SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for a new Adult Day Health Care (ADHC) Waiver opportunity or an existing opportunity is vacated, the individual who meets criteria for the priority group, or whose date is reached on the ADHC Waiver Request for Services Registry (RFSR), shall receive a written notice indicating that a waiver opportunity is available. The applicant will receive a waiver offer packet that includes an ADHC Waiver Services Decision Form and a Support Coordination Agency Freedom of Choice (FOC) and Release of Information form.

The applicant must complete and return the packet if interested in accepting the ADHC Waiver opportunity and to determine if he/she meets the preliminary level of care and/or any additional program requirements.

If the applicant meets the preliminary level of care and/or additional program requirements, he/she will be linked to a support coordination agency. A support coordinator will be assigned to conduct an in-home assessment with the applicant and inform him/her of all available services. The support coordinator shall also assist the applicant as needed with the financial eligibility process conducted by the Medicaid eligibility office.

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

- The types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the beneficiary safely in the community;
- The individual cost of each waiver service; and
- 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 the provider FOC list. FOC will be offered initially and annually thereafter for each identified waiver service.

The support coordinator is responsible for the following:

- Notifying the selected provider that they have been chosen by the beneficiary to provide the necessary services;

- Completing assessments and POCs;
- Obtaining an agreement to provide services and copies of any completed assessments and/or plans written by the provider; and
- Forwarding the POC packet to the Office of Aging and Adult Services (OAAS) regional office or its designee, as applicable for review and approval following the established protocol.

NOTE: Authorization to provide service is always contingent upon having an approved POC or POC revision.

Prior Authorization

All services under the ADHC Waiver must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid beneficiary by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and that it meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon the passing of all 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 contractor and is specific to a beneficiary, provider, service code, established quantity of units, and for specific dates of service.

PA revolves around the POC document, which means that only the service codes and units specified in the approved POC will be prior authorized. Services provided without a current PA are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current PA.

The ADHC provider is responsible for the following activities:

- Developing an Individual Service Plan (ISP) in accordance with the approved POC and as stipulated in the ADHC licensing regulations and Medicaid certification rules (LAC 50. XXI.2303. A.);
- Checking PAs to verify that they match the approved services in the beneficiary's POC and any mistakes must be immediately corrected;

- Verifying that services were documented as evidenced by time entries, attendance records, progress notes and progress summaries and are within the approved service limits as identified in the beneficiary's POC prior to billing for the service;

- Verifying that services were delivered according to the beneficiary's approved POC prior to billing for the service;

- Proper use of the Electronic Visit Verification (EVV) system;

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

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

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

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

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

Support Coordination

The data contractor issues authorizations for support coordination service for the POC year. A service unit is one month and each authorization covers a maximum of seven months, or seven service units. Typically, two PAs will be issued for a one year POC. At the end of each month, after the support coordination agency fulfills the service requirements and inputs the required documentation in the case management database, the data contractor will release one service unit of the PA.

Transition Intensive Support Coordination (TISC)

Authorization for TISC is issued upon receipt of the POC (provisional or initial). A service unit is one month. The authorization includes a unit of service for each month with a maximum of six (6) units of service per authorization. At the end of each month, after the support coordination agency fulfills the service requirements and inputs the required documentation in the case management database, the data contractor will release one service unit of the PA.

NOTE: Authorization for services will not be issued retroactively unless a person leaving a facility is involved with special circumstances as determined and approved by OAAS.

Transition Services

Authorization for Transition Services has a lifetime cap of $1,500. The authorization period is the effective date indicated on the POC or revision request through the POC end date. After the approved purchases are made, the POC (provisional, initial or revision) that includes the transition services, the receipts for the purchases and the *"*Transition Services Form*"* are sent to the data contractor. (See Appendix B for a copy of this form).

The data contractor issues and releases the PA to the support coordination agency upon receipt of complete and accurate information. The support coordination agency is responsible for reimbursing the purchaser (beneficiary, family, provider, own agency, etc.) upon receipt of reimbursement.

Adult Day Health Care Services

ADHC service units are 15 minutes. Adult Day Health Care (ADHC) services are assigned a PA number for the year. Approved units of service are issued on a quarterly basis. Units of service approved for one week cannot exceed established limits. For PA purposes, a week is defined as beginning at 12:00 a.m. Sunday and ending at 11:59 p.m. the following Saturday. Payment for services is capped at 50 hours per week and no more than 10 hours per day.

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

Post Authorization

Some services require post authorization before the provider is able to bill for services rendered. Post authorization may occur either through EVV or documentation submitted by the support coordinator.

EVV	Additional Documentation
Adult Day Health Care (ADHC)	Transition Services

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

Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

Changing ADHC Providers

Beneficiaries or their responsible representative must request any change in amount(s) of service/units to the support coordinator.

All requests for changes in ADHC providers require a new Freedom of Choice by the beneficiary or his/her responsible representative. (Refer to 9.3- Beneficiary Rights and Responsibilities, Freedom of Choice of Agencies/Providers, for details on "good cause" criteria and timelines).

The support coordinator will provide the beneficiary with the current FOC list of ADHC providers. Once a new provider has been selected, the support coordinator will ensure the new provider is notified of the request. With written consent from the beneficiary, both the transferring and receiving providers share responsibility for ensuring the exchange of medical and program information which includes the following:

- Progress notes from the last six months, or if the beneficiary has received services from the provider for less than six months, all progress notes from date of admission;
- Written documentation of services provided, including monthly and quarterly progress summaries;
- Current ISP;
- Current assessments upon which the ISP is based;
- A summary of the beneficiary's behavioral, social, health and nutritional status;
- Records tracking beneficiary's progress towards Individualized Service Plan (ISP) goals and objectives;
- Documentation of the amount of authorized services remaining in the POC, including direct service case record documentation; and
- Documentation of exit interview.

The support coordinator will facilitate the transfer of the above referenced information to the receiving ADHC provider and forward copies of the following to the new ADHC provider:

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

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

Prior Authorization for New ADHC Providers

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

Changing Support Coordination Agency

A beneficiary may change to a different support coordination agency for any reason after being with that agency for six (6) months, or at any time for good cause, as long as the new agency has not met its maximum number of beneficiaries, and as approved by the OAAS regional office or its designee.

Good cause is defined as the following:

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

After the beneficiary has selected and been linked by the data contractor to a new support coordination agency, the new agency must inform the transferring agency and complete the FOC file transfer. The new agency must obtain the case record and authorized signature, and inform the transferring agency.

Upon receipt of the completed form, the transferring agency must have provided copies of the following information to the new agency:

- Most current POC;
- Current assessments on which the POC is based;
- Number of services used in the POC year; and
- Most recent six months of progress notes.

NOTE: The new support coordination agency must bear the cost of copying which cannot exceed the community's competitive copying rate. If the new agency does not receive the information in a timely fashion, the appropriate OAAS regional office should be contacted for assistance.

The transferring support coordination agency must provide services up to the transfer of records and is eligible to bill for support coordination services for the month in which the dated notification is received (transfer of records) by the receiving agency.

In the month the transfer occurs, the receiving agency shall begin services within three (3) days after the transfer of records and is eligible to bill for services the first full month after the transfer of records. Immediately after the transfer of records, the receiving agency must submit the required documentation to the data contractor to obtain prior authorization.

Prior Authorization for New Support Coordination Agency

A new PA number will be issued to the new support coordination agency with an effective starting date as the first day of the first full calendar month following the date of the transfer of the records. The transferring agency's PA number will expire on the date of the transfer of the records.

OAAS or its designee will not backdate the new PA period to the first day of the calendar month in which the FOC and transfer of records are completed. If the new support coordination agency receives the records and admits a beneficiary in the middle of a month, they cannot bill for services until the first day of the next month.