/CCSP:</p> <p>Georgia Department of Human Services Division of Aging Services Community Care Services Program Two Peachtree Street, NW 33rd Floor Atlanta, GA 30303-3142 Rev 1/1/14</p>
<p>Section 601.3 E of the CCSP General Services Manual</p>	<p>Capacity Increase - ALS Group ONLY - An ALS facility wishing to increase the bed capacity (up to 24 beds) of a currently enrolled personal care home must submit a completed <i>Request for Approval to Increase Bed Capacity</i> application to the Division of Aging Services. (See Appendix B of the ALS Manual for the application). An ALS facility is prohibited from increasing its census without DAS approval of the <i>Request for Approval to Increase Bed Capacity</i> application. Rev. 1/1/14</p>

Policy Revisions included in the October 2013 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
CCSP General Services Manual, Section 601.1 Q	Providers who serve more than one PSA region must meet their network meeting attendance requirement by attending meetings in different regions in different calendar quarters.
CCSP General Services Manual, Section 606.4 C 14	The member’s clinical record must include copies of the comprehensive care plan, updated every <u>90</u> calendar days.
CCSP General Services Manual, Appendix E	Use this version of the Level of Care form to replace earlier versions. The newly revised form will allow entry of diagnosis codes in both ICD-9 and ICD-10 formats in preparation for the switch to ICD-10 in 2014. Care coordination agencies are encouraged to begin entering diagnosis codes in both formats at all initial assessments and reassessments beginning immediately.
CCSP General Services Manual, Section 606.9 B	<p><u>Unlicensed proxy caregivers</u> are allowed to perform certain health maintenance activities as long as they have the member’s full written informed consent and are trained and certified as specified in Chapter 111-8-100 of the Rules of the Georgia Department of Community Health, Healthcare Facility Regulation Division, entitled “Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities.”</p> <p>If a <u>licensed nursing staff member or a proxy caregiver administers medications</u>, member records must include, in addition to information specified in 606.9A of the CCSP General Manual, the following documentation:</p> <ol style="list-style-type: none"> <li data-bbox="841 1423 1421 1713">(1) Physician's authorization for the administration of any medication. The physician may renew this authorization on the Level of Care and Placement Instrument at the time of the member's level of care re-determination or through written physician orders at any other time. <li data-bbox="841 1747 1421 1921">(2) When obtaining a physician's verbal authorization, documentation of the consultation, and written follow up within 30 days to confirm the authorization.

MANUAL SECTION	REVISION
	<p>(3) The name, dosage, route, and frequency of any medications administered by the licensed nursing staff member or proxy caregiver. The person administering the medication must sign and date all notations.</p>
<p>CCSP Adult Day Health Services Manual, Section 1101.1 And CCSP Alternative Living Services Manual, Sections 1203.1 C 3 and 1253.1 C 3.</p>	<p>Elderly and Disabled Waiver members living in ALS facilities may receive services at an Adult Day Health Services facility for up to 2 full days per week.</p>

Policy Revisions included in the July 2013 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
<p>CCSP General Services Manual, Section 601.1.B</p>	<p><u>Authorization Document</u>- The provider agency, if incorporated, must submit to the CCSP and DCH a copy of its Certificate of Existence – Good Standing Certificate from the Office of the Secretary of State. If the provider agency is not incorporated, it must have available its current business license or other proof of legal authorization to conduct business in the state of Georgia.</p>
<p>CCSP General Services Manual, Section 601.1.Q</p>	<p>Providers enrolled in the CCSP are required to attend at least two of four quarterly AAA Network Meetings during the state fiscal year in the Planning and Service Areas (PSA) in which services are being rendered. (Refer to attachment “A “for the counties served by the 12 PSA’s).</p>
<p>CCSP General Services Manual, Appendix B, Item 18, last bullet point</p>	<p>Submit a current copy of proof of your business’ liability insurance coverage in the amount of one million dollars. <u>If you are applying to provide personal support services under CCSP as a private home care provider, include proof that worker’s compensation coverage is part of your insurance package.</u></p>
<p>CCSP General Services Manual, Section 1007 (new section)</p>	<p>CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers’ definitions in sections 1861-r and 1842(b)(18)C. The Affordable Care Act (ACA) requires physicians or other eligible providers to be enrolled in the GA Medicaid Program to order, prescribe and refer items or services for Medicaid beneficiaries. Physicians or other eligible providers who are already enrolled in Medicaid as billing providers are not required to enroll separately as Ordering, Prescribing, or Referring (OPR) providers. Enrollment of these providers will begin on April 1, 2013.</p> <p>Beginning July 1, 2013, if the National Provider Identifier (NPI) of the ordering, prescribing, or referring (OPR) provider noted on the GA Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim will not be paid. Furthermore, the NPI of the provider ordering, prescribing or referring the member for the service rendered must be</p>

	included on the claim submitted by the rendering provider. Providers who do not have NPIs and who are not authorized to enroll as Medicaid or CHIP providers (i.e. medical residents at hospitals) must apply the NPI of the supervising physician to the claim.
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Policy Revisions included in the April 2013 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
Appendix E of the CCSP General Services Manual	The Level of Care form has been updated to facilitate routing to the physician and to update policy on who can sign the form.
Appendix EE of the CCSP General Services Manual	The Critical Incident Report Form has been updated.
Appendix V of the CCSP General Services Manual	Contact information for the AAAs and Care Coordination Agencies has been updated.
Section 1704.1.1 of the CCSP Home Delivered Meals Manual	A member is limited to a maximum of 14 meals per week, or 62 per month, plus emergency meals twice per year. (See below.)
Section 1704.3.E of the CCSP Home Delivered Meals Manual	Up to 6 shelf stable meals can be provided to a member no more than twice yearly to be held by the member for periods when conditions won't permit meal delivery, such as emergency conditions caused by extreme weather, power outages, etc. The provider must communicate with care coordination to have these meals authorized in the care and service plans and service authorization. Provision of emergency meals must be clearly documented in the member's record, including annotation on the delivery log.

Policy Revisions included in the January 2013 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
<p>Section 605.2 C of the CCSP General Services Manual</p>	<p><u>Evaluating a Member who is Transitioning to the Community under the Money Follow the Person (MFP) Program</u> - When a provider receives a referral to provide services for a member who is preparing to be discharged from a nursing home to the community under the MFP program, <u>the provider should conduct the face-to-face evaluation in the nursing home prior to discharge</u>, as soon as possible after the referral is received. This is done so that services can begin on the first day the member returns home, as authorized by the CCSP care coordinator. A re-evaluation of the member’s needs can be conducted when services have started after the member is settled in the community, following the guidelines in Section 605.3 of this manual.</p>
<p>Section 606.7 A. 8 and B. 2 of the CCSP General Services Manual</p>	<p>If discharge occurs because the member enters another home and community based waiver, such as SOURCE, ICWP or NOW/COMP, send notice of discharge based on the discharge date negotiated with the new waiver case manager by the CCSP care coordinator, waiving the 30 day advance notice requirement.</p>
<p>Sections 1002 and 1003 of the CCSP General Services Manual</p>	<p>The section on relative caregivers has been revised as Section 1002. All relative caregivers must be approved in advance by the CCSP Program Specialist in the Medicaid Division of the Department of Community Health before they begin caring for a CCSP or SOURCE member. Reimbursement for relative caregivers, including the payment of overtime, is discussed in Section 1003. Please review these sections carefully.</p>
<p>Sections 1600.1, 1602.2, 1602.4 and 1602.6 of the CCSP Emergency Response Systems Manual</p>	<p>These sections have been revised to allow ERS providers to offer wireless ERS devices that use cellular technology. This is allowed for members who don’t maintain a land line telephone and are willing to sign a form saying they are accepting this type device as an alternative. All charging equipment and backup batteries must be provided as part of the wireless unit. Monthly testing is required as with any other ERS unit, and silent testing is not allowed.</p>
<p>Section 1405 of the CCSP Personal Support Services Manual</p>	<p>CCSP members in hospice and consumer direction can only have <i>extended</i> personal support services (in-home respite) authorized in their care plan.</p>

Policy Revisions included in the October 2012 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
Appendix I of the CCSP General Services Manual	The CCNF has been replaced with a new edition of the form. Please begin using this form effective immediately.
Appendix AA of the CCSP General Services Manual	The information on Georgia Families, which is the managed care part of Medicaid that involves the care management organizations (CMOs), has been updated. All the exempt classes of Medicaid eligibility, or aid categories, are listed in this appendix.
Appendix A of the CCSP Adult Day Health Manual	“Member Name” has been added to page 2 of the form before the Progress Notes. Enter the member’s name here to tie the progress notes to the specified member. This will help prevent problems when you have an audit of your program.

Policy Revisions included in the July 2012 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
Section 601.1 N of the CCSP General Services Manual	This revision is to confirm that ERS providers do <u>not</u> have to maintain an office in Georgia in order to be Georgia Medicaid service providers.
Appendix T of the CCSP General Services Manual	This Appendix has been updated with information on the new NET brokers.
Section 1203.4 B and 1253.6 B of the CCSP Alternative Living Services Manual	The supervisory visit requirement has been updated to make it the same for group and family model ALS homes. New guidelines on additional requested visits have been added. Please read these sections carefully.

Policy Revisions included in the April 2012 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
Section 606.16 C of the CCSP General Manual	Documentation requirements for supervisory visit notes have been changed to require the signature of the nurse and the date of the visit, plus the date of the previous supervisory visit.
Section 1203.4 B of the CCSP Alternative Living Services Manual	Supervisory visits must be conducted <u>at least every other week</u>, with no more than 16 days between each visit. At least every other visit must be conducted by the RN.
Section 1703.1 A of the CCSP Home Delivered Meals Manual	Item 2 has been inserted to require the HDM provider to provide each member with safe storage, handling and preparation instructions for alternative meals.

Policy revisions included in the January 2012 Edition of the CCSP Policy Manuals

MANUAL SECTION	REVISION
Note following Section 605.2 of the CCSP General Manual	CCNF and provider referral packets may be submitted electronically using encryption or a secure Web site.
Section 1701 of the CCSP Home Delivered Meals Manual	HDM providers must be <u>current</u> non-Medicaid Title III / Social Services Block Grant (SSBG) Nutrition Contractors OR licensed and accredited hospitals or nursing facilities
Note following Section 1704.5 of the CCSP Home Delivered Meals Manual	Providers will be reimbursed for meals delivered on (or intended for in the case of weekly delivery) the date of the member's admission to or discharge from the hospital. Date span billing across any nights in the hospital will result in denial or recoupment of the entire span.
Section 1706 of the CCSP Home Delivered Meals Manual	<p>Frozen or shelf stable meals that are delivered weekly are to be billed for the date they are expected to be <u>consumed</u>. (EXAMPLE: Meals that are delivered for the 7 day week on Monday 10/1/12 must be billed for 10/1/12 through 10/7/12.)</p> <p align="right">Rev.</p> <p align="center">1/2012</p>
Sections 1300 and 1301 of the CCSP Home Delivered Services Manual	The sections have been rewritten to clarify the definition of home delivered services, and that home health agencies must have a CCSP home delivered services provider number in order to render these services to a CCSP member after the 50 state plan visits are exhausted.
Section 1305 of the CCSP Home Delivered Services Providers	The procedure code for nursing visits has been corrected to T1030 TD.
Section 1403.1.B of the CCSP Personal Support Services Manual	Item 7 is added to emphasize the policy that no aide is to be employed who has been convicted of any of the felonies listed in Section 1406 of the PSS Manual.

**PART II - POLICIES AND PROCEDURES
FOR
COMMUNITY CARE SERVICES**

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PREFACE

Policies and procedures in this manual apply to all Community Care Services Program providers. See Specific Program Requirements Chapters (under separate cover) for additional policies and procedures specific to each service type:

Part II	Chapter 1100	Adult Day Health
Part II	Chapter 1200	Alternative Living Services
Part II	Chapter 1300	Home Delivered Services
Part II	Chapter 1400	Personal Support Services
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All Community Care providers must adhere to Part I - Policies and Procedures for Medicaid/Peachcare for Kids

PART II CHAPTER 600

CCSP SERVICE OVERVIEW

600. **Introduction to the Community Care Services Program**

The Community Care Services Program (CCSP) operates under a Home and Community-Based Waiver (1915c) granted by the Centers for Medicare and Medicaid Services (CMS). This Waiver permits the Division of Medical Assistance to use Title XIX funds to purchase services for CCSP members who meet program requirements.

The Community Care Services Program assists individuals who are older and/or functionally impaired to continue living in their own homes and communities as an alternative to nursing home placement. Individuals served by the program are required to meet the same level of care for admission to a nursing facility and be Medicaid eligible or potentially Medicaid eligible.

The Community Care Services Program is a consumer-oriented program, with the following goals:

- To provide quality services, consistent with the needs of the individual member, which are effective in improving/maintaining the member's independence and safety in the community as long as possible.
- To provide cost effective services.
- To involve the member or member's representative in the provision and decision-making process regarding member care.
- To demonstrate compassion for those served by treating members with dignity and respect while providing quality services.

Provision of quality services and supervision of member care are vital to preventing premature institutional placement. Service providers are expected to be qualified and to provide services in compliance with the policies, procedures, and goals of the CCSP and of any other applicable regulatory agency. (See Section 601.1)

Providers' performance standards must exceed basic licensing requirements; specific areas of accountability include:

- Reliability of service
- Competency and compatibility of staffing
- Responsiveness to members' concerns
- Communicate and coordinate services with care coordination staff

The Community Care Services Program operates on a defined fiscal year budget and may not exceed budget allocations. When budget allocations are at maximum use and the Program is "full", eligible members needing services are placed on a waiting list to be admitted for services only as member discharges occur and as funding permits.

The Community Care Services Program Policies and Procedures Manuals define standard policies and procedures for services provided in the CCSP. All enrolled providers must adhere to the requirements as outlined in these manuals.

600.1 **Structure and Administration of the Program**

Services under the CCSP are provided with the cooperation of the following state and local public agencies and private businesses:

A. The Division of Medical Assistance (DMA) of the Department of Community Health (DCH) is responsible for provider enrollment and reimbursement to providers for services provided to those members who have applied and been approved for the Program. DMA conducts utilization reviews of providers to assure that only authorized and appropriate CCSP services are delivered. **Effective July 1, 2016, DMA is also responsible for the overall coordination, administration, and quality assurance of the program. The CCSP Unit at DMA reviews and recommends approval of provider enrollment applications, conducts site visits and provider training. It also supervises the care coordination services that are provided to CCSP members in the 12 services regions of Georgia. (Rev 7/2016)**

Rev. 07/09

B. The Division of Aging Services (DAS) of the Georgia Department of Human Services (DHS) provides Adult Protective Services (APS) for the prevention of abuse, neglect and exploitation of individuals. **(Rev 7/2016)**

Rev 07/09

C. The Georgia Department of Behavioral Health / Developmental Disabilities, and Addictive Diseases provides psychological and psychiatric evaluations and therapeutic services through regional boards.

Rev 07/09

D. The Division of Family and Children Services (DFCS) of the Georgia Department of Human Services determines Medicaid eligibility and member cost share (if any) for potentially Medicaid eligible members entering the CCSP.

Rev 07/09

E. The Office of Information Technology (IT) of the Georgia Department of Human Services provides information technology to the CCSP Unit and Area Agencies on Aging regarding service authorization. (Rev 7/2016)

Rev. 07/09,
10/09

F. The Healthcare Facility Regulation Division (HFRD) of the Georgia Department of Community Health licenses and monitors personal care

homes, private home care providers, **adult day health providers** and home health agencies. **Revised 4/2016**

- G. Area Agencies on Aging (AAA)/Lead Agency (12 statewide) are designated in each Planning and Service Area by the Division of Aging Services as the local administrator and points of contact for members or members' representatives, service providers, and potential service providers. The Lead Agency assures program accessibility by serving as the focal point responsible for local administration, coordination and implementation of the CCSP, including telephone screening of all potential CCSP members.
- H. Hewlett Packard (HP) (GHP) is under contract with DMA to reimburse Medicaid provider(s) and operate the Provider Enrollment Unit. GHP distributes information about enrollment, trains Medicaid providers in the billing process, and reimburses them for authorized services. GHP also operates the Billing Inquiry Unit to assist Medicaid providers with questions related to billing.
- I. The Care Coordinator (CC) facilitates the process of assessing, planning, authorizing, arranging, coordinating, and evaluating service delivery to the CCSP member. The care coordinator provides the member and member's representative with a single access of resource information. The Area Agencies on Aging either provide these services directly or contract with other entities to provide them.
- J. **The Georgia Medical Care Foundation (GMCF) reviews the member's assessment documents and validates or denies the member's need for a nursing home level of care. If the level of care is approved, GMCF issues a Level of Care Prior Authorization (LOC PA) for a length of stay of up to 365 days. (Rev 7/2015)**
- K. The member's physician, familiar with the specific health and service needs of the member, provides the required medical information, **approves the plan of care and attests to the member's need for a nursing home level of care**, and consults with the care coordinator as requested. **(Rev. 7/2015)**
- L. Service Providers enrolled in CCSP deliver services as ordered on the care plan authorized by the care coordinator. By sharing information with the care coordinator, providers serve as a vital component of the member's care team.

600.2 **Services of the Program**

The Community Care Services Program offers the following services as an alternative to institutional care. Qualified providers may seek enrollment in one or more of the services.

- M. Adult Day Health (ADH) provides nursing services, medical supervision, health, therapeutic, and social services activities in a congregate community-based day program.
- N. Alternative Living Service (ALS) provides twenty-four-hour supervision, personal care, nursing supervision, and health-related support services in licensed personal care homes.
- O. Emergency Response System (ERS) provides two-way verbal and electronic communication with a central monitoring station seven days a week, 24 hours a day to geographically and socially isolated members.
- P. Home Delivered Meals (HDM) provide and deliver prepared meals to the CCSP member's home. Each meal meets at least 1/3 of the recommended daily nutritional requirement.
- Q. Home Delivered Services (HDS) provide home health services rendered on an intermittent basis by certified, licensed home health agencies to members in their homes.
- R. Personal Support Services (PSS) provide personal care tasks such as assistance with eating, bathing, dressing, personal hygiene, preparation of meals, light housekeeping tasks, and other activities of daily living. Extended Personal Support Services refer to those tasks designed for members who need assistance with activities of daily living, as well as relieve those person(s) normally providing care and/or oversight.
- S. Respite Care (RC) provides for temporary relief of the individual(s) normally providing care. Respite Care is provided in an approved facility such as a personal care home or adult day health center. Respite care may include overnight care.
- T. Skilled Nursing Services (SNS) by Private Home Care Providers provide skilled nursing intervention/monitoring when a home health agency is unable to provide service to the member.

600.3 **Authority**

In the Community Care and Services for the Elderly Act, (O.C.G.A. 49-6, Article 5). The Georgia General Assembly stated its intent as follows:

- To assist functionally impaired elderly in living dignified and reasonably independent lives in their own homes or with their families
- To establish a continuum of care for such elderly in the least restrictive environment suitable to their needs

- To maximize the use of existing community social and health services to prevent unnecessary placement of individuals in long-term care facilities
- To develop innovative approaches to program management, staff training and service delivery that impact cost avoidance, cost effectiveness and program efficiency.

Rev 07/09

It is further the intent of the General Assembly that the Georgia Department of Human Services shall serve as the agency responsible for planning and implementing the provision of community-based services to the elderly reimbursable under the "Georgia Medical Assistance Act of 1977."

Rev 07/09

The Georgia Department of Human Services established a Community Care unit within the Division of Aging Services. **Effective July 1, 2016, this unit was transferred by the Georgia General Assembly to the Division of Medical Assistance (DMA) in the Georgia Department of Community Health (DCH).** The Community Care unit plans and oversees implementation of a system of coordinated community care and support services for the elderly. The Community Care unit develops uniform assessment criteria that are used to determine an individual's functional impairment and evaluates on a periodic basis the individual's need for community support services or institutionalized long-term care. **(Rev 7/2016)**

601. **Conditions of Participation**

In addition to the conditions for provider participation in the Medicaid Program which are outlined in Part I - Policies and Procedures For Medicaid/Peachcare For Kids, Community Care Services Program (CCSP) providers must meet all the following conditions at the time of initial enrollment and demonstrate continued compliance.

601.1 **General Conditions**

- A. Legal Right to Perform Business in the State of Georgia –
- B. Authorization Document- The provider agency, if incorporated, must submit to the CCSP and DCH a copy of its Good Standing - Certificate of Existence from the Office of the Secretary of State. **The provider agency must also submit its current business license and/or other proof of legal authorization to conduct business in the State of Georgia. Rev. 7/1/13, 1/1/14**
- C. Licensure - If state or local law requires licensure of the agency, organization, facility or staff for the service the agency wishes to provide, the provider agency must submit proof of licensure to the **CCSP Unit**, upon application **and by request thereafter**. The provider agency must post current licensure and permits (if applicable) in a conspicuous location open to public view. Licensure requirements for each service are included in each specific service provider manual. **Rev. 1/1/14, 7/2016**

NOTE:

In accordance with Section 105 of Part I Policies and Procedures For Medicaid/Peachcare for Kids, providers must be fully licensed without restriction. **Provisional licenses are not acceptable.**
Rev. 1/1/14

- D. Compliance with Rules and Regulations - The provider agency must comply with Part I Policies and Procedures For Medicaid/Peachcare For Kids, the CCSP General Manual and the applicable CCSP service-specific manual(s), and with all applicable federal, state and local laws, rules, and regulations. (See Section 600 of the CCSP General Manual).

Compliance - Neither the provider agency nor its owner(s) or management may be currently under suspension from accepting CCSP referrals or delivering services in any Medicaid program.

In addition, the provider agency must have had no deficiencies within the past three years from any licensing, funding or regulatory entity associated with enrollment in any Medicaid, Private Home Care, or Title III-funded services or with the provision of any related business, unless all such deficiencies have been corrected to the satisfaction of the imposing entity **and the CCSP Unit. Rev. 1/1/14, 7/2016**

- E. Sponsor or Parent Organization - If a provider has a sponsor or parent organization, the sponsor or parent organization must maintain full responsibility for compliance with all conditions of participation. Daily operations of the program may be delegated to a subdivision or subunit of the sponsor or parent organization.
- F. Disclosure of Ownership - The provider must have available the names and social security numbers of all persons with direct or indirect ownership interest of five percent or more.
- G. Reports - The provider must furnish service reports to the DMA as requested. (Rev 7/2016)
- H. Organizational Structure - The provider must diagram a **readable** organizational structure, administrative control, and lines of authority for the delegation of responsibility and supervision from the administrative level to the member care level, **to include names and position titles. Rev. 1/1/14**
- I. Written Member Care Policies and Procedures - The provider agency must have written member care policies and procedures which are

Rev. 04/08

reviewed at least annually, revised as needed, and address at a minimum:

Rev. 04/08

1. Scope of Services Offered (See specific service manual)
2. Admission Criteria (See Sections 603. B and 605)
3. Discharge Criteria (See Sections 606.7)
4. Accepting Members Referred by Care Coordination (See Sections 603 and 605)

Rev. 07/09

5. Cost Share Determination, Billing, Collection, and Refund (See Sections 606.21 and 606.22)
6. Member Protection Assurances (See Section 604)
7. Documentation in the client's record (See Section 606.17, 606.18 and 606.19)
8. Supervision of Services and Care (See Section 606.17)
9. Emergency Information (See Section 606.12)
10. Personnel Code of Ethics (See Section 607.3 C)
11. Clinical Records Management (See Sections 601.5 and 606.4, and 606.5)
12. Use and Maintenance of Supplies and Equipment (if applicable)
13. Medications (if applicable) (See Section 606.9)
14. Coordination of Member Care with Physicians, Care coordinators, and Other Providers (See Section 606.2)
15. Scheduling of Staff, including sufficient coverage when scheduled staff is unable to work (See Sections 601.1 J, K, L, M and 607)
16. Staff Orientation, Training, and Development (See Section 607.5)
17. Personnel Policies (See Section 601.1J and 607.3)
18. Member's Rights and Responsibilities (See Section 604.1)
19. Infection Control (Section 607.5, Appendix Q)

- 20. Discharge planning (See Section 606.6 and 606.7)
- 21. Program Evaluation (See Section 609)
- 22. Disaster preparedness (see Section 608)
- 23. Critical Incident Reporting (See Section 601.1) **Rev. 1/1/14**

NOTE:

Refer to specific services manuals for additional required policies and procedures.

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Provider agency policies and procedures must be clear and concise with regard to the specific agency guidelines and instruction to agency staff. The provider agency policies and procedures must also reflect a clear understanding of the CCSP and program requirements.

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J. Subcontracting - Provider agencies may subcontract for the provision of services as long as the subcontract contains, at a minimum, the following elements:

1. Names of all parties entering into the subcontract
2. A stipulation requiring subcontractor's to perform in accordance with all Conditions of Participation which pertain to the service purchased under subcontract, and requiring the contractor to assume responsibility if the selected subcontractor fails to do so
3. A stipulation requiring the contractor agency to maintain responsibility for and assure the subcontractor's performance of administrative, supervisory, professional and service delivery responsibilities relative to meeting all requirements of the CCSP
4. A stipulation that the subcontractor will comply with local, state and federal laws, rules and regulations and will adhere to CCSP policies and procedures as they now exist or may hereafter be amended
5. A statement identifying the party responsible for paying employment taxes
6. A stipulation that the persons delivering services meet minimum staff qualifications
7. Identification of the specific CCSP service(s) to be provided
8. A stipulation that the subcontractor will participate as needed in case conferences to coordinate member care

9. Termination procedures, including an escape clause and the subcontractor's signed agreement that they received an explanation of the advantages and disadvantages of a short-term or long-term contract. Rev 9/2011

A sample of all subcontracts for provision of CCSP services must be submitted to the **CCSP Unit** for prior approval and a copy maintained in the provider agency's office. Any changes in above contract terms must be resubmitted to the **CCSP Unit**. (7/2016)

- K. Service Contracts/Agreements - If providers require members to sign a service contract or other binding written agreement before receiving services, the service agreement will be in a format that the member can read and easily understand. **The agreement may not require members to waive their legal rights.**

NOTE:

A member cannot be held liable for damage caused by normal wear and tear of provider's furniture and equipment.

- L. Staff Qualifications - The provider agency must engage a sufficient number of qualified and experienced staff to render services in accordance with currently accepted standards of medical practice. The provider agency must have criteria-based job descriptions that clearly list required minimum qualifications, training, and experience. Criteria-based job descriptions must include specific tasks, job responsibilities, and duties for each staff position. A job description, signed and dated by the employee, must be maintained in each personnel file. (Refer to specific service manuals for program requirements related to staffing.)
- M. Staffed Business Hours - The provider agency must be open for business with staff available at least 8 hours per day Monday through Friday.
1. Business Hours - The provider agency must maintain regularly scheduled business hours and must have in place a means to assure easy, **local or toll-free telephone access** to a responsible individual able to assist with information and support as needed. Providers must provide an active on-call service that coordinates dependably with care coordinators, members, and members' families/representatives.
 2. Service Availability - The provider agency must be able to provide services 24 hours a day, seven days a week, including holidays, if required or needed by the member. A supervisor must be available at all times to staff members who are rendering

services. If a provider is unable to provide services as indicated in the member's care plan or when requested by the member, the care coordinator will broker/re-broker services with another provider who can meet the member's needs. Exception: Adult Day Care Centers and Home Delivered Meal providers are not required to deliver services 24 hours a day.

3. Access -All providers must have a **local or toll-free published telephone number** for members and care coordinators to access and report problems with service delivery. PSS, RC, ALS, HDS, SNS and ERS providers must provide telephone access to enable members to call 24 hours a day, seven days a week, including holidays. Toll free numbers that require an access code may not be used.
4. 30-Minute Response - The provider agency must respond to calls from members/representatives and/or families requesting assistance, within 30 minutes of the contact.

N. Office Space - Each provider, **with the exception of emergency response services (ERS) providers**, must maintain business premises within the State of Georgia. The provider is responsible for ensuring compliance with all local zoning ordinances. The business premises must be appropriate to conduct the CCSP program and must include (Rev 7/12):

1. A separate office which provides privacy for visitation by members, member's families/ representatives, employees, program auditors, care coordinators and other business visitors.
2. The office provides for the maintenance and storage of confidential member records.
3. A designated separate, professional office, if located in a personal residence that is used exclusively as a business office with a separate business telephone line.
 - The office must have a designated means of public access, remote from the personal residence entrance/exit, and must ensure adequate parking for visitor.
 - Branch offices must meet the same physical requirements as those described above. Branch offices are not required to have full-time staff, but the provider must be accessible to members, employees and the general public by telephone at the primary office.

- O. Member Protection Assurance – All CCSP providers, their employees, subcontractor's, and volunteers are mandated reporters of suspected or actual abuse, neglect, exploitation, elopement, unexpected death, serious injury and any other critical event/situation that has or may place a member's health, safety, and welfare in jeopardy or at risk. Refer to Section 604.1 and Appendix EE of the CCSP General Manual.

All CCSP providers are required to:

- Have written policies and procedures that address steps the agency takes to prevent abuse, neglect, and/or exploitation; action the agency takes when such incidences are reported; and action the agency takes to prevent future occurrences of such incidences
- Screen each potential employee for criminal background history
- Prohibit individuals with a prior conviction on charges of abuse, neglect, mistreatment or financial exploitation from performing direct member care duties
- Provide training at least annually to all employees, subcontractor's, and volunteers on how to recognize situations of possible abuse, neglect, exploitation, and/or the likelihood of serious physical harm to individuals who receive services through the CCSP
- Observe at least annually staff providing direct care to members
- Report all allegations of mistreatment, abuse, neglect, exploitation, elopement, unexpected death, serious injury, injuries of unknown origin, and any other critical event/situation **immediately (within 24 hours of the event)** to the administrator and to other officials in accordance with state law (Appendix EE)
- Provide for thorough investigation of all alleged member protection violations
- Prevent further potential abuse while the investigation is in progress
- Complete the investigation within five (5) business days of the incident and submit a written report of the findings to the administrator or designated representative and to other officials in accordance with state law (Appendix EE)
- Prevent further potential abuse, etc., while the investigation is in progress
- Take appropriate actions if alleged violation is verified

Providers, their employees, subcontractor's and volunteers shall be familiar with and shall be able to recognize situations of possible

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abuse, neglect, exploitation, and/or likelihood of serious physical harm to individuals who receive services through the CCSP.

- **Abuse** – is defined as any intentional or grossly negligent act or series of acts or intentional or grossly negligent omission to act which causes injury to a client, including but not limited to assault or battery, failure to provide treatment or care, or sexual harassment of the client. Abuse may be mental, verbal, sexual, or physical.
- **Neglect** – is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.
- **Exploitation** – is defined as an unjust or improper use of another person or the person's property through undue influence, coercion, harassment, duress, deception, false representation, false pretense, or other similar means for one's own profit or advantage.
- **Mistreatment** – is defined as any behavior or practice that has the potential to or results in any type of individual exploitation.
- **Unexpected Death** – is defined as death that occurs suddenly when the individual is in apparent good health or as the result of homicide, suicide, or accident.
- **Serious Injury** – is defined as bodily injury that involves a substantial risk of death, unconsciousness, extreme physical pain, sexual assault, violence, protracted and obvious disfigurement or impairment.
- **Elopement** – is defined as a cognitively impaired person successfully leaving a facility unsupervised and undetected.

Providers immediately (or no later than the close of the next business day) verbally report incidents to the Care Coordination office in the following circumstances:

Critical Incidents include, but are not limited to:

- Unauthorized or inappropriate touching of a member such as pushing, striking, slapping, pinching, beating, fondling
- Use of physical or chemical restraints
- Withholding food, water, or medications unless the member has requested the withholding
- Psychological or emotional abuse (i.e., verbal berating, harassment, intimidation, or threats of punishment or deprivation)

- Isolating member from member's representative, family, friends, or activities
- Sexual harassment, exploitation, or rape
- Failure to provide basic care or seek medical care
- Ostracizing the member or "giving the silent treatment"
- Inadequate assistance with personal care, changing bed linen, laundry, etc.
- Taking a member's money or property by force, threat, or deceit
- Use of a member's money or property against the member's wishes or without the member's knowledge
- Leaving member alone for long periods of time
- Elopement
- Sudden death

Reportable Critical Events include:

- Alleged criminal acts by staff against a client or DHS ward
- Alleged criminal acts which are reported to the police by a person who receives services
- Client or DHS Ward missing without authority or permission and without others' knowledge of whereabouts
- Financial exploitation or mismanagement of client funds
- The intentional or willful damage to property by a client that would severely impact operational activities or the health and safety of the client or others
- Whether by a client or staff person on duty or other person, any threat of physical assaults, or behavior so bizarre or disruptive that it places others in a reasonable risk of harm or, in fact, causes harm
- Inappropriate sexual contact or attempted contact by a staff person (on or off duty), volunteer or visitor, directed at a client receiving services funded by a federal, state, or local public authority

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NOTE: ALS and ADH providers will complete an incident report of any event/situation that has placed the client's health, safety, and/or welfare in jeopardy or at risk. **If an incident that occurs in an ADH involves a member who resides in an ALS, the provider must also notify the ALS. (Rev. 10/14)** All other service providers will complete an incident report of such events/situations if any of their staff were present at the time of the incident or were a part of the incident. Interventions must be specific to the client's cognitive, physical or mental impairment and target reduction of risk for client injury and reduce risk of

recurrent incidents.

Within three days of the verbal notification of the incident to the Care Coordination office, providers will submit a follow-up Community Care Notification Form (CCNF) to the care coordinator.

The care coordinator will submit applicable documents related to the incident to the **CCSP Unit**. The CCSP will use this information as a quality management strategy to identify trends and to implement system-wide improvement strategies. **(7/2016)**

P. Standard Assurances - The provider agency may not discriminate or permit discrimination against any person or group of persons on the grounds of age, race, sex, color, religion, national origin, handicap, or member's failure to execute advance directives. All providers are required to submit a signed and dated Standard Assurance, Assurance of Compliance with *Title VI of the Civil Rights Act of 1964* and Letter of Understanding signed by the person legally authorized to act for the agency or person to whom responsibility for these assurances is delegated. The necessary forms are included in the enrollment packet.

Q. Communication with Area Agencies on Aging (AAA) – The applicant agency must conduct a face-to-face visit with the Area Agency on Aging Director(s) of each Planning and Service Area (PSA) where the applicant is seeking to initiate services. The applicant agency will consult with the AAA in order to learn about the aging network in the PSA and to gain assistance with the provider's market analysis. (See Appendix A.) Providers enrolled in the CCSP are required to attend at least two of four quarterly AAA Network Meetings during the state fiscal year (July 1 – June 30) in the Planning and Service Areas (PSA) in which services are being rendered. Providers who serve more than one PSA region must meet their network meeting attendance requirement by attending meetings in different regions in different calendar quarters. Refer to attachment “A” for the counties served by the 12 PSA’s. **The minimum network meeting attendance requirement can consist of participation via Webinar, when available, for one meeting, and attendance in person at another meeting.** (Rev. 7/1/13, 10/1/13, 4/1/14 and 1/1/2015)

NOTE:

Refer to Section 601.3 D if applicant is a current CCSP provider.

R. Accepting Referrals - The provider agency must accept all appropriate referrals from CCSP care coordinators, including members who are currently Medicaid eligible or potentially Medicaid eligible.

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- S. Member Referrals - The provider agency must understand that approval for enrollment in the CCSP does not guarantee referrals. Care coordinators make referrals to enrolled providers based on member choice, rotation, and availability of CCSP funding. **Providers are encouraged to secure funding sources other than Medicaid.**
- T. Disclosure - If any agency knowingly fails to disclose all requested information or provides false information, the **CCSP Unit** will not recommend approval of enrollment to the DMA. If at any time following enrollment a provider agency is found to have falsified or knowingly failed to disclose application information, the Division has the right to recommend that provider's termination from the CCSP. **(Rev 7/2016)**
- U. Alzheimer's Disclosure Form - Any provider agency that advertises, markets, or offers to provide specialized care, treatment, or therapeutic activities for one or more persons with a probable diagnosis of Alzheimer's Disease or Alzheimer's-related dementia is required to complete the Alzheimer's Disclosure Form. (Refer to Appendix H.)
- V. Enrollment Training – **The applicant must attend Provider Orientation Training.** See 601.2 C 5 of this manual for details. **Rev. 1/1/14, 4/1/14**

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- W. HIPAA Compliance – All applicants/providers must demonstrate compliance with the Health Insurance Portability and Accountability Act of 1996. (For additional information refer to www.communityhealth.state.ga.us.)
- X. Business Experience – **All applicants must submit proof of business experience.** See 601.2 B 1 n for details. **Rev. 4/11, 1/14, 4/14**
- Y. Insurance Coverage- **The applicant must submit proof that the provider agency has at least \$1,000,000 in general liability insurance coverage. Private home care providers must submit proof of their agency's worker's compensation insurance coverage.** **Rev. 1/1/14**
- Z. Electronic Mail- The applicant must maintain a professional, business electronic mail address

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601.2 New Provider Enrollment (revised 4/1/2014, 1/1/2015))

New provider enrollment is accomplished in a three (3) step process:

1. Information Session (Optional)
2. Pre-Qualification Process

3. CCSP Medicaid Provider Application Process

Enrollment cycles will occur two (2) times per year. Pre-qualification materials will be accepted during the specified month of the enrollment period. All providers must meet the requirements of pre-qualification to be considered for further review.

A. Information Session for Potential Providers

The CCSP Unit will host a CCSP Enrollment Information Session prior to the beginning of each recruitment cycle. The information session includes a review of enrollment requirements and a question and answer session. Attendance is not required. (Rev 7/2016)

Please visit check the CCSP Page under Medicaid programs at dch.georgia.gov for schedule and registration procedures.

B. Pre-Qualification Process

The CCSP Unit utilizes a Pre-Qualification determination process to review provider applicants for CCSP services. Applicants who meet the Pre-Qualification requirements are invited to continue to the next screening level. (Rev 7/2016)

Interested providers must submit Pre-Qualification documents, as specified in Section C.1 below, during a specified recruitment cycle. All applicants must meet the requirements of pre-qualification to be eligible to submit an application packet. Pre-Qualification documents postmarked after the last day of the recruitment cycle will be returned without review and may not be resubmitted until the next scheduled recruitment cycle.

Recruitment cycles are as follows:

- March 1st- March 31st
- September 1st – September 30th

1. Required Pre-Qualification Documents

- a. **A Notice of Intent to Become a CCSP Service Provider (Appendix FF) (Rev 7/2014)**
- b. Resumes for the following agency personnel:
 - Owner(s)
 - Director
 - Lead/Supervising Registered Nurse (RN)
- c. The organization's current Secretary of State Certificate of Good Standing
- d. The applicant organization's current/valid business license

- e. An IRS Letter 147C or Form SS4 to verify the organization's legal name and federal tax ID
- f. Proof of \$1,000,000 General Liability Insurance coverage
- g. Proof of Workers' Compensation Insurance coverage (*personal support, skilled nursing and home delivered services providers only*).
- h. Current license issued by the Georgia Department of Community Health, Healthcare Facilities Regulation Division (***adult day health, personal support, skilled nursing, home delivered services and group model alternative living services provider only.***) *Provisional permits are not accepted. (Rev 1/2015)*
- i. **A business plan, including a plan of comprehensive supervision, including nursing supervision, for sub-contracted personal care home (*alternative living services-family model providers only*) (Rev 1/2015)**
- j. **A copy of a sample contract your agency plans to use to sub-contract with family model personal care homes (*alternative living services-family model providers only*) (Rev 1/2015)**
- k. A letter from an Area Agency on Aging verifying a current contract to deliver services under a Title III or Social Services Block Grant funded meals program (*home delivered meals providers only*)
- l. **Specifications for all types of equipment used for emergency response (*emergency response system providers only*) (Rev 1/ 2015)**
- m. A copy of the current Georgia state license for the applicant organization's lead/supervising registered nurse (RN) (*Not required for emergency response system or home delivered meals providers*)
- n. The most recent inspection documents, free of deficiencies, from the following agencies, as applicable to your organization:
 - Georgia Healthcare Facilities Regulation Division (HFRD)
 - Local fire department
 - DCH Utilization Review (*current Medicaid providers only*).
- o. A signed and notarized affidavit certifying a minimum of twelve (12) months experience for the applicant in the service for which the organization intends to make application for enrollment as a provider
- p. The agency's most recent self-evaluation results
- q. Alzheimer's Disclosure Form (if applicable) manual ref. 601.1Q

2. Submission Process

- a. All pre-qualification documents must arrive in hardcopy format, with each section tabbed and identified. Faxed and e-mailed documents cannot not be accepted.
- b. Documents must be organized in order of the check list provided in Appendix GG.
- c. Submit all pre-qualification documents via US Postal Service certified mail - return receipt requested, FedEx, or UPS delivery to the address listed below. (Rev 7/2016)

Department of Community Health
 Division of Medicaid
 CCSP Unit
 Two Peachtree Street, NW
 37th Floor
 Atlanta, Georgia 30303-3159

- d. The organization’s email address specified in the Pre-Qualification documents must be valid and able to accept emails from CCSPMessages@dhr.state.ga.us, as this will be the main form of communication between the CCSP Unit and the applicant. It is the responsibility of the applicant to ensure that emails from the CCSP Unit are accepted by their email system and do not go to the “spam” mailbox. (Rev 7/2016)

3. Response to Pre-Qualifiers

- a. The CCSP Unit will send, via email, an acknowledgment of receipt within 3 business days of the date Pre-Qualification documents are received at the Unit.
- b. If ALL Pre-Qualification documents are not submitted, **the application will be withdrawn without review** and cannot be resubmitted until the next recruitment cycle. **Documents for withdrawn applications will not be returned.** (Rev 1/2015)
- c. By the 15th of April for the first recruitment cycle, or the 15th of October for the second recruitment cycle, the CCSP Unit will notify the applicant of any deficiencies identified. Pre-Qualification applicants will be notified of their ONE (1) opportunity to submit corrections and shall be given at least 2 weeks (14 days) from the date of notification to submit corrections.
- d. Pre-Qualification approval decisions will be made on or before May 1st for the first cycle and November 1st for the second cycle. (Rev 7/2016)
 - i. If the Pre-Qualification documents are free of deficiencies, a CCSP Medicaid provider application packet will be emailed to the applicant.
 - ii. If the Pre-Qualification documents are not free of deficiencies, they will be returned and cannot be resubmitted until the next recruitment cycle.

C. CCSP Medicaid Provider Application Process

A packet of CCSP Medicaid application documents, referred to hereafter as the application packet, will be sent via e-mail to the applicant organization once Pre-Qualification documents are accepted as complete.

1. Required Application Documents

- a. Completed AAA Consult Form (Appendix Y) Rev 7/2014
- b. Department of Community Health Facility Enrollment Application (**Complete online at www.mmis.georgia.gov at “Enrollment Wizard” in the dropdown box under “Provider Enrollment.”**) (Rev 1/ 2015)
- c. Disaster Plan
- d. Signed and dated Standard Assurance
- e. Signed and dated Assurance of Compliance with Title VI of the Civil Rights Act of 1964
- f. Signed and dated Letter of Understanding
- g. Signed and dated Letter of Agreement (ALS only)
- h. Electronic funds transfer agreement with voided check attached
- i. **Completed and signed IRS Form W-9 for your company. (Enter company info only, not your name or SSN.) (Rev 1/2015)**
- j. Policies and Procedures for your organization, as outlined in Section 601.1 I of this manual. *This item may be requested in the application packet or viewed at the site visit, at the discretion of the CCSP provider specialist who is assigned to process the application. (Rev 7/2016)*

2. Submission Process

- a. The application packet must be completed and returned to the CCSP Unit within 2 weeks (14 days) from the date of the email from the CCSP provider specialist who sent the application packet materials. (Rev 7/2016)
- b. The completed application packet must be submitted in hard copy (no faxes or e-mails), tabbed and organized in the order of the checklist provided in Appendix HH of this manual.
- c. Applications postmarked after the due date will be returned without review and cannot be resubmitted until the next application cycle.

3. Review of the Application Packet

- a. The CCSP Unit will email the applicant an acknowledgment of receipt within 3 business days of the date the application packet is received.
- b. If ALL Pre-Qualification documents are not submitted, **the application will be withdrawn without review** and cannot be resubmitted until the next recruitment cycle. **Documents for withdrawn applications will not be returned.** (Rev 1/2015)
- c. The CCSP Unit will notify the applicant of any deficiencies within 30 calendar days of receipt of a complete application packet. (Rev 7/2016)

- d. Applicants will be notified of their ONE (1) opportunity to submit any needed corrections and will be given at least 2 weeks (14 days) from the date of notification to submit corrections.
- e. When the application packet is determined to be free of deficiencies, a site visit may be arranged.

4. Site Visit

All applicants may have a site visit of their facility conducted by a CCSP Program Specialist. The only exception is for ERS provider agencies located out of state. The site visit may include but is not limited to the following:

- a. A tour of the facility
- b. A review of organization's policy and procedure manual
- c. Observation of the client and personnel record storage system
- d. Interviews with available agency staff
- e. Observation of general operations

5. Provider Orientation Training

- a. Prior to being assigned your Medicaid provider number, you will be required to attend a Provider Orientation training session. You will receive an invitation to this training from the CCSP Unit once you have completed the enrollment process and the decision has been made to recommend enrollment. *Failure to attend Provider Orientation training will result in a recommendation to deny enrollment.*
- b. Existing CCSP providers applying for a new CCSP service may have this training requirement waived at the discretion of the CCSP Unit. (Rev 7/2016)

6. Enrollment Decision

- a. If the CCSP provider specialist determines the applicant organization is qualified to be a provider after a careful review of the application packet, a successful site visit, and the provider's attendance at Provider Orientation Training, the provider specialist will send a letter of recommendation of enrollment to the Department of Community Health's (DCH) Medicaid Division, along with all documents from the application packet that are required to assign a Medicaid provider ID.
- b. If the CCSP provider specialist determines the provider has not completed the application process or is otherwise not qualified to be a provider, the provider specialist will send a letter of recommendation of denial of enrollment to DCH.

7. Notification of Enrollment Decision

- a. The CCSP Unit will notify the Area Agencies on Aging and Care Coordination agencies of the approval of the application, with a copy of the notification sent to the applicant. This notification will include the newly assigned Medicaid provider ID and the effective date.
- b. The Department of Community Health will notify the organization if the application is denied. This notification will include the reason for denial and appeal rights, as stated in Part I, Policies and Procedures for Medicaid/Peachcare for Kids Manual.
- c. If the application is denied, the applicant will not be permitted to re-apply for a period of one (1) year from the date of the denial.
- d. If at any time during the enrollment process or following enrollment a provider agency is found to have falsified or knowingly failed to disclose application information, the CCSP Unit will exercise their right to recommend the provider agency be denied enrollment or terminated as a CCSP Medicaid provider. (Rev 7/2016)

601.3 Expansion Procedures for Active CCSP Medicaid Providers (revised 4/1/2014, 1/1/2015)

A. Adding a CCSP Service or an Additional Location for an Existing Service

1. Active CCSP Medicaid service providers must submit an enrollment application in accordance with Section 601.2 of this manual for each additional service.
2. A provider who is requesting to expand into a new service must have been an active CCSP Medicaid Provider for a minimum of 12 months.
3. **Active CCSP Medicaid service providers who are adding an additional service location for an existing service must submit a Department of Community Health Facility Enrollment Application or Additional Location Application (online), plus a copy of their current HFRD license, most recent clean HFRD inspection report, local business license and proof of current liability/worker's comp insurance coverage. (Rev 1/2015)**

B. Expanding the Service Area of an Existing Service

1. Providers wishing to expand the geographical area that an existing, Medicaid enrolled office serves must submit a **Service Expansion Application** (Appendix B). This application must be submitted according to the guidelines identified here.
2. A Medicaid Facility Enrollment Application must be completed if the expanded area will be served from an office that is not currently enrolled.
 - a. Service Area Expansion applications are **not accepted** during new the provider enrollment review months of March, April, September and October.

- b. Applications received in months these months will be **withdrawn** without review.
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- c. Providers seeking service area expansion must have been active CCSP Providers for a minimum of twelve (12) months.
- d. Neither the provider agency nor its owner(s) or management may be currently under adverse action in any Medicaid program.
- e. The provider agency must have no deficiencies within the past three years from any licensing, funding or regulatory entity associated with Medicaid, Private Home Care or Title III-funded services. If deficiencies are cited, they must be corrected to the satisfaction of the imposing entity.
- f. **A private home care provider must submit a copy of the letter issued by DCH’s Healthcare Facility Regulation Division that approves the addition of the counties in the service area expansion request to the service area associated with the provider’s state license. Revised 4/2016**
- g. **Requests for expansion of a provider’s service area are limited to no more than 2 per calendar year. Revised 4/2016**

C. Service Expansion Application Review

- a. Within 3 business days of receipt of the Application documents, the CCSP Unit will send an emailed acknowledgment of receipt.
- b. If ALL required documents are not submitted, the application will be **withdrawn without review. Rev 1/ 2015**
- c. Within 30 calendar days of receipt of the application documents, the CCSP Unit will notify the applicant of any deficiencies.
- d. Applicants will be notified of their ONE (1) opportunity to submit any needed corrections and will be given at least 2 weeks (14 days) from the date of notification to submit corrections.
- e. The agency may receive a site visit as part of the application review process.
- f. Within 45 days of receipt of the Application documents, a decision regarding the submitted documents will be made, with notification to the applicant following the procedures outlined in section 601.2 C 7 of this manual. Final decisions on whether to approve a request to expand a service area are made by the Department of Community Health.
- g. If the expansion is denied, the applicant will not be permitted to re-submit a service area expansion application for a period of 6 months from the date of the denial.

601.4 Change in Enrollment Data

A. Change of Ownership or Legal Status or Buy Out

- 1. New Providers purchasing an existing business with a current provider number
 - a. The purchasing entity must **first** become an enrolled CCSP provider by following the policies and procedures as set forth in

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Chapter 600, Section 601.2 while also following Federal Guidelines as stipulated 42 C.F.R. § 442.14 (further clarification can be found in Part I Medicaid/PeachCare for Kids Policies and Procedures, Chapter 100, Section 105.)

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NOTE

If the existing business is currently serving CCSP clients, please refer to #3-Interim Reimbursement found in this section.

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2. Required Notification:

Any enrolled provider undergoing a change (including, but not limited to, dissolution, incorporation, re-incorporation, reorganization, change of ownership of assets, merger or joint venture) that results in the provider either becoming a different legal entity or being replaced in the CCSP by another provider, must:

Give the Division of Medical Assistance ten (10) day prior **written** notice before affecting a change such as dissolution, incorporation, re-incorporation, and reorganization, change of ownership of assets, merger, or joint venture where by the provider becomes a different legal entity or is replaced in the program by another provider. The successor provider must submit an executed Statement of Participation to become effective at the time of the above-described change. Failure of the successor to execute a new Statement of Participation will prevent the Division from reimbursing any further services as of the date of the change.

Provide **written** notice of intent to sell or change ownership or legal status must be given at least thirty (30) days prior to the date of the change to:

CCSP Members
Care coordinators
Area Agency on Aging
The CCSP Unit at DCH/Medicaid
Healthcare Facility Regulations Division, if applicable

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Refer to Sections 105.7 and 105.8 of Part I Policies and Procedures for notifying the Division of Medical Assistance of a change of ownership or legal status.

NOTE:

If the new legal entity chooses not to enroll in the CCSP, services will be rebrokered to an enrolled CCSP provider within thirty (30) days of the effective date of the change for those members who wish to continue receiving CCSP services.

3. Interim Reimbursement:

Medicaid reimbursement for the current provider will terminate on the effective date of the sale. However, if the new owner chooses to apply for a Medicaid provider number, Medicaid reimbursement may be effective for the new owner during the period of time between the effective date of ownership and effective date of approval to enroll in the CCSP **if** the following conditions are met:

- The new owner/applicant submits a Letter of Intent to the CCSP Unit, prior to the effective date of ownership, **with assurance that it will provide CCSP services according to all CSP Policies and Procedures.**

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- The new owner/applicant submits HFR license in the new owner/applicant name **or** evidence that application for this HFR license has been made, if license is required.
- The new owner/applicant submits to the CCSP Unit enrollment applications (CCSP and Medicaid) within thirty (30) days of the letter of intent. If the enrollment applications are not acceptable, the applicant will have thirty (30) days to make revisions. If, after the revision period, the revisions are not acceptable, the CCSP Unit will recommend denial of the application to DCH.

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- The new owner/applicant completes 180 days of operation of the existing business during which time, no CCSP member will be admitted to the agency.

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The CCSP Unit will review the applications and provider enrollment documents, HFR survey reports, provider complaint logs, Utilization Review documents, and Ombudsman recommendations and care coordination provider check lists, if applicable. Enrollment or denial in the CCSP will be recommended to DCH. DCH will notify the applicant in writing the approval or denial of the application

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EXCEPTION: If the new owner is currently an enrolled CCSP Medicaid service provider in good standing, please refer to policies and procedures found in this chapter, section 601.3

4. Participation Contingency:

Participation of the new owner in the CCSP will be contingent upon the following conditions being met:

- Satisfactory completion of applications

- Satisfactory site visit by CCSP Unit staff members, if applicable

New management will be **required** to attend mandatory CCSP Provider Trainings.

Failure to meet above contingencies will result in the CCSP Unit's recommending recoupment of all Medicaid funds and recommending termination from the CCSP.

NOTE:

Medicaid Provider Numbers, Personal Care Home permits, Private Home Care Licenses, and Certificates of Need, are not automatically transferable. Providers are required to notify the licensing/permitting agency of any changes in ownership, legal status, or location.

Purchase of an existing enrolled provider agency requires that the purchaser complete the enrollment process and obtain a Medicaid Provider Number. Without a Medicaid Provider Number, Medicaid reimbursement will not occur.

B. Change of Provider Data

A provider must ensure that the CCSP is provided updated, accurate information, which includes but is not limited to:

- correct address of the agency/business location
- correct street address of the service location, if different from above
- current phone number(s)
- name of contact person(s)
- data on subcontractor's providing direct member care
- Electronic Mail Address (e-mail)

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Enrolled providers are required to furnish written notice to the CCSP Unit at the Division of Medical Assistance, the Healthcare Facility Regulations Division (if applicable), the Area Agency on Aging, the Care Coordination agency and the CCSP members, at least 30 calendar days prior to any change in provider data. (See Section D for addresses.) Changes requiring written notice include, but are not limited to:

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- address of the provider agency administrative/business office
- address of the service location

- telephone numbers
- subcontractor data changes
- change in permit/license issued by the Healthcare Facility Regulations Division

If the contact person for the administrative or service location changes, the provider must notify the CCSP Unit within 30 calendar days of the change. (See Section D below for addresses).

Alternative Living Services, Adult Day Health, and Out-of-Home Respite Care facilities may not relocate without:

- A satisfactory site visit
- Submission of the required permits and inspections from the regulating agencies
- Submission of business license and certificate of occupancy
- Approval of the proposed location from the CCSP Unit.

NOTE

CCSP will not accept a change of address notice unless the agency produces (or submits) evidence that the change of address has been validated by the Georgia Department of Community Health, Healthcare Facility Regulations Division (HFRD), if applicable, the county business office, and/or Secretary of State's Office, prior to the request with CCSP.

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C. Termination of Provider Number/Enrollment in CCSP

1. Provider-Initiated Termination

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- A provider seeking to terminate enrollment in the CCSP must provide written notice to the CCSP Unit at the Division of Medical Assistance, the Healthcare Facility Regulations Division, if applicable, and Area Agency on Aging and Care Coordination no less than 30 calendar days prior to termination date, stating that it intends to cease accepting CCSP referrals and terminate participation in the CCSP. (See Section D for addresses).
- The provider must provide written notice of discharge to CCSP members at least thirty (30) calendar days prior to the effective date of termination.

NOTE:

Even when the change in ownership and/or legal status results in no visible change in services to the member, the provider must inform members and care coordinators.

2. Termination of Provider Number/Enrollment by the DMA

- The DMA may suspend or terminate a provider as described in Part I, Chapter 400.
 - Failure to correct conditions that warrant suspension will result in termination from the CCSP.

D. Notice - Send notices of change in ownership/legal status, change of provider data or notices of intent to voluntarily terminate provider number/ enrollment in CCSP to:

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Georgia Department of Community Health
Division of Medicaid
Community Care Services Program (CCSP) Unit
Two Peachtree Street, NW
37th Floor
Atlanta, GA 30303-3159

and if applicable, to:

Georgia Department of Community Health
Healthcare Facility Regulations Division - Director's Office
Two Peachtree Street, NW
31st Floor
Atlanta, GA 30303 - 3159

E. Response from State Agencies - The CCSP Unit will acknowledge receipt of notice of a change in ownership/legal status within ten business days of receipt. The Unit will send copies of the acknowledgment to Area Agencies on Aging Director(s). The CCSP Unit will forward all changes to Hewlett Packard (HP) (GHP).

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601.5 **Records Management**

Providers must maintain clinical records related to the provision of CCSP services in accordance with accepted professional standards and practice and with the standards in this manual. Records must be made available to DHS, DMA and their agents as requested. The provider must maintain all CCSP records within the state of Georgia. Records are maintained in a manner that is:

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- secure

- accurate
- confidential
- accessible

A. Records Retention

1. The provider must maintain current clinical records for active members and organize the clinical records for easy reference and review. For discharged members, the provider must maintain the clinical record for a minimum of six years from the last date of service. This policy applies even if the provider ceases operation (Refer to Part I, Policies and Procedures). Providers who utilize electronic signatures to validate supervision of services should refer to Part I, Policies and Procedures, **Definitions #60** and Section 106 (R). **(Rev. 10/2011, 1/2015)** Additionally, CCSP permits electronic signatures and/or computer-generated signatures only if the supervisor's access codes and electronic script is generated on the documents required in the member file.

2. In accordance with 45 CFR Part 17, the state and federal governments shall have access to any pertinent books, documents, papers, and records for the purpose of making audit examinations, excerpts, and transcripts. The provider must retain records for six years after submission of the final claims for payment. If any litigation, claim, or audit is initiated before the expiration of the six - year period, the provider must retain records until all litigation, claims, or audit findings involving the records are resolved.

B. Destruction of Records

1. A provider may destroy records not required to be maintained. The destruction of records must be conducted in such a way that member confidentiality is preserved.
2. When records are accidentally destroyed, the responsible party must in a timely manner reconstruct them to the extent possible. Each reconstructed case record must be clearly labeled "reconstructed".

602. **Corrective Action**

602.1 **Corrective Action taken by the AAA or the CCSP Unit at DCH/Medicaid**

(Rev 7/2016)

A. Removal from Rotation List/Suspension of Referrals as Corrective Action

- The Care Coordination agency may recommend to the Area Agency on Aging that a provider be removed from the rotation list and have

referrals suspended. The AAA or the **CCSP Unit** may remove a provider from the rotation list/suspend referrals when appropriate documentation supports this action.

B. Reasons for Removing a Provider From the Rotation List/ Suspending Referrals

A provider may be removed from the rotation list and have referrals suspended for reasons including, but not limited to:

- Provider fails to accept referrals
- Provider fails to provide services as required by the comprehensive care plan
- Provider refuses to accept member because one or more of other needed services are brokered to another provider
- Provider overcharges members for services
- Provider fails to refund fees
- Provider has a documented history of confirmed complaints related to member care/issues
- Provider agency has allegations of member abuse, neglect, exploitation, and/or fraud
- Healthcare Facility Regulations Division imposes sanctions against the provider that result in limitation, suspension, restriction, or revocation of the license/permit
- Provider fails to submit requested plan of correction.
- Failure of the provider to comply with Utilization Review or failure of
of
the provider to correct deficiencies cited as the result of an audit
- Provider fails to attend a minimum of two (2) AAA network meetings per year.

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C. Definition of Removal from Rotation List/Suspension of Member Referrals

When a provider agency is removed from the rotation list, care coordination agencies will not broker any CCSP members to the provider agency and will not refer new CCSP referrals to the provider agency for a

specific period of time. The provider agency may continue providing services to CCSP members currently brokered to the agency.

NOTE:

Care coordinators may inform members currently receiving services from the provider that the CCSP has sanctioned the provider agency. The member may choose to continue receiving services from the provider agency or may request a new provider.

D. Procedure for Removing a Provider From the Rotation List/Suspension of referrals

The AAA or CCSP Unit will notify the provider in writing that the provider agency has been removed from the rotation list and that all referrals have been suspended and the reason(s) for the corrective action. The written notice will include the effective date of the removal from the rotation list/suspension of referrals, the duration of the corrective action, the request for a written plan of correction within fifteen (15) working days, the time frame in which the provider is to correct the deficiencies, and the appeal process should the provider disagree with the corrective action imposed.

Failure to submit the written plan of correction may result in additional adverse action.

The duration of the removal from the rotation list/suspension of referrals will be imposed for a specific time period. For the first offense, a minimum of three (3) months will be imposed; for subsequent offenses, a minimum of six (6) months will be imposed. The AAA or CCSP Unit may shorten or lengthen the duration of the corrective action, depending upon the reason for the action.

NOTE:

If a provider agency is removed from the rotation list /had referrals suspended two or more times within a twelve (12) month period, **the CCSP Unit will determine the appropriate adverse action.**

E. Due Process

The provider shall have ten (10) days from the date of the written notice of removal from the rotation list/suspension of referrals from the AAA or CCSP Unit to submit a written request for an Administrative Review. All requests for reviews must be submitted to the address specified in the corrective action notice to the provider. The written request for an Administrative Review must include all grounds for appeal and must be accompanied by any supporting documentation and explanations that the provider wishes the CCSP Unit to consider. Failure of the provider to comply with the requirements of administrative review, including the failure to submit all necessary documentation, within ten (10) days shall

constitute a waiver of any and all further appeal rights, including the right to a hearing, concerning the matter in question.

The CCSP Unit shall render the Administrative Review decision within thirty (30) days of the date of receipt of the provider's request for an Administrative Review.

Following an evaluation of any additional documentation and explanation submitted by the provider, a final written determination regarding removal from the rotation list/suspension of referrals will be sent to the provider. If the provider wishes to appeal this determination regarding removal from the rotation list/suspension of referrals, the provider may appeal the decision **of the CCSP Unit**. The appeal must be in writing and received by the Unit within ten (10) business days of the date the Administrative Review decision was received by the provider. The appeal shall be determined within forty-five (45) days of the date on which the **CCSP Unit manager's** office received the request to appeal.

The request for the appeal must include the following information:

- A written request to appeal the decision of the Administrative Review
- Identification of the adverse administrative review decision or other Division action being appealed
- A specific statement of why the provider believes the administrative review decision or other Division action is incorrect; and
- Submission of all documentation for review

An appeal shall not stay the action appealed.

The **CCSP Unit manager** will reach a decision within forty-five (45) days of receiving the appeal. If the manager's decision upholds that of the CCSP Unit, removal from the rotation list/suspension of referrals shall remain in effect for the time specified.

The decision of the CCSP Unit manager is final. No further appeal rights will be available to the provider.

F. Reinstating to the Rotation List/Referrals

If the provider submits the required plan of correction within the time frame specified in the written notice of removal from the rotation list/suspension of referrals and demonstrates that the deficiencies have been corrected, the AAA or CCSP Unit will notify the provider that the agency has been reinstated to the rotation list and may receive referrals. The AAA or CCSP Unit will notify the care coordination agency when

the provider has been reinstated to the rotation list and may receive referrals.

G. Failure of Provider to Correct Deficiencies

If the provider fails to submit the required plan of correction and fails to demonstrate that deficiencies have been corrected, the provider will remain off the rotation list/suspension of referrals and **the CCSP Unit will consider further corrective or adverse actions**, including re-brokering of services with another provider and termination of the provider's enrollment in the CCSP.

602.2 **Complaints (Rev 7/2016)**

If a complaint is referred to the CCSP Unit and, after initial scrutiny, appears to involve criminal activity or lack of program integrity, the Director of the **CCSP Unit manager** shall have the discretion to refer the complaint to the Georgia DHS Office of Investigative Services, the Department of Community Health (Program Integrity), law enforcement agencies, and other regulatory entities.

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602.3 **Serious and Unusual/Unexpected Incidents/Emergencies (Rev 7/2016)**

- In the event of allegations of abuse, neglect, exploitation, fraud, and/or member health, safety, and/or welfare are at risk or in immediate jeopardy, and the provider agency has failed to act appropriately, the Care Coordination Agency will immediately notify the Area Agency on Aging. The Area Agency on Aging **will notify the CCSP Unit** of the incident.
- When there is the threat of immediate jeopardy to the health, safety, and/or welfare of a member, the CCSP Unit will immediately notify the Care Coordination agency to relocate CCSP members, if appropriate. **The CCSP Unit will then consider additional appropriate adverse action.**
- Depending upon the nature of the incident, the provider may be asked to submit specific policies and procedures for review by the Area Agency on Aging and/or **CCSP Unit** to determine if the provider agency followed policy and standard of practice.

NOTE: See Appendix W

602.4 **Adverse Action (Rev 7/2016)**

A. Conditions of Adverse Action

The CCSP Unit at DCH/DMA can take action that requires enrolled providers to correct deficiencies before the action can be ended. Adverse

actions may be imposed independently or in conjunction with other regulatory agencies. (Refer to Part I, Policies and Procedures, and Section 601.1D of the CCSP-General Manual).

The CCSP Unit determines the adverse action and notifies the provider agency and CCSP of its decision and notice of action.

B. Reasons to Impose Adverse Action

The CCSP Unit will determine the adverse action(s) it believes will most likely achieve correction of the deficiencies cited. The Unit can take an adverse action for reasons including, but not limited to:

1. Failure to Accept Referrals – The provider agency fails to accept referrals made for approved planning and service areas, in accordance with stated service hours, or the agency fails to provide the Area Agency on Aging written reasons for failure to accept referrals.
2. Pattern of Non-Compliance with Policies and Procedures – A pattern of non-compliance is established if the provider agency is cited for policy violations within the previous three (3) years. A pattern of non-compliance is determined through:
 - Utilization Review Reports or other audits conducted by the Division of Medical Assistance;
 - reviews and site visits conducted by the Department of Community Health, Healthcare Facility Regulations Division (HFR) and/or its agents;
 - and/or reports from members, members' representatives, member families, Area Agencies on Aging, and/or care coordination.

The provider agency must notify the CCSP Unit in writing of any non-compliance, even if temporary, as soon as it occurs (i.e., resignation of a required staff member) to request a temporary written waiver from the Unit.

3. Failure to Render Services – Failure of a provider agency to provide services as required by the care plan in accordance with currently accepted standards of medical practice, including the provision of nursing supervision.

If the provider agency experiences temporary staffing problems and is unable to provide services as required by the member's care plan, the provider must immediately notify the care coordinator. If the problem is expected to continue more than ten (10) business days, or the member's condition is such that a delay/interruption of service would

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be a disservice to the member, the care coordinator will re-broker the member's services with another provider.

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4. Failure to Maintain Quality of Care – Care and/or services provided are of such quality that the health, safety and/or welfare of members are placed at risk.
5. Refusal to Accept Member – Refusal by a provider agency to accept a member because of one or more of the other services needed by the member is brokered to another provider or because the member has cost share liability.
6. Failure to Maintain Current Licensure – Failure of provider agency to maintain current licenses for the agency and personnel as required by Georgia law. **(Rev. 10/2015)**
7. Failure to Act on Charges of Abuse, Neglect, and/or Exploitation of Members – Failure of a provider agency to take measures to stop identified known abuse, neglect, and/or exploitation of members.
8. Relocation Without Prior Approval and Notification – Moving members from an Adult Day Health Center, a Respite Care Facility, or an Alternative Living Services facility without obtaining prior approval of the **CCSP Unit** or without furnishing sufficient prior notice to the CCSP member(s), member representative(s), and care coordinator(s).
9. Failure to Respond to an Adverse Action – Failure of a provider agency to submit a timely plan of corrective action or any other reports or documentation as requested or required by **the CCSP Unit**.
10. Refusal of Access to Member and Member Records – Failure of a provider agency or its subcontractor(s) to permit staff or contracted personnel acting on behalf of the State of Georgia access to members, member records or other documentation required for participation in the CCSP.
11. Falsification of Records or other Acts of Fraud/Abuse
12. Inappropriate Charging – Willful overcharging of members and/or their representative(s) for services.
13. Failure to Refund Fees – Failure of a provider agency to refund fees to members after a determination that a member is due a refund

NOTE:

Retroactive Medicaid eligibility and/or other reasons may cause a provider to owe refunds to a member.

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14. Failure to Notify Prior to Termination – Failure of a provider agency to provide required notice prior to termination of services. Providers who abruptly discontinue services may not request re-enrollment for a period of one (1) year from the date services were discontinued. (See Section 404.2 Part I Medicaid/Peachcare for Kids).

15. Failure to Respond to Member's Needs for 24-Hour Service – (See Section 601.1M of the CCSP General Manual).

C. Types of Adverse Action(s)

Types of adverse action the CCSP Unit may impose include but are not limited to:

1. Suspension of Provider – The provider agency will be suspended from participating in the Medicaid program for a defined period of time not to exceed one year.
2. Termination of Provider Enrollment
3. Re-Brokering of Member Services – When the health, safety, and/or welfare of CCSP members is at risk and/or in immediate jeopardy, the CCSP Unit will notify the care coordination agency to immediately re-broker services of CCSP members to another approved CCSP provider. The CCSP Unit may consider further adverse action.
4. Delaying the processing of pending and additional provider enrollment applications and expansion requests.

NOTE:

Even in the absence of any adverse action, care coordination may re-broker service(s) to another provider at any time the member requests a change in providers.

602.5 Duration of Adverse Action

The adverse action letter will stipulate the time frame within which the provider is required to correct deficiencies. The DCH shall determine the period of adverse action.

NOTE:

The CCSP Unit may conduct an unannounced site visit prior to removal of the adverse action to determine whether the provider has achieved compliance. Failure to achieve compliance by the end of the adverse action period will result in a recommendation to continue the adverse action and/or impose additional adverse action.

602.6 Provider Notification of Adverse Action and Appeal Rights

The DCH will send to the provider a Notice of Adverse Action in accordance with Part I, Chapters 400 and 500 of Policies and Procedures. The notice will include:

A. Reason for imposing the adverse action

The effective date and duration of the proposed adverse action(s) will be determined by DCH. The provider may appeal the action taken by DCH, but appealing the action will not stay the action appealed.

B. The address to which requested information is to be sent and the name of a DCH contact person to call for clarification regarding the notice.

C. The actions and time frame necessary to oppose/appeal the adverse action. If the provider fails to request an Administrative Review or fails to submit the requested information within the time frame specified in the Notice of Adverse Action, the adverse action becomes final and no further administrative or judicial review will be available. If the provider fails to respond to the notice or to correct the deficiencies, the DCH will make a determination on the adverse action, including re-brokering of services with another provider and termination of the provider's enrollment in the CCSP.

NOTE:

CCSP providers under adverse action are subject to the provisions of Part I, Policies and Procedures For Medicaid/Peachcare for Kids, Georgia Department of Community Health, Division of Medical Assistance, Chapter 400 – Adverse Action, and Chapter 500 – Appeals.

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603. Admissions

A. Each provider must maintain written policies, procedures and criteria for accepting members referred by the care coordinator. The policies, procedures and criteria apply uniformly to all CCSP referrals. (See Appendix C of the CCSP General Manual).

NOTE: The member must be informed in writing in advance of running any credit checks. Rev 10/14

B. Admissions policies, procedures and criteria may not discriminate or permit discrimination against any person or group of persons on the grounds of age, race, sex, color, religion, national origin, or handicap, in accordance with Title VI of the Civil Rights Act of 1964, as amended, and Section 504 of the Rehabilitation Act of 1973.

C. The Federal Omnibus Budget Reconciliation Act of 1990 includes provisions known as the Patient Self- Determination Act. The Act requires providers of personal care services who receive reimbursement under

Medicare and/or Medicaid to inform members of their right to execute Advance Directives for health care (see Appendix D of the CCSP General Manual). Under the Patient Self-Determination Act, a provider may not discriminate against a member who has or who has not executed an Advance Directive.

Home Delivered Meals Services and Emergency Response System providers are exempt from advance directives requirements.

Providers rendering personal care services (Adult Day Health, Personal Support Services, Home Delivered Services, Alternative Living Services, Respite Care, and Skilled Nursing Services) must:

- Comply with all requirements of law respecting Advance Directives.
- Provide written information to members regarding their rights under law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives.
- Document in the member's clinical record whether an Advance Directive has been executed.
- Maintain in the provider agency file a copy of any executed Advance Directives.
- Provide education for staff on member information concerning Advance Directives.
- Never condition the provision of care or otherwise discriminate against a member who has or has not executed an Advance Directive.

604. **Member Assurances**

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604.1 **CCSP Member Rights and Responsibilities**

A. Refer to Sections 601.1 - O of the CCSP General Manual. Providers must acknowledge that members have rights and responsibilities regarding participation in the CCSP. At the time of admission the provider reviews member rights and responsibilities with the member and/or member's representative. After the member reads and signs a copy of the member's rights and responsibilities, the provider gives a copy of the rights and responsibilities to the member and the member's representative if applicable. The provider places a copy in the member's record.

Member rights recognized by the provider include:

1. The right of access to accurate and easy-to-understand information

2. The right to be treated with respect and to maintain one's dignity and individuality
3. The right to voice grievances and complaints regarding treatment or care that is furnished or not furnished, without fear of retaliation, discrimination, coercion, or reprisal
4. The right to a choice of approved service provider(s)
5. The right to accept or refuse services
6. The right to be informed of and participate in preparing the care plan and any changes in the plan
7. The right to be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered
8. The right to confidential treatment of all information, including information in the member record
9. The right to receive services in accordance with the current care plan
10. The right to be informed of the name, business telephone number and business address of the person supervising the services and how to contact that person
11. The right to have property and residence treated with respect
12. The right to be fully and promptly informed of any cost share liability and the consequences if any cost share is not paid
13. The right to review member's records on request
14. The right to receive adequate and appropriate care and services without discrimination.
15. The right to be free from mental, verbal, sexual and physical abuse, neglect, exploitation, isolation, corporal or unusual punishment, including interference with daily functions of living
16. The right to be free from chemical or physical restraints

NOTE:

Providers must be aware of additional member rights and responsibilities required under specific program licensure and must include signed copies of these rights and responsibilities in the member's record.

B. Member responsibilities recognized by the provider include:

1. The responsibility to notify service provider(s) of any changes in care needs
2. The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate with and respect the rights of the caregivers providing care
3. The responsibility to be as accurate as possible when providing information on health history and personal care needs
4. The responsibility to participate actively in decisions regarding individual health care and service/care plan
5. The responsibility to comply with agreed-upon care plans
6. The responsibility to notify the member's physician, service provider(s), and/or caregiver of any change in one's condition
7. The responsibility to maintain a safe home environment or to inform provider(s) of the presence of any safety hazard in the home
8. The responsibility to be available to provider staff at times services are scheduled to be rendered
9. The responsibility to pay any cost share liability, if applicable

605. **Provider's Evaluation of Member's Needs**

605.1 **Level of Care**

- A. Medical services rendered to a member will be ordered by a physician or nurse practitioner on the Level of Care and Placement Instrument. See Appendix E of the CCSP General Manual.
- B. A CCSP member must meet the level of care criteria for intermediate nursing home placement. **The Georgia Medical Care Foundation (GMCF) must validate the member's level of care (LOC) and assign a length of stay (LOS) not to exceed a maximum of 365 days. The member's physician signs the Form 5588 (CCSP Level of Care Placement Instrument) to attest to the member's need for a nursing home LOC, after which the CCSP care coordinator RN signs the 5588 to certify the LOC. CCSP services may not begin under the**

LOS indicated on the Form 5588 until the RN signs the form to certify the LOC. (Rev. 7/2015)

- C. Providers may render CCSP services only to members with a current level of care. Each CCSP member is given an approved Level of Care (LOC) certification for program participation. A LOC certification is approved for no more than a 365 day length of stay. (Rev 1/2015)**
- D. If a member needs a change in service within 60 days from the beginning date of the LOS, the care coordinator will document and date the added services on the Comprehensive Care Plan and provide a copy to the member's physician and the service provider(s). No face to face visit or physician letter is required in this situation unless the client is returning to the community from a nursing/rehabilitation facility. See Appendix G of the CCSP General Manual. (Rev 7/2015)**
- E. If a member with a current LOS under an LOC experiences a change in condition or change in status that requires the addition of new services and/or a change in the level of services, and the change occurs more than 60 days after the beginning date of the LOS, a new LOC assessment (reassessment) is not required. However, approval of the new comprehensive care plan by the member's physician is required. The CCSP nurse care coordinator must make a home visit to assess the member's condition and service needs. Changes must be documented on the comprehensive care plan, and the comprehensive care plan must be submitted to the member's physician by way of the Physician Change in Services Letter (Appendix EE) to request his/her approval of the new plan of care. Copies of the Appendix EE with the physician's signature and the updated comprehensive care plan must be sent to the provider for the member's file. The following are examples of changes or new services for which physician approval is required:**

**The new service to be added is a skilled service.*

**The member needs a change in their level of Adult Day Health (ADH) services.*

**The change in service is from one category to another, such as from personal support services (PSS) to alternative living services (ALS).*

**A change in service or new service is required for a member after their discharge from a facility that requires a LOC on a DMA-6, such as a nursing or rehabilitation facility.*

**A member transfers from one planning and service area to another and requires new services. (Rev. 7/2015)*

F. ADH therapies, HDS and SNS (skilled services) additions require physicians orders before specific medical procedures can be provided. Orders for therapy services must include specific procedure and modalities used frequency and duration of services. (Rev. 7/2015)

G. The care coordinator may add Home Delivered Meals, **Out of Home Respite Care**, and Medical Social Services to the Comprehensive Care Plan at any time without completing a reassessment. **(Rev 4/2015)**

H. A member must meet all CCSP eligibility criteria to participate in the program.

EXCEPTION: If a member continues to receive services while an appeal of a Level of Care termination is in process, and the LOC expires before the hearing decision is known, the RN does not complete a LOC re-determination. Services may continue to such a member even though there is no current LOC.

605.2 **Provider's Initial Evaluation of the Member**

Individuals participating in the CCSP are at risk for nursing facility placement and thus require timely evaluation and service delivery.

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A. Contacting the Provider Agency - Prior to sending a referral packet, care coordinators will telephone provider agencies. Upon receipt of the telephone call, the provider agency must contact the care coordinator within 24 hours if the provider can conduct a face-to-face evaluation in the member's primary place of residence within three business days. If the member is unavailable for evaluation within three business days, the provider will notify the care coordinator. If the member's needs warrant, care coordinators may request the provider to evaluate the member within a shorter time frame.

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B. Face-to-Face Evaluation - A provider agency must conduct a face-to-face evaluation of the member in the member's primary place of residence within **three** business days of receiving the referral from the care coordinator. Within 3 business days of the face-to-face evaluation, the provider will use the CCNF to notify the care coordinator of the decision to accept or refuse the referral. If the provider accepts the referral, the provider indicates on the CCNF the date that services will begin. If the member is hospitalized, institutionalized, or the home environment is not conducive for evaluation purposes, the provider must evaluate the member in a mutually-agreed-upon setting. Services are to begin within 48 hours, if possible, after the provider evaluates the member. If services are to be provided in the member's residence, the provider also must assess the home to determine if it is an appropriate and safe environment

for service delivery. The Adult Day Health Provider may elect to evaluate the client in the Adult Day Health setting or the member's primary place of residence, depending on the mutually –agreed needs of the member. (Rev. 4/10)

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- C. Evaluating a Member who is Transitioning to the Community under the Money Follow the Person (MFP) Program - When a provider receives a referral to provide services for a member who is preparing to be discharged from a nursing home to the community under the MFP program, the provider should conduct the face-to-face evaluation in the nursing home prior to discharge, as soon as possible after the referral is received. This is done so that services can begin on the first day the member returns home, as authorized by the CCSP care coordinator. A re-evaluation of the member's needs can be conducted when services have started after the member is settled in the community, following the guidelines in Section 605.3 of this manual. (Rev. 01/2013)

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- D. Additional Provider Information - If the provider accepts the member for service, the provider will gather any information, other than that already contained in the referral packet, necessary to complete the member's data file in accordance with the provider's requirements.

Care coordination will forward a referral packet to the provider agency within 24 hours of brokering services.

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- E. Care Plan Changes - If applicable, the provider must contact the care coordinator to obtain prior approval of any desired changes in amount, duration, and scope of services in the comprehensive care plan. **The provider must render services to individuals according to the comprehensive care plan.** If the provider determines that the services outlined in the comprehensive care plan are not appropriate for the member, the provider notifies the care coordinator immediately. The care coordinator makes a decision after discussions with the provider.
- F. Notifying Care Coordinator - Within three business days from the date the provider evaluates the member, the provider must send to the care coordinator a Community Care Notification Form (CCNF-See Appendix I of the CCSP General Manual) to advise the beginning date of service. **The provider agency's failure to initiate service as agreed on the CCNF may result in the care coordinator's rebrokering the service with another provider and recommending adverse action against the provider agency.**
- G. Member Inappropriate for Services or Declines - If, after the face-to-face evaluation, a provider determines that the member is inappropriate for

service, or if for any reason a member declines services from the provider, the provider must immediately telephone the care coordinator during regularly scheduled office hours and/or within 24 hours. The provider must return the referral packet with the Community Care Notification Form (CCNF) to the care coordinator within three business days from the date the provider determines that the member is inappropriate or the member declines services.

H. Accepting the Referral and Initiating Services - Services are required to begin within 48 hours of the provider's face-to-face evaluation of the member or at the next appropriate day as dictated by the frequency order unless extenuating circumstances delay the start of services. Within three business days of the initial evaluation visit, the provider must send to the care coordinator a Community Care Notification Form (CCNF) indicating the start date of services and documenting the reason(s) for any delay in starting services.

Care coordinators are required to follow up with providers who do not begin services within 48 hours of the face-to-face evaluation unless the stated reason for not starting services is justified as indicated above.

<p>NOTE: The Community Care Notification Form (CCNF) and the provider referral packet may be submitted electronically using encryption or by means of a secure Web site. Rev. 1/12</p>

605.3 **Provider's Reevaluation of the Member - After Service Initiation**

The provider agency engages a Registered Nurse to conduct initial evaluations and periodic re-evaluations of the member's medical needs during each supervisory visit or more frequently if the member's condition warrants. (Refer to service-specific manuals for frequency of supervisory visits). During the reevaluation the provider RN:

- Reviews the member's problems, approaches to those problems, and identifies responses to the approaches
- Reviews and completes needed updates to the member's care plan
- Communicates problem approaches, updates to care plans and any other pertinent information to appropriate staff caring for a member
- Communicates recommendations for changes in the member's total care and sends the CCNF to the care coordinator.

<p>NOTE:</p>

A provider must secure care coordinator approval prior to changing services. Within 3 business days after receiving verbal approval from the care coordinator, the provider must follow up by sending to the care coordinator a completed CCNF reflecting the agreed upon change(s) in service.

606. **Member Services**

606.1 **Care Coordinator**

The care coordinator assumes care management responsibilities including member assessment and development of the comprehensive care plan. The care coordinator's basic roles and responsibilities are to:

- A. Investigate and refer to appropriate community resources
- B. Develop the comprehensive care plan in consultation with the member and service providers
- C. Identify desired member outcomes and services needed to restore or preserve member health and safety
- D. Serve as a member of a comprehensive care team dedicated to effective delivery of services
- E. Certify member's level of care (LOC)
- F. Initiate a discharge plan at initial assessment and coordinate discharge of member
- G. Implement the comprehensive care plan by recommending and coordinating the delivery of home and community-based services (HCBS)
- H. Broker each CCSP service as an individual service
- I. Monitor and evaluate service delivery to members to assure that services are rendered as ordered and provided in a timely and cost effective manner
- J. Determine if services are appropriate and effective, monitor changes in member's health and review the comprehensive care plan at least **every 90 days (Rev. 4/2014)**
- K. Document case activities and service information
- L. Coordinate case conferences, as appropriate, with providers and member/member's representative

- M. Communicate with all agencies providing direct services to the member and resolve problems relating to coordination of services
- N. Monitor frequency and amount of service in order to ensure that costs are within established limits
- O. Initiate the Service Authorization Form (SAF) and forward copies to provider(s). *The SAF is created from the Service Order and reflects the number of days in the month. SAFs are generated initially and when there is a change in services. A copy of the initial SAF and any revised SAFs will be forwarded to the provider(s). Rev 10/14*
- P. Make referrals to Protective Services and other non-CCSP services as appropriate
- Q. Arrange for emergency services
- R. **Schedule and complete an annual level of care (LOC) reassessment within 60 days of the expiration of the current length of stay (LOS)**
- S. **Arrange and complete a face to face nursing visit with the member when the member experiences a change in condition**
- T. **Coordinate transfer to other services when the member needs changes or other services (discharge or transfer to a hospital, nursing home, or other community-based care).**
- U. **If the member requests, assist the member with request for a hearing to appeal an adverse action affecting the member's level of services. (R through U revised 7/2015)**

606.2 **Member Care**

- B. To assure that their efforts effectively complement one another and support the goals and objectives outlined in both the comprehensive care plan and the Member's Care Plan, there must be ongoing interaction among provider, care coordinator, and member/member's representative. The member's clinical record and provider's notes from case conferences must reflect adequate communication, reporting and effective coordination of services.
- C. When a provider communicates with the member's physician, including telephone contacts and medical orders, the provider must adequately document the information in the member's clinical record

606.3 **Change of Member's Residence**

- A. If the member changes place of residence but remains within the provider's service area, the provider must remind the member to notify the Social Security Administration of the address change. The provider will use the CCNF to notify the care coordinator of the address change within three business days of learning of it.
- B. If the member moves to another planning and service area in which the current provider is approved to render CCSP services, the provider must use the CCNF to notify the current care coordinator, who transfers the care coordination file to the new care coordinator.
- C. If the member moves to another planning and service area in which the current provider is **not** an approved CCSP provider, the provider will use the CCNF to notify the care coordinator. **In addition, the provider must send a complete copy or summary of the member's clinical record to the current care coordinator to include in the care coordination case record.** Before placing the record in the inactive file, the provider will check to determine if the original clinical record includes the member's new address and the effective date of transfer. Upon receipt of the CCNF and clinical record information, the current care coordinator will transfer the copy of the member's clinical record and the original care coordination case record to the new planning and service area.

606.4 Clinical Records

- A. A provider must maintain clinical records on all members in accordance with accepted professional standards and practices. To facilitate retrieving and compiling information, the provider must assure that clinical records are accurately documented, readily accessible, and organized.

A provider must protect the confidentiality of member information and safeguard against loss, destruction, or unauthorized use. The provider must have written procedures known to all staff and sub-contractor which govern the use and removal of records and the conditions for release of information.

- B. A provider must protect the confidentiality of member information and safeguard against loss, destruction, or unauthorized use. The provider must have written procedures known to all staff and sub-contractor which govern the use and removal of records and the conditions for release of information.
- C. The clinical record for each member must contain sufficient information to identify the member clearly, to justify the comprehensive care plan and treatment, and to document accurately the results of treatment. All provider clinical records must include the following:

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1/15

1. Referral packet forwarded by the care coordinator. The referral packet includes:
 - a. Copy of Level of care and Placement Instrument, signed and dated by the physician
 - b. MDS-HC V9 and Comprehensive Care Plan which includes:
 - i. Client Detail
 - ii. Assessment Questions short
 - iii. Determination of Need
 - iv. **Care Plan, including CAPs, Service Order and Task Lists (Rev 1/2015)**
 - v. Copy of signed Authorization for Release of Information and Informed Consent (Signature page)
 - vi. If client is MAO or PMAO, copy of the completed Potential CCSP MAO Financial Worksheet, which contains client signed Statement of Intent: Cost Responsibility
 - c. Any other relevant information, including:
 - i. Psychological and Psychiatric evaluations
 - ii. Information about client that the provider needs before completing an evaluation/assessment
 - iii. Copy of the DHS Authorization for Release of Information, if applicable (See Appendix L of the CCSP General Manual)

NOTE: If the level of care is not consistent with the comprehensive care plan, an addendum must be noted on the service order, and a copy of the Physician Change in Services Letter (Appendix EE) must be attached. (Rev. 7/2015)

2. results of the provider's initial evaluation of the member and the provider's acceptance or reason for non-acceptance of the individual into service
3. notes from case conferences indicating results of all provider's reevaluation of the member

4. current and previously signed and dated Member Care Plans (see Appendix K of the CCSP General Manual) by the provider RN during each supervisory visit.

EXCEPTION: ERS and HDM services do not require member care plans.

5. documentation of supervisory visits and clinical notes signed and dated by the person(s) rendering services, and incorporated in the medical record
6. medication, dietary, treatment, and activity orders when ordered on a specific member
7. documentation of all communication (written and verbal) between the provider RN and the member's physician
8. documentation of all communication (written or verbal) between provider staff, care coordinator, and other service providers or persons involved in the member's care
9. instructions for dealing with medical emergencies of the individual member (in accordance with advance directives, if appropriate) and documented on the emergency information plan. (See Appendix U)
10. documentation of member's service on a member service record form

EXCEPTION: ERS providers are not required to complete a service record form.

11. if the service is provided in the member's home, clear and specific directions to the member's home from the provider agency
12. Advance Directives, if applicable (See Appendix D of the CCSP General Manual)
13. discharge plan and, if appropriate, discharge notice
- 14. copies of the comprehensive care plan, updated every 90 calendar days (rev 10/1/13)**
15. signed copy of member's rights and responsibilities (See Section 604.1 of the CCSP General Manual)
16. admission or service agreement, if applicable. Such admission or service agreements must be typed in sufficiently large, clear, and commonly used type face to be easily read, and in language which is

appropriate for the educational levels and cultural backgrounds of the members.

NOTE:

Home Delivered Services providers refer to the Home Delivered Services Manual for clinical record requirements for CCSP members.

606.5 **Authorization for Release of Information**

- A provider is prohibited from disclosing information contained in member records to any person other than authorized representatives of DCH, DHS, or providers without the expressed written consent of the member.
- A provider must use only the official Georgia Department of Community Health form to authorize release of member information (Appendix L of the CCSP General Manual). This form authorizes the sharing of member information among DCH, DHS, and providers. The care coordinator will include a copy of the signed form, if applicable, in the initial referral package sent to each provider.
- To share member information with persons other than those specified above, the provider must obtain additional written authorization from the member prior to releasing any such information.

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606.6 **Discharge Planning**

- A. Providers and care coordinators must maintain a coordinated program of discharge planning to ensure that each member has a planned program of continuing care which meets the member's post- discharge needs.
- B. The care coordinator must begin developing the discharge plan during the initial assessment. Thereafter, the provider's RN is responsible for coordinating discharge planning in consultation with the member, the member's care coordinator, the member's physician, other provider staff, other involved service agencies, and other local resources available to assist in the development and implementation of the individual member's discharge plan.
- C. Member Care Plans must clearly reflect discharge planning efforts.
- D. The care coordinator and providers must consider the following factors in discharge planning:
 - problem identification
 - anticipated progress

- evaluation of progress to date
 - target date for discharge
 - identification of alternative resources for care after discharge.
- E. Upon discharge, the provider will furnish an appropriate discharge summary to those responsible for the member's post-discharge care. The discharge summary must include information concerning:
- information on current diagnoses
 - an evaluation of rehabilitation potential
 - description of course of prior treatment
 - copy of the most recent Member Care Plan
 - other pertinent information needed by post-discharge caregiver

606.7 **Discharge of Members**

If a care coordinator or UR analyst recommends a reduction or termination of service(s), the member may choose to appeal the adverse action decision and request continuation of services during the appeal process. For services to continue, the member must appeal within 10 days of the adverse action notice. If the member does not appeal, discharge from service occurs 10 days from the member's receipt of the adverse action notice.

NOTE:

Payment to the provider for delivered services continues during the appeal process.

- A. Discharge occurs when any of the following occurs:
1. The care coordinator determines that the member is no longer appropriate or eligible for services under the CCSP.
 2. DMA's Utilization Review (UR) staff recommends in writing that a member be discharged from service. (See Appendix M of the CCSP General Manual.)
 3. The enrolled member has received no CCSP services for 60 consecutive calendar days. If a CCSP member is hospitalized or

receiving Medicare Home Health Services, the member is considered to have received a reimbursable waived service.

4. An MAO member fails to pay cost share in accordance with the provider-member agreement.

NOTE: CCSP service providers may discharge a member who fails to pay cost share. However, a member cannot be discharged from CCSP for failure to pay cost share. Discharge from CCSP occurs when there is no provider who is willing to serve the member.
(Rev. 10/2015)

5. The member/member's representative consistently refuses service(s).
 6. The member's physician orders the member's discharge from CCSP.
 7. The member enters a nursing facility. The provider must send the notice of discharge immediately upon the member's placement in a nursing facility. **EXCEPTION:** ERS services may continue for up to 2 months (62 days) if the member is expected to return home.
 8. **The member enters another home and community based waiver, such as SOURCE, ICWP or NOW/COMP. Send notice of discharge based on the discharge date negotiated with the new waiver case manager by the CCSP care coordinator, waiving the 30 day advance notice requirement. Rev. 01/2013**
 9. member exhibits and/or allows illegal behavior in the home; or member or others living in the home have inflicted or threatened bodily harm to another person within the past 30 calendar days.
 10. member/member's representative or care coordinator requests immediate termination of services. The provider must document in the member's record the member's request for a change in provider.
 11. member moves out of the planning and service area to another area not served by the provider.
 12. member dies.
 13. provider can no longer provide services ordered on the comprehensive care plan.
- B. When a CCSP member is discharged from the program, the provider must deliver service through the effective date of discharge EXCEPT when any one of the following occurs:
1. member enters a nursing facility

2. member enters another HCBS waiver program Rev 01/2013

3. member exhibits and/or allows illegal behavior in the home
4. member/member's representative or care coordinator requests immediate termination of services
5. member moves out of planning and service area
6. member dies.

C. In all discharges, the provider agency must:

- a. Send a written notice to the member/member's representative/legal guardian and the care coordinator thirty calendar days prior to actual discharge date.

EXCEPTION: When UR or the care coordinator recommends discharge or the member dies.

- b. Include in the written discharge notice **the effective date** of discharge **and the reason for discharge**.
- c. Send the discharge CCNF to the care coordinator.
- d. Notify the member's physician

EXCEPTION: ERS and HDM providers send only a CCNF to the care coordinator.

- e. Document the reason for discharge in the member's record.

606.8 **Change in Level of Service**

A. A decrease in the member's level of services is appropriate when the following occurs:

1. The care coordinator, in consultation with the provider determines that the current level of service is no longer appropriate, or
2. DMA's Utilization Review (UR) recommends a reduction in the level of services (see Appendix M of the CCSP General Manual).

NOTE:

If the member files for a hearing within ten calendar days of the date of notice (adverse action letter) of the decrease or termination of services, and the member wishes to continue to receive services until the hearing decision is known, the provider will be reimbursed for services rendered, pending the outcome of the hearing.

3. If the member does not file for a hearing within the 10 days, the order to decrease the level of services will become effective as stated in the notice to the member.
- B. An increase in the member's level of services is appropriate when the care coordinator determines that the current level of service is no longer sufficient. Utilization Review Analysts may recommend an increase in services.
 - C. When the provider determines that a member needs an increase in level of services, the provider confers with the care coordinator to secure approval prior to increasing the level of services. Within 3 business days after receiving verbal approval from the care coordinator, the provider must follow up by sending to the care coordinator a completed CCNF reflecting the agreed upon increase in level of services. If appropriate, the care coordinator then updates the comprehensive care plan and generates a revised Service Authorization Form (SAF).

606.9 **Medications - Monitoring and Administration**

A. **Monitoring Member Medications**

The provider's supervising RN must monitor all prescription and over-the-counter medications taken by CCSP members. Member records must contain the following information related to medication:

1. A current list of prescription and over-the-counter medications taken by the member, including the name of each medication, dosage, route, and frequency taken.
2. All drug side effects observed by or reported to the provider supervising RN by the member or other provider staff.
3. Documentation that the provider reports to the physician in a timely manner any problems identified with medications. The provider must record the physician's order to change any medication.

B. **Administration of Medications**

Only the attending physician may prescribe therapeutic or preventive medications. Only licensed nursing staff may administer medication, and only on direct orders from the physician.

EXCEPTION: Unlicensed proxy caregivers are allowed to perform certain health maintenance activities as long as they have the member's full written informed consent and are trained and certified as specified in Chapter 111-8-100 of the Rules of the Georgia Department of Community Health, Healthcare Facility Regulation

Division, entitled “Rules and Regulations for Proxy Caregivers used in Licensed Healthcare Facilities.”

If a licensed nursing staff member or a proxy caregiver administers medications, member records must include, in addition to information specified in 606.9A of the CCSP General Manual, the following documentation:

- (1) Physician's authorization for the administration of any medication. The physician may renew this authorization on the Level of Care and Placement Instrument at the time of the member's level of care re-determination or through written physician orders at any other time.**
- (2) When obtaining a physician's verbal authorization, documentation of the consultation, and written follow up within 30 days to confirm the authorization.**
- (3) The name, dosage, route, and frequency of any medications administered by the licensed nursing staff member or proxy caregiver. The person administering the medication must sign and date all notations.**

NOTE:

In the clinical record, the provider must record physician's orders for all prescribed medications and treatments directly related to services being delivered. Over-the-counter medications, supplements, and herbs are reported to the member's pharmacist **and/or** physician by the supervising RN for determination of any possible interaction with the member's prescription/ medications. The label of a prescription medication constitutes the pharmacist's transcription of documentation of the order. Such medications should be noted in the clinical record and listed on the re-certification plan of care (HCFA-4850).

C. Assistance With Self-Administered Medications

An aide may assist the member with physician-prescribed medications that are to be self-administered. Assistance is limited to the following:

1. Reminding the member to take the medicine
2. Reading to the member the correct dosage and frequency indicated on the container label
3. Assisting the member with pouring or taking the medication

The aide will report to the RN supervisor any changes in the member's condition, including those which may be related to medications.

The provider agency, member and/or supervising registered nurse must immediately communicate any concerns regarding the member's medications, including the number or frequency in use, to the member's physician. The supervising registered nurse must report these concerns to the care coordinator within 24 hours. Within three business days of verbally notifying the care coordinator, the provider must send a completed Community Care Notification Form to the care coordinator.

606.10 **Durable Medical Equipment (DME)**

- A. For procedures relating to purchase, rental, repair, maintenance, and delivery of equipment and appliances, refer to the DMA Policies and Procedure Manual for Durable Medical Equipment.
- B. Call the Provider Enrollment Unit at 1-800-766-4456 (toll-free) to request the DME service manual.
- C. The provider must either assure provision of DME or make a referral to the care coordinator, as follows:

If the DME item is directly related to the service being provided under the CCSP, and is reimbursable under the Medicaid program, the CCSP provider assists the member in obtaining the item through a vendor enrolled with the Division of Medical Assistance. If requested by the DME vendor, the provider assists the member in obtaining a prescription or certificate of Medical Necessity from the physician.

If the needed equipment is not directly related to the service being provided, the provider agency will alert the care coordinator, who will assist the member in obtaining the item(s) through a Medicare or Medicaid approved vendor.

- D. Within three business days of identifying the member's need for DME, the CCSP provider must send to the care coordinator a completed Community Care Notification Form (CCNF).

606.11 **Non-Emergency Transportation Services (NET)**

For more detailed information, contact the NET broker serving the member's location. Refer to Appendix T of the CCSP General Manual for NET Brokers.

NOTE: The Elderly and Disabled Waiver 1915 (c) does not include transportation in the rate for personal support or extended personal support services. NET is available to all Medicaid participants under the State Plan to provide transportation to medical appointments and for waiver services such as adult day health. A provider who allows an aide to make use of a member's or aide's car for transport needs to be sure

the member's or aide's auto insurance assumes liability in case of an accident. Consider having the member or their family sign an agreement that discusses the assumption of liability in case of an accident. The provider should also carry adequate liability and worker's comp insurance to cover any accidents. Any such transportation activities are at the risk of those who engage in them. Providers should consult their legal team to determine the extent of liability to which the agency may be exposed through such transportation activities, particularly if an aide assumes that this is part of their normal duties. (Rev 4/2015)

606.12 **Emergency Information**

- A. The provider must maintain written emergency information on each member. The emergency information must be easily accessible in the member's record and, at a minimum, includes:
1. name and telephone number of the member's attending physician
 2. member's hospital preference
 3. names and phone numbers of member's representative and other emergency contacts
 4. Known medication/pertinent medical information, including allergies
- B. Provider staff members who deliver services must receive initial and ongoing training in dealing with medical emergencies. Provider staff must maintain current certification and/or training in basic first aid and cardiopulmonary resuscitation (CPR). Certification must be obtained through an approved, certified instructor.

EXCEPTION: ERS and HDM providers.

- C. The clinical record must contain the member's written authorization for staff to seek emergency treatment, including transportation for treatment. **The provider must keep emergency information current by reviewing and updating it at least yearly and as needed. (See Appendix U of the CCSP General Manual).**

606.13 **Fees for Services**

- A. **CCSP Members**
1. A provider may not solicit or accept any contributions or gratuities from members or others for CCSP services rendered.

2. The care coordinator uses the Service Authorization Form (SAF) to indicate the amount of the cost share for each MAO member and the provider assigned to collect it.

NOTE: Members receiving Supplemental Security Income (SSI) are not required to pay toward the cost of their CCSP services.

3. **The CCSP Unit** determines the approved room and board rate for CCSP Alternative Living Services' members. **(Rev 7/2016)**
4. Providers may not charge CCSP members interest rates or late fees for CCSP services.

B. Private Pay Members

If an agency's private pay fee schedule is less than the approved CCSP reimbursement rate, the provider must submit the schedule to the DMA for review. The schedule must include justification for charging a lower fee to private-pay members.

606.14 **Food and Nutrition**

Providers must deliver meals that meet the nutritional standards according to the specific program requirements for each service type (see Appendix O of the CCSP General Manual).

606.15 **Service Delivery Hours**

Providers rendering CCSP services in the member's home must use flexible scheduling to meet the individual member's needs and preferences for service. The provider's RN must be available to provider staff during hours that they deliver services. (See Section 601.1 M of the CCSP General Manual)

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606.16 **Physician Certification**

The care coordinator orders services for members.

A licensed physician, nurse practitioner or physician assistant must approve the member services listed on the Form 5588 (CCSP Level of Care and Placement Instrument) except in the following situations:

- o **The member experiences a change in condition that requires a new service, additional services (such as additional personal support service hours) or a change in the level of Adult Day Health services and the**

change occurs more than 60 days after the beginning date of the member's current length of stay (LOS) under a nursing home level of care (LOC). The physician's approval for new services or a change in the level of ADH services must be communicated through the physician's signature on the Physician Change in Services Letter (Appendix EE).

o The care coordinator adds other CCSP services within 60 days of the beginning date of the current LOS under a nursing home LOC. (Rev. 7/2015)

Skilled and therapy service providers (ADH, SNS and HDS) require medical orders for specific medical procedures provided by agency staff. Physician orders for therapy services must include the specific procedures and modalities used and the amount, frequency, and duration.

EXCEPTION: Home Delivered Service providers must follow appropriate regulations regarding the Medical Plan of Treatment. Refer to the Department of Community Health's Policies and Procedures for Home Health Services.

NOTE: The care coordinator may add HDM, RC and Medical Social Services at any time

606.17 **Supervision of Services by a Registered Nurse (RN)**

Registered Nurse (RN) supervision is the provision of medical oversight to ensure that the provider serves the member effectively and safely in the community. Medical oversight includes assessing and monitoring the member's condition and implementing/arranging interventions to prevent or delay unnecessary and more costly institutional placement. A RN must supervise all CCSP services.

The registered nurse may assign certain tasks to unlicensed assistive personnel. The registered nurse will utilize the "RN Assignment Decision Tree," generated by the Georgia Board of Nursing, to assist the registered nurse in making appropriate decisions regarding whether to assign a task to an unlicensed person. The RN Assignment Decision Tree assists the registered nurse in evaluating the client care tasks on an individual client basis; it guides the nurse in assigning only those tasks that can be safely performed by trained unlicensed assistive personnel. (Refer to Appendix Z of the CCSP General Manual).

EXCEPTION: HDM and ERS providers

NOTE:

Refer to the specific service manual for additional staffing and supervision requirements, exceptions, or substitutions. Providers not following the required supervision policies will face adverse action, up to and including possible termination from the CCSP.

- A. The major tasks of the Registered Nurse include, but are not limited to:
1. Assessing and evaluating the member's needs, current status, environment, and changes during each supervisory visit or more often if indicated by member's condition
 2. Reviewing the Level of Care and Placement Instrument
 3. Conducting supervisory visits and re-evaluations of member care at the required frequency (refer to service-specific manual) or more often if medically necessary

NOTE:

Nursing staff are prohibited from administering medications to members or providing any other member care while conducting supervisory visits.

4. Developing, coordinating, and revising member care plan. Communicating all revisions to appropriate staff.
5. Preparing progress/clinical notes, reviewing progress note entries of all staff, **reviewing and co-signing documentation of all LPN supervisory visits** and instructing staff on charting protocol. **The RN must indicate his/her review of notes and LPN supervisory visits, as well as the follow-up and resolution of problems, by signing and dating the documentation of all of the above. (Rev. 12/10)**
6. Conducting and maintaining ongoing communication with other service providers, the physician, care coordinator, and other relevant parties of changes in the member's medical condition or any change in member status that requires follow-up and/or additional services. The RN/provider must obtain the care coordinator's prior approval for changes in the member's service except in emergency cases.
7. Counseling and educating the member/representative, caregiver(s), and staff in meeting the member's medical and related needs.
8. Other duties assigned by the provider agency such as quality assurance activities and/or planning, scheduling and conducting in-service training sessions, etc.

9. In addition to the tasks listed above, the **Home Delivered Service RN** reviews the Medical Plan of Treatment (MPOT) and obtains the physician's dated signature a minimum of every sixty-two calendar days.

B. Nursing supervision of CCSP services must comply with the following guidelines:

1. The RN supervisor must document, sign and date supervisory visits/notes/ contacts and label them as such. Names and titles must be legible. **Staff may use initials if their signatures are on file at the provider agency.** The supervisory RN signature must be an original, not a rubber stamp.

EXCEPTION: An electronic signature and computer-generated signature, requiring the supervisory RNs' access codes to generate, are permitted.

2. The provider RN supervisor must conduct a face-to-face supervisory visit with the member to cover every period of service provided. If the member is not present, the visit is not considered a supervisory visit.

C. **Documentation of each RN or LPN supervisory visit must include the following:**

1. An evaluation of the member's health status and needs, noting changes in medical condition, medications, etc.
2. An evaluation of the quality of care being rendered, including member's statement of the level of satisfaction with services received
3. Results of the care being rendered
4. Planned interventions and follow-up for any problems identified
5. Any needed revisions to the member's care plan
6. **The nurse's signature and date of the visit (see note below).**
7. **The date of the previous supervisory visit. (Rev. 4/12)**

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NOTE: A checklist does not replace narrative documentation, but can be used in addition to support narrative.

NOTE: The RN or LPN who makes the supervisory visit must sign and date the documentation of the visit. If the supervisory visit was made by an LPN, the supervising RN must review and

co-sign the documentation of the LPN's visit within 10 days unless otherwise stated in the provider manual for the particular service. (Rev. 12/10; 10/14).

606.18 **Member Care Plan**

The Member's Care Plan (see Appendix K of the CCSP General Manual) reflects the provider agency's plan to deliver the services agreed upon by the provider agency, the member/member's representative and the care coordinator based on the comprehensive care plan.

Individuals who participate in the Community Care Services Program have been determined to be at risk for nursing facility placement. Therefore, after the initial evaluation, the provider RN must review the care plan and revise, **sign and date** it as part of each supervisory visit, or as often as the member's condition requires. The provider RN communicates all revisions to the care plan to appropriate staff. The member care plan must be re-written at least once per year.

NOTE:

Home Delivered Meals and Emergency Response Services do not require a member care plan.

- A. The written member care plan must identify the following:
1. specific physical, mental, and social health problems of the member.
 2. specific approaches that will be taken to address the member's health needs/problems
 3. persons or agencies responsible for providing services to the member
 4. instructions for timely discharge or referral, if appropriate
 5. any other appropriate items
- B. Guidelines for Preparation of Care Plan
1. The provider RN initiates member care plans within 72 hours of the provider's initial evaluation of the member. The provider RN maintains current member care plans, including any changes in effective dates of coverage. The provider RN reviews the member care plans during each supervisory visit or more often if required by the member's condition
 2. The provider RN will develop the member care plan and coordinate care with input from the provider staff involved in the member's care. Provider staff must immediately bring to the attention of the provider RN any concerns about significant changes in the member's status.

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3. Before a provider implements changes in frequency and type of service, the provider must discuss these care plan revisions with the care coordinator. The care coordinator must review and approve changes in services.
4. The member care plan must indicate approaches necessary to achieve identified goals (e.g., nutrition education, methods of care coordination, etc.).

NOTE:

A copy of the recommended member care plan format is included in Appendix K of the CCSP General Manual. A provider may use a different format as long as it includes all elements listed on the form provided.

606.19 **Progress/Clinical Notes**

A member's clinical record must contain written progress notes, or clinical notes, which reflect the member's progress toward the goals and objectives identified in the member care plan. The RN supervising the member's care will prepare progress notes; however, any staff rendering care to the member may make notations in the clinical record. The notations may be recorded on the service form that reflects the date of service and must describe significant events/reactions/situations and follow-up which affect the member's care. All entries must be signed and dated at the time of occurrence. **The provider RN must review, sign and date all entries made by non-licensed staff.** Progress notes must be kept readily available for review by supervising personnel. The provider RN must train non-licensed staff on how, when, and where to keep progress notes. At a minimum, the provider RN must include progress note entries in the supervisory visit documentation, in accordance with the minimum frequency requirements of the specific CCSP service being delivered. (Refer to service-specific manuals).

606.20 **Community Care Notification Form**

- A. Service providers and care coordinators are expected to be proactive on behalf of the CCSP member and maintain active dialogue within the care team.

The provider and care coordinator use the Community Care Notification Form (Appendix I of the CCSP General Manual) to maintain an ongoing, documented dialog concerning:

- Beginning date of services
- Reason(s) for delay in starting services

- Acceptance or rejection of member referral following the initial evaluation
- Provider's evaluation that the member is inappropriate for CCSP services
- Member address change
- Changes in member's situation or environment (including social supports)
- Changes in the member's physical or mental condition/status
- Recommendations for changes to the care plan, including changes in services that increase or decrease the total cost of services.

NOTE:

If visit(s) is (are) shortened or omitted due to a member's absence, the provider may submit a completed CCNF on the last working day of that month.

- Concerns regarding the number and frequency of member's self-administered medications
- Provider identification of member's need for durable medical equipment
- Member hospitalization, discharge, or death
- Problems with cost share collection

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If any of the above occurs, the provider must telephone the care coordinator within 24 hours and will submit the completed CCNF to the care coordinator within three business days of the change or action.

The procedure for notification is as follows:

1. Notification Regarding New Members:

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Refer to Section 605.2 of the CCSP General Manual

2. Notification Regarding Changes in Services:

Service providers must contact the care coordinator either before providing the service or the next business day. The provider must request all changes in service by completing the CCNF and forwarding it to the care coordinator.

The provider must obtain approval from the care coordinator prior to rendering a new service.

Within three business days after receiving the CCNF, the care coordinator will initial, date, and return the CCNF to the provider, approving or denying the change in service.

If changes in the comprehensive care plan are approved, the care coordinator will revise the comprehensive care plan to reflect the changes and forward a copy to the provider(s). The provider RN will revise the member care plan to reflect the changes in the member's care.

Non-Emergency Service - If the provider and/or provider RN determines that the member needs a change in service, the provider must obtain approval from the care coordinator **before** initiating a change in service. The provider must telephone the care coordinator on the first business day following the determination that a member needs a change in service and must follow up with a completed CCNF within three (3) business days.

Emergency Visit - If the provider and/or provider RN determines an emergency visit is required, the provider must immediately call the care coordinator and follow up with a Community Care Notification Form within three (3) business days. Examples of emergency situations include, but are not limited to:

- loss of caregiver support
- need for urgent care
- need for immediate attention due to compromised safety or health.

Exceeding the Authorized Cost - If a needed change in service (emergency or non-emergency) would cause the cost of care to exceed the amount authorized on the Service Authorization Form (SAF), the provider RN must obtain payment authorization in accordance with Chapter 800 of the CCSP General Manual.

1. Change in Address

- a. If a member moves to another address within the same Planning and Service Area, OR moves to another Planning and Service Area in which the current provider is approved to render services

The provider must:

- telephone the care coordinator, within 24 hours of learning about the member's move
 - send a completed CCNF to the care coordinator within 3 business days advising of the address change
 - transfer member records to the office serving the member's new address, if applicable
- b. Member moves to another Planning and Service Area in which the current provider is not approved for service

The provider must:

- telephone the care coordinator, within 24 hours of learning of the address change
- send a completed CCNF to the care coordinator, within 3 business days
- send a discharge CCNF and a statement summarizing the services provided to the member, the reason for the member's move, and any special concerns to the care coordinator

B. Hospitalization and Other Changes that Affect the Plan/Delivery of Care

- The provider will send a completed CCNF to the care coordinator, within 3 business days
- The provider will telephone the care coordinator within 24 hours of learning of the hospitalization, emergency room visit or other change in the member's status (e.g., physical or social health status, informal support system, environmental/community status, etc.).
- The provider sends a completed CCNF to the care coordinator within three business days.

C. Nursing Facility Placement

- The provider will telephone the care coordinator and follow up with a completed CCNF to the care coordinator within three business days of learning that the member has been admitted to a nursing facility.
- **If a nursing facility discharges a member who needs CCSP services reinstated, the nurse care coordinator must complete a face to face review of the member, within 48 hours of having received notice of the discharge, to assess the need for services not currently included on Form 5588 (CCSP Level of Care and**

Placement Instrument). If new services are indicated, the nurse care coordinator must document the new services on the member care plan and submit a request for approval to the member's physician on the Physician Change in Services Letter (Appendix EE). (Rev. 7/2015)

- Providers who render services to members without a current CCSP Level of Care and Placement Instrument will not receive Medicaid reimbursement.

D. Member's Death:

Within three business days after the provider learns of a member's death, the provider will use the CCNF to notify the care coordinator. The information on the CCNF must include the date of death (if known) and the last date of service. Refer to Section 606.7-of the CCSP General Manual.

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606.21 **Potential Medical Assistance Only (PMAO) Members**

PMAO members have incomes which exceed the current Supplemental Security Income (SSI) level. PMAO Members, screened by care coordinators and providers to determine their potential eligibility for CCSP Medicaid benefits, may be required to pay toward the cost of their CCSP services (cost share).

- A. Brokering PMAO Members - PMAO members, who do not yet possess current Medicaid member numbers, are determined eligible for Medicaid services by the Division of Family and Children Services (DFCS). Care coordinators will broker services for Potentially Medical Assistance Only (PMAO) members with providers. If the member is PMAO:
1. During assessment, the care coordinator must inform the member of the possible requirement to pay a portion of the cost of services (cost share), and must discuss the Medicaid eligibility process with the member/representative.
 2. Both the care coordinator and the service provider must reinforce the member's cost share responsibility by clearly informing the member that if cost share is not paid, the member is at risk of losing CCSP services.
 3. The care coordinator must include in the referral packet sent to the provider a copy of the PMAO Financial worksheet indicating estimated cost share.
 4. Once the care coordinator receives a CCNF verifying that the PMAO member has begun receiving service, the care coordinator must advise

the member to apply for Medicaid benefits through the local County DFCS, and will assist the member in arranging transportation to DFCS if necessary.

5. Within two weeks of referring the member to DFCS, the care coordinator must contact the County DFCS to determine the Medicaid application date and/or if the member has been interviewed.
 6. The care coordinator must make a good faith effort to ensure that the member is proceeding with the Medicaid eligibility process. If the care coordinator determines that the member is having difficulty with the process, a case conference is scheduled with the member and DFCS to define areas where assistance is needed.
 7. Within 45 days of the Medicaid application date, the care coordinator must contact DFCS to ascertain the member's eligibility status. If DFCS has not yet determined the member's Medicaid eligibility, the care coordinator will contact DFCS at least every two weeks until eligibility is established.
- B. Accepting a PMAO member - When the provider accepts a referral for a PMAO member, the care coordinator must give the member a **written** estimate of the cost share amount **prior** to the delivery of services.

The provider must inform the member in writing that the member is responsible for the total cost of all services rendered if DFCS later determines that the member is ineligible for Medicaid, or if the member fails to proceed with the Medicaid application.

- C. Cost Share Collection -The provider must have written policies clearly describing cost share billing/collection and refund policies and procedures. For PMAO members, the provider may either:
1. collect only the estimated cost share from the member. If this method is chosen, services to the member must be delivered before collecting cost share. The provider must bill the member for cost share at least monthly. The provider is not required to wait until the end of the month before collecting cost share, but may collect cost share as service is provided until the provider has collected the entire cost share.
- EXCEPTION:** ALS providers may collect cost share at the beginning of the service month.
- or**
2. collect the entire cost of service from the member until DFCS establishes Medicaid eligibility

Prior to delivering service, the provider must furnish the member written notice as to which of the above collection methods will be used.

- D. Reconciliation of the Member's Account - Within 30 calendar days of receipt of the SAF(s) showing the actual cost share, the provider must return any excess cost share collected, or bill the member for any remaining cost share due the provider. A member determined ineligible for Medicaid is responsible for the entire cost of services delivered.
- E. Reimbursement from Medicaid - The provider may not submit claims for Medicaid reimbursement until DFCS assigns the member a Medicaid member number. Within three business days of the receipt of the Community Care Communicator (CCC), Form 5590, from DFCS, the care coordinator must generate Service Authorization Forms showing the member's Medicaid member number and actual cost share. (Refer to Chapter 700 of the CCSP General Manual).
- F. Member MAO Eligibility - Once eligibility is established and the actual cost share is determined, the PMAO member becomes MAO eligible.

NOTE:

In situations where a member's cost share is reduced after the member has paid, the care coordinator will adjust the SAF to enable the provider to bill Medicaid for the difference. The provider's cost share policy will state if the overpayment shall be credited or refunded.

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606.22 **Medical Assistance Only (MAO) Members**

A Medical Assistance Only (MAO) member is one who receives Medicaid benefits but who receives no cash assistance such as Supplemental Security Income (SSI). MAO members may be required to pay toward the cost of CCSP services (cost share).

A. Cost Share Collection

1. The CCSP provider must furnish the member a written statement of the amount of cost share, if any, each month cost share is due.

The monthly statement will include:

- ii. The date of the statement
- iii. The amount due,
- iv. The date payment is due
- v. The statement that, "If the bill is not paid within 30 calendar days, discharge from the agency will be effective the 46th calendar day from the date of this statement".

2. Providers will bill for cost share at least monthly.

(See Section 606.13 A2 of the CCSP General Manual).

B. Members Failing to Pay Cost Shares

The provider may discharge a member from service for failure to pay cost share after the provider has given appropriate written notice on the monthly statement (see Section 606.22 A1 of the CCSP General Manual).

The care coordinator and provider will advise members and/or member's representatives that providers may discharge members who fail to pay cost share.

If the member does not pay cost share by the 31st day, as indicated on the monthly statement, the provider will notify the care coordinator that services will be discontinued on the 46th day from the date of the statement.

Within three business days, the provider will submit a CCNF and a copy of the cost share bill to the care coordinator (see Section 606.13 of the CCSP General Manual).

If the Care Coordinator attempts to broker the service with another provider, the Care Coordinator will inform the potential/subsequent provider of the member's failure to pay the required cost share to the current provider(s).

Care coordinators will frequently discuss cost share with members but will not engage in collection activities.

Providers who have difficulty collecting cost share will discuss the problem with the care coordinator as soon as it occurs.

607 **Staffing**

607.1 **General**

A. **Staff Qualifications** –The provider must employ a sufficient number of qualified and experienced staff members who are appropriately skilled and available to render services in their approved service areas in accordance with currently accepted standards of medical practice (refer to the service-specific manuals for program requirements related to staffing). Providers are required to screen each potential employee for competency.

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Personnel providing CCSP services must:

- be qualified by education, training and/or experience to perform the tasks assigned
 - fulfill all training requirements
 - undergo criteria-based job performance evaluations of their job performance at least annually, including evaluation by members at least annually.
 - be supervised by appropriately credentialed staff who are licensed and accountable for quality service and outcomes
- B. Registered Nurse (RN) Supervision and Credentials - All CCSP services (except ERS and HDM) require that a licensed RN supervise the services delivered to CCSP members. Refer to the service-specific manuals for information regarding other required licenses.
- C. Licensure – Providers maintain evidence of current licensure for all staff members in occupations requiring Georgia licenses or permits
- D. Designated Professional Staff - A licensed professional, designated to provide professional supervision and oversight, will be available to staff at all times that services are being rendered to members.
- E. Designated Management Staff - The provider must designate a responsible staff person to act as manager in the administrator/manager's absence.
- F. **NOTE:** All provider staff members responsible for documentation of member records must be identified by name and discipline and include a sample of the staff member's signature and initials. This legend must be on file with provider agency and available at the agency place of business.

607.2 **Volunteers**

Providers may use volunteers to provide CCSP services, provided they meet the same qualifications required of paid staff. The provider is responsible for the supervision and performance of any volunteer who provides direct member service for the provider agency.

607.3 **Personnel Policies**

- A. The provider must have written personnel policies and procedures.

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- B. The provider must establish and maintain current personnel records for all staff and volunteers. Each personnel record must include the following, at a minimum:
1. criteria-based job description, signed and dated by the employee
 2. criteria-based performance evaluation
 3. job application and/or resume
 4. proof of current Georgia licensure, if applicable
 5. documentation of knowledge of agency's policies related to Member Protection Assurances
 6. documentation of all training completed
 7. proof of satisfactory physical examinations and tuberculosis screening, as required
 8. signed and dated copy of the code of ethics.
 9. evidence of a satisfactory criminal history background check determination
- C. Code of Ethics - All providers must have an ethics policy which is signed and dated by all persons under the provider's direction. The ethics policy, at a minimum, must prohibit employees, volunteers or contracted individuals from:
1. using the member's car for personal reasons
 2. consuming the member's food or beverage
 3. using the member's telephone for personal calls
 4. discussing political or religious beliefs, or personal problems with the member
 5. accepting gifts or financial gratuities (tips) from the member or member's representative
 6. lending money or other items to the member; borrowing money or other items from the member or member's representative
 7. selling gifts, food, or other items to or for the member
 8. purchasing any items for the member unless directed in member care plan

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9. bringing other visitors (e.g., children, friends, relatives, pets, etc.) to the member's home
10. smoking in the member's home
11. reporting for duty under the influence of alcoholic beverages or illegal substances
12. sleeping in the member's home
13. remaining in the member's home after services have been rendered

607.4 Personnel Under Contract

All agreements with contracted personnel including those responsible for their own withholding taxes, must be in writing. Refer to Section 601.1 J of the CCSP General Manual.

A provider may delegate authority, but responsibility for performance of individuals under contract may not be delegated to another agency or organization.

607.5 Staff Development and Training

- A. The CCSP provider is responsible for developing and implementing a continuing education program for all employees/staff members, subcontractors and volunteers of the agency. Continuing education will consist of orientation for all new employees/staff, subcontractor's and volunteers and ongoing staff development and training programs related to the responsibilities of each individual's position.

<p>NOTE: Provider agencies licensed by the Healthcare Facility Regulations Division must comply with all rules and regulations related to certification and/or training in cardiopulmonary resuscitation, emergency first aid, and continuing education.</p>

- B. The provider must furnish all staff development and training opportunities related to the performance of their jobs. In addition, provider staff and volunteers, if applicable, must attend CCSP training sessions as requested or required.
- C. Providers must develop an ongoing in-service training plan and schedule for staff, subcontracted individuals, and volunteers. For all CCSP services except ERS and HDM, the plan must include, at a minimum, the following topics:
 - o orientation to the agency

- CCSP overview including program policies and procedures
- sensitivity to the needs and rights of older individuals
- re-certification and/or training in techniques of first aid and cardiopulmonary resuscitation (CPR)
- member rights/Elder Abuse Reporting Act/Advance Directives
- Personnel Code of Ethics
- Business Ethics
- infection control procedures (see Appendix Q of the CCSP General Manual)
- fire safety and accident prevention and safety
- confidentiality of member information
- medication management
- disaster planning/emergency procedures
- caring for members with Alzheimer's and related illnesses.

The provider must establish and maintain records to document the implementation of the training plan including, the name(s) and credentials of the trainer(s), training date, content, length of time and persons attending for each training.

For ERS and HDM providers, in-service training must include orientation to the agency, CCSP policies and procedures, and other service related training as required.

- D. All administrative and non-direct member care staff will demonstrate awareness and working knowledge of the topics listed in section 607.5C of the CCSP General Manual. In addition, all administrative and non-direct member care staff will receive training in:
- Business Ethics
 - Financial Planning
 - Medicaid Waivers
 - Medicaid and Medicare Benefits

E. The CCSP provider will establish and maintain records that document the orientation and on-going staff development and training of each individual. The records will, at a minimum, include:

- the topic presented
- the name(s) and credentials of the trainer(s)
- the training date,
- the length of time of the training
- an outline or description of the content of the training
- the name of each individual who attended the training

F. ERS and HDM providers will include an orientation to the agency, CCSP policies and procedures, and other service related training as required for the orientation and staff development and training for their employees/staff, subcontractor's and volunteers.

608. **Environmental Safety Procedures**

608.1 **Disaster Preparedness**

The provider must establish and maintain written policies and procedures for members and staff to follow in the event of a disaster, to include procedures to see that care is provided during emergency situations (e.g., flood, fire, bomb threat, etc.) that may impede the provider's ability to reach members' homes. (Refer to *Rules and Regulations for Disaster Preparedness Plans, Chapter 290-5-45*). Procedures for disasters occurring at a CCSP facility must also be included.

A. Triage Levels

The provider establishes and maintains policies and procedures for assuring that a system of contingency plans for emergencies or disasters is in place. These plans will assure back-up care when usual care is unavailable and the lack of immediate care would pose a serious threat to the health, safety, and welfare of the member.

These policies and procedures should provide uninterrupted service according to the priority levels identified by the care coordinator for each member enrolled in the CCSP. These policies and procedures include:

- Delivery of member service(s).

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- Staff assignment and responsibilities.
- Names and phone numbers of the CCSP Unit, Area Agency on Aging, care coordination staff., and if applicable, the Healthcare Facility Regulations Division and Long Term Care Ombudsman.
- Notification to care coordination, attending physicians, and responsible parties.
- Availability of members' records.

Emergencies include, but are not limited to, the following:

- Inclement weather (heavy rains, snow storm, etc.).
- Natural disasters (flood, tornado, hurricane, ice storms, etc.).
- Major industrial or community disaster (power outage, fire, explosion, roadblocks).
- Agency employee illness or severe staffing shortage affecting significant number of employees.
- Damage, destruction or fire at the agency's location.
- Remote areas where transportation would be limited.
- Suspected abuse, neglect and/or exploitation.

Communication with care coordination is an essential component to this process. Using the Community Care Notification form, (CCNF), the provider will notify the care coordinator if he is not in agreement with the assigned Triage level. Assigned Triage levels will be documented in the comment section of the Comprehensive Care plan. Care coordinators will use the following to assign Triage levels.

Level One members:

- Require only minimal amount of care
- Require less complex treatments and/or observation and/or instruction
- Provide self-care, ADLs, or have a willing and able-bodied caregiver
- Do not exhibit any unusual behavioral problems

Level Two members:

- Require an average amount of care

- No longer experiencing acute symptoms
- Require periodic treatments and/or observation and/or instruction
- Require some assistance with ADLs, require help for limited periods, or have willing and capable caregivers
- Exhibit some psychological or social problems

Level Three members:

- Require an above average amount of care
- Require daily treatment and/or observation and/or instruction
- Have willing caregivers whose capabilities are limited
- Require assistance with ADLs
- Ambulate with the assistance of two people
- Exhibit disorientation or confusion

Level Four members:

- Require a maximum amount of care and have no caregivers in the home
- Exhibit acute symptoms
- Are confined to bed
- Require complete care
- Require treatment and/or procedures necessary to sustain life

B. Staff Training and Drills

- The provider must assure that all staff members are provided ongoing training in disaster preparedness. The training program must include drills so that employees are able to promptly and correctly carry out their assigned roles in case of a disaster.
- Disaster drills must be conducted at least annually and must be documented as to date, time, staff/member participation, problems, and action taken to prevent problems from recurring.

C. Posting of Instructions

- The provider posts emergency instructions and evacuation routes in a prominent place in each room of the facility and orients all members to these routes.

608.2 **Evacuation Procedures**

Evacuation drills must be **conducted at least every other month** in all CCSP facilities and must be documented. A designated place for members and staff to meet outside the facility following evacuation must be described in the written disaster procedures. One or more staff members must be assigned to make sure everyone is out of the building.

608.3 **Smoking Control**

If RC, ADH, and ALS providers permit smoking in a facility providing CCSP services, the provider must designate a separate and distinct smoking area. All smoking is confined to the designated area.

609. **Program Evaluation**

609.1 **General**

The Georgia Departments of Human Services and Community Health monitor program administration and perform utilization reviews of member services and care. Providers will develop a written continuous quality improvement plan that addresses how the agency determines the effectiveness of services, identifies areas that need improvement, and implements programs to improve services and quality of care.

609.2 **Program Evaluation and Customer Satisfaction**

- A. Providers must establish and adhere to policies for program evaluation and conduct comprehensive reviews of their programs at least once a year. Provider agency administrative and program staff, members, and members' representatives participate in the review.

The provider agency will determine who will conduct self-evaluation reviews and will establish written policies and procedures for conducting them. At a minimum, the comprehensive program evaluation consists of a review of the agency's administrative policies and procedures, members' clinical records (available to authorized staff only), and members' satisfaction with services.

1. Policy and Administrative Review: The provider reviews policies and procedures at least annually and revises them as needed. The provider indicates in policy how changes in agency policies and procedures are communicated to all staff.

2. Clinical Record Review: The provider will monitor and review a 25% random sample or a minimum of 50 records (both active and closed clinical records), whichever is less, to:
 - assure that staff follow established policies and procedures in providing services
 - determine the adequacy of member care plans
 - determine the appropriateness of staff decisions regarding the particular care ordered for members.

The review must include a summary of the program's effectiveness and a plan and time frame to correct deficiencies. The provider must maintain review results in the administrative files and keep them available for review when requested.

3. Member Satisfaction: The agency must conduct quality improvement activities which include collection, measurement and evaluation of member satisfaction with the services provided by the agency. The member satisfaction review must include direct communication with members. The provider agency's quality improvement activities must include:
 - publication of a local or toll-free telephone number for a designated staff person responsible for addressing quality improvement issues, member complaints, and conducting ongoing member satisfaction activities. The contact telephone number must be distributed to all CCSP members and/or member representatives
 - routine assessments of member satisfaction during supervisory visits. For frequency, refer to the requirement for supervision indicated in each service-specific manual.
 - collection and analysis of feedback regarding service staff reliability, responsiveness, competency, empathy, and courtesy
 - specific time frames for reporting, investigating and resolving service complaints
 - specific activities for addressing results of quality improvement activities.
- B. The provider maintains a written report describing the findings of the evaluation and any corrective action taken. The provider must document follow-up to assure the issues have been resolved.

609.3 **Program and Administrative Monitoring (Rev 7/2016)**

The CCSP Unit uses results of monitoring by various entities to determine provider compliance with CCSP requirements.

- A. The **CCSP Unit** or its representative will monitor providers to ensure compliance with program and administrative requirements. If needed or requested, the CCSP Unit provides technical assistance.
- B. The DCH conducts utilization reviews and audits.
- C. The Healthcare Facility Regulations Division issues permits and licenses for personal care homes, private home care providers, and home health agencies. In addition, the HFR investigates complaints and conducts inspections to determine ongoing compliance with licensure requirements.

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609.4 **Utilization Review**

- A. The DCH performs periodic Utilization Reviews of CCSP member services to assure the medical necessity for continued care and the effectiveness of the care being rendered. Each provider is reviewed as frequently as deemed appropriate or necessary, with on-site reviews or audits sometimes conducted with no prior notice.
- B. During each review visit, the DCH examines member records and conducts in-home or on-site individual member assessments.
 - 1. The DCH examines member records to assure that they contain the following:
 - a current Level of Care and Placement Instrument that is signed, dated, certified, and initialed
 - physicians' orders if applicable
 - provider care plans
 - documentation of services provided, their frequency, and appropriateness of service revisions
 - documentation of supervisory visits.
 - 2. The DCH conducts on-site assessments of members to determine if the member's condition warrants continuation of the current level of services rendered by all providers. The assessments determine whether:

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- additional needs exist
 - care provided is adequate
 - services have been effective
 - alternative methods of care should be considered
- C. GMCF routinely provides the CCSP Unit with copies of Utilization Review reports. CCSP Unit staff members review each report and the provider's written response to all deficiencies cited in the report.
- D. Upon completion of the on-site visit, the DCH forwards to the provider a written report of the Utilization Review findings. The provider must submit a corrective plan of action to the DCH within fifteen (15) calendar days of the date of the utilization review report. **The provider's failure to comply with the request for a corrective plan of action may result in adverse action, including suspension of referrals or termination from the program.**
- E. When Utilization Review reports include recommendations for changes in member services, the DCH will mail the report to the provider five business days prior to mailing the member letter(s). The member has the right to appeal any adverse action recommendations made by the DMA. Adverse actions imposed by DMA include:
1. reducing service(s)
 2. terminating service(s)
 3. determining service is inappropriate
 - If the member appeals by filing for a hearing within ten calendar days of the date of the member letter, the member may continue to receive services until the Administrative Law Judge (ALJ) makes a decision. Providers must consult with the care coordinator to confirm that the member has requested a hearing within ten calendar days and wishes to remain in service. The DCH will reimburse the provider for services rendered during the DHS hearing process if the member's request for hearing was filed within the ten calendar day limit.
 - If the member does not file for a hearing within ten calendar days of the adverse action letter, the DCH's recommendation becomes effective at the end of the ten calendar days as stated in the utilization review report and the DMA notice to the member. However, the member has the right to request a hearing within 30

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calendar days from the date of the member's letter. (See Appendix M of the CCSP General Manual).

PART II - CHAPTER 700

ELIGIBILITY CONDITIONS

701. General

The DMA reimburses enrolled providers for CCSP services provided to eligible persons only. Eligible persons are those who:

1. have been determined Medicaid eligible or potentially Medicaid eligible
2. have been assessed appropriate for the Community Care Services Program by the care coordinator
3. are certified for a level of care appropriate for placement in an intermediate care facility
4. are in need of service(s) which can be provided by the CCSP at less cost than the Medicaid cost of nursing facility care

NOTE:

A member may **NOT** participate in more than one Medicaid waiver program at the same time. However, a provider may participate in more than one Medicaid waiver program.

Medicaid Waiver Programs include:

- ◆ Community Care Services Program (CCSP)
- ◆ Independent Care Waiver Program (ICWP)
- ◆ Community Model Waiver
- ◆ Service Options Using Resources in the Community Environment (SOURCE)
- ◆ Shepherd Care Project
- ◆ Georgia Pediatric Program (GAPP)
- ◆ Comprehensive Supports Waiver (COMP formerly CHSS)
- ◆ New options Waiver (NOW formerly MRWP)
- ◆ Deeming Waiver (Katie Beckett)

702. Verification of Medicaid Eligibility

Medicaid Eligible Members

The care coordinator must verify a member's Medicaid eligibility prior to brokering services with a provider. The provider verifies eligibility monthly thereafter by checking the member's Medicaid card at www.mmis.georgia.gov . **A copy of the Medicaid Card is included in Appendix BB.** If the member is

ineligible for Medicaid benefits, the DMA does not reimburse a provider for services rendered. Refer to Section II of the DCH Part I Policies and Procedures Manual's Billing Appendix for additional methods to check Medicaid eligibility.

PMAO Members

Care coordinators broker potentially medical assistance only (PMAO) members with providers. Providers may not bill Medicaid for services rendered to PMAO members until the care coordinator has issued SAFs reflecting the member's Medicaid member number.

In cases of lost or stolen Medicaid cards or other emergency situations, a provider may verify Medicaid eligibility for the current month by calling the Verification Unit at the Division at 1 (800) 766-4456.

To verify Medicaid eligibility for past months, a provider may request information in writing from:

Division of Medical Assistance
Medicaid Card Control Unit
P.O. Box 38435
Atlanta, Georgia 30334

The request must include the following information:

1. Member's name exactly as it appears on the Medicaid card
2. Member's Medicaid or Social Security number
3. Member's birth date
4. Dates for which the provider is requesting verification
5. Return address of provider agency

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Note: Refer to Section 606.21 E of the CCSP General Manual.

PART II - CHAPTER 800

PAYMENT AUTHORIZATION

If the provider anticipates that the member's service costs will exceed the level of service(s) authorized, the provider must notify the care coordinator.

Close communication with the care coordinator is important in the prior approval / prepayment request process. The care coordinator consults with the provider to determine if a reassessment is needed when the member's need for services increases.

801. **Prior Approval** (Rev 7/2016)

If, prior to the beginning of the service month, the provider anticipates that the member's service costs will exceed the authorized cost:

- The provider must call the care coordinator and request approval to increase the level of services. If the care coordinator agrees, the increased level will be approved.
- Within three business days of the care coordinator's verbal approval, the provider will complete the CCNF, attaching the physician's order or other relevant medical/social information, if applicable, and send it to the care coordinator.
- The care coordinator will then complete the DMA-80, if necessary, and submit it to the **CCSP Unit**. (See Appendix R of the CCSP General Manual)
- The CCSP Unit will send the approval to the care coordinator who will forward it to the provider.
- If the care coordinator does not approve the additional service level, additional services will not be authorized.

802. **Prepayment Review**

If an unforeseen emergency not anticipated at the beginning of the service month causes the level of a member's services to exceed the level of services authorized, the provider may request a prepayment review. A prepayment review is appropriate only in an emergency situation.

- The provider must contact the care coordinator to advise that services have been provided at a higher level and that a CCNF is forthcoming.
- If the care coordinator agrees that the higher service level is appropriate, the provider must send to the care coordinator the completed CCNF and any attachments such as physician's orders and additional medical/social

information, by the 15th day of the month following the month in which service(s) were rendered.

- The care coordinator will complete the DMA-80, (see Appendix R of the CCSP General Manual) if necessary, and submit it to the CCSP Unit for approval.
- The CCSP Unit will send the approval to the care coordinator who will forward it to the provider.
- If the care coordinator does not approve the higher service level, additional services will not be authorized, and the provider will not be reimbursed for the higher level of services.

803. **DMA-80s for PMAO Members**

Care coordinators may **not** submit DMA-80 requests for PMAO members who are in the eligibility determination process and do not yet have a Medicaid number. Once DFCS verifies the member's Medicaid eligibility, the care coordinator must complete the DMA-80s for retroactive reimbursement, attach a copy of the **Community Care Communicator** (CCC), and forward with a completed **Care Coordination Transmittal** to the CCSP Unit as a **prepayment review**.

NOTE:

If ERS installation is the sole reason for the cost of the member's service(s) exceeding the cost limit, the care coordinator is not required to submit a DMA-80 to the CCSP Unit. The care coordinator may approve the installation at the local level and the provider may proceed with installation immediately.

804. **Cost Share and the CCSP Cost Limit**

Cost share is the amount that a member pays towards the cost of waiver services.

To determine the amount billed to Medicaid, the care coordinator determines the total cost of services and deducts the cost share.

The care coordinator and the provider determine if the cost of the member's services are within the cost limit.

PART II - CHAPTER 900

SCOPE OF SERVICES

901. Covered Services

The DCH reimburses providers only for CCSP services:

- A. rendered by approved enrolled providers who comply with the policies and procedures contained in the:
 - DCH Part I Policies and Procedures Manual
 - Part II Chapters 600 – 1000 Policies and Procedures for Community Care Services (CCSP) General Manual
 - CCSP policies and procedures contained in service specific manuals.
- B. supervised by staff as required in the appropriate service Policy and Procedure Manuals
- C. ordered on the Comprehensive Care Plan by the CCSP care coordinator and reflected on the SAF
- D. provided to persons who are Medicaid eligible at the time the services were rendered
- E. provided to persons who are certified for a level of care appropriate for placement in an intermediate care facility
- F. If an individual is enrolled in the CCSP waiver and is diagnosed with a terminal illness, he/she may elect to enroll in a hospice program. He/she may continue to receive waiver services that are not duplicative of hospice services.

An individual who is not enrolled in the CCSP and is receiving hospice services may be referred to the CCSP. If the individual meets eligibility criteria for CCSP, the individual may receive CCSP services that are not duplicative of hospice services. The hospice agency continues to assume full responsibility for the professional management of the individual's hospice care in accordance with the hospice Conditions of Participation

Waiver services that are not duplicative of hospice services are:

- Adult Day Health
- Home Delivered Meals
- Extended Personal Support (Respite)

- Alternative Living Services *
- Emergency Response Services

Rev. 10/08

***EXCEPTION:** An individual who is receiving hospice services and is admitted to ALS (a personal care home) as a hospice client may not receive CCSP services. A CCSP client who is living in ALS at the time hospice services are ordered may continue living in ALS as a CCSP member. A member who begins hospice services after already in ALS, and they were not placed in ALS by the hospice agency, may receive concurrent hospice and CCSP services. (Rev. 7/2015)

Requests or claims for other waiver services while enrolled in a hospice program will be denied.

901.1 Waiver Residential Services

An individual's home is where he or she resides. An individual may continue to receive residential services in a waiver program. When this occurs, the hospice agency assumes full responsibility for the professional management of the individual's **hospice** care in accordance with the hospice Conditions of Participation. When an individual elects hospice, the hospice agency and the waiver resident **must** communicate, establish, and agree upon a coordinated plan of care for both providers which reflects the hospice philosophy and is based on an assessment of the individual's need and unique living situation.

- Evidence of the coordinated plan of care must be in the clinical records of both providers. The facility and the hospice must communicate with each other when any changes are indicated to the plan of care and each provider must be aware of the other's responsibilities in implementing the plan of care.
- All **hospice services must** be provided directly by hospice employees and cannot be delegated. The hospice may involve the facility staff in assisting with the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely utilize the services of the patient's family/caregiver.
- The facility **must** offer the same service to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The hospice patient should not experience any lack of facility services or personal care because of his/her status as a hospice patient.

NOTE:

The provider RN will not provide supervision of care and services to the

902. **Non-Covered Services**

- A. Supportive Living Services oriented to the mental health needs of the member.
- B. Adult Day Care Services oriented to the social service needs of the member.
- C. Medical rehabilitation services provided on an outpatient basis but not provided as part of the CCSP Comprehensive Care Plan.
- D. While the member is in a treatment facility, institution or nursing facility, PSS, ADH, RC, HDS, SNS, and HDM services are not covered.

NOTE:

See Sections 1203.10 and 1253.12 of the Alternative Living Services manual and Section 1602.3 of the Emergency Response Services manual for the authorized time limits in these services.

- E. Services not authorized by the CCSP care coordinator.
- F. Services not rendered in accordance with the provisions of all applicable Policy and Procedure manuals.
- G. Refer to Chapter 700, Eligibility Conditions, and Chapter 1000, Basis for Reimbursement, of the CCSP General Manual for additional information that impacts the scope of services.

PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001 Processing the SAF

Reimbursement is made to CCSP providers who have:

- completed the CCSP enrollment process
- been assigned a CCSP Medicaid provider number
- provided the services ordered on the Comprehensive Care Plan and authorized on the SAF

CCSP services must be rendered **before** providers submit claims for reimbursement.

NOTE:

Before filing claims providers must reconcile service units **actually provided** with service units authorized on the SAF; **providers can only bill the Department for services provided**. If the provider or their billing agent over bills the Department, the provider must refund the overpayment to the Department. Failure to refund overpayment will result in recoupment and possible adverse action against the provider. See Section VIII-Adjustments in the DCH Billing Manual for instructions on refunding overpayments to the Department.

1002 Relative Caregivers

1002.1 Georgia Medicaid will not reimburse for personal care services or any waiver services when provided to recipients by legally responsible relatives, i.e., spouses or parents of minor children, when the services are those that these persons are already legally obligated to provide.

Services provided by relatives, except as noted above, may be covered only if the following criteria are met:

- The relative meets the qualifications for providers of care;
- **The relative's serving as caregiver has been approved by DCH, based on the documentation submitted by CCSP care coordination to confirm the existence of extenuating circumstances. Any request for care by a family member must clearly identify the name of the family caregiver and plans for backup care and respite for the caregiver;**
Rev. 01/2013 and 7/2016
- The relative must meet all required training and qualifications before he/she assumes the role of paid caregiver for the member; **Rev. 01/2013**

- There is adequate justification as to why the relative is the provider of care, e.g., the lack of other qualified providers in remote areas, **or other extenuating circumstances.** **Rev. 01/2013**

Adequate justification for the use of relatives for members shall consist of tangible information to support the request. Examples of information needed are copies of newspaper ads where the provider advertised for personal support staff, copies of prior existing notes where from time to time the case manager documented in the member's file that the provider is having trouble finding staff to provide the member's care, and attestations showing there is lack of qualified providers in a remote area.

“Relative” is defined as a person who is related by blood **or legal adoption** within the third degree of consanguinity or by marriage. Third degree of consanguinity means mother, father, grandmother, grandfather, sister, brother, daughter, son, granddaughter, grandson, aunt, uncle, great aunt, great uncle, niece, nephew, grand niece, grand nephew, 1st cousins, 1st cousins, once removed, and 2nd cousins. **Rev 10/14**

1002.2 In the case of self-directed care provided by a relative, all of the following criteria must be met:

- *The relative must have prior approval by DCH, **based on documentation submitted to DCH by CCSP care coordination to confirm the existence of extenuating circumstances. Any request for self-directed care by a relative must clearly identify the names of the relative caregiver, the employer-representative and plans for backup care and respite for the caregiver; (Rev. 01/2013 and 7/2016)**
- *An agreement must be in place between the member, employee and or the provider before services are rendered;
- *The member must pay the caregiver at a rate that does not exceed that which would otherwise be paid to a provider of a similar service;
- *The service must not be an activity that the family would ordinarily perform or is responsible to perform.

See Appendix S of the CCSP General Manual for current procedure codes and reimbursement rates.

1003 Reimbursement for Consumer Directed Personal Support Services

Reimbursement for wages in excess of 40 hours per week to a consumer directed PSS aide can only be made after obtaining approval from DCH. Members who use the consumer directed option should hire enough employees so as to avoid overtime. If any overtime hours are approved by DCH, they will be paid at the employee's normal hourly rate since home care employees are not covered by state and federal labor laws on overtime pay. Rev. 01/2013

1004 Duplication of Services

Waiver Programs include:

- Comprehensive Supports Waiver (COMP formerly CHSS)
- Community Care Services Program (CCSP)
- Independent Care Waiver Program (ICWP)
- New Options Waiver (NOW formerly MRWP)
- Community Model Waiver Program
- Shepherd Care Project
- Service Options Using Resources in the Community Environment (SOURCE)
- Georgia Pediatric Program (GAPP)
- Deeming Waiver (Katie Beckett)

Rev. 04/09

A member may receive more than one service within a single waiver program, but a member may not participate in more than one waiver program at any given time. Claims submitted for services rendered to the same member under more than one Waiver Program will be denied.

Rev. 01/10

1. Member Exclusions

- Members who are at the time of application for enrollment or at the time of enrollment, domiciled or residing in an institution, including skilled nursing facilities, hospital swing bed units, hospice, intermediate care facilities for the mentally ill, or correctional institutions
- Members who are enrolled in the Georgia Families program
- Children enrolled in the Medical Services Program administered by the Georgia Division of Public Health (Children's Medical Services)
- Members enrolled in the Service Options Using Resources In Community Environments (SOURCE) program

- Children in foster care or otherwise in the custody of the State
- Participants in some other waiver programs (BCC Waiver, Independent Care Waiver, Mental Retardation Waiver, Laurens County Waiver)
- Participants in the Recipient Lock –In program (GEXP, , SOURCE, PASSR, HMO, GAPP)
- Children enrolled in the Georgia Pediatric Program (GAPP)
- Members with retroactive eligibility only and members with presumptive eligibility
- Children with severe emotional disturbances whose care is coordinated under the TRIS or PRTF programs
- Children who are receiving services under Title V (CMS) funding

1006 Billing Tips

- A. Use a current DCH Billing Manual.** Manuals may be obtained from www.mmis.georgia.gov. Manuals may also be obtained by calling GHP Provider Enrollment at 1-800-766-4456.
- B. Check the CCSP member's Medicaid eligibility each month.** The SAF authorizes service units but it is **NOT** proof of Medicaid eligibility. (See Section II, Billing Manual, Division of Medical Assistance, for methods of determining member eligibility).
- C. Do Not provide services without authorization** from the care coordinator.
- D. Prepare claims carefully and submit claims timely after the service has been provided**

To assure maximum use of CCSP service dollars, it is necessary to periodically “de-authorize” unused units of service from the system. This “de-authorization” removes unpaid units of service from the GHP Prior Authorization file and updates the record to reflect the number of paid units only. Claims that are denied due to de-authorization must be re-authorized by the Care Coordinator.

- E. Timeliness** - Providers are allowed 180 days from the last day of the month of service to submit claims. If you are having difficulty getting a claim paid you must keep the claim timely by billing a minimum of every 3 months.
- F. Providers are encouraged not to bill more frequently than every two weeks.** Monthly billing is advised.

- G. **Bill only for actual dates and units of service provided.**
- H. **Keep copies of all documentation** such as Remittance Advices, and document all telephone contacts (name(s), agency, date and time of contact) made regarding billing.
- I. **Carefully review each Remittance Advice** for accuracy and address problems timely.
- J. Denied claims must be resubmitted when the problem has been corrected. GHP does not maintain the denied claim on file.
- K. Attend all training offered on CCSP Billing.
- L. **The paper version of the CMS-1500 claim form has been revised. Please use the new version if submitting paper claims. Rev 4/2014**

1007 General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers (Rev 4/1/2014)

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. As a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in sections 1861-r and 1842(b)(18)C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, **the claim cannot be paid.**

Effective 4/1/2014, DCH will begin editing claims submitted through the web, EDI and on CMS-1500 forms for the presence of an ordering, referring or prescribing provider as required by program policy. The edit will be informational until 6/1/2014. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny.

For the NEW CMS-1500 claim form:

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.
Rev. 7/13, 4/14

1008 Resolving Billing Problems

- A. Carefully review the error code message (EOB) and recheck the information on the Remittance Advice (RA) against the information on the Service Authorization Form (SAF), correct any error and re-bill the claim.
- B. Contact the GHP Telephone Inquiry Unit for information updates on the claim you are billing. The GHP system updates weekly.
- C. If the SAF is not posted as a "PA Record" in the HP Enterprise Services (HPES) system, complete the CCSP Billing Inquiry Form (Appendix Y of the CCSP General Manual). For all other billing issues, contact GHP telephone inquiry.
- D. For assistance with billing problems **unrelated** to 700 error codes, providers must complete the **Provider Inquiry Form** and mail, with a copy of the RA, to the address on the form. The problem will be researched.
- E. Request an on-site visit by a GHP Field Representative by calling GHP Telephone Inquiry. See Appendix X of the CCSP General Manual for telephone numbers.

NOTE:

To speed resolution of billing problems, please use the correct Inquiry form as instructed in C above. Do not fax billing inquiry information unless requested to do so by the Billing Inquiry staff.

**Appendix A
Requested Counties Form**

**CCSP Application
Attachment A**

INSTRUCTIONS: Place a check (✓) beside the counties requesting.

Statewide

1 – Northwest

Georgia
 Bartow
 Catoosa
 Chattooga
 Dade
 Fannin
 Floyd
 Gilmer
 Gordon
 Haralson
 Murray
 Paulding
 Pickens
 Polk
 Walker
 Whitfield

2 – Georgia Mountains

Banks
 Dawson
 Forsyth
 Franklin
 Habersham
 Hall
 Hart
 Lumpkin
 Rabun
 Stephens
 Towns
 Union
 White

3 – Atlanta Regional

Cherokee
 Clayton
 Cobb
 DeKalb
 Douglas
 Fayette
 Fulton
 Gwinnett
 Henry
 Rockdale

4 – Southern Crescent

Butts
 Carroll
 Coweta
 Heard
 Lamar
 Meriwether
 Pike
 Spalding
 Troup
 Upson

5 – Northeast Georgia

Barrow
 Clarke
 Elbert
 Greene
 Jackson
 Jasper
 Madison
 Morgan
 Newton
 Oconee
 Oglethorpe
 Walton

6 – River Valley

Chattahoochee
 Clay
 Crisp
 Dooly
 Harris
 Macon
 Marion
 Muscogee
 Quitman
 Randolph
 Schley
 Stewart
 Sumter
 Talbot
 Taylor
 Webster

7 – Middle Georgia

Baldwin
 Bibb
 Crawford
 Houston
 Jones
 Monroe
 Peach
 Pulaski
 Putnam
 Twiggs
 Wilkinson

8 – Central Savannah River

Burke
 Columbia
 Glascock
 Hancock
 Jefferson
 Jenkins
 Lincoln
 McDuffie
 Richmond
 Screven
 Taliaferro
 Warren
 Washington
 Wilkes

9 – Heart of GA/Altamaha

Appling
 Bleckley
 Candler
 Dodge
 Emanuel
 Evans
 Jeff Davis
 Johnson
 Laurens
 Montgomery
 Tattnall
 Telfair
 Toombs
 Treutlen
 Wayne
 Wheeler
 Wilcox

10 – Southwest Georgia

Baker
 Calhoun
 Colquitt
 Decatur
 Dougherty
 Early
 Grady
 Lee
 Miller
 Mitchell
 Seminole
 Terrell
 Thomas
 Worth

11 – Southern Georgia

Atkinson
 Bacon
 Ben Hill
 Berrien
 Brantley
 Brooks
 Charlton
 Clinch
 Coffee
 Cook
 Echols
 Irwin
 Lanier
 Lowndes
 Pierce
 Tift
 Turner
 Ware

12 – Coastal

Bryan
 Bulloch
 Camden
 Chatham
 Effingham
 Glynn
 Liberty
 Long
 McIntosh

NOTES: ADH, ALS, and Out of Home Respite Providers should check the one county in which the facility is located.
 Up to 10 counties may be requested for initial enrollment and for each expansion request.

Revised 4/1/14

APPENDIX B - CCSP Expansion Application

Submission Requirements/ Checklist for CCSP Service Area Expansion Request

Submit the below General Application to Expand Service Area request, via postal mail, to:

Georgia Department of Community Health

Medicaid Division

CCSP Unit

Two Peachtree Street, N.W.

37rd Floor

Atlanta, GA 30303-3159

Assemble in the order listed below (tabbed and clearly identified):

1. Signed and dated expansion application
2. Signed statement that the Applicant Organization assumes supervisory, administrative and professional responsibility for the operation of the services and assures the quality of the service.
3. Prototype of each subcontract agreement to be signed by independent contract
4. Resumes of the following personnel:

~Lead/ Supervising RN(s)

~Staff responsible for day to day operations

5. Current state license from HFRD (**adult day health providers**, private home care providers and personal care homes only) **Revised 4/2016**
6. Food service permit from health department (on-site food service providers)
7. Most recent inspection reports from the following agencies:

~Healthcare Facilities Regulation Division (HFRD)

~Fire Inspection (adult day health and personal care homes)

~Health Department (on-site food service providers)

~Utilization Review

**All inspections must be clear of deficiencies.

8. Copy of supervising RN(s) Georgia license
9. If services will be contracted, copy of contract agreement(s)
10. Proof of \$1,000,000 liability insurance coverage
11. PSS/PSSX/SN providers must submit proof of worker's compensation coverage
12. Agency's most recent self-evaluation policies/ procedures and most recent results
13. Medicaid Enrollment Application (if the services will be provided out of a new office)

Community Care Services Program
GENERAL APPLICATION to
EXPAND SERVICE AREA

Complete the General Application to Expand Service Area and NEATLY PRINT the information requested. If additional space is required to properly answer each question, label and attach the applicant organization's response.

1. Name of Applicant Organization (Legal and DBA):

2. Provider Enrollment Medicaid Number _____ Fed Tax ID _____

3. Service you are expanding (e.g., PSS, SNS, etc.) _____

4. Mailing Address:

5. Street Address:

6. Business Telephone Number: (_____) _____

7. After-Hours Telephone Number: (_____) _____

8. FAX Number: (_____) _____

9. Business E-mail Address: _____

10. Administrative Contact Person:

_____ (_____)
Name Title Telephone Number

Location

11. Operational Contact Person:

_____ (_____)
Name Title Telephone Number

12. Current and Proposed Geographic Areas of Service: Mark "C" for those counties being currently served. Mark "P" for those counties proposed to be served (up to 10).

**Appendix A
Requested Counties Form**

**CCSP Application
Attachment A**

INSTRUCTIONS: Place a check (✓) beside the counties requesting.

Statewide

1 – Northwest Georgia

___ Bartow
___ Catoosa
___ Chattooga
___ Dade
___ Fannin
___ Floyd
___ Gilmer
___ Gordon
___ Haralson
___ Murray
___ Paulding
___ Pickens
___ Polk
___ Walker
___ Whitfield

2 – Georgia Mountains

___ Banks
___ Dawson
___ Forsyth
___ Franklin
___ Habersham
___ Hall
___ Hart
___ Lumpkin
___ Rabun
___ Stephens
___ Towns
___ Union
___ White

3 – Atlanta Regional

___ Cherokee
___ Clayton
___ Cobb
___ DeKalb
___ Douglas
___ Fayette
___ Fulton
___ Gwinnett
___ Henry
___ Rockdale

4 – Southern Crescent

___ Butts
___ Carroll
___ Coweta
___ Heard
___ Lamar
___ Meriwether
___ Pike
___ Spalding
___ Troup
___ Upson

5 – Northeast Georgia

___ Barrow
___ Clarke
___ Elbert
___ Greene
___ Jackson
___ Jasper
___ Madison
___ Morgan
___ Newton
___ Oconee
___ Oglethorpe
___ Walton

6 – River Valley

___ Chattahoochee
___ Clay
___ Crisp
___ Dooly
___ Harris
___ Macon
___ Marion
___ Muscogee
___ Quitman
___ Randolph
___ Schley
___ Stewart
___ Sumter
___ Talbot
___ Taylor
___ Webster

7 – Middle Georgia

___ Baldwin
___ Bibb
___ Crawford
___ Houston
___ Jones
___ Monroe
___ Peach
___ Pulaski
___ Putnam
___ Twiggs
___ Wilkinson

8 – Central Savannah River

___ Burke
___ Columbia
___ Glascock
___ Hancock
___ Jefferson
___ Jenkins
___ Lincoln
___ McDuffie
___ Richmond
___ Screven
___ Taliaferro
___ Warren
___ Washington
___ Wilkes

9 – Heart of GA/Altamaha

___ Appling
___ Bleckley
___ Candler
___ Dodge
___ Emanuel
___ Evans
___ Jeff Davis
___ Johnson
___ Laurens
___ Montgomery
___ Tattall
___ Telfair
___ Toombs
___ Treutlen
___ Wayne
___ Wheeler
___ Wilcox

10 – Southwest Georgia

___ Baker
___ Calhoun
___ Colquitt
___ Decatur
___ Dougherty
___ Early
___ Grady
___ Lee
___ Miller
___ Mitchell
___ Seminole
___ Terrell
___ Thomas
___ Worth

11 – Southern Georgia

___ Atkinson
___ Bacon
___ Ben Hill
___ Berrien
___ Brantley
___ Brooks
___ Charlton
___ Clinch
___ Coffee
___ Cook
___ Echols
___ Irwin
___ Lanier
___ Lowndes
___ Pierce
___ Tift
___ Turner
___ Ware

12 - Coastal

___ Bryan
___ Bulloch
___ Camden
___ Chatham
___ Effingham
___ Glynn
___ Liberty
___ Long
___ McIntosh

NOTES: ADH, ALS, and Out of Home Respite Providers should check the one county in which the facility is located. Up to 10 counties may be requested for initial enrollment and for each expansion request.

Revised 4/1/14

13. List the Medicaid provider number and effective dates for all Medicaid services you currently provide:

Medicaid Service	Medicaid Provider Number	Effective Dates

Target Population:

14. How many CCSP clients are currently receiving services from your agency? _____

15. Are you currently providing this service in the proposed area to non-CCSP clients? Yes ___ No ___

Supervision:

16. Provide the name and telephone numbers of the person responsible for day-to-day operations and the Registered Nurse supervisor in each Planning Service Area (PSA).

Planning and Service Area	Person Responsible for Day-to-Day Operations Location & Telephone Number	Person Responsible for Registered Nurse Supervision Location & Telephone

Administration and Clinical Records:

17. Please provide the location and mailing address for the expanded area office:

Location

Mailing Address _____

Telephone Number _____ () _____

FAX Number () _____

Contact Person _____

I hereby certify that my application for CCSP Expansion of Service is complete and contains all required materials in accordance with submission requirements established by the CCSP Unit at the GA Department of Community Health / Division of Medical Assistance.

I understand that my application will be returned to me if it is not complete and that this could delay any consideration and/or approval to expand service area(s).

Signature of person legally authorized to act for the Applicant Organization

Date

APPENDIX C

REFERRAL SYSTEM FOR USE WITH MULTIPLE CCSP PROVIDERS OF THE SAME SERVICE.

A. Client is able to choose

Where more than one CCSP provider offers the same major service within a given geographic area, a choice of these providers is presented to the client. The client or client representative indicates the preferred provider.

Factors affecting the client's choice are:

1. Physician's recommendation for service

If the client's physician specifies a preference for a particular CCSP provider to render services to the client, the client will be informed of the physician's recommendation, and whether or not the particular services needed are provided by the recommended provider. The client makes the final choice regarding the service provider.

2. Availability of services

If the client is in need of immediate (emergency) services and the CCSP provider chosen by the client is unable to render the immediate service, an alternate provider may be utilized.

If the CCSP provider chosen does not provide the comprehensive services needed (i.e., O.T.) the client may be referred to an alternate provider.

<p>NOTE: Care coordinator/Lead Agency notifies the CCSP Unit when a CCSP provider does not offer a required service.</p>
--

B. Client is unable to choose

If, for any reason (unfamiliarity with service providers, confused mental state, etc.), a client is unable to choose from among multiple providers of the same service, the CCSP care coordinator utilizes the rotation procedure for that Planning and Service Area.

APPENDIX D

INFORMATION ABOUT ADVANCE DIRECTIVES

WHAT ARE ADVANCE DIRECTIVES?

Advance Directives are documents that state an individual's choices about medical treatment or name someone to make choices about medical treatments for the individual if the individual is unable to make those decisions. Advance Directives are written before the onset of serious illness. The Patient Self-Determination Act requires all programs that provide home health care or personal care services and that participate in Medicaid and Medicare programs to have written policies and procedures on Advance Directives. The State of Georgia has two forms of Advance Directives: the Living Will and the Durable Power of Attorney for Health Care.

WHAT IS A LIVING WILL?

A Living Will is one type of an Advance Directive. A Living Will is a document that is used only when a person has a terminal condition. It instructs the physician regarding decisions to withhold or withdraw certain medical procedures which could be used to prolong life. A Living Will deals with how an individual wishes to be treated when that individual is dying. The Living Will allows an individual to die naturally, without death being artificially prolonged by various medical procedures.

WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

A Durable Power of Attorney for Health Care is another form of Advance Directives. This document allows one to designate a person or persons to make decisions regarding health care when the individual is unable to do so.

AM I REQUIRED TO HAVE ADVANCE DIRECTIVES?

No. No one is required to have Advance Directives. Each individual has the right to choose whether or not to have Advance Directives.

Rev.
10/01/03

WHAT ARE MY RIGHTS?

Each individual has the right to refuse any medical or surgical treatment or services that the individual does not wish to receive. Georgia law allows individuals to sign Advance Directives so that the individual's wishes will be followed even if the individual becomes unable to communicate those wishes to the health care provider.

CAN I BE REFUSED ADMISSION TO THE COMMUNITY CARE SERVICE PROGRAM IF I DO NOT HAVE AN ADVANCE DIRECTIVE?

No. Federal law prohibits programs from refusing to admit a client because the client does not have an Advance Directive. However, individuals will be asked if they do have an advance directive and those answers will be documented.

WHERE CAN I GET MORE INFORMATION ABOUT ADVANCE DIRECTIVES?

This information sheet is one way of providing clients with information about Advance Directives. If you would like more information about Advance Directives, you may contact the Division of Aging Services at (404) 657-5319 or an attorney.

ADVANCE DIRECTIVE CHECKLIST

Please read the following three statements. After reading the statements, please write your initials at the end of **each** statement.

1. I have been given written materials on my rights to accept or refuse medical treatment and/or services and on my rights to formulate Advance Directives.

_____ (Client's initials)

2. I understand that I am not required to have an Advance Directive in order to receive services or medical treatment from

_____ (Client's initials) (CCSP Provider)

3. I desire that the terms of any Advance Directive that I execute will be followed by

_____ (Client's initials) (CCSP Provider)

Please read the following statements. After reading the statements, please check **ONE** of the following statements:

1. _____ I have executed an Advance Directive and will provide a copy to the CCSP provider agency providing services. I understand that the staff of:

(CCSP Provider) will not be able to follow the terms of my Advance Directive until I provide a copy of it to the staff.

2. _____ I have not executed an Advance Directive and do not wish to discuss Advance Directives at this time.

3. _____ I have not executed an Advance Directive but would like to obtain additional information about Advance Directives.

Client's Signature

Date

Witness' Signature

Date

APPENDIX E (Form 5588) – Revised 4/1/2015

Instructions

Community Care Services Program Level of Care and Placement Instrument

LEVEL OF CARE

Purpose: The Level of Care (LOC) page summarizes the client's physical, mental, social, and environmental status to help determine the client's appropriateness for the Community Care Services Program (CCSP) or other services. In addition, the LOC page represents the physician's order for all waived services provided by CCSP.

Who Completes Form: Initial assessments are completed by the RN care coordinator. Subsequent reassessments are completed by the RN or LPN. However, the LOC is always certified by the RN care coordinator. The client's physician, nurse practitioner or physician assistant participates in all assessments and reassessments by completing designated sections of the LOC page and signing the form.

When the Form is Completed:

The RN care coordinator completes the LOC page at initial assessments and reassessments.

Instructions:

SECTION IA. IDENTIFYING INFORMATION

Client Information in Section I is completed from information obtained from referral source or individual (patient) being referred.

1. Enter complete name, address & telephone number, including area code, of care coordination team.
2. Enter client's last name, first name, and middle initial, in that order, exactly as it appears on the Medicaid, Medicare, or social security card.
3. Enter home address of client, including street number, name of street, apartment number (if applicable), or rural route and box number, town, state and zip code.
4. Enter client's area code and telephone number.
5. Enter client's county of residence.
6. Enter planning and service area (PSA) number where client resides.
7. Enter client's Medicaid number exactly as it appears on the Medicaid card.

NOTE: Potential Medical Assistance Only (PMAO) applicants do not have a current Medicaid number. For PMAO applicants, please leave this item blank.

8. Enter client's nine-digit social security number.

9. Enter client's mother's maiden name.
- 10, 11, 12. Enter client's sex ("M" or "F"), age, and date of birth (month/day/year).
13. Enter client's race as follows:
 A = Asian/Pacific Islander H = Hispanic W = White
 B = Black NA = Native American
14. Enter client's marital status as follows:
 S = Single M = Married W = Widowed
 D = Divorced SP = Separated
15. Check (✓) appropriate type of recommendation:
 1. Initial: First referral to CCSP or re-entry into CCSP after termination
 2. Reassessment: Clients requiring annual recertification or reassessment because of change in status.
16. Enter referral source by name and title (if applicable), or agency and type as follows:
 MD = Doctor S = Self HHA = Home health agency
 NF = Nursing facility FM = Family PCH = Personal Care Home
 HOSP = Hospital ADH = Adult Day Health APS = Adult Protective Services
 O = Other (Identify fully) DFCS = Division of Family & Children Services
- 17, 18. Client signs and dates in spaces provided. If client is unable to sign, spouse, parent, other relative, or legal/authorized representative may sign and note relationship to client after signature.

NOTE: This signature gives client's physician permission to release information to care coordinator regarding level of care determination.

SECTION I B. PHYSICIAN'S EXAMINATION REPORT AND DOCUMENTATION

Section B is completed and signed by licensed medical person completing medical report.

19. The licensed physician/nurse practitioner/physician assistant enters client's primary, secondary, and other (if applicable) diagnoses. CCRN may pre fill Line 19 based on client self-report when physical impairments and/or medication(s) indications support the self-reported diagnosis. In situations where the CCRN completes the primary diagnosis; a cover letter to the physician which clarifies the nurses completion of Line 19 must accompany the assessment documents.

* The primary diagnosis should support CCSP eligibility.

NOTE: After the physician/ nurse practitioner returns signed LOC page, care coordination team enters the ICD codes. Enter ICD codes for "primary diagnosis", "secondary diagnosis" or "third diagnosis" in the appropriate box. Care coordination teams secure codes from ICD code book, local hospitals or client's physician. **Beginning October 2013, please enter the ICD codes in both ICD-9 and ICD-10 formats in preparation for the implementation of ICD-10 in October 2015. Rev 10/14**

20. The physician/nurse practitioner (RNP)/physician assistant (PA) checks appropriate box to indicate if client is free of communicable diseases.
21. List all medications, including over-the-counter (OTC) medications and state dosage, how the medications are dispensed, frequency, and reason for medication. Attach additional sheets if necessary and reference.
22. List all diagnostic and treatment procedures the client is receiving.
23. List all waived services ordered by care coordination team.

NOTE: Waivered services ordered by care coordination and approved by the physician/nurse practitioner/physician assistant are considered physician's orders for CCSP waived services.

24. Enter appropriate diet for client. If "other" is checked (√), please specify type. Completion of this item is important as this information may serve as the service order for home delivered meals. (Nutrition Screening Initiative (NSI), Appendix 100, is to be completed in conjunction with the LOC page, MDS-HC and CCP.)
25. Enter number of hours out of bed per day if client is not bedfast. Check (√) intake if client can take fluids orally. Check (√) output if client's bladder function is normal without catheter. Check (√) all appropriate boxes.
26. Check (√) appropriate box to indicate client's overall condition.
27. Check (√) appropriate box to indicate client's restorative potential.
28. Check (√) *all* appropriate boxes to indicate client's mental and behavioral status. Document on additional sheet any behavior that indicates need for a psychological or psychiatric evaluation.
29. Check (√) appropriate box to indicate if client has decubiti. If "Yes" is checked and surgery did occur, indicate date of surgery.
30. Check (√) appropriate box.
31. Check (√) appropriate box.
32. If applicable, enter number of treatment or therapy sessions per week that client receives or needs.
33. Enter appropriate numbers in boxes provided to indicate level of impairment or assistance

needed.

NOTE: Information on the MDS-HC **must** match the LOC form.

34. Care coordination team or the admitting/attending physician/nurse practitioner/physician assistant indicates whether client's condition could or could not be managed by provision of Community Care or Home Health Services by checking (✓) appropriate box.

NOTE: If physician/nurse practitioner/**physician assistant** indicates that client's condition cannot be managed by provision of Community Care and/or Home Health Services, the physician may complete and sign a DMA-6

35. Care coordination team or the admitting/attending physician/nurse practitioner/**physician assistant** certifies that client requires level of care provided by an intermediate care facility.
36. Admitting/attending physician (**RNP or PA**) certifies that CCP, plan of care addresses patient's needs for Community Care. If client's needs cannot be addressed in CCSP and nursing facility placement is recommended, the physician may complete and sign a DMA-6.
37. This space is provided for signature of admitting/attending physician/ nurse practitioner/ physician assistant indicating his certification that client needs can or cannot be met in a community setting. **Only a licensed physician (MD or DO), nurse practitioner or physician assistant may sign the LOC page.**

NOTE: **MD, DO, RNP or PA** signs within 60 days of care coordinator's completion of form. Physician/nurse practitioner's signature must be original. Signature stamps are not acceptable. **Electronic signatures are acceptable when Medicaid criteria for electronic signatures is met. See Policies and Procedures for Medicaid/PeachCare for Kids Part I –Definitions and Part I/Section 106 (R).** UR will recover payments made to the provider if there is no physician/RNP/PA signature. "Faxed" copies of LOC page are acceptable.

- 38, 39, 40, 41, 42. Enter admitting/attending physician's name, address, date of signature, licensure number, and telephone number, including area code, in spaces provided. **If nurse practitioner or physician assistant is completing the document, he or she will provide information relative to his/her license and contact information. LOC cover letter will reference instructions for RNP and PA.**

NOTE: The date the physician signs the form is the service order for CCSP services to begin. UR will recover money from the provider if date is not recorded.

43, 44, 45. REGISTERED NURSE (RN) USE ONLY

43. The registered nurse checks (✓) the appropriate box regarding Nursing Facility Level of Care (LOC). When RN denies a level of care, the nurse signs the form after the "No" item in this space. The RN does not use the customized "Approved" or "Denied" stamp.
44. LOS (Length of Stay) - Indicate time frame for certification. **LOS cannot exceed 365 days. If the level of care has been certified by the Georgia Medical Care Foundation, use the date of GMCF's approval as the beginning date of the length of stay.**
45. Licensed person certifying level of care signs in this space and indicates title (R.N.) and date of signature.

NOTE: Date of signature must be within 60 days of date care coordinator completed assessment as indicated in Number 18. Length of stay is calculated from date shown in Number 44. The RN completes a recertification of a level of care prior to expiration of length of stay.

Distribution: The original is filed in the case record. Attach a copy with the CCC to DFCS at initial assessment and reassessment. Include a copy with the provider referral packet.

Georgia Department of Human Services
 COMMUNITY CARE SERVICES PROGRAM LEVEL OF CARE AND PLACEMENT INSTRUMENT

Section 1 - A. Identifying Information

1. CCSP ASSESSMENT TEAM NAME AND ADDRESS		2. Patient's Name (Last, First, Middle Initial)		Client ID	
3. Home Address:					
4. Telephone Number		5. County		6. PSA	
7. Medicaid Number		8. Social Security Number		9. Mother's Maiden Name:	
10. Sex		11. Age	12. Birthday	13. Race	14. Mental Status
					15. Type of recommendation <input type="checkbox"/> Initial Assessment <input type="checkbox"/> Reassessment

16. Referral Source

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Department of Human Services with necessary information including medical data.

17. Signed _____ 18. Date _____
(Patient, Spouse, Parent or other Relative or Legal Representative)

B. Physician's Examination Report, Recommendation and Nursing Care Needed

19. Diagnosis on Admission to Community Care (Hospital transfer record may be attached)

1. Primary		2. Secondary		3. Other	
ICD 9 CODE		ICD 10 CODE		ICD 9 CODE	

20. Is Patient free of communicable disease? Yes No

21. Medications (including OTC) <input type="checkbox"/> see attached sheet for listing				22. Diagnostic and Treatment Procedures	
Name		Dosage	Route	Frequency	Type/Frequency

23. COMMUNITY CARE SERVICES ORDERED:

24. Diet		25. Hours Out of Bed Per Day		26. Overall Condition		27. Restorative Potential		28. Mental and Behavioral Status				
<input type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Formula <input type="checkbox"/> Low Sodium <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other		<input type="checkbox"/> Inlet <input type="checkbox"/> IV <input type="checkbox"/> Output <input type="checkbox"/> Restraint <input type="checkbox"/> Catheter Care <input type="checkbox"/> Colostomy Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Suctioning		<input type="checkbox"/> Improving <input type="checkbox"/> Stable <input type="checkbox"/> Fluctuating <input type="checkbox"/> Deteriorating <input type="checkbox"/> Critical <input type="checkbox"/> Terminal		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Questionable <input type="checkbox"/> None		<input type="checkbox"/> Agitated <input type="checkbox"/> Noisy <input type="checkbox"/> Dependent <input type="checkbox"/> Confused <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Independent <input type="checkbox"/> Cooperative <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed <input type="checkbox"/> Violent <input type="checkbox"/> Well Adjusted <input type="checkbox"/> Forgetful <input type="checkbox"/> Wandering <input type="checkbox"/> Disoriented <input type="checkbox"/> Alert <input type="checkbox"/> Withdrawn <input type="checkbox"/> Inappropriate Reaction				
29. Decubiti		30. Stool		31. Bladder		32. Indicate Frequency per Week						
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infected <input type="checkbox"/> On Admission <input type="checkbox"/> Surgery Date		<input type="checkbox"/> Continent <input type="checkbox"/> Occas. Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy		<input type="checkbox"/> Continent <input type="checkbox"/> Occas. Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter		Physical Therapy	Occupational Therapy	Remote Therapy	Reality Orientation	Speech Therapy	Bowel/Bladder Retrain	Activities Program

33. Record Appropriate

Legend		IMPAIRMENT					ACTIVITIES OF DAILY LIVING						
1. Severe 2. Moderate 3. Mild 4. None		Sight	Hearing	Speech	Limited Motion	Paralysis	1. Dependent 2. Needs Assistance 3. Independent 4. Not Applicable	Beds	Wheel Chair	Transfers	Bath	Ambulation	Dressing
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. This patient's condition could could not be managed by provision of Community Care or Home Health Services

35. I certify that this patient requires does not require the intermediate level of care provided by a nursing facility.

36. I certify that the attached plan of care addresses the client's needs for Community Care.

37. Physician's Signature _____

38. Physician's Name (Print) _____

39. Physician's Address _____

40. Date signed by Physician _____

41. Physician's License No. _____

42. Physician's Phone No. _____

ASSESSMENT TEAM USE ONLY

43. Nursing Facility Level of Care Yes No 44. L.O.S. _____ 365 DAYS Certified _____ thru _____

45. Signed by person certifying LOC: _____ Title: _____ Date Signed: _____

APPENDIX F – LEVEL OF CARE
Minimum Data Set for Home Care – Version 9 (MDS-HC v.9)
(InterRAI Home Care v. 2.0)
Revised Sept 2011
(See next page.)

SECTION C. COGNITION

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING

Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do

- 0. **Independent**—Decisions consistent, reasonable, and safe
- 1. **Moderately independent**—Some difficulty in new situations only
- 2. **Minimally impaired**—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times
- 3. **Moderately impaired**—Decisions consistently poor or unsafe; cues / supervision required at all times
- 4. **Severely impaired**—Never or rarely makes decisions
- 5. **No discernable consciousness, coma** [Skip to Section G]

2. MEMORY / RECALL ABILITY

Code for recall of what was learned or known

- 0. Yes, memory OK
- 1. Memory problem
- a. **Short-term memory OK**—Seems / appears to recall after 5 minutes
- b. **Procedural memory OK**—Can perform all or almost all steps in a multitask sequence without cues
- c. **Situational memory OK**—Both: recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bed room, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING OR AWARENESS

[Note: Accurate assessment requires conversations with staff, family or others who have direct knowledge of the person's behavior over this time]

- 0. Behavior not present
- 1. Behavior present, consistent with usual functioning
- 2. Behavior present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)
- a. **Easily distracted**—e.g., episodes of difficulty paying attention, gets sidetracked
- b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loss of train of thought
- c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING—e.g., restlessness, lethargy, difficult to arouse, altered environmental perception

- 0. No
- 1. Yes

5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)

- 0. Improved
- 1. No change
- 2. Declined
- 3. Uncertain

SECTION D. COMMUNICATION AND VISION

1. MAKING SELF UNDERSTOOD (Expression)

Expressing information content—both verbal and non-verbal

- 0. **Understood**—Expresses ideas without difficulty
- 1. **Usually understood**—Difficulty finding words or finishing thoughts BUT if given time, little or no prompting required
- 2. **Often understood**—Difficulty finding words or finishing thoughts AND prompting usually required
- 3. **Sometimes understood**—Ability is limited to making concrete requests
- 4. **Rarely or never understood**

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)

Understanding verbal information content (however able, with hearing appliance normally used)

- 0. **Understands**—Clear comprehension
- 1. **Usually understands**—Misses some part / intent of message BUT comprehends most conversation
- 2. **Often understands**—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
- 3. **Sometimes understands**—Responds adequately to simple, direct communication only
- 4. **Rarely or never understands**

3. HEARING

Ability to hear (with hearing appliance normally used)

- 0. **Adequate**—No difficulty in normal conversation, social interaction, listening to TV
- 1. **Minimal difficulty**—Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet [2 meters] away)
- 2. **Moderate difficulty**—Problem hearing normal conversation, requires quiet setting to hear well
- 3. **Severe difficulty**—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly, or person reports that all speech is mumbled)
- 4. **No hearing**

4. VISION

Ability to see in adequate light (with glasses or with other visual appliance normally used)

- 0. **Adequate**—Sees fine detail, including regular print in newspapers / books
- 1. **Minimal difficulty**—Sees large print, but not regular print in newspapers / books
- 2. **Moderate difficulty**—Limited vision; not able to see newspaper headlines, but can identify objects
- 3. **Severe difficulty**—Object identification in question, but eyes appear to follow objects; sees only light, colors, shapes
- 4. **No vision**

SECTION E. MOOD AND BEHAVIOR

1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD

Code for indicators observed in last 3 days, irrespective of the assumed cause [Note: Whenever possible, ask person]

- 0. Not present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days
- a. **Made negative statements**—e.g., "Nothing matters; I would rather be dead; What's the use; Regret having lived so long; Let me die"
- b. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received
- c. **Expressions, including non-verbal, of what appear to be unrealistic fears**—e.g., fear of being abandoned, being let alone, being with others; intense fear of specific objects or situations
- d. **Repetitive health complaints**—e.g., persistently seeks medical attention, incessant concern with body functions
- e. **Repetitive anxious complaints / concerns (non-health related)**—e.g., persistently seeks attention / reassurance regarding schedules, meals, laundry, clothing, relationships
- f. **Sad, pained, or worried facial expressions**—e.g., furrowed brow, constant frowning
- g. **Crying, tearfulness**
- h. **Recurrent statements that something terrible is about to happen**—e.g., believes he or she is about to die, have a heart attack
- i. **Withdrawal from activities of interest**—e.g., long-standing activities, being with family / friends
- j. **Reduced social interactions**
- k. **Expressions, including non-verbal, of a lack of pleasure in life (anhedonia)**—e.g., "I don't enjoy anything anymore"

2. SELF-REPORTED MOOD

- 0. Not in last 3 days
- 1. Not in last 3 days, but often feels that way
- 2. In 1-2 of last 3 days
- 3. Daily in the last 3 days
- 8. Person could not (would not) respond

Ask: "In the last 3 days, how often have you felt..."

- a. **Little interest or pleasure in things you normally enjoy?**
- b. **Anxious, restless, or uneasy?**
- c. **Sad, depressed, or hopeless?**

3. BEHAVIOR SYMPTOMS

Code for indicators observed, irrespective of the assumed cause

- 0. Not Present
- 1. Present but not exhibited in last 3 days
- 2. Exhibited on 1-2 of last 3 days
- 3. Exhibited daily in last 3 days
- a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety
- b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at
- c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused
- d. **Socially inappropriate or disruptive behavior**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through others' belongings
- e. **Inappropriate public sexual behavior or public disrobing**
- f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating

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SECTION F. PSYCHOSOCIAL WELL-BEING

- 1. SOCIAL RELATIONSHIPS**
[Note: Whenever possible, ask person]
 0. Never
 1. More than 30 days ago
 2. 8 to 30 days ago
 3. 4 to 7 days ago
 4. In last 3 days
 8. Unable to determine
- a. **Participation in social activities of long-standing interest**
- b. **Visit with a long-standing social relation or family member**
- c. **Other interaction with long-standing social relation or family member**—e.g., telephone, e-mail
- d. **Conflict or anger with family or friends**
- e. **Fearful of a family member or close acquaintance**
- f. **Neglected, abused, or mistreated**
- 2. LONELY**
Says or indicates that he / she feels lonely
 0. No 1. Yes
- 3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)**
Decline in level of participation in social, religious, occupational or other preferred activities
 IF THERE WAS A DECLINE, person distressed by this fact
 0. No decline
 1. Decline, not distressed
 2. Decline, distressed
- 4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)**
 0. Less than 1 hour
 1. 1-2 hours
 2. More than 2 hours but less than 8 hours
 3. 8 hours or more
- 5. MAJOR LIFE STRESSORS IN LAST 90 DAYS**—e.g., episode of severe personal illness; death or severe illness of close family member/friend; loss of home; major loss of income/assets; victim of a crime such as robbery or assault; loss of driving license/car
 0. No 1. Yes

SECTION G. FUNCTIONAL STATUS

- 1. ADL SELF PERFORMANCE AND CAPACITY**
Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS
Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.
0. *Independent*—No help, setup, or supervision
 1. *Setup help only*
 2. *Supervision*—Oversight /cuing
 3. *Limited assistance*—Help on some occasions
 4. *Extensive assistance*—Help throughout task, but performs 50% or more of task on own
 5. *Maximal assistance*—Help throughout task, but performs less than 50% of task on own
 6. *Total dependence*—Full performance by others during entire period
 8. *Activity did not occur*—During entire period
 [DO NOT USE THIS CODE IN SCORING CAPACITY]
- a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)
- b. **Ordinary housework**—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)
- c. **Managing finances**—How bills are paid, checkbook is balanced, household expenses are budgeted, credit card account is monitored
- d. **Managing medications**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)
- e. **Phone use**—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)
- f. **Stairs**—How full flight of stairs is managed (12-14 stairs)
- g. **Shopping**—How shopping is performed for food and household items (e.g., selecting items, paying money) - EXCLUDE TRANSPORTATION

- h. **Transportation**—How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)

2. ADL SELF-PERFORMANCE
Consider all episodes over 3-day period.

Fail episodes are performed at the same level score ADL at that level. Fail episodes at level 6, and others less dependent, score ADL as a 9. Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2-5.

0. *Independent*—No physical assistance, setup, or supervision in any episode
 1. *Independent, setup help only*—Article or device provided or placed within reach, no physical assistance or supervision in any episode
 2. *Supervision*—Oversight /cuing
 3. *Limited assistance*—Guided maneuvering of limbs, physical guidance without taking weight
 4. *Extensive assistance*—Weight-bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
 5. *Maximal assistance*—Weight-bearing support (including lifting limbs) by 2+ helpers —OR—Weight-bearing support for more than 50% of subtasks
 6. *Total dependence*—Full performance by others during all episodes
 8. *Activity did not occur during entire period*

- a. **Bathing**—How takes a full-body bath / shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area - EXCLUDE WASHING OF BACK AND HAIR
- b. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands - EXCLUDE BATHS AND SHOWERS
- c. **Dressing upper body**—How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.
- d. **Dressing lower body**—How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.
- e. **Walking**—How walks between locations on same floor indoors
- f. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair
- g. **Transfer toilet**—How moves on and off toilet or commode
- h. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes - EXCLUDE TRANSFER ON AND OFF TOILET
- i. **Bed mobility**—How moves to and from lying position, turns from side to side, and positions body while in bed
- j. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

3. LOCOMOTION /WALKING

- a. **Primary mode of locomotion**
 0. Walking, no assistive device
 1. Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair
 2. Wheelchair, scooter
 3. Bedbound
- b. **Timed 4-meter (13 foot) walk**
 [Lay out a straight unobstructed course. Have person stand in still position, feet just touching start line]
Then say: "When I tell you begin to walk at a normal pace (with cane/walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop. Is this clear?" Assessor may demonstrate test.
Then say: "Begin to walk now" Start stopwatch (or can count seconds) when first foot falls. End count when foot falls beyond 4-meter mark.
Then say: "You may stop now"
 Enter time in seconds, up to 30 seconds:
 30-30 or more seconds to walk 4 meters
 77. Stopped before test complete
 88. Refused to do the test
 99. Nottested—e.g., does not walk on own

PERFORMANCE
CAPACITY



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- c. **Distance walked**—Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed)
- 0. Did not walk
 - 1. Less than 15 feet (under 5 meters)
 - 2. 15-149 feet (5-49 meters)
 - 3. 150-299 feet (50-99 meters)
 - 4. 300+ feet (100+ meters)
 - 5. 1/2 mile or more (1+ kilometers)

- d. **Distance wheeled self**—Farthest distance wheeled self at one time in the LAST 3 DAYS (includes independent use of motorized wheelchair)
- 0. Wheeled by others
 - 1. Used motorized wheelchair / scooter
 - 2. Wheeled self less than 15 feet (under 5 meters)
 - 3. Wheeled self 15-149 feet (5-49 meters)
 - 4. Wheeled self 150-299 feet (50-99 meters)
 - 5. Wheeled self 300+ feet (100+ meters)
 - 8. Did not use wheelchair

4. ACTIVITY LEVEL

- a. **Total hours of exercise or physical activity in LAST 3 DAYS**—e.g., walking
- 0. None
 - 1. Less than 1 hour
 - 2. 1-2 hours
 - 3. 3-4 hours
 - 4. More than 4 hours

- b. In the LAST 3 DAYS, number of days went out of the house or building in which he/she resides (no matter how short the period)
- 0. No days out
 - 1. Did not go out in last 3 days, but usually goes out over a 3-day period
 - 2. 1-2 days
 - 3. 3 days

5. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL

- 0. No
 - 1. Yes
- a. **Person believes he / she is capable of improved performance in physical function**
- b. **Care professional believes person is capable of improved performance in physical function**

6. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO

- 0. Improved
- 1. No change
- 2. Declined
- 3. Uncertain

7. DRIVING

- a. **Drove car (vehicle) in the LAST 90 DAYS**
- 0. No
 - 1. Yes
- b. **If drove in LAST 90 DAYS, assessor is aware that someone has suggested that person limits OR stops driving**
- 0. No, or does not drive
 - 1. Yes

SECTION H. CONTINENCE

1. BLADDER CONTINENCE

- 0. *Continent*—Complete control; DOES NOT USE any type of catheter or other urinary collection device
- 1. *Control with any catheter or ostomy* over last 3 days
- 2. *Infrequently incontinent*—Not incontinent over last 3 days, but does have incontinent episodes
- 3. *Occasionally incontinent*—Less than daily
- 4. *Frequently incontinent*—Daily, but some control present
- 5. *Incontinent*—No control present
- 8. *Did not occur*—No urine output from bladder in last 3 days

2. URINARY COLLECTION DEVICE (Exclude pads / briefs)

- 0. None
- 1. Condom catheter
- 2. Indwelling catheter
- 3. Cystostomy, nephrostomy, ureterostomy

3. BOWEL CONTINENCE

- 0. *Continent*—Complete control; DOES NOT USE any type of ostomy device
- 1. *Control with ostomy*—Control with ostomy device over last 3 days
- 2. *Infrequently incontinent*—Not incontinent over last 3 days, but does have incontinent episodes
- 3. *Occasionally incontinent*—Less than daily
- 4. *Frequently incontinent*—Daily, but some control present
- 5. *Incontinent*—No control present
- 8. *Did not occur*—No bowel movement in the last 3 days

4. PADS OR BRIEFS WORN

- 0. No
- 1. Yes

SECTION I. DISEASE DIAGNOSES

Disease code

- 0. Not present
- 1. Primary diagnosis/diagnoses for current stay
- 2. Diagnosis present, receiving active treatment
- 3. Diagnosis present, monitored but no active treatment

1. DISEASE DIAGNOSES

MUSCULOSKELETAL

- a. **Hip fracture during last 30 days (or since last assessment if less than 30 days)**
- b. **Other fracture during last 30 days (or since last assessment if less than 30 days)**

NEUROLOGICAL

- c. **Alzheimers disease**
- d. **Dementia other than Alzheimers disease**
- e. **Hemiplegia**
- f. **Multiple sclerosis**
- g. **Paraplegia**
- h. **Parkinson's disease**
- i. **Quadriplegia**
- j. **Stroke / CVA**

CARDIAC OR PULMONARY

- k. **Coronary heart disease**
- l. **Chronic obstructive pulmonary disease**
- m. **Congestive heart failure**

PSYCHIATRIC

- n. **Anxiety**
- o. **Bipolar disorder**
- p. **Depression**
- q. **Schizophrenia**

INFECTIONS

- r. **Pneumonia**
- s. **Urinary tract infection in last 30 days**

OTHER

- t. **Cancer**
- u. **Diabetes mellitus**

2. OTHER DISEASE DIAGNOSES

Diagnosis	Disease Code	ICD code
a.		
b.		
c.		
d.		
e.		
f.		

[Note: Add additional lines as necessary for other disease diagnoses]

SECTION J. HEALTH CONDITIONS

1. FALLS

- 0. No fall in last 90 days
- 1. No fall in last 30 days, but fell 31-90 days ago
- 2. One fall in last 30 days
- 3. Two or more falls in last 30 days

2. RECENT FALLS

- [Skip if last assessed more than 30 days ago or if this is first assessment]
- 0. No
 - 1. Yes
- [Blank] Not applicable (first assessment, or more than 30 days since last assessment)

3. PROBLEM FREQUENCY

- Code for presence in last 3 days
- 0. Not present
 - 1. Present but not exhibited in last 3 days
 - 2. Exhibited on 1 of last 3 days
 - 3. Exhibited on 2 of last 3 days
 - 4. Exhibited daily in last 3 days

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- BALANCE**
- a. **Difficult or unable to move self to standing position unassisted**
 - b. **Difficult or unable to turn self around and face the opposite direction when standing**
 - c. **Dizziness**
 - d. **Unsteady gait**
- CARDIAC OR PULMONARY**
- e. **Chest pain**
 - f. **Difficulty clearing airway secretions**
- PSYCHIATRIC**
- g. **Abnormal thought process**—e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality
 - h. **Delusions**—Fixed false beliefs
 - i. **Hallucinations**—False sensory perceptions
- NEUROLOGICAL**
- j. **Aphasia**
- GISTATUS**
- k. **Acid reflux**—Regurgitation of acid from stomach to throat
 - l. **Constipation**—No bowel movement in 3 days or difficult passage of hard stool
 - m. **Diarrhea**
 - n. **Vomiting**
- SLEEP PROBLEMS**
- o. **Difficulty falling asleep or staying asleep; waking up too early; restlessness; non-restful sleep**
 - p. **Too much sleep**—Excessive amount of sleep that interferes with person's normal functioning
- OTHER**
- q. **Aspiration**
 - r. **Fever**
 - s. **GI or GU bleeding**
 - t. **Hygiene**—Unusually poor hygiene, unkempt, disheveled
 - u. **Peripheral edema**
- 4. DYSPNEA (Shortness of breath)**
- 0. Absence of symptom
 - 1. Absent at rest, but present when performed moderate activities
 - 2. Absent at rest, but present when performed normal day-to-day activities
 - 3. Present at rest
- 5. FATIGUE**
- Inability to complete normal daily activities—e.g., ADLs, IADLs
- 0. **None**
 - 1. **Minimal**—Diminished energy but completes normal day-to-day activities
 - 2. **Moderate**—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
 - 3. **Severe**—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
 - 4. **Unable to commence any normal day-to-day activities**—Due to diminished energy
- 6. PAIN SYMPTOMS**
- [Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]
- a. **Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched, or other non-verbal signs suggesting pain)**
 - 0. No pain
 - 1. Present but not exhibited in last 3 days
 - 2. Exhibited on 1-2 of last 3 days
 - 3. Exhibited daily in last 3 days
 - b. **Intensity of highest level of pain present**
 - 0. No pain
 - 1. Mild
 - 2. Moderate
 - 3. Severe
 - 4. Times when pain is horrible or excruciating

- c. **Consistency of pain**
 - 0. No pain
 - 1. Single episode during last 3 days
 - 2. Intermittent
 - 3. Constant
 - d. **Breakthrough pain**—Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain
 - 0. No
 - 1. Yes
 - e. **Pain control**—Adequacy of current therapeutic regimen to control pain (from person's point of view)
 - 0. No issue of pain
 - 1. Pain intensity acceptable to person; no treatment regimen or change in regimen required
 - 2. Controlled adequately by therapeutic regimen
 - 3. Controlled when therapeutic regimen followed, but not always followed as ordered
 - 4. Therapeutic regimen followed, but pain control not adequate
 - 5. No therapeutic regimen being followed for pain; pain not adequately controlled
- 7. INSTABILITY OF CONDITIONS**
- 0. No
 - 1. Yes
 - a. **Conditions / diseases make cognitive, ADL, mood or behavior patterns unstable** (fluctuating, precarious, or deteriorating)
 - b. **Experiencing an acute episode, or a flare-up of a recurrent or chronic problem**
 - c. **End-stage disease, 6 or fewer months to live**
- 8. SELF-REPORTED HEALTH**
- Ask: "In general, how would you rate your health?"
- 0. Excellent
 - 1. Good
 - 2. Fair
 - 3. Poor
 - 6. Could not (would not) respond
- 9. TOBACCO AND ALCOHOL**
- a. **Smokes tobacco daily**
 - 0. No
 - 1. Not in last 3 days, but is usually a daily smoker
 - 2. Yes
 - b. **Alcohol**—Highest number of drinks in any "single sitting" in LAST 14 DAYS
 - 0. None
 - 1. 1
 - 2. 2-4
 - 3. 5 or more

SECTION K. ORAL AND NUTRITIONAL STATUS

- 1. HEIGHT AND WEIGHT [INCHES AND POUNDS— COUNTRY SPECIFIC]**
- Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in LAST 30 DAYS.
- a. HT (in.) b. WT (lb.)
- 2. NUTRITIONAL ISSUES**
- 0. No
 - 1. Yes
 - a. **Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS**
 - b. **Dehydrated or BUN / Cre ratio > 25** [Ratio, country specific]
 - c. **Fluid intake less than 1,000 cc per day (less than four 8 oz cups/day)**
 - d. **Fluid output exceeds input**
- 3. MODE OF NUTRITIONAL INTAKE**
- 0. **Normal**—Swallows all types of foods
 - 1. **Modified independent**—e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
 - 2. **Requires diet modification to swallow solid food**—e.g., mechanical diet (e.g., puree, minced, etc.) or only able to ingest specific foods
 - 3. **Requires modification to swallow liquids**—e.g., thickened liquids
 - 4. **Can swallow only pureed solids —AND— thickened liquids**
 - 5. **Combined oral and parenteral or tube feeding**
 - 6. **Nasogastric tube feeding only**
 - 7. **Abdominal feeding tube**—e.g., PEG tube
 - 8. **Parenteral feeding only**—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
 - 9. **Activity did not occur**—During entire period

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4. DENTAL OR ORAL

0. No 1. Yes
- a. Wears a denture (removable prosthesis)
 - b. Has broken, fragmented, loose, or otherwise non-intact natural teeth
 - c. Reports having dry mouth
 - d. Reports difficulty chewing

SECTION L. SKIN CONDITION

1. MOST SEVERE PRESSURE ULCER

0. No pressure ulcer
- 1. Any area of persistent skin redness
 - 2. Partial loss of skin layers
 - 3. Deep craters in the skin
 - 4. Breaks in skin exposing muscle or bone
 - 5. Not codeable, e.g., necrotic eschar predominant

2. PRIOR PRESSURE ULCER

0. No 1. Yes

3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER—e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer

0. No 1. Yes

4. MAJOR SKIN PROBLEMS—e.g., lesions, 2nd or 3rd degree burns, healing surgical wounds

0. No 1. Yes

5. SKIN TEARS OR CUTS—Other than surgery

0. No 1. Yes

6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION—e.g., bruises, rashes, itching, mollting, herpes zoster, intertrigo, eczema

0. No 1. Yes

7. FOOT PROBLEMS—e.g., bunions, hammer toes, overlapping toes, structural problems, infections, ulcers

0. No foot problems
- 1. Foot problems, no limitation in walking
 - 2. Foot problems limit walking
 - 3. Foot problems prevent walking
 - 4. Foot problems, does not walk for other reasons

SECTION M. MEDICATIONS

1. LIST OF ALL MEDICATIONS

List all active prescriptions, and any non-prescribed (over the counter) medications taken in the LAST 3 DAYS

[Note: Use computerized records if possible; hand enter only when absolutely necessary]

For each drug record:

- a. Name
- b. Dose—A positive number such as 0.5, 5, 150, 300. [Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg)]
- c. Unit—Code using the following list:

gts (Drops)	mEq (Milli-equivalent)	Puffs
gm (Gram)	mg (Milligram)	% (Percent)
L (Liters)	ml (Milliliter)	Units
mcg (Microgram)	oz (Ounce)	OTH (Other)
- d. Route of administration—Code using the following list:

PO (By mouth/oral)	REC (Rectal)	ET (Ertal Tube)
SL (Sublingual)	TOP (Topical)	TD (Transdermal)
IM (Intramuscular)	IH (Inhalation)	EYE (Eye)
IV (Intravenous)	HAS (Nasal)	OTH (Other)
Sub-Q (Subcutaneous)		
- e. Freq—Code the number of times per day, week, or month the medication is administered using the following list:

Q1H (E very hour)	5D (5 times daily)
Q2H (E very 2 hours)	Q2D (Every other day)
Q3H (E very 3 hours)	Q3D (E very 3 days)
Q4H (E very 4 hours)	Weekly
Q6H (E very 6 hours)	2W (2 times weekly)
Q8H (E very 8 hours)	3W (3 times weekly)
Daily	4W (4 times weekly)
BD (At bedtime)	5W (5 times weekly)
BID (2 times daily)	6W (6 times weekly)
(includes every 1-2 hrs)	1M (Monthly)
TID (3 times daily)	2M (Twice every month)
QID (4 times daily)	OTH (Other)
- f. PRN 0. No 1. Yes

g. Computer-entered drug code

9 ATC or NDC code

a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	9 ATC or NDC code
1.						
2.						
3.						
4.						
5.						

[NOTE: Add additional lines, as necessary, for other drugs taken] [Abbreviations are Country Specific for Unit, Route, Frequency]

2. ALLERGY TO ANY DRUG

0. No known drug allergies 1. Yes

3. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN

0. Always adherent
- 1. Adherent 80% of time or more
 - 2. Adherent less than 80% of time, including failure to purchase prescribed medications
 - 3. No medications prescribed

SECTION N. TREATMENT AND PROCEDURES

1. PREVENTION

0. No 1. Yes
- a. Blood pressure measured in LAST YEAR
 - b. Colonoscopy test in LAST 5 YEARS
 - c. Dental exam in LAST YEAR
 - d. Eye exam in LAST YEAR
 - e. Hearing exam in LAST 2 YEARS
 - f. Influenza vaccine in LAST YEAR
 - g. Mammogram or breast exam in LAST 2 YEARS (for women)
 - h. Pneumovax vaccine in LAST 5 YEARS or after age 65

2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)

0. Not ordered AND did not occur
- 1. Ordered, not implemented
 - 2. 1-2 of last 3 days
 - 3. Daily in last 3 days

TREATMENTS

- a. Chemotherapy
- b. Dialysis
- c. Infection control—e.g., isolation, quarantine
- d. IV medication
- e. Oxygen therapy
- f. Radiation
- g. Suctioning
- h. Tracheostomy care
- i. Transfusion
- j. Ventilator or respirator
- k. Wound care

- PROGRAMS
- l. Scheduled toileting program
 - m. Palliative care program
 - n. Turning/repositioning program

3. FORMAL CARE

Days (A) and Total minutes (B) of care in last 7 days

Extent of care/treatment in LAST 7 DAYS (or since last assessment or admission, if less than 7 days) involving:

	(A) # of Days	(B) Total Minutes in last week
a. Home health aides		
b. Home nurse		
c. Homemaking services		
d. Meals		
e. Physical therapy		
f. Occupational therapy		
g. Speech-language pathology and audiology services		
h. Psychological therapy (by any licensed mental health professional)		

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- 4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT**
Code for number of times during the LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS)
- a. Inpatient acute hospital with overnight stay
- b. Emergency room visit (not counting overnight stay)
- c. Physician visit (or authorized assistant or practitioner)
- 5. PHYSICALLY RESTRAINED**—Limbs restrained, used bed rails, restrained to chair when sitting
0. No 1. Yes

SECTION O. RESPONSIBILITY

- 1. LEGAL GUARDIAN [EXAMPLE-USA]**
0. No 1. Yes

SECTION P. SOCIAL SUPPORTS

- 1. TWO KEY INFORMAL HELPERS**
- a. Relationship to person
1. Child or child-in-law Helper 1 2
2. Spouse
3. Partner / significant other
4. Parent / guardian
5. Sibling
6. Other relative
7. Friend
8. Neighbor
9. No informal helper
- b. Lives with person
0. No Helper 1 2
1. Yes, 6 months or less
2. Yes, more than 6 months
8. No informal helper
- AREAS OF INFORMAL HELP DURING LAST 3 DAYS**
0. No 1. Yes 8. No informal helper
- c. IADL help
- d. ADL help
- 2. INFORMAL HELPER STATUS**
0. No 1. Yes
- a. Informal helper(s) is unable to continue in caring activities—e.g., decline in health of helper makes it difficult to continue
- b. Primary informal helper expresses feelings of distress, anger, or depression
- c. Family or close friends report feeling overwhelmed by person's illness
- 3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING DURING LAST 3 DAYS**
For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbors
-
- 4. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY**
0. No 1. Yes

SECTION Q. ENVIRONMENTAL ASSESSMENT

- 1. HOME ENVIRONMENT**
Code for any of following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)
0. No 1. Yes
- a. **Disrepair of the home**—e.g., hazardous clutter, inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors; holes in floor, leaking pipes
- b. **Squalid Condition**—e.g., extremely dirty, infestation by rats or bugs
- c. **Inadequate heating or cooling**—e.g., too hot in summer, too cold in winter
- d. **Lack of personal safety**—e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street
- e. **Limited access to home or rooms in home**—e.g., difficulty entering or leaving home, unable to climb stairs, difficulty maneuvering within rooms, no railings although needed

- 2. LIVES IN APARTMENT OR HOUSE RE-ENGINEERED ACCESSIBLE FOR PERSONS WITH DISABILITIES**
0. No 1. Yes
- 3. OUTSIDE ENVIRONMENT**
0. No 1. Yes
- a. **Availability of emergency assistance**—e.g., telephone, alarm response system
- b. **Accessibility to grocery store without assistance**
- c. **Availability of home delivery of groceries**
- 4. FINANCES**
Because of limited funds, during the last 30 days made trade offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care
0. No 1. Yes

SECTION R. DISCHARGE POTENTIAL AND OVERALL STATUS

- 1. ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)**
0. No 1. Yes
- 2. OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS)**
0. Improved [Skip to Section S]
1. No change [Skip to Section S]
2. Deteriorated
- CODE FOLLOWING THREE ITEMS IF "DETERIORATED" IN LAST 90 DAYS - OTHERWISE SKIP TO SECTION S**
- 3. NUMBER OF 10 ADL AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION**
- 4. NUMBER OF 8 IADL PERFORMANCE AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION**
- 5. TIME OF ONSET OF THE PRECIPITATING EVENT OR PROBLEM RELATED TO DETERIORATION**
0. Within last 7 days
1. 8 to 14 days ago
2. 15 to 30 days ago
3. 31 to 60 days ago
4. More than 60 days ago
8. No clear precipitating event

SECTION S. DISCHARGE

[Note: Complete Section S at Discharge only]

- 1. LAST DAY OF STAY**
- —
- Year Month Day
- 2. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT**
1. Private home / apartment / rented room
2. Board and care
3. Assisted living or semi-independent living
4. Mental health residence—e.g., psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter)
9. Long-term care facility (nursing home)
10. Rehabilitation hospital / unit
11. Hospice facility / palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other
15. Deceased

SECTION T. ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING / COMPLETING THE ASSESSMENT

1. Signature (sign on above line)
2. Date assessment signed as complete
- —
- Year Month Day

Georgia Department of Community Health COMMUNITY CARE SERVICES PROGRAM

Client Name John Doe	SSN 666-66-6666	Medicaid #	Care Plan Type	Recommendation	Date 4/30/01	Next Care Plan
--------------------------------	---------------------------	-------------------	-----------------------	-----------------------	------------------------	-----------------------

Needs IADL Need ADL Need	Goals Assure Proper Hygiene	Comments
---------------------------------------	---------------------------------------	-----------------

Service Community Care Services Program	Provider	Phone	C <input type="checkbox"/>	Freq	Units 0	Cost	Ordered	Begin	End	Payment Medicaid
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Client Chose CCSP vs. Nursing Home Placement

Client Signature on File

Care Coordinator

Collaborating Team Member

Signature Date

Signature Date

Signature Date

Instructions
Community Care Services Program

COMPREHENSIVE CARE PLAN (CCP)

Purpose: The CCP is used for the Initial Plan of Care. It is used again at the 30 day review, which takes place after the Initial Plan of Care, for subsequent comprehensive care plan reviews, and for reassessments.

NOTE: Clients must receive the first waived service within 60 days of LOC determination which is date the RN signs LOC page in #42 or the assessment is void.

Who Completes/When completed: The care coordinator completes the CCP at initial assessment, 30-day review, comprehensive care plan review, and reassessment.

Instructions:

NOTE: Instructions for the CCP are numbered. These items correspond to CCP screen items in CHAT.

1. Enter name of client.
2. Enter Social Security number of client.
3. Enter Medicaid number of client. Leave this item blank if the client is a PMAO client who does not have a Medicaid number at this point.
4. Enter care plan type, i.e., Initial, 30 day, CCP Review or Reassessment.
5. Indicate care coordination team's recommendation for client. **NOTE:** If skilled waived services ordered document in comments section that client meets homebound criteria.

NOTE: If nursing home placement is recommended, skip #7-22. Have client or representative sign signature page and complete #23 and #24.

6. Enter date CCP is completed.
7. Indicate date of next care plan review. If this is an initial assessment the next CCP Review will be due 30 days from the date services were brokered.
8. **Problems/Needs:** Record the problems/needs of the client as established at the assessment/30 day review/reassessment/care plan review visit. Document any deviation from normal functioning that requires different or additional health or social services. For

non-CCSP service, list the problem here.

9. Goals/Approach: Record the goals and/or objectives for the CCSP services ordered/provided. This is used as a basis for measurable evaluation of the client's condition at reassessment and follow-up. Approach describes the process followed to achieve goals set with client. For *non-CCSP service*, leave the "Goals/Approach" column blank.
10. Use the Comments section to explain why services were ordered, changed, discontinued, etc., or to add any specific information regarding any services being provided to client or to alert provider with specific instructions. Include discharge plan recommendations.
11. Service: Record all services including CCSP which the client currently receives. In the comment section, document services received in the past three months that are now terminated. The care coordinator uses the client's input to develop the care plan services.
12. Enter name of provider, including non-CCSP providers.
13. Enter the telephone number including area code of provider agency.
14. Indicate whether the CCSP provider was the client's choice or was selected from the rotation list. If the client chooses a provider, but the care coordinator does not broker service with the selected provider, document an explanation in case notes.
15. Enter the frequency of service to be provided. For non-CCSP services enter frequency of service if known.
16. Enter the units of service to be provided For non-CCSP services enter units of service if known.
17. Enter the estimated cost per month for the service to be provided. In the Cost column record the Medicaid rate. Calculate cost per month by multiplying rate per unit of service by number of units provided (for example: ALS \$24.66 x 30 units per month = \$739.80). Use current provider rates to determine cost per month. *If total cost of client services is expected to exceed cost cap consistently, client is not appropriate for CCSP.* For non-CCSP services leave estimated cost blank.
18. Enter the date the CCSP service is ordered/brokered.
19. Enter the date the CCSP service started as indicated on the initial Community Care Notification Form (CCNF). Leave blank at Initial, to be completed when the CCNF is received from the provider(s) or no later than the 30 day review.
20. Enter the date any service was terminated.
21. Enter the payment/fund source for CCSP and non-CCSP services if known. NOTE: This

includes Medicaid Home Health Services. Any deviation from the care plan is discussed and explained in Comments section.

22. Signature of care coordinator who completed this care plan.
23. Signature of collaborating team member and date signed needed at initial assessment and reassessment. This signature is not needed for CCP reviews and Interim CCPs.
24. Indicate date signed. Indicate whether or not client chooses CCSP or nursing home placement by checking (✓) the appropriate box. Have client or representative sign the signature page to indicate the choice.
25. Indicate if client or representative signed signature page by checking () appropriate box.
26. Enter date client or representative signed signature page.

NOTE: Care coordinator who completes assessment/reassessment signs CCP at time of assessment. Collaboration team member signs prior to form being sent to physician for review and completion.

Distribution: Send LOC page, addendum to medication list (if applicable) and CCP to physician for review and completion. Upon return from physician, maintain original in client file and send copies to each provider providing services to the client and Level of Care page to DFCS if client is MAO or PMAO.

NOTE on instruction 23 (above): The signature of the collaborating team member is only required when the assessment is performed by an LPN or the service addition is made by a staff member other than an RN. (Rev 1/2015)

Enter the estimated cost per month for the service to be provided. In the Cost column record the Medicaid rate. Calculate cost per month by multiplying rate per unit of service by number of units provided (for example: ALS \$31.04 x 30 units per month = \$931.20. Use current provider rates to determine cost per month. *If total cost of client services is expected to exceed cost cap consistently, client is not appropriate for CCSP.* For non-CCSP services leave estimated cost blank.

APPENDIX H
Georgia Department of Human Services

Alzheimer's Disclosure Form

General Information/Background

During the 1994 session of the Georgia General Assembly, Title 31 of the Official Code of Georgia Annotated was amended to include a new article (number 7), requiring facilities, programs, or entities advertising specialized care for persons with a probable diagnosis of Alzheimer's disease or related dementia to provide written disclosure of information related to staffing, training, activities, involvement with the family, and program costs, among others. The Act requires that this information be provided to any person seeking information concerning placement in or care, treatment, or therapeutic activities from the program.

Which Organizations Must Complete This Form

Any program, facility, entity or any instrumentality of the state or political subdivision of the state other than those excluded by Code Section 31-8-181 (Disclosure of Treatment of Alzheimer's Disease or Alzheimer's Related Dementia) which advertises, markets, or offers to provide specialized care, treatment, or therapeutic activities for one or more persons with a probable diagnosis of Alzheimer's Disease or Alzheimer's-related dementia is required to complete this form. The Act does not apply to physicians or their employees. However, if a physician operates, manages, owns or controls a nursing home, personal care home, hospice, respite care service, adult day program or home health agency, the entity is still required to make the disclosure. Hospitals are exempt from the disclosure requirement. However, a hospital's nursing home, respite care service, adult day program, or home health agency is required to make the disclosure if it holds itself out as providing specialized care for persons with Alzheimer's Disease or Alzheimer's-related dementia.

Instructions

Please complete this form in the spaces provided and provide copies of this form to any person seeking information concerning placement in or care, treatment, or therapeutic activities for persons with Alzheimer's Disease or Alzheimer's-related dementia. **Information requested must be completed on this form, unless otherwise indicated.** This form must be revised whenever significant changes occur.

Failure to provide disclosure as required shall be considered a violation of Part 2 of Article 15 of the Chapter 1 of Title 10, the Fair Business Practices Act of 1995, and could result in a civil penalty of up to a maximum of \$2,000 per violation, per day. If the facility providing specialized care for persons with a probable diagnosis of Alzheimer's Disease fails to provide the Disclosure Form or the information contained within is inaccurate, contact:

The Administrator
Governor's Office of Consumer Affairs
2 Martin Luther King Jr., Drive, Suite 356
Atlanta, GA 30334
(404) 656-3790
Facsimile (404) 651-9018

Name of Program, Facility, or Entity: _____

Address: _____

Phone Number: _____ Date Completed _____

For further information regarding this program, contact _____
(specify phone number). _____

.....

Section 1: Philosophy and Mission

Describe the overall philosophy and mission which reflects the needs of people with Alzheimer's Disease or related dementias. (Useful information might include type of license, permit or accreditation, or name of monitoring agency).

.....

Section 2: Admission and Discharge Requirements

Admission

Please attach a copy of the admission application form. If there is no form, please describe how the facility or program obtains information on physical status, mental status, functional ability, and medication profile of the person with dementia.

What is the title of the staff member who performs the assessment for admission?

Discharge

Does the facility/program have written criteria related to discharge? Yes ____ No ____ (If yes, attach copy).

Are family members provided a copy of discharge criteria? Yes ____ No ____

Describe any circumstances under which a person can be discharged without notice: _____

Is the family informed of discharge? Yes ____ No ____

.....

Section 3: Defining Programs/Services

If applicable, describe how the facility or program develops care plans to meet individual needs of people with dementia.

(Useful information might include whether a person needs assistance with activities of daily living (ADL's): activities that address level of functioning; level of supervision needed; frequency of care plan updates; involvement of families in care plan development; or the credentials of the staff person who develops the care plan).

What are the Alzheimer's specific qualifications of the person(s) that develops the individualized care plans?

Are families consulted in the preparation of individualized care plans? Yes ____ No ____

How often are clients re-evaluated: _____
.....

Section 4: Training/Staffing

Is training provided to new employees regarding Alzheimer's Disease and other dementias? Yes ____ No ____

Describe the training for your staff that enables them to provide the specialized programs and services your organization provides for persons with dementia. (Example: Music Therapy for persons with Alzheimer's Disease. *Attach copy of the training plan if available.* Useful information might include topics of training sessions: hours of initial training; frequency of in-service training; credentials of employee trainers.)

Additional questions for nursing homes, personal care homes, adult day programs, and other programs where applicable:

What is the program's ratio of staff to persons with dementia? _____

If applicable, how does this ratio differ from the program's ratio of staff to clients for non-dementia persons?

.....

Section 5: Description of the Physical Environment

Describe the physical environment of the facility, if applicable. (Useful information might include amount of privacy provided; enclosed outdoor area for walking; safety features of the building; frequency of fire or disaster drills; building

modifications to create soothing atmosphere; visions' policy). _____

.....

Section 6: Frequency and Types of Activities

What special activities are planned for participants with dementia? (List activities in this space or attach a copy of activity calendar as a supplement if desired). _____

.....

Section 7: Family Support Programs

Describe any programs, services or activities provided to family members or friends or members of clients with dementia. (Useful information might include ways these programs complement your care/treatment/activities: support groups, information and referral; care plan conferences; social functions or other activities.)

.....

Section 8: Charge Structure

Specify the name and phone number of the staff person who can provide information regarding fees, AND attach a copy of any fees to the potential participant, family, or other decision maker (e.g., guardian). Include basic and any potential supplementary charges, including support services (e.g., occupational therapy, physical therapy, speech therapy, incontinence supplies, vision and hearing aids, dental, laundry, etc.).

How often is a copy of a list of incurred, itemized expenses provided to the client or their family? (Please specify)

When an increase in charges occurs, how much advance notice does the program/facility provide to clients and their families? _____

What is the policy regarding non-payment or late payment? Specify penalties, etc. _____

Alzheimer's Disclosure Form

Glossary of Terms

Accreditation - assurance by public or private agency that a facility, program, or entity meets standards which are separate from and in addition to any applicable state licensure requirements. Accreditation may include both 1) assurance that a facility, program, or entity meets standards of quality set forth by the accrediting agency (e.g., Joint Commission on Accreditation of Health Organizations {JCAHO} and 2) assurance that a facility, program, or entity meets standards necessary to qualify for the receipt of funds from the accrediting agency (e.g., the Division of Medical Assistance for Medicaid, Health Care Financing Administration (HCFA) for Medicare).

Alzheimer's Disease - A progressive neurodegenerative disease characterized by loss of function and death of nerve cells in several areas of the brain, leading to loss of cognitive function such as memory and language. The cause of this nerve cell death is unknown. Alzheimer's disease is the most common type of dementia.

care plan - a determination by a social worker or nurse of the problems and needs of the client based on information obtained during assessment and observations of individual functional capabilities. In addition, care plans include what service(s) are needed to meet client needs, set goals toward which to work, and indicate specific, expected changes in client capabilities at a specific future time as a result of services implemented.

client - in this document, the person with dementia who is receiving specialized Alzheimer's services.

dementia - the loss of intellectual functions (such as thinking, remembering, and reasoning) of sufficient severity to interfere with an individual's daily functioning. Dementia is not a disease itself, but rather a group of symptoms which may accompany certain diseases and conditions. Symptoms also include changes in personality, mood, and behavior. Dementia is irreversible when caused by disease and injury, but may be reversible when caused by drugs, alcohol, hormone or vitamin imbalances, or depression.

resident - in this document, a person with dementia who makes his/her home in a nursing home or personal care home.



DHS
GEORGIA
DEPARTMENT OF
HUMAN RESOURCES

Form 5534 (2-97)

Appendix I - COMMUNITY CARE NOTIFICATION FORM (CCNF), FORM 6500

(Complete all the information below; this is needed for correct entry into our system)

1. Mark (X) the appropriate box to indicate the reason for sending CCNF:
 Initial Change Complaint/Concern Transfer Discharge Other _____

2. To: _____ Date: _____

3. From: _____ Telephone: _____
 (Agency Name)

4. Client Name: _____ Medicaid #: _____ AIMS ID: _____

Check if new address Client Address: _____

City: _____ Zip: _____ County: _____ Telephone: _____ New Number

5. SERVICES: PSS PSSX ERS ALS ADH (HALF, FULL)(LEVEL I, LEVEL II) HDM
 SNS (RN, LPN) HDS OHR COMMENTS: _____

6. Date your RN/Staff completed initial evaluation with client: _____ ***(Must be RN for ALS, ADH and PSS/X)***
 Services were accepted Services were not accepted – REASON: _____

7. Date services began: _____ ***(Please fill in frequency grid below #12 for PSS, PSSX, ADH, MEALS {delivery day and quantity})***

8. Service Issues: (Check below and clarify in #13 please)
 Request service increase Failure to pay cost share Fall/Incident
 Request service decrease Client termination Client had ER visit, WHERE _____
 Requested provider change Health/Safety Issue Client in hospital, NAME _____
 Request for information Client out of home
 Other: _____

9. Discharge (briefly describe actions leading up to need for discharge process): _____

10. Date discharge (30-day) letter sent _____ Actual discharge date _____ Last day of service _____

11. Are services continuing through 30-day notice? Yes No ***Please enter final monthly units below***
 FINAL UNITS PSS PSSX ADH ERS HDM ALS RN LPN OHR

12. SERVICE FREQUENCY: Weekly Monthly Bi-Monthly

INITIAL OR CURRENT SERVICES IN HOME

WEEKDAY	UNITS ONCE DAILY	AM UNITS	PM UNITS	BEGIN DATE	END DATE
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					

UNIT CHANGE

WEEKDAY	UNITS ONCE DAILY	AM UNITS	PM UNITS	BEGIN DATE	END DATE
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					

13. If complaint or concern, be specific _____

14. Sender name or signature: _____ Title: _____ Date: _____ Email: _____

15. Recipient name or signature: _____ Title: _____ Date: _____ Email: _____

16. Recipient response: _____

Revised 02/14

Instructions
Community Care Services Program

Appendix I - COMMUNITY CARE NOTIFICATION FORM (CCNF), *Electronic* FORM 6500

Purpose: Providers and care coordinators use the CCNF to share information about clients.

Who Completes/When Completed: Provider and care coordinators use CCNF to advise each other regarding client services and other information, such as hospitalization, death, and other changes.

Instructions:

1. Use a check (X) mark to indicate the reason for completion of the CCNF.
2. Enter the individual's name to whom the CCNF is being sent and the date.
3. Enter the name and telephone number including area code of the agency completing the CCNF.
4. Enter the complete client name, Medicaid number and AIMs identification number (if available). Use an X to indicate if "new" address for client. Document the client's full address, including county, and telephone number including the area code. Use an X to check the box if the client's telephone number is a "new" telephone number.
5. Using check box, indicate the service type(s) of the waiver service(s) to which this communication relates and document any comments needed to provide additional clarity.
6. Enter date that provider RN or staff member completed the initial evaluation of client and use check box to indicate whether or not services were accepted. If services were not accepted; then, document the reason.
7. Complete the date that services began and complete the frequency grid in item #12 for PSS, PSSX, ADH, Meals (dates service provided and number of units)
8. Document service issues using check boxes and clarify, as needed, in #13.
9. Document item with a description of the events/actions which led to discharge.
10. Enter date that the discharge letter was sent and indicate whether services are continuing through the 30 day notice.
11. Document the actual date that the client was discharged from service and the last date of service prior to discharge and final units for the month of discharge.

12. Document service frequency and complete the table to indicate the **initial** or **current** services and the table which indicated the changes in units and frequency for the new service(s).

13. If sending a CCNF because of a complaint or concern, give specific details

14. Sender completes name or signature, title, and the date the form was completed.

15. Recipient completes name or signature, title, and records the date on the form.

16. Note any recipient response to the CCNF.

Distribution: If the Provider initiates the CCNF, the provider sends the original to the care coordinator electronically and the Care Coordinator reviews and returns CCNF electronically within three business days. Likewise, if the Care Coordinator initiates the CCNF the original, the Care Coordinator sends it electronically to the provider and the provider returns the original CCNF electronically within three business days. Providers and care coordinators print a copy and file it in client case record.

APPENDIX J

Last Update Date

DCH – Division of Medicaid
Community Care Services Program
Service Authorization Form

Print date:

Print time:

Case Manager:

Client Name:

SAF #:

Version

Medicaid #:

SSN:

Date of Birth:

County:

Services Begin Date:

Services End:

SAF Month:

Reason:

Provider ID

Procedure

Rate

Units

Amount

Net Amount

Gross Total:

Client Liability

Net Total:

Authorization and Approval

Case Manager:	Phone No:
---------------	-----------

Authorizing Signature: _____ Date: ____/____/____

_____ Authorization and Approval _____

This service authorization has been Pended until
A DMA-80 number has been approved by the GA Department of Community Health's Medicaid Division

Case Manager:	Phone #:
---------------	----------

Appendix K Client Care Plan

APPENDIX K

1. Client Name: _____ 2. Medicaid #: _____ 3. Provider Agency: _____
4. Medicaid Diagnosis: _____ 5. Service Provider: ___ ADH ___ ALS ___ PSS ___ RC ___ HDS
6. Physician's Name: _____ 7. Effective Dates: _____ to _____

8. Problem	9. Approach	10. Goal	11. Target Date	12. Agency/Person(s) Providing Services	13. Date

14. Discharge Plans:

15. Provider R.N.: _____ 16. Date: _____

(Signature)

INSTRUCTIONS FOR COMPLETING CLIENT CARE PLAN

1. **Client's Name:** Copy as appears on #2 of the Comprehensive Care Plan or #5 on the Client Assessment.
2. **Medicaid #:** Copy from #8 on the Comprehensive Care Plan or #9 on the Client Assessment.

Rev. 10/02

Note: A potential MAO client will NOT have a Medicaid card.

3. **Provider Agency:** Your agency's name.
4. **Medical Diagnosis:** Copy from Client Assessment Instrument.
5. **Service Provider:** Type of CCSP service you are providing to the client.
6. **Physician's Name:** Client's physician's name.
7. **Effective Dates:** The INITIAL date is the date you admit the client for service TO the date of the next RN supervisory visit. Client Care Plan is be reviewed/revised by the provider's R.N. during each supervisory visit.

Rev.
07/10

EXCEPTION: ALS and ADH review is every 30 days.

8. **PROBLEM:** Refer to #11 on the Comprehensive Care Plan plus your own observations of client's status.
9. **APPROACH:** Indicate how you intend to address the specific problem/need. (Example: if the ALS Client needs assistance with bathing, your "approach" might be to provide ALS personal care services).
10. **GOAL:** The goal should address the specific problem(s) that the client has. (Example: the goal for the ALS Client in the above example could be to "promote good personal hygiene").
11. **TARGET DATE:** If the APPROACH calls for a specific time frame, indicate that time frame here. (Example: if a client is non-compliant with medications and the provider is spending a specific period to time teaching the client how to competently self-administer medications, indicate the time frame).
12. **AGENCY/PERSONS(S) PROVIDING SERVICES:** Your agency name - if specific staff person, note name.
13. **DATE:** Refers to time frame for achieving GOALS (number 11. above). Example: for the ALS Client referred to above who is to receive assistance with bathing, the DATE would be "on-going" after the initial date was entered when the provider began giving service).

14. **Discharge Plans:** It is the provider's responsibility to plan with the client and/or the client's family what will occur if the client is no longer appropriate for service with the provider. Refer to Section 606.6 and 606.7 of the Policies and Procedures for CCSP for discharge planning information.
15. **Provider R.N. (signature):** The provider's R.N. signs every Client Care Plan to document the review frequency (i.e., every 60-62 calendar days or every 30 days depending on the service).
16. **Date:** The provider's R.N. dates every Client Care Plan.

Georgia Department of Community Health

Name of Individual/Consumer/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by
Requesting Agency

ID Number Used by
Releasing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize:

(Name of Person or Agency Requesting Information)

(Address)

to obtain from:

(Name of Person or Agency Holding the Information)

(Address)

the following type(s) of information from my records (and any specific portion thereof):

for the purpose of:

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)

ninety (90) days unless I specify an earlier expiration date here: _____

one (1) year. _____ (Date)

the period necessary to complete all transactions on matters related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

(Date)

(Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness)

(Title or Relationship
to Individual)

(Signature of Parent or other legally Authorized
Representative, where applicable)

(Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual)

(Signature of Individual or legally authorized Representative)

APPENDIX M

UTILIZATION REVIEW/APPEAL PROCESS

<p>If Recommendation is <u>Decrease in Services</u></p> <p>The Utilization Review (UR) analyst will visit the Community Care recipient in the home or ADH center (after chart review at agency) and recommend reduction in service.</p> <p>The report, with recommendations, is received at DMA. DMA reviews UR worksheets and if it concurs with the recommendations regarding decreases in services, a letter is sent to the recipient with a copy to the DCH Legal Services Office and the local county Department of Family and Children Services. The letter notifies the recipient of DMA's intent to reduce services. The letter includes steps the recipient must take to obtain a hearing and specific instructions for the recipient to notify the care coordinator of the intent to appeal.</p> <p>DFCS will assist the recipient if a hearing is requested (notify DHS Legal Services Office).</p> <p>The DHS Legal Services Office will notify DMA if the recipient appeals and of the date and location of the hearing.</p>	<p>If Recommendation is <u>Discharge from Services</u></p> <p>The Utilization Review (UR) analyst will visit the Community Care recipient in the home or ADH center (after chart review at the agency) and recommend discontinuation of services.</p> <p>The report, with recommendations, is received at DMA. DMA reviews UR worksheets and if it concurs with the recommendations regarding discontinuation of services, a letter is sent to the recipient with a copy to the CCSP Unit, DCH Legal Services Office and county Department of Family and Children Services. The letter notifies the recipient of DMA's intent to discontinue services. It includes steps the recipient must take to obtain a hearing and specific instructions for the recipient to notify the care coordinator of the intent to appeal.</p> <p>If an MAO recipient does not request a hearing within ten (10) calendar days of receipt of the letter, the care coordinator informs DFCS to terminate eligibility.</p> <p>DFCS will assist the recipient if a hearing is requested (notify DHS Legal Services Office).</p> <p>The DHS Legal Services Office will notify DMA if the recipient appeals and of the date and location of the hearing.</p>
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APPENDIX N

Designating a Representative

CCSP clients have the option of designating a representative to assist, at the client's direction, in matters of health, well-being, and access to records, information, or notices regarding client care. Designating a representative is optional. If the client has a Durable Power of Attorney for Health Care currently in effect, the client should not designate a representative.

Representative is defined as a person who voluntarily, with the client's written authorization, may act upon the client's direction with regard to matters concerning the health and welfare of the client, including being able to access personal records contained in the client's file and receive information and notices pertaining to the client's overall care and condition. Neither the care coordinator nor a member of the provider's family, governing body, administration, or staff may serve as the representative for the client.

Designating a Representative

I, _____, authorize
(Client's Name)

_____ as my representative
(Representative's Name)

(Representative's Address)

(_____) _____
(Representative's Telephone Number)

To act on my direction in matters of:

_____ Health and Well-Being

_____ Access to any records pertaining to me or my care

_____ Receiving information and notices pertaining to my care and condition

Signed: _____ Date _____

I choose not to designate a representative at this time

Signed _____ Date _____

Client Consent for Medical Treatment

CCSP clients who have not designated a client representative, or do not have a legal guardian are subject to the following law concerning consent for medical treatment:

O.C.G.A. 31-9-1 Consent for Surgical or Medical Treatment
--

31-9-1. Short title.

This chapter shall be known and may be cited as the Georgia Medical Consent Law. (Code 1933, ' 88-2901), enacted by Ga. L. 1971, p.438, '1.)

31-9-2. Persons authorized to consent to surgical or medical treatment.

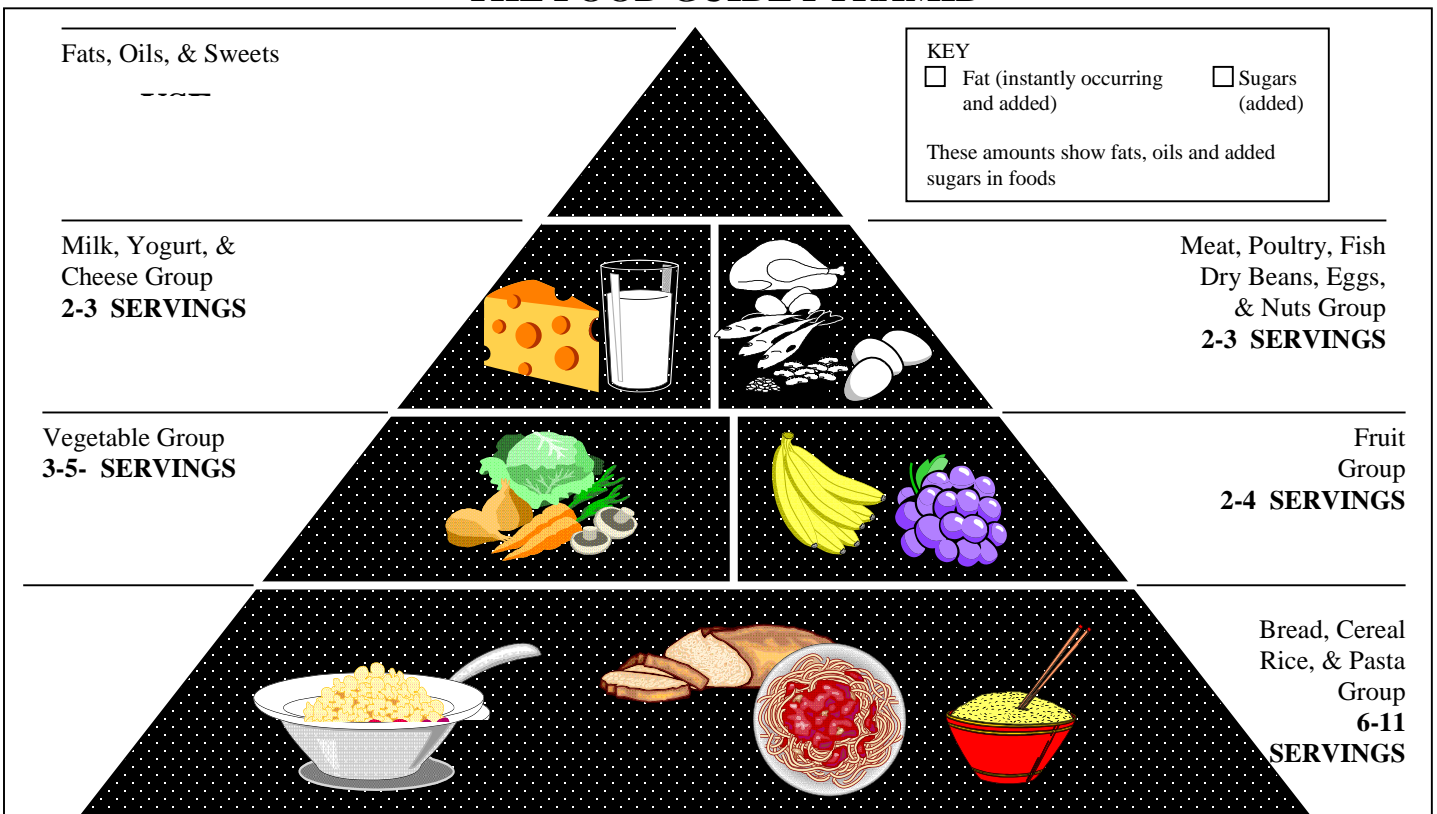
- (a) In addition to such other person as may be authorized and empowered, any one of the following persons is authorized and empowered to consent, either orally or otherwise, to any surgical or medical treatment or procedures not prohibited by law which may be suggested, recommended, prescribed, or directed by a duly licensed physician:
- (1) Any adult, for himself, whether by living will or otherwise;
 - (1.1) Any person authorized to give such consent for the adult under a health care agency complying with Chapter 36 of Title 31, the Durable Power of Attorney for Health Care Act;
 - (2) In the absence or unavailability of a living spouse, any parent, whether an adult or a minor, for his minor child;
 - (3) Any married person, whether an adult or a minor, for himself and for his spouse;
 - (4) Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his care; and any guardian, for his ward;
 - (5) Any female, regardless of age or marital status, for herself when given in connection with pregnancy, or the prevention thereof, or childbirth;
 - (6) Upon the inability of any adult to consent for himself and in the absence of any person to consent with paragraph (2) through (5) of this subsection the following person in the following order of priority:

- (A) Any adult child for his parents;
 - (B) Any parent for his adult child;
 - (C) Any adult for his brother or sister; or
 - (D) Any grandparent for his grandchild.
- (b) Any person authorized and empowered to consent under subsection (a) of this Code section shall, after being informed of the provisions of this Code section, act in good faith to consent to surgical or medical treatment or procedures which the patient would have wanted had the patient understood the circumstances under which such treatment or procedures are provided.
- (c) For purposes of this Code section, inability of any adult to consent for himself shall mean a determination in the medical record by a licensed physician after the physician has personally examined the adult that the adult lacks sufficient understanding or capacity to make significant responsible decisions regarding this medical treatment or the ability to communicate by any means such decisions. (Code 1993, ' 88-2904, enacted by Ga. L. 1971, p. 438, ' 1; Ga. L. 1972, p. 688, ' 1; Ga. L. 1975, p. 704, ' 2; Ga. L. 1991, p. 335, ' 1.)

31-9-3. Emergencies

- (a) As used in this Code section, the term emergency means a situation wherein (1) according to competent medical judgement the proposed surgical or medical treatment or procedures are reasonably necessary and (2) a person authorized to consent under Code Section 31-9-2 is not readily available, and any delay in treatment could reasonably be expected to jeopardize the life or health of the person affected or could reasonably result in disfigurement or impaired faculties.
- (b) In addition to any instances in which a consent is excused or implied at law, a consent to surgical or medical treatment or procedures suggested, recommended, prescribed, or directed by a duly licensed physician will be implied where an emergency exists (Code 1933, ' 88-2905, enacted by Ga. L. 1971, p. 438, ' 1).

APPENDIX O THE FOOD GUIDE PYRAMID



SOURCE: U.S. Department of Agriculture/U.S. Department of Health and Human Services

What Counts as a Serving?

With the Food Guide Pyramid, what counts as a "serving" may not always be a typical "helping" of what you eat. Here are some examples of servings:

Bread, Cereal, Rice & Pasta - 6-11 servings recommended

Examples of one serving:

- 1 slice of bread
- 1 oz. Of ready-to-eat cereal
- 1/2 cup of cooked cereal, rice, or pasta
- 3 or 4 small plain crackers

Vegetables - 3-5 servings recommended

Examples of one serving:

- 1 cup of raw leafy vegetables
- 1/2 cup of other vegetables, cooked or chopped raw
- 3/4 cup of vegetable juice

Fruits - 2-4 servings recommended

Examples of one serving:

- 1 medium apple, banana, or orange
- 1/2 cup of chopped, cooked, or canned fruit
- 3/4 cup of fruit juice

Milk, Yogurt, and Cheese - 2-3 servings recommended

Examples of one serving:

- 1 cup of milk or yogurt
- 1 1/2 oz. Of natural cheese
- 2 oz. of process cheese

Meat, Poultry, Fish, Dry beans, Eggs and Nuts

- 2-3 servings recommended

Examples of one serving:

- 2-3 oz. of cooked lean met, poultry, or fish
- 1/2 cup of cooked dry beans, 1 egg, or 2 table-
spoons of peanut butter = 1 oz. of lean meat

How Much Is an Ounce of Meat?

Here's a handy guide to determining how much meat, chicken, fish, or cheese weigh:

1 ounce is the size of a match box.

3 ounces are the size of a deck of cards.

8 ounces are the size of a paperback book.

The Food Guide Pyramid-Putting the Dietary Guidelines Into Action

Learning to eat right is now made simpler with the new Food Guide Pyramid by the U.S. Department of Agriculture (USDA). The Pyramid is a graphic description of what registered dietitians and other nutrition experts have been advising for year:

Build your diet on a base of grains, vegetables, and fruits. Add moderate quantities of lean meat (poultry, fish, eggs, legumes) and dairy products, and limit the intake of fats and sweets.

The Food Guide Pyramid illustrates how to turn the Dietary Guidelines for Americans (issued by USDHHS/USDA in 1990) into real food choices.

The Dietary Guidelines--and their relationship to the Food Guide Pyramid--are as follows:

- **Eat a variety of foods.** The body needs more than 40 different nutrients for good health, and since no single food can supply all these nutrients, variety is crucial. Variety can be assured by choosing foods each day from the five major groups shown in the Pyramid: (1) Breads, Cereals, Rice & Pasta (6-11 servings); (2) Vegetables (3-5 servings); (3) Fruits (2-4 servings); (4) Milk, Yogurt & cheese (2-3 servings); (5) Meat, Poultry, Fish, Dry Beans, Eggs & Nuts (2-3 servings) and (6) Fats, Oils and Sweets (use sparingly).

- **Maintain healthy weight.** Being overweight or underweight increases the risk of developing heart problems, so it is important to consume the right amount of calories each day. The number of calories needed for ideal weight (which varies according to height, frame, age, and activity) will generally determine how many servings in the Pyramid are needed.

- **Choose a diet low in fat, saturated fat, and cholesterol.** As shown in the Pyramid, fats and oils should be used sparingly, since diets high in fat are associated with obesity, certain types of cancer, and heart disease. A diet low in fat also makes it easier to include a variety of foods, because fat contains more than twice the calories of an equal amount of carbohydrates or protein.

- **Choose a diet with plenty of vegetables, fruits, and grain products.** Vegetables, fruits, and grains provide the complex carbohydrates, vitamins, minerals, and dietary fiber needed for good health. Also, they are generally low in fat. To obtain the different kinds of fiber contained in these foods, it is best to eat a variety.

- **Use sugars only in moderation.** Sugars, and many foods containing large amounts of sugars, supply calories but are limited in nutrients. Thus, they should be used in moderation by most healthy people and sparingly by those with low calorie needs. Sugars, as well as foods that contain starch (which breaks down into sugars), can also contribute to tooth decay. The longer foods containing sugars or starches remain in the mouth before teeth are brushed, the greater the risk for tooth decay. Some examples of foods that contain starches are milk, fruits, some vegetables, breads, and cereals.

- **Use salt and sodium only in moderation.** Table salt contains sodium and chloride, which are essential to good health. However, most Americans eat more than they need. Much of the sodium in people's diets comes from salt they add while cooking and at the table. Sodium is also added during food processing and manufacturing.

- **If you drink alcoholic beverages, do so in moderation.** Alcoholic beverages contain calories but little or no nutrients. Consumption of alcohol is linked with many health problems, causes many accidents, and can lead to addiction. Therefore, alcohol consumption is not recommended.

Adapted from *At the Center*. National Center for Nutrition and Dietetics. Chicago, IL. Summer 1992.

APPENDIX P

Rev. 10/09, 01/10

POTENTIAL CCSP MAO FINANCIAL WORKSHEET

Client's Name _____ Date of Birth _____

Section I.	<u>INCOME</u>	<u>AMOUNT</u>
	Social Security	\$ _____
	VA Benefits	\$ _____
	Retirement/Pension	\$ _____
	Interest/Dividends	\$ _____
	Other (specify)	\$ _____
	<u>TOTAL INCOME</u>	\$ _____

NOTE: If monthly income exceeds the Medicaid Cap, stop here and refer client to DFCS for information about a Medicaid Qualifying Trust.

Section II.	<u>RESOURCES</u>	<u>ESTIMATED VALUE</u>
	Cash	\$ _____
	Checking Account	\$ _____
	Savings Account	\$ _____
	Credit Union Account	\$ _____
	Certificate of Deposit or IRA \$ _____	\$ _____
	Stocks or Bonds	\$ _____
	Patient Fund Account (held by nursing home)	\$ _____
	House or property other than home- place that is not producing income	\$ _____
	Face Value of Life Insurance Policies	\$ _____
	Burial Contract	\$ _____
	Other (specify)	\$ _____
	<u>TOTAL RESOURCES</u>	\$ _____
	Subtract Individual or Spousal Impoverishment Resource Limit	_____

NOTE: Use the Spousal Impoverishment Resource Limit when one spouse is in CCSP and the other is not in CCSP, nursing home or other institutional living arrangement.

List any resource (including home place) where ownership has been transferred in the last 60 months:

Section III. Statement of Intent: Cost Responsibility

I have applied for services through the Community Care Services Program. I am aware that I am responsible for the cost of services under the Community Care Services Program until the Department of Family and Children services determines my eligibility for Medicaid and cost share amount. I understand that I must apply for CCSP Medicaid benefits through the county Department of Family and Children

Services (DFCS). If DFCS determines that I have to pay a cost share, I will pay the monthly cost share to the appropriate provider(s). While waiting for DFCS to determine my cost share amount, I agree to pay the appropriate provider(s) the full cost of services or the ESTIMATED cost share indicated on the line below, whichever the provider chooses.

\$ _____
ESTIMATED COST SHARE: Based on the information provided by the client/representative, this is an estimate of the client cost share. This estimated cost share was discussed with the client/representative. They agree to apply for CCSP Medicaid at DFCS, and understand the DFCS will determine Medicaid eligibility and exact cost share amount.

ALL THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

(Client / Client Representative's signature)

(Date)

This form is not an application for Medicaid benefits. The care coordinator will advise you when to apply for Medicaid.

Care Coordinator

(Date)

Rev. 02/07

INSTRUCTIONS

Community Care Services Program

**POTENTIAL CCSP MEDICAL ASSISTANCE ONLY (MAO) FINANCIAL
WORKSHEET**

Purpose: The Financial Worksheet is completed at the initial assessment of MAO or PMAO clients and when a change in income or resources may affect eligibility for the CCSP.

Who Completes/When Completed: The RN completes at the initial assessment. The care coordinator completes thereafter when income or resources change.

Instructions:

Section I. Income--record total income reported by client.

Section II. Resources--record client's statement of all resources based on current market value and total.

Section III. Statement of Intent:- Cost share Responsibility -- Explain cost share responsibility to client and include information that DFCS determines the cost share amount. Give client written information about Medicaid and DFCS. Indicate the estimated cost share and discuss with client.

Distribution: Send a copy of this form to DFCS with the CCC and LOC. File the original in the client's case record.

APPENDIX Q

INFECTION CONTROL PROCEDURES

The CCSP provider staff must observe the following procedures in the provision of services to prevent exposure to infectious disease. These procedures are universal precautions to prevent the spread of infectious diseases.

All blood and body fluids visible with blood are to be treated as potentially infectious. Wash hands and other skin surfaces immediately and thoroughly if soiled with blood or body fluids, and **change gloves after contact with each client.** Wash hands before and after giving care to clients.

A. Wear latex gloves when:

1. Touching blood/body fluids, mucous membranes, or non-intact skin.
2. Handling items or surfaces soiled with blood/body fluids visible with blood.
3. Performing venipuncture and other vascular access procedures.
4. Cleaning and decontaminating spills of blood/body fluids.
5. Although no diseases are known to be spread by direct skin contact with feces or other body fluids, gloves should be worn when having contact with feces and any body fluids as a basic hygiene measure.

B. Standard housekeeping cleaning procedures to be used.

1. For spills of blood and body fluids, wipe up spill with soap and water and then disinfect area with a commonly used germicide or freshly prepared 1:10 bleach solution (1 part bleach to 10 parts water).
2. All soiled linen should be bagged at the location where it was used; it should not be sorted or rinsed in client-care areas. Linen soiled with blood or body fluids should be placed and transported in bags that prevent leakage.
3. Linens and personal clothing items laundered should be washed using routine laundering procedures.
4. Dish washing using routine cleaning procedures effectively destroys pathogenic (disease causing) organisms. Dishes of clients with hepatitis B or AIDS do not need to be separated from the rest of the facility clients. Do not share unwashed utensils or use common drinking glasses with any client.

C. Environmental procedures to be used:

1. Use a gown or apron during procedures that are likely to generate splashes of blood or other body fluids. Universal precautions also recommend the use of masks/eye wear during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of the mucous membrane of the mouth and nose/eyes.
2. Dispose of secretions directly into the toilet. An individual toilet for a client is not required, but is recommended if the person has diarrhea.
3. Care should be taken to prevent injuries caused by needles and other sharp instruments or devices.
4. To prevent needle stick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, and other sharp items should be placed in puncture-resistant containers for disposal. The puncture-resistant containers should be located as close as practical to the use area.
5. Direct mouth-to-mouth contact is not recommended. It is recommended that mouthpieces, ventilation bags or other ventilation devices be kept in areas where the need is predictable. However, if such devices are not available an employee should not hesitate to provide CPR (Cardiopulmonary Resuscitation) procedures.

APPENDIX R

PRIOR AUTHORIZATION REQUEST
DMA-80 (6/87)

PRIOR AUTHORIZATION REQUEST*		<small>FOR DMA USE ONLY</small>		<small>PRIOR AUTHORIZATION NO.</small>			
GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE ATLANTA, GEORGIA 30334				Include This Number On All Claim Forms →	386740		
1. Recipient Name (Last, First, Init.)			2. Medicaid ID No.				
3. Birthdate	4. Sex	5. Address		6. Telephone (Area Code/Number) Nursing Home <input type="checkbox"/> Yes <input type="checkbox"/> No			
7. Prescribing Physician/Practitioner Name And Address			10. Provider Of Service(s) Name And Address				
8. Medicaid Provider Number		9. Telephone (Area Code/Number)		11. Medicaid Provider Number			
				12. Telephone (Area Code/Number)			
<input type="checkbox"/> HOME HEALTH <input type="checkbox"/> PODIATRIST <input type="checkbox"/> OPTOMETRIST <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PSYCHOLOGIST <input type="checkbox"/> DME/OP <input type="checkbox"/> DDS <input type="checkbox"/> PHARMACY							
13. Authorization Period: From _____ Through _____			14. Description Of Service(s) Requested		DEPT. USE ONLY		
					15. Rec. Type		
					16. Ctg. Of Svc.		
17. Primary Diagnosis Requiring Service(s)					18. ICD-9-CM		
19. Justification And Circumstances For Required Service(s) (Use separate page if necessary)							
STATEMENT OF SERVICE(S)							
LINE NO.	21. Description Of Procedures, Drugs, Equipment Or Other Services	22. Procedure/ Drug Code	23. Requested Or Estimated Price Per Unit	24. Bill Units	25. Months or Units Of Service	26. Units Per Claim Max. Min.	27. Max. Units Per Month
1							
2							
3							
4							
5							
6							
7							
8							
28. PROVIDER'S SIGNATURE _____					29. DATE SUBMITTED _____		
30. REQUEST: <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> PENDING/ADDITIONAL INFORMATION			31. DMA SIGNATURE _____		32. DATE APPROVED _____		
<input type="checkbox"/> APPROVED AS AMENDED							
33. Explanation to Provider							
<small>*Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program.</small> <small>DMA-80 (6-87) COPIES: WHITE: DMA; PINK: SERVICING PROVIDER; GREEN: RECIPIENT'S FILE; YELLOW: REQUESTING PROVIDER</small>							

APPENDIX S

REIMBURSEMENT RATES FOR CCSP

Continue using local codes until further notice.
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Procedure Codes

Local Code	Description	National Code	Description	Modifier	Rate
Y3801	Home Delivered Services; Nursing Visit	T1030	Nursing care, in home, by registered nurse	TD	Provider Specific (-Fifty-first unit of service)
Y3802	Home Delivered Services; Physical Therapy	S9131	Physical therapy, in home, per diem		Provider Specific Fifty-first unit of service
Y3803	Home Delivered Services; Speech Therapy	S9128	Speech therapy, in the home, per diem		Provider Specific fifty first unit of service
Y3804	Home Delivered Services; Occupational Therapy	S9129	Occupational therapy, in the home, per diem		Provider Specific Fifty-first unit of service
Y3805	Home Delivered Services; Medical Social Services	S9127	Social work visit, in the home, per diem		Provider Specific Fifty-first unit of service)
Y3806	Home Delivered Services; Home Health Aide	T1021	Home health aide or certified nurse assistant, per visit		Provider Specific Fifty-first unit of service)
Y3725	Adult Day Health Level I Full Day	S5102	Day care services, adult, per diem		\$50.45 per day minimum 5 hours
Y3726	Adult day Health Level I Partial Day	S5101	Day care services, adult, per half day		\$30.27 per day minimum 3 hours
Y3740	Adult Day Health; Physical Therapy	S9131	Physical therapy in the home, per diem; services delivered under an outpatient physical therapy plan of care	GP	\$44.15 per visit
Y3750	Adult Day Health; Speech Therapy	S9128	Speech therapy, in the home, per diem; services delivered under an outpatient speech therapy plan of care	GN	\$44.15 per visit
Y3790	Adult Day Health; Occupational	S9129	Occupational therapy, in the home, per diem; services	GO	\$44.15 per visit

Local Code	Description	National Code	Description	Modifier	Rate
	Therapy		delivered under an outpatient occupational therapy plan		
Y3827	Adult Day Health Level II Full Day	S5102	Day care Services, adult, per diem: intermediate level of care	TF	\$63.07 per day
Y3828	Adult Day Health Level II Partial Day	S5101	Day care services, adult, per half day; intermediate level of care	TF	\$37.85 per day
Y3617	Alternative Living Services - Group Model	T1020	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant); Group Setting	HQ	\$37.38 per day (Rev. 10/14)
Y3625	Alternative Living Services – Family Model	T1020	Personal care services, per diem, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant); Individualized service provided to more than patient in same setting	TT	\$37.38 per day (payment to the individual family model home must be no less than \$18.69 per day) (Rev. 10/14)
Y3600	Out of Home Respite (12 hours)	S5151	Unskilled respite care, not hospice, per diem; intermediate level of care	TF	\$42.57 per night minimum 12 hours
Y3715	Out of Home Respite (hourly)	S5150	Unskilled respite care, not hospice, per 15 minutes		\$3.00 per unit, 32 units (8 hours) maximum, 12 units minimum (3 hours)
Y3832	Personal Support Service	T1019	Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)		\$5.05 per 15 minute unit (not to exceed 10 units (2.5 hours) (Rev. 10/14)
Y3840	Extended Personal	T1019	Personal care services. Per 15	TF	\$4.49 per 15

Rev 01/10

Local Code	Description	National Code	Description	Modifier	Rate
	Support		minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant) intermediate level of care		minute unit for a minimum of 12 units (3 hours) (Rev. 10/14)
	Consumer Direction	T1019	Personal care services for PSS clients who are eligible and choose to participate in Consumer-Directed Care. Not for an inpatient or resident of a hospital, nursing facility, or ICF/MR	UC	\$4.80 for 15 minutes, or \$19.20 per hour (This service is billed at \$1 per unit.) (Rev. 1/15)
	Fiscal Intermediary	T2040	Financial Management Services for members participating in the Consumer Directed Option for Personal Support Services	UC	\$80.00 per unit for a maximum of one (1) unit per calendar month
Y3823	Emergency Response Monitoring (Monthly)	S5161	Emergency response system; service fee, per month (excludes installation and testing)		\$31.53 per month
Y3824	Emergency Response Monitoring (Weekly)	T2025	Emergency response system; waiver services; not otherwise specified (NOS)	U9	\$7.88 per week
Y3825	Emergency Response Installment	S5160	Emergency response system; installation and testing		Up to \$94.60 one installment
Y3831	Home Delivered Meals	S5170	Home Delivered Meals		\$6.58 per meal
Y3850	Skilled Nursing Services RN	S9123	Nursing care, in the home, by registered nurse, per diem		\$65.00 per visit
Y3851	Skilled Nursing Services LPN	S9124	Nursing care, in home, by licensed practical nurse, per diem		\$50.00 per visit

APPENDIX T

NON-EMERGENCY TRANSPORTATION BROKER SYSTEM

Non-Emergency Transportation

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?

If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, **you must contact the NET Broker serving the county you live in** to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, **call the Member CIC at 866-211-0950.**

Region	Broker Phone	Counties served
North	Southeastrans Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	Southeastrans 404-209-4000	Fulton, DeKalb and Gwinnett
Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	LogistiCare	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley,

	Toll free 1-888-224-7985	Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth
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APPENDIX U
CLIENT EMERGENCY INFORMATION FORM

Client's Name: _____

Medicaid Number: _____

Home Address _____

Home Telephone _____

Emergency transportation for treatment: -----

Advance Directive Information: _____

Medical Information	
Physician's Name:	
Physician's Telephone:	
Client's Hospital Preference:	
Known Medication Allergies/Pertinent Medical Information:	

Client Representative or Family Members/Emergency Contacts:

1. Name: _____ Telephone: (____) _____

Rev. Relationship: _____ Review Date: _____

10/01/03

Date: _____

2. Name: _____ Telephone: (____) _____

Rev. Relationship: _____ Review Date: _____

10/01/03

Date: _____

Appendix V – Revised April 1, 2013
CONTACT INFORMATION PSA Region • Area Agency on Aging • Care Coordination

<i>Planning & Service Area (Region #)</i>	<i>Area Agency on Aging Address/ Phone / E-Mail</i>	<i>Care Coordination Address/ Phone / E-Mail</i>
Atlanta Region (3) Cherokee Clayton Cobb DeKalb Douglas Fayette Fulton Gwinnett Henry Rockdale	Atlanta Regional AAA 40 Courtland Street, N.E. Atlanta, GA 30303-2538 (404) 463-3333 FAX (404) 463-3264 Toll Free: 1-800-676-2433 aginginfo@atlantaregional.com www.agewiseconnection.com	Visiting Nurse Health System CCSP Care Management Staff (VNHS) 5775 Glenridge Drive, NE Suite E375 Atlanta, GA 30328 (404) 222-2417 or (404) 222-2404 FAX (404) 527-8041 ON CALL: (404) 989-3413
Central Savannah River Area (8) Burke Columbia Glascocock Hancock Jefferson Jenkins Lincoln McDuffie Richmond Screven Taliaferro Warren Washington Wilkes	Central Savannah River AAA 3023 Riverwatch Parkway Suite A, Bldg 200 Augusta, GA 30907-2016 (706) 210-2013 Director Line (706) 210-2018 Aging Program FAX (706) 210-2006 Toll Free: 1-866-552-4464 www.csrarc.ga.gov	Sabea LLC 3506 A Professional Circle Martinez, Georgia 30907 (706) 860-6726 FAX (706) 447-3925 Toll Free: 1-800-371-1352 www.sabeacare.com
Coastal Georgia (12) Bryan Bulloch Camden Chatham Effingham Glynn Liberty Long McIntosh	Coastal Georgia AAA 1181 Coastal Dr. SW Darien, GA 31305 (912) 437-0800 FAX (912) 437-0856 Toll Free: 1-800-580-6860 www.crc.ga.gov	CCSP Care Coordination Unit Coastal Health District 420 Mall Boulevard Savannah, GA 31406 (912) 353-5001 or 1-888-698-2984 FAX (912) 692-4576 ON CALL: (912) 353-5001, press #5

Appendix V – Revised April 1, 2013
CONTACT INFORMATION PSA Region • Area Agency on Aging • Care Coordination

<i>Planning & Service Area (Region #)</i>	<i>Area Agency on Aging Address/ Phone / E-Mail</i>	<i>Care Coordination Address/ Phone / E-Mail</i>
<p>Georgia Mountains (2)</p> <p>Banks Stephens Dawson Towns Forsyth Union Franklin White Habersham Hall Hart Lumpkin Rabun</p>	<p>Legacy Link AAA P. O. Box 2534 Gainesville, GA 30503-2534 (770) 538-2650 FAX (770) 538-2660 Intake Screening: 1-800-845-5465 Physical Address: 508 Oak St., Ste 1, Gainesville, GA 30501 Website: www.legacylink.org</p>	<p>Legacy Link, Inc. (Mailing Address) 508 Oak Street, Suite 1 P.O. Box 2534 Gainesville, GA 30503</p> <p>Care Coordination (Physical Address) 465 EE Butler Pkwy Gainesville, Ga. 30501 770-538-2650 FAX (770) 538-2660 or (770) 538-2791 Toll Free: 1-800-845-LINK EMERGENCY NUMBER: (770) 538-2650 (770) 503-6513 (RN Backup)</p>
<p>Heart of Georgia Altamaha (9)</p> <p>Appling Montgomery Bleckley Tattnall Candler Telfair Dodge Toombs Emanuel Treutlen Evans Wayne Jeff Davis Wheeler Johnson Wilcox Laurens</p>	<p>Heart of Georgia Altamaha AAA 331 West Parker Street Baxley, GA 31513-0674 (912) 367-3648 FAX (912) 367-3640 Toll Free: 1-888-367-9913 www.hogarc.org</p>	<p>>Concerted Services P.O. Box 1965 2100 Riverside Avenue Waycross, GA 31501 (912) 285-6083 FAX (912) 285-6284</p> <p>>Concerted Services P.O. Box 1550 111 Medical Arts Drive Reidsville, GA 30453 (912) 557-6687 FAX (912) 557-3039 EMERGENCY NUMBER: (229) 868-8407</p> <p>>Concerted Services P.O. Box 562 305 South Richardson Street Mt. Vernon, Georgia 30445 (912) 583-3900 or 1-800-399-1302 FAX (912) 583-3919 EMERGENCY NUMBER: (229) 868-8407</p>
<p>Middle Georgia (7)</p> <p>Baldwin Peach Bibb Pulaski Crawford Putnam Houston Twiggs Jones Wilkinson Monroe</p>	<p>Middle Georgia AAA 175 Emery Highway, Suite C Macon, GA 31217-3679 (478)751-6466 FAX (478)752-3243 Toll Free: 1-888-548-1456 http://www.middlegeorgiarc.org/</p>	<p>Middle Georgia Care Coordination 2719 Sheraton Drive, Suite C-120 Executive Drive North Macon, GA 31204 (478) 752-3260 FAX (478) 752-1058 EMERGENCY #: (478) 973-9514</p>

Appendix V – Revised April 1, 2013
CONTACT INFORMATION PSA Region • Area Agency on Aging • Care Coordination

<i>Planning & Service Area (Region #)</i>	<i>Area Agency on Aging Address/ Phone / E-Mail</i>	<i>Care Coordination Address/ Phone / E-Mail</i>
<p>Northeast Georgia (5)</p> <p>Barrow Morgan Clarke Newton Elbert Oconee Greene Oglethorpe Jackson Walton Jasper Madison</p>	<p>Northeast Georgia AAA 305 Research Drive Athens, GA 30605 (706)369-5650 Fax: (706)425-2954 Toll Free: 1-800-474-7540 www.negrc.org</p>	<p>Northeast Georgia Community Care Services Program 1711 Prince Avenue Athens, GA 30606 (706) 354-1621 or 1-800-689-5123 FAX (706) 354-0837 EMERGENCY NUMBER: (706) 540-5934</p>
<p>Northwest Georgia (1)</p> <p>Bartow Murray Catoosa Paulding Chattooga Pickens Dade Polk Fannin Walker Floyd Whitfield Gilmer Gordon Haralson</p>	<p>Northwest Georgia AAA P.O. Box 1798 Rome, GA 30162-1798 (706) 295-6485 FAX (706) 295-6665 Toll Free: 1-800 -759-2963 Screening FAX (706) 802-5508 Physical Address: 1 Jackson Hill Dr., Rome, GA 30161 www.nwgrc.org</p>	<p>Floyd County Board of Health Community Care Services Program 101 E. 2nd Avenue, Suite 200 Rome, GA 30161-3137 (706) 295-6654 or 1-800-414-5221 FAX (706) 802-5059 or (706) 295-6564 or (706) 295-6631 EMERGENCY NUMBERS: 1-888-615-7733 or (706) 295-6654</p>
<p>River Valley (6)</p> <p>Chattahoochee Quitman Clay Randolph Crisp Schley Dooly Stewart Harris Sumter Macon Talbot Marion Taylor Muscogee Webster</p>	<p>River Valley AAA 1428 Second Avenue-P.O. Box 1908 Columbus, GA 31902-1908 (706) 256-2900 FAX (706) 256-2908 Toll Free: 1-800-615-4379 www.rivervalleyrcaaa.org</p>	<p>>Direct Service Corporation 1500 Second Avenue Columbus, GA 31901 (706) 321-9545 FAX (706) 596-8517 EMERGENCY NUMBER: 1-800-519-1393</p> <p>>Middle Flint Council on Aging 140 Georgia Highway 27 East Americus, GA 31709 (229) 928-2126 FAX (229) 924-0304 EMERGENCY NUMBER: 1-800-361-0709</p>

Appendix V – Revised April 1, 2013
CONTACT INFORMATION PSA Region • Area Agency on Aging • Care Coordination

<i>Planning & Service Area (Region #)</i>	<i>Area Agency on Aging Address/ Phone / E-Mail</i>	<i>Care Coordination Address/ Phone / E-Mail</i>
<p>Southern Georgia (11)</p> <p>Atkinson Cook Bacon Echols Ben Hill Irwin Berrien Lanier Brantley Lowndes Brooks Pierce Charlton Tift Clinch Turner Coffee Ware</p>	<p>Southern Georgia AAA 1725 South Georgia Parkway, West Waycross, GA 31503-8958 (912) 285-6097 FAX (912) 285-6126 Toll Free: 1-888-732-4464 www.sgrc.us/AAA</p> <p>Care Coordination Address/Phone/E-Mail: >Diversified Resources, Inc. P.O. Box 612 – 11097 North Main Street Nahunta, GA 31553 (912) 462-8449 FAX (912) 462-7817 EMERGENCY NUMBER/TOLL FREE: 1-866-903-7473 Counties: Brantley and Charlton</p> <p>>Diversified Resources, Inc. P.O. Box 7614 1411 U.S. Highway 41N Tifton, GA 31793 (229) 386-9296 FAX (229) 386-9271 EMERGENCY NUMBER/TOLLFREE: 1-800-575-7004 Counties: Ben Hill, Irwin, Tift, Turner, and Wilcox</p>	<p>>Diversified Resources, Inc. P.O. Box 1099 – 147 Knight Avenue Circle Waycross, GA 31502 (912) 285-3089 FAX (912) 285-0367 EMERGENCY NUMBER/TOLL FREE: 1- 800-283-0041 Counties: Atkinson, Bacon, Charlton, Clinch, Coffee, Pierce, and Ware</p> <p>>Diversified Resources, Inc. 2700-C N. Oak Street Valdosta, GA 31601 (229) 253-9995 FAX (229) 253-9930 EMERGENCY NUMBER/TOLL FREE: 1-800- 706-9674 Counties: Berrien, Brooks, Cook, Echols, Lanier, and Lowndes</p>
<p>Southwest Georgia (10)</p> <p>Baker Lee Calhoun Miller Colquitt Mitchell Decatur Seminole Dougherty Terrell Early Thomas Grady Worth</p>	<p>SOWEGA AAA 1105 Palmyra Road Albany, GA 31701-1933 (229) 432-1124 Fax: (229) 483-0995</p> <p>Toll Free: 1-800-282-6612 www.sowegacoa.org</p>	<p>1105 Palmyra Road Albany, GA 31701 (229) 432-1124 or 1-800-282-6612 FAX (229) 483-0995</p>

<i>Planning & Service Area (Region #)</i>	<i>Area Agency on Aging Address/ Phone / E-Mail</i>	<i>Care Coordination Address/ Phone / E-Mail</i>
<p>Three Rivers (4)</p> <p>Butts Pike Carroll Spalding Coweta Troup Heard Upson Lamar Meriwether</p>	<p>Southern Crescent AAA P.O. Box 1600 Franklin, GA 30217-1600 (706) 407-0016 or (678) 552-2853 FAX (706) 675-9210 or (770) 854-5402 Toll Free: 1-866-854-5652 Physical Address: 13273 Hwy. 34 East www.scaaa.net</p>	<p>>McIntosh Trail Management Services, Inc. P.O. Box 308 Meansville, GA 30256 (770) 567-5948 FAX (770) 567-5953</p> <p>>McIntosh Trail Management Services, Inc. P.O. Box 310 Franklin, GA 30217-0310 (706) 675-2985 or (706) 675-6495 FAX (770) 854-7431</p>

APPENDIX W

SUPPLEMENT TO PART II, CHAPTERS 600-1000, SECTION 602.1-602.3 RELATED TO CORRECTIVE ACTION

Roles and Responsibilities

Care Coordination Agency:

- ◆ Receives complaint
- ◆ Records on complaint log
- ◆ Note: CC Agency may refer the issue to the AAA for their action.
- ◆ Discusses with provider; requests written plan of correction within 10 days; documents contact with provider
- ◆ Reports to HFR (Personal Care Home or Home Health Section) if complaint is of regulatory nature
- ◆ Reviews plan of correction; determines if acceptable
 - Refers to AAA if not acceptable
- ◆ Documents if issue resolved, including date of resolution
 - Refers to AAA if not resolved
- ◆ Submits copy of complaint log to AAA at end of each month
- ◆ Tracks complaint logs to determine if providers have repeated complaints on complaint log; recommends to AAA removal from rotation list/suspension of client referrals
- ◆ Refers immediately to AAA and the CCSP Unit if complaint places client's health, safety and/or welfare at risk or in immediate jeopardy

Area Agency on Aging:

- ◆ Requests a meeting with provider to discuss issues/concerns/complaints; makes provider aware of seriousness of complaints and documents meeting as a verbal warning of need to correct issue
 - Additional complaints will result in written warning from AAA; if acceptable plan of correction is not submitted and/or if issue is not resolved, AAA may remove from rotation list/suspend client referrals
- ◆ Recommends further adverse action to the CCSP Unit if issues are not resolved after written warning and/or removal from rotation list/suspension of client referrals
- ◆ Receives and reviews complaint logs submitted by care coordination agency each month, submits complaint logs to the CCSP Unit by fifth (5th) working day of each month; determines if trends/patterns are occurring
- ◆ Tracks complaint logs to determine if providers have received repeated complaints on complaint log; repeated unresolved complaints indicate need to remove provider agency from rotation list/suspend client referrals
- ◆ Refers immediately to the CCSP Unit if complaint places client's health, safety, and/or welfare at risk or in immediate jeopardy

Rev.
10/01/03

Rev.
01/01/04

The CCSP Unit:

- ◆ Reviews complaint logs submitted each month by AAA; determines if trends/patterns have developed; when indicated reviews with AAA to determine if adverse action is indicated.
- ◆ If adverse action other than removal from rotation list/suspension of client referrals is indicated, requests supporting documentation (i.e., policies, procedures, incident reports, etc.) from Care Coordination Agency and/or AAA. Makes recommendation to DCH
- ◆ Instructs care coordination to re-broker services immediately if the health, safety, and/or welfare of clients is at risk or in immediate jeopardy and/or if allegations of abuse, neglect, and/or exploitation have been reported.
- ◆ Notifies DCH within 24 hours of re-brokering of services
- ◆ Refers appropriate complaints for investigation and resolution
- ◆ Notifies AAA and coordination Agency of resolution

Rev.
10/01/03

Provider Agency:

- ◆ Discusses complaint with Care Coordination Agency
- ◆ Submits written plan of correction to address issues
- ◆ Submits documentation to indicate issue has been resolved
- ◆ Maintains communication with Care Coordination Agency
- ◆ Meets with AAA if indicated
- ◆ Submits requested information to AAA and/or the CCSP Unit
- ◆ Maintains compliance with CCSP and all other regulatory agencies
- ◆ Notifies care coordination of all serious and unusual events and incidents and action taken to prevent further occurrences of such events

APPENDIX X

HEWLETT PACKARD (HP)

Provider Correspondence

(Including claims submission)

HPES

P.O. Box 105200

Tucker, GA 30085-5200

Prior Authorization & Precertification

GHP

P.O. Box 105329

Atlanta, GA 30348

Provider Inquiry Numbers:

800-766-4456 (Toll free)

The web contact address is

www.mmis.georgia.gov

Provider Enrollment

HPES

P.O. Box 105201

Tucker, GA 30085-5201

Fax:

Electronic Data Interchange (EDI)

1-877-261-8785

- Asynchronous
- Web portal
- Physical media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/
- Internet Protocol (TCP/IP)

APPENDIX Y

AAA CONSULT FORM

MEMORANDUM

To: DHS/Division of Aging Services
Community Care Services Program

From: _____, AAA Director
Planning and Service Area _____

Re: CCSP Pre-Enrollment Provider Consultation

Date: _____

Provider/Applicant:

has consulted with this Planning and Service Area. The following issues were discussed:

- ◆ Current market for _____ service in this PSA
- ◆ Referral Process
- ◆ Funding Network Meetings
- ◆ Other (explain)

For existing provider agencies requesting expansion of service area, please attach the agency's complaint history. (Rev 10/12)

Rev.
1/01, 12/10

Note: Refer to Appendix Y for a list of counties served by each Area Agency on Aging.

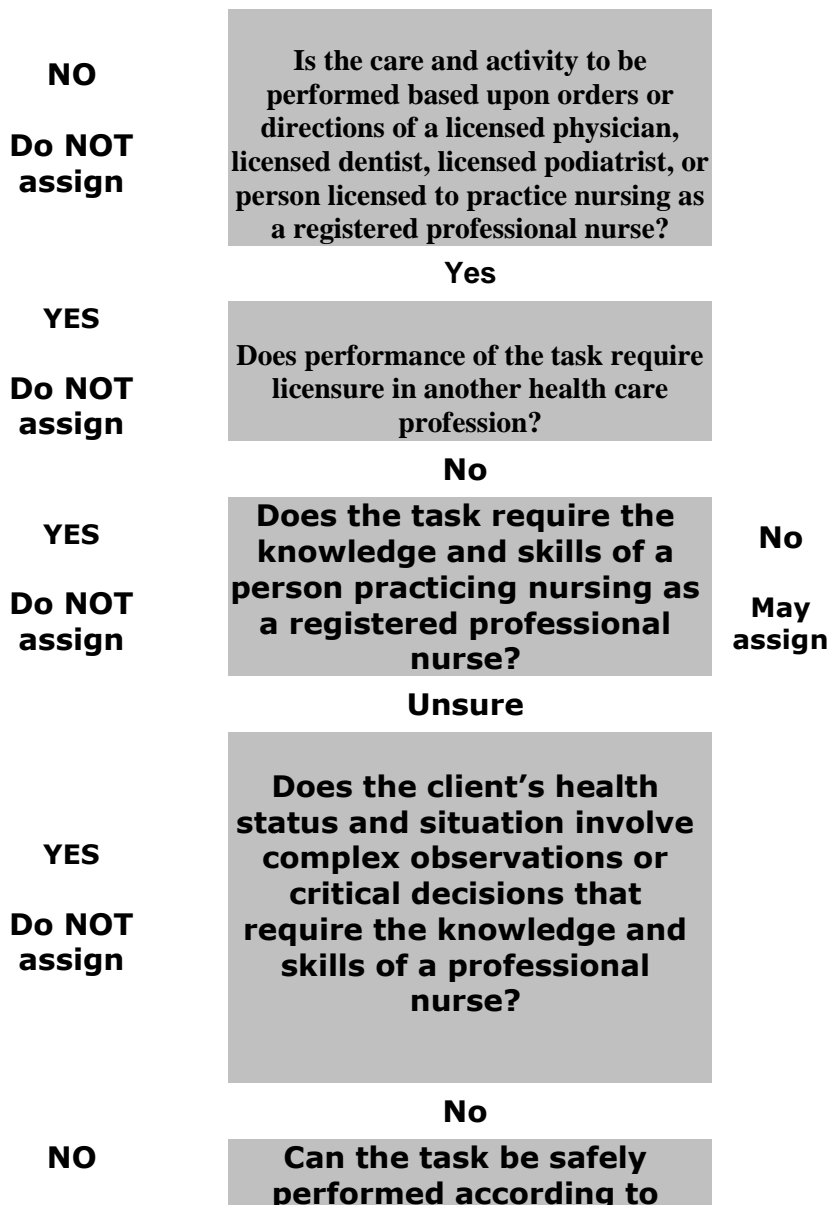
January 1, 2012

Community Care Services

A-1

APPENDIX Z

RN ASSIGNMENT DECISION TREE
Assignment to Unlicensed Assistive Personnel (UAP)



**Do NOT
assign**

**exact, unchanging
directions?**

Yes

NO

**Do NOT
assign**

**Are the results of the task
reasonably predictable?**

Yes

NO

**Do NOT
assign to
that UAP**

**Has the RN verified that the
UAP has the knowledge and
skills necessary to accept
assignment?**

Yes

May assign

Appendix AA

Georgia Families

Georgia Families (GF) is a statewide program designed to deliver health care services to members of Medicaid and PeachCare for Kids®. The program is a partnership between the Department of Community Health (DCH) and private Care Management Organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the three CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes. In addition, each CMO may contract with a behavioral health or therapy service organization in order to coordinate physical and mental health services to improve member care, coordination, and efficiency.

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid as well as new services. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs as well as expanded access to plans and providers, giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education.

The Department of Community Health has contracted with three CMOs to provide these services: **Amerigroup Community Care, Peach State Health Plan and WellCare of Georgia.**

Members can contact Georgia Families at www.georgia-families.com or call **1-888-GA-ENROLL** (1-888-423-6765) for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

CMOs

Amerigroup Community Care 800-600-4441 www.myamerigroup.com	Peach State Health Plan 800-704-1484 www.pshpgeorgia.com	WellCare of Georgia 866-231-1821 www.wellcare.com
--	--	--

Children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families.

Georgia Families Regions

Region	Counties	Health Plans
Atlanta	Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Henry, Jasper, Newton, Paulding, Pickens, Rockdale, Spalding, Walton	Amerigroup Community Care Peach State Health Plan WellCare of Georgia
Central	Baldwin, Bibb, Bleckley, Chattahoochee, Crawford, Crisp, Dodge, Dooly, Harris, Heard, Houston, Johnson, Jones, Lamar, Laurens, Macon, Marion, Meriwether, Monroe, Muscogee, Peach, Pike, Pulaski, Talbot, Taylor, Telfair, Treutlen, Troup, Twiggs, Upson, Wheeler, Wilcox, Wilkinson	Amerigroup Community Care Peach State Health Plan WellCare of Georgia
East	Burke, Columbia, Emanuel, Glascock, Greene, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Putnam, Richmond, Taliaferro, Warren, Washington, Wilkes	Amerigroup Community Care Peach State Health Plan WellCare of Georgia
North	Banks, Catoosa, Chattooga, Clarke, Dade, Dawson, Elbert, Fannin, Floyd, Franklin, Gilmer, Gordon, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Oconee, Oglethorpe, Polk, Rabun, Stephens, Towns, Union, Walker, White, Whitfield	Amerigroup Community Care Peach State Health Plan WellCare of Georgia
Southeast	Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Pierce, Screven, Tattnall, Toombs, Ware, Wayne	Amerigroup Community Care Peach State Health Plan WellCare of Georgia
Southwest	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Clay, Clinch, Coffee, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Terrell, Thomas, Tift, Turner, Webster, Worth	Amerigroup Community Care Peach State Health Plan WellCare of Georgia

Georgia Families Eligibility Categories

Included Populations	Excluded Populations
PeachCare for Kids®	Nursing home
Low-Income Medicaid (LIM)	Federally Recognized Indian Tribe
Right from the Start Medicaid (RSM)	Georgia Pediatric Program (GAPP)
Women's Health Medicaid (WHM)	Community Based Alternative for Youths (CBAY)
Transitional Medicaid	Children's Medical Services program
Refugees	Medicare Eligible
Planning for Healthy Babies	Supplemental Security Income (SSI) Medicaid Medically Needy
Resource Mother's Outreach	Long-term care
Children (Newborn)	
Breast and Cervical Cancer	

Included Categories of Eligibility:

COE	DESCRIPTION
104	LIM - Adult
105	LIM - Child
118	LIM - 1 st Yr Trans Med Ast Adult
119	LIM - 1 st Yr Trans Med Ast Child
120	LIM - 2 nd Yr Trans Med Ast Adult
121	LIM - 2 nd Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
126	Stepchild
135	Newborn Child
170	RSM Pregnant Women
171	RSM Child
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	BCC Waiver
471	RSM Child
506	Refugee (DMP) - Adult
507	Refugee (DMP) - Child
508	Post Ref Extended Med - Adult
509	Post Ref Extended Med - Child
510	Refugee MAO - Adult
511	Refugee MAO - Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1

596	Refugee RSM Exp Child DOB <=/= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 - 200% FPL
792	Peachcare 201 - 235% FPL
793	Peachcare > 235% FPL
800	Presumptive BCC
804	Lim REI Adult
805	Lim REI Child
818	TMA REI Adult
819	TMA REI Child
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
872	RSM 150% Expansion (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
896	RSM Exp Child <=/= 10/01/83 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Moth Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility:

COE	DESCRIPTION
124	Standard Filing Unit - Adult
125	Standard Filing Unit - Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down
148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
177	Family Planning Waiver
180	Interconceptional Waiver
210	Nursing Home - Aged
211	Nursing Home - Blind
212	Nursing Home - Disabled
215	30 Day Hospital - Aged
216	30 Day Hospital - Blind

217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
228	Disabled Adult Child – Blind
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind
282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged

284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
308	SSI Work Continuance – Blind
309	SSI Work Continuance – Disabled
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary

663	Q12 Beneficiary
664	Qua. Working Disabled Individual
815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien - Adult
873	Emergency Alien - Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy



*Information for Providers Serving Medicaid Members
in the Georgia Families 360SM Program*

Georgia Families 360SM, the state's new managed care program for children, youth, and young adults in Foster Care, children and youth receiving Adoption Assistance, as well as select youth in the juvenile justice system, launched Monday, March 3, 2014. Amerigroup Community Care is the single Care Management Organization (CMO) that will be managing this population.

DCH, Amerigroup, and partner agencies -- the Department of Human Services (DHS) and DHS' Division of Family and Children Services (DFCS), the Department of Juvenile Justice (DJJ) and the Department of Behavioral Health and Developmental Disabilities (DBHDD), as well as the Children's and Families Task Force continue their collaborative efforts to successfully rollout this new program.

Amerigroup is responsible through its provider network for coordinating all DFCS, DJJ required assessments and medically necessary services for children, youth and young adults who are eligible to participate in the Georgia Families 360SM Program. Amerigroup will coordinate all medical/dental/trauma assessments for youth upon entry into foster care or juvenile justice (and as required periodically).

Georgia Families 360SM members will also have a medical and dental home to promote consistency and continuity of care. Providers, foster parents, adoptive parents and other caregivers will be involved in the ongoing health care plans to ensure that the physical and behavioral health needs of these populations are met.

Electronic Health Records (EHRs) are being used to enhance effective delivery of care. The EHRs can be accessed by Amerigroup, physicians in the Amerigroup provider network, and DCH sister agencies, including the DFCS, regardless of where the child lives, even if the child experiences multiple placements.

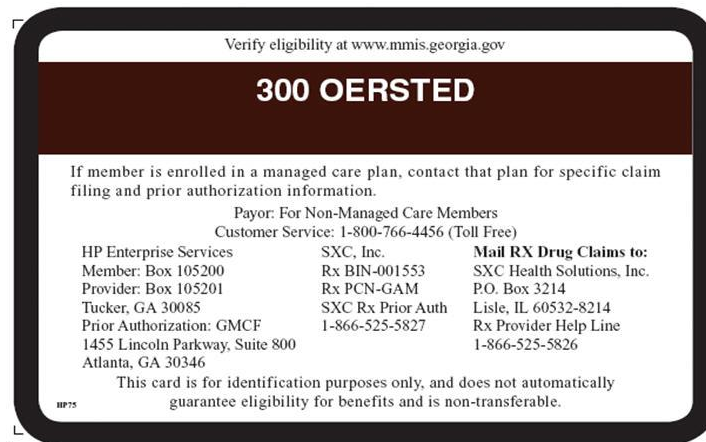
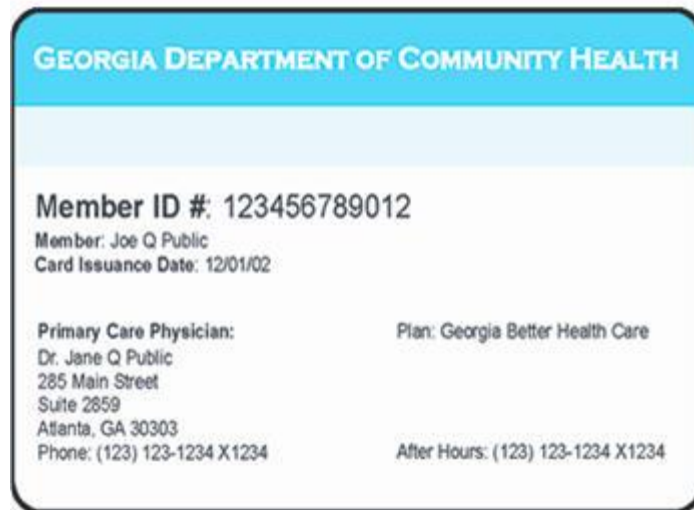
Ombudsman and advocacy staff are in place at both DCH and Amerigroup to support caregivers and members, assisting them in navigating the health care system. Additionally, medication management will focus on appropriate monitoring of the use of psychotropic medications, to include ADD/ADHD medications.

Providers can obtain additional information by contacting the Provider Service Line at 1-800-454-3730 or by contacting their Provider Relations representative.

To learn more about DCH and its dedication to A Healthy Georgia, visit www.dch.georgia.gov.

Appendix BB

Medicaid Card



APPENDIX CC
Reporting of Allegations of Abuse, Neglect, Exploitation

If suspected or real abuse, neglect, exploitation, etc., occur in:	Then, report immediately to (within 24 hours of the event):	Complete an Incident Report
Adult Day Health Facility	DCH’s Healthcare Facility Regulation Division , Care Coordinator, client’s family/ representative, client’s physician, local law enforcement, Adult Protective Services if applicable Rev 4/2016	Yes Notify Care Coordinator by phone and follow up with CCNF within 3 days of verbally reporting incident
Alternative Living Services Facility	DCH’s Healthcare Facility Regulation Division , Care Coordinator, client’s family/ representative, Long Term Care Ombudsman, client’s physician, local law enforcement Rev 4/2016	Yes Notify Care Coordinator by phone and follow up with CCNF within 3 days of verbally reporting incident
Out-of-Home Respite Care	DCH’s Healthcare Facility Regulation Division , Care Coordinator, client’s family/ representative, client’s physician, local law enforcement, Adult Protective Services if applicable Rev 4/2016	Yes Notify Care Coordinator by phone and follow up with CCNF within 3 days of verbally reporting incident
Private Home	DCH’s Healthcare Facility Regulation Division , Care Coordinator, client’s family representative, client’s physician, local law enforcement, Adult Protective Services if applicable Rev 4/2016	Yes Notify Care Coordinator by phone and follow up with CCNF within 3 days of verbally reporting incident
Reference: Office of the State Long-Term Care Ombudsman, Georgia Department of Human Services		

NOTE: All emergencies should be reported immediately to “911”

Outcome of event?

To file aps report..... <http://aging.dhs.georgia.gov/adult-protective-services>

Letterhead Here

DATE: _____

CLIENT NAME: _____ **DOB:** _____ **SSN XXX - XX -**

TO: _____ **FROM:** _____

The attached Level of Care page was signed by your office and certified on the above named client during a home assessment for (certification/recertification) into the Community Care Services Program (CCSP). Also attached is the Comprehensive Care Plan developed for _____. The Home and Community-Based Services Medicaid Waiver Program allows states to provide non-institutional services, reimbursable by Medicaid, to individuals at risk of institutional placement or who are receiving institutional care and need help in returning to the community.

Subsequent to the date of your approval on the attached Level of Care page, _____ has experienced a change in circumstances that necessitates a change in his/her plan of care. Below we have listed the changes that prompted a change in services, as well as the new services planned for _____.

Client changes necessitating service revisions:

Changes to plan of care:

Your signature below approves the changes to the service plan on the above named client, and your signing certifies that your patient requires the intermediate level of care provided by a nursing facility, and that your patient's condition can be managed by the provision of services in the community in lieu of nursing home placement.

Signature: _____ **Date:** _____

PLEASE return no later than ____ . This fax contains _____ pages, including cover.

Thank You,

RN/LPN/Care Coordinator

Appendix EE – Physician Change in Services Letter – 7/2015

Appendix FF – Notice of Intent to Become a CCSP Service Provider

INSTRUCTIONS: (Complete Parts I – IV.)

1. Please complete each item of this *Notice of Intent to Become a CCSP Service Provider*. Refer to *Part I – Policies and Procedures for Medicaid/PeachCare for Kids, Part II – Policies and Procedures for Community Care Services Program (CCSP)* Section 601.2 and each applicable CCSP service-specific manual.
2. Submit the completed CCSP Pre-Qualification Documents within the scheduled recruitment cycles (March 1st – March 31st or September 1st – September 30th) to:

Georgia Department of Community Health
Medicaid Division
Community Care Services Program
Two Peachtree Street, NW, Suite 37th Floor
Atlanta, Georgia 30303-3159

PART I – AGENCY INFORMATION

1. Legal name of agency/applicant organization:

NOTE: If the agency is regulated by the Department of Community Health, Healthcare Facility Regulation Division (HFRD), the applicant's governing body and agency/facility name **must be identical** to the name(s) listed on the permit issued by the HFRD, as well as, all other documents submitted in your packet.

2. Mailing Address:

3. County of Mailing Address: _____

4. Street Address/Physical Location:

5. County of Street Address/Physical Location: _____

6. Business Telephone: _____

7. Fax Number: _____

8. After-Hours Number: _____

9. Business Electronic Mail Address (e.g., username@bellsouth.net):

10. Contact Person, Title, and Telephone:

PART II- SERVICE FOR WHICH APPLYING

11. Indicate the service for which application is being made.

- | | |
|---|--|
| <input type="checkbox"/> Adult Day Health (ADH) | <input type="checkbox"/> Home Delivered Meals* |
| <input type="checkbox"/> Alternative Living Services (ALS) – Family | <input type="checkbox"/> Home Delivered Services** |
| <input type="checkbox"/> Alternative Living Services (ALS) – Group | <input type="checkbox"/> Out-of-Home Respite Care |
| <input type="checkbox"/> Emergency Response Services | <input type="checkbox"/> Personal Support Services |
| <input type="checkbox"/> Skilled Nursing Services | |

*Please submit current Title III status with the Area Agency on Aging, current monitoring results, and a letter from the Area Agency on Aging on letterhead stating that the applying agency is in good standing.

**Submit the Home Health Medicaid Number: _____

PART III – ENROLLMENT INFORMATION

12. Is this a “buyout” or change of ownership?

- Yes No

If “yes”, list the name and CCSP Medicaid Provider Number of the previous owner/provider agency:

13. Is the applicant currently enrolled in the CCSP or any other waiver program or state plan service? Yes
 No

If “yes”, list the service, Medicaid Provider Number, and date of enrollment for each service:

Other Waiver or State Plan Service	Medicaid Provider Number	Date of Enrollment

14. Place a check (✓) beside the county(ies) in which the CCSP service will be provided.

NOTE: Up to or ten (10) counties may be requested, but keep in mind you must have the capacity to serve the regions/counties that are checked. Adult Day Health (ADH), Alternative Living Services (ALS) and Out-of-Home Respite providers can only check the one (1) county in which the facility is located.

Statewide

1 – Northwest GA

- Bartow
- Catoosa
- Chattooga
- Dade
- Fannin
- Floyd
- Gilmer
- Gordon
- Haralson
- Murray
- Paulding
- Pickens
- Polk
- Walker
- Whitfield
- Jackson

2 – Georgia Mountains

- Banks
- Dawson
- Forsyth
- Franklin
- Habersham
- Hall
- Hart
- Lumpkin
- Rabun
- Stephens
- Towns
- Union
- White
- Macon

3 – Atlanta Regional

- Cherokee
- Clayton
- Cobb
- DeKalb
- Douglas
- Fayette
- Fulton
- Gwinnett
- Henry
- Rockdale
- Wayne
- Wheeler
- Wilcox

4 – Southern Crescent

- Butts
- Carroll
- Coweta
- Heard
- Lamar
- Meriwether
- Pike
- Spalding
- Troup
- Upson
- Hancock
- Jasper
- Madison
- Morgan
- Newton
- Oconee
- Oglethorpe
- Walton

5 – Northeast Georgia

6 – River Valley

- Barrow
- Clarke
- Elbert
- Greene
- Chattahoochee
- Clay
- Crisp
- Dooly
- Harris
- Candler
- Marion
- Muscogee
- Quitman
- Randolph
- Schley
- Stewart
- Sumter
- Talbot
- Taylor
- Webster
- Long
- McIntosh

7 – Middle Georgia

- Baldwin
- Bibb
- Crawford
- Houston
- Jones
- Monroe
- Peach
- Pulaski
- Putnam
- Twiggs
- Wilkinson

8 – Central Savannah River

- Burke
- Columbia
- Glascock
- Atkinson
- Jefferson
- Jenkins
- Lincoln
- McDuffie
- Richmond
- Screven
- Taliaferro
- Warren
- Washington
- Wilkes

9 – Heart of GA/Altamaha

- Appling
- Bleckley
- Tift
- Dodge
- Emanuel
- Evans
- Jeff Davis
- Johnson
- Laurens
- Montgomery
- Tattnall
- Telfair
- Toombs
- Treutlen

10 – Southwest Georgia

- Baker
- Calhoun
- Colquitt
- Decatur
- Dougherty
- Early
- Grady
- Lee
- Miller
- Mitchell
- Seminole
- Terrell
- Thomas
- Worth

11 – Southern Georgia

- Bacon
- Ben Hill
- Berrien
- Brantley
- Brooks
- Charlton
- Clinch
- Coffee
- Cook
- Echols
- Irwin
- Lanier
- Lowndes
- Pierce

12 – Coastal

- Bryan
- Bulloch
- Camden
- Chatham
- Effingham
- Glynn
- Liberty

PART IV – CERTIFICATION

I hereby certify that my pre-qualification documents to enroll in the Community Care Services Program (CCSP) are complete and contain all required materials in accordance with submission requirements established by the Department of Community Health. I understand that if my pre-qualification documents are not in accordance with submission requirements detailed in the CCSP General Services Manual, my application **will not be returned** and will not be considered to continue in the established enrollment process. I understand that if my application is not considered, I will be notified via email or mail and can resubmit during any specified recruitment cycle.

Signature of person legally authorized to act
for the organization or person to whom legal authority is delegated

Typed name and title of above person

Date

Typed name and title of person completing the application

Appendix GG - Pre-Qualification Checklist

All information/documents listed below must arrive in legible hardcopy with each section tabbed and identified as listed in this Pre-Qualification Checklist. No hand delivered, faxed or email documents will be accepted. Documents must be submitted via United States mail service, return receipt requested, United States Postal Service, FedEx or UPS to:

*GA Department of Community Health
Division of Medicaid
Community Care Services Program
Two Peachtree Street, NW
37th Floor
Atlanta, Georgia 30303- 3159*

Items to be submitted for Pre-Qualification:	
1. Completed Letter of Intent to Become a CCSP Service Provider (Appendix FF)	
2. Resumes	
a. Owner(s)	
b. Director	
c. Lead/ Supervising RN	
3. Secretary of State Certificate of Good Standing (if incorporated)	
4. Current/valid local business license	
5. Internal Revenue Service (IRS) form 575c, 147C or SS4	
6. Proof of \$1,000,000 General Liability Insurance	
7. Proof of Workers' Compensation Insurance (private home care providers only)	
8. Current state license issued by GA Department of Community Health's Healthcare Facility Regulation Division	
9. (private home care providers and personal care homes only)	
10. Title III funding contract (home delivered meals providers only)	
11. Low Voltage Contractor license, if applicable (emergency response system providers only)	
12. Copy of current RN license for lead supervising Registered Nurse (all providers except home delivered meals and emergency response system)	
13. Most recent inspection report from the following agencies, clear of deficiencies:	
a. Healthcare Facilities Regulation Division (private home care providers and personal care homes only)	
b. Fire inspection from local fire marshal (adult day health providers and personal care homes only)	
c. Utilization Review (current Medicaid providers only)	
14. Notarized, signed affidavit attesting 12 months of service experience in the service for which you are applying	
15. Most recent self-evaluation results	
16. Completed Alzheimer's Disclosure Form, if applicable	
17. Planning and Service Area form (Attachment A)	

Appendix HH - Application Checklist

All information/documents listed below must arrive in legible hardcopy with each section tabbed and identified as listed in this Application Checklist. No hand delivered, faxed or email documents will be accepted. Documents must be submitted via United States mail service, return receipt requested, United States Postal Service, FedEx or UPS to:

*GA Department of Community Health
Division of Medicaid
Community Care Services Program
Two Peachtree Street, NW
37th Floor
Atlanta, Georgia 30303- 3159*

CCSP application documents:	
1. Department of Community Health Facility Enrollment Application	
2. Statement of Participation	
3. Electronic Funds Transfer Agreement (“EFT Agreement” under “Provider Enrollment” at www.mmis.georgia.gov)	
4. Voided Check, or letter from your bank to verify your bank account and routing numbers	
5. Copy of Disaster Plan	
6. Signed and dated Standard of Assurance (Attachment B)	
7. Signed and dated Civil Rights Assurance (Attachment C)	
8. Letter of Understanding (Attachment D)	
9. Letter of Agreement (Attachment E – ALS only)	
10. Policies and Procedures for your Agency (Submit only when requested by your enrolling CCSP Provider Specialist.)	