SERVICE ACCESS AND AUTHORIZATION

Tiered Waiver Process

When funding is appropriated for an Office of Citizens with Developmental Disabilities (OCDD) waiver opportunity or an existing opportunity is vacated and funded, the next individual on the Developmental Disability Request for Services Registry (DDRFSR) with the highest urgency of need screening score will receive a written notice indicating that a waiver opportunity is available. That individual will receive a needs-~~-~~based assessment and participate in a person centered planning process. At the conclusion of that process, if it is determined that the Supports Waiver (SW) is the most appropriate waiver for this individual, a SW offer will be extended.

The applicant will receive a waiver offer packet that includes a Support Coordination Agency Freedom of Choice (FOC) form. The support coordinator is a resource to assist individuals in the coordination of needed supports and services. The applicant must complete and return the packet to the Medicaid data management contractor in order to be linked to a support coordination agency. The packet should include a current 90-L form that has been signed and dated by his/her primary care physician/nurse practitioner/physician's assistance.

After the applicant is linked to a support coordination agency, the support coordinator will assist the applicant in gathering the documents that may be needed for both the financial eligibility and medical certification process for level of care determination. The support coordinator informs the individual of the FOC of enrolled waiver providers and the availability of services, as well as the assistance provided through the support coordination service.

The Supports Waiver is the first waiver that is offered to adults, aged 18 (if no longer in high school and wanting to find employment) and older, in the tiered waiver process. When it has been determined ~~that another OCDD waiver will not meet the needs of the applicant, and~~ the SW is the most appropriate waiver, another home visit is made to finalize the plan of care (POC). The following must be addressed in the POC:

1. The applicant's assessed needs;

2. The types and quantity of services (including waiver and all other services, both paid and unpaid) necessary to maintain the applicant safely in the community;

3. The individual cost of each waiver service; and

4. The total cost of waiver services covered by the POC.

Provider Selection

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

Initial Plan of Care

The support coordinator is responsible for:

1. Notifying the provider that the beneficiary has selected their agency to provide the necessary service;

2. Scheduling a meeting with the provider and the beneficiary to discuss services needed by the beneficiary;

3. After the meeting, forwarding a copy of the draft POC and request the provider sign and return the following:

    a. Budget pages; and

    b. Required POC provider attachments as indicated in the POC.

4. Forwarding the initial POC packet, including provider attachments, to the local governing entity (LGE) for review and approval.

Annual Plan of Care

Annual POCs follow the same process as the initial POC except for the following:

1. Support coordinator supervisors are allowed to approve an annual POC based on OCDD policy; and

2. A copy of any POC approved by the Support coordinator Supervisor and supporting documentation will be forwarded to the LGE office.

NOTE: The authorization to provide a service is contingent upon approval by the LGE ~~office~~ or support coordination supervisor.

Prior Authorization

All services in the SW program must ~~be prior authorized~~receive prior authorization. Prior authorization (PA) is the process to approve specific services prior to service delivery and reimbursement for an enrolled Medicaid beneficiary by an enrolled Medicaid provider. The purpose of PA is to validate the service requested as being medically necessary and to verify that it meets the criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon passing all the edits contained within the claims payment process, the beneficiary's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

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

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

The service provider is responsible for the following activities:

1. Checking PAs to ensure that all PAs for services match the approved services in the beneficiary's approved POC. Any mistakes must be ~~immediately~~ corrected immediately to match the approved services in the POC;

2. Verifying that the direct service worker's timesheet or electronic clock in/out is completed correctly and services were delivered according to the beneficiary's approved POC before billing for the service;

3. Verifying that services were documented as evidenced by timesheets or electronic clock in/out and progress notes and are within the approved service limits as identified in the beneficiary's POC;

4. Verifying service data in the~~ direct service provider,~~ Electronic Visit Verification (EVV) system or LaSRS depending on the service and modifying the data, if needed, based on actual service delivery;

5. Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system;~~.~~

a. It is the provider's responsibility to ensure that billing information for the dates of service, procedure codes, and number of units delivered is correct and matches the information in LaSRS. Inconsistencies between LaSRS and provider's billing system may result in recoupment;

6. Billing only for the services that were approved in the beneficiary's POC and delivered to the beneficiary;

7. Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary (FI) with each payment; and

8. Checking billing records to ensure the appropriate payment was received.

NOTE: Service providers have a one-year timely filing billing requirement under Medicaid regulations.

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

NOTE: Authorization for services will not be issued retroactively unless approved due to special circumstances by the OCDD waiver director/designee.

Post Authorization

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

Changes in Service Needs

All requests for changes in services and/or service hours must be made by the beneficiary or his/her personal representative to their support coordinator.

Changing Direct Service Providers

Beneficiaries/families may change direct service providers ~~once every service authorization quarter (three months)~~ with the effective date being the beginning of a ~~the following~~ quarter. All

requests for changes in services and/or service hours must be made by the beneficiary/family through the support coordinator.

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

Examples of g~~G~~ood cause reasons include:

1. A beneficiary/family moving to another region in the state where the current direct service provider does not or cannot provide services;

2. The beneficiary/family and the direct service provider have unresolved difficulties and mutually agree to a transfer;

3. The beneficiary's health, safety or welfare have been compromised; or

4. The direct service provider has not rendered services in a manner satisfactory to the beneficiary/family.

The beneficiaries/families must contact their support coordinator to change direct service providers. The support coordinator will assist in facilitating a team meeting involving the current direct service provider(s) if agreed upon~~to~~ by the beneficiary/family.

This meeting will address the reason for wanting to terminate services with the current service provider(s). Whenever possible, the current service provider will have the opportunity to submit a corrective action plan with specific time lines, not to exceed 30 days, to attempt to meet the needs of the beneficiary.

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

1. Provide the beneficiary/family with the current FOC list of service providers in his/her region;

2. Assist the beneficiary/family in completing the FOC and release of information form;

3. Ensure the current provider is notified immediately upon knowledge of the request and prior to the transfer; and

4. Obtain the case record from the releasing provider which must include:

a. Progress notes from the last six (6) months, or if the beneficiary has received services from the provider for less than six (6) months, all progress notes from date of admission;

b. Written documentation of services provided, including monthly and quarterly progress summaries;

c. Current POC;

d. Records tracking beneficiary's progress towards POC goals and objectives;

e. Behavior management plans, current and past if applicable;

f. Documentation of the amount of authorized services remaining in the POC, including applicable time sheets; and

g. Documentation of exit interview.

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

1. Most current POC;

2. Current assessments on which POC is based;

3. Number of services used in the calendar year;

4. Records from the previous service provider; and

5. All other waiver documents necessary for the new service provider to begin providing supports and services.

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

The new service provider must bear the cost of copying, which cannot exceed the community's competitive copying rate. If the existing provider charges a rate that exceeds the competitive copying rate, then the provider should contact the support coordinator to resolve the issue.

Prior Authorization for New Service Providers

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

Upon approval, a new PA number will be issued to the new provider with the effective start~~ing~~ date agreed upon. The transferring agency's PA number will expire on the date immediately preceding the PA date for the new provider. New providers who provide services prior to the start date on the new PA will not be reimbursed.

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

Changing Support Coordination Agencies

A beneficiary has the option to change support coordination agencies once every 6 months or at any time if there is "good cause." The beneficiary should notify the LGE office or contact the Medicaid data management contractor to request this change. ~~A beneficiary may change support coordination agencies after a six month period or at any time for good cause, if the new agency has not met their maximum number of beneficiaries. Thereafter, a beneficiary may request a change in support coordination agencies every 12 months.~~ Good cause is defined as:

1. A beneficiary/family moving to another region in the state;

2. The beneficiary/family and the support coordination agency have unresolved difficulties and mutually agree to a transfer;

3. The beneficiary's health, safety or welfare have been compromised; or

4. The support coordination agency has not rendered services in a manner satisfactory to the beneficiary/family.

Participating support coordination agencies should refer to the Support Coordination section in this manual, ~~LDH *Case Management Services Provider* manual~~ which provides a detailed description of their roles and responsibilities.