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 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 a Waiver Decision Form and a Support Coordination Agency Freedom of Choice form.

The applicant must complete and return the packet to indicate interest in receiving an ADHC Waiver opportunity and to determine if he/she meets the 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 provider. 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 parish 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. The following must be addressed in the Plan of Care:

- The types and number of services (including waiver and all other services) necessary to maintain the applicant safely in the community,
- The individual cost of each waiver service, and
- The total cost of waiver services covered by the Plan of Care.

Provider Selection

The support coordinator must present the recipient with a list of providers who are enrolled in Medicaid to provide those services that have been identified on the Plan of Care. The support coordinator will have the recipient or responsible representative complete the provider Freedom of Choice (FOC) form. FOC will be offered initially and annually thereafter for each identified waiver service.

The support coordinator is responsible for:

- Notifying the provider that the recipient has selected their agency to provide the necessary services,

- Securing from selected providers a commitment to provide services, assessments and/or plans (based on the providers specific type of service), and

- Forwarding the Plan of Care 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: The authorization to provide service is contingent upon approval by the OAAS regional office or its designee.

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 recipient by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and that it meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon the passing of all edits contained within the claims payment process, the recipient's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

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

PA revolves around the Plan of Care document, which means that only the service codes and units specified in the approved Plan of Care 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 service provider is responsible for the following activities:

- Developing an Individual Service Plan (ISP) in accordance with the approved Plan of Care.

- Checking prior authorizations to verify that all prior authorizations for services match the approved services in the recipient's Plan of Care. Any mistakes must be immediately corrected to match the approved services in the Plan of Care.

- Verifying that the case record documentation is completed correctly and that services were delivered according to the recipient's approved Plan of Care prior to billing for the service.

- Verifying that services were documented as evidenced by timesheets, attendance records, progress notes and progress summaries and are within the approved service limits as identified in the recipient's Plan of Care prior to billing for the service.

- Completing data entry into the direct service provider data system, Louisiana Services Tracking (LAST) system.

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

- Billing only for the services that were delivered to the recipient and are approved in the recipient's Plan of Care.

- Reconciling all remittance advices issued by the Department of Health and Hospitals (DHH) fiscal intermediary with each payment.

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

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

Support Coordination

Authorization for support coordination service is issued by the data management contractor through two authorization periods for the Plan of Care year. A service unit is one month and each authorization covers a five to seven month period, or five to seven service units. At the end of the month, after the support coordination provider fulfills the service requirements and inputs the required documentation in the Case Management Information System (CMIS), the data contractor will release one service unit of the PA.

Transition Intensive Support Coordination

Authorization for transition intensive support coordination is issued upon receipt of the Plan of Care (provisional or initial) and the "Request for Payment/Override Form" that have been approved by the OAAS regional office. (See Appendix B for a copy of this form)

A service unit is one month. The authorization includes a unit of service for each month with a maximum of six 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 CMIS, 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

Only one authorization for transition services is issued. The authorization period is the effective date of the Plan of Care or revision request through the Plan of Care end date. After the approved purchases are made, the Plan of Care (provisional, initial or revised) that includes the transition services, the receipts for the purchases and the "Transition Service Expense and Planning Approval (TSEPA) Form" are sent to the data management contractor. (See Appendix B for a copy of this form)

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

Adult Day Health Care Services

Adult Day Health Care Services are assigned a PA number for the year. Approved units of service are calculated on a weekly basis to the provider and must be used for the specified week. Units of service approved for one week cannot be combined with units of service for another week. For PA purposes, a week is defined as beginning at 12:00 a.m. Sunday and ending at 12:00 a.m. the following Sunday. Payment for services is capped for each week.

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. To receive post authorization, a service provider must enter the required information into the billing system maintained by the Medicaid data contractor. The Medicaid data contractor checks the information entered into the billing system by the service provider against the prior authorized units of service. Once post authorization is granted, the service provider may bill the DHH 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 Providers

All requests for changes in services and/or service hours must be made by the recipient or his/her responsible representative.

Changing Support Coordination Providers

A recipient may change support coordination providers after a six month period or at any time for good cause if the new provider has not met its maximum number of recipients. Thereafter, a recipient may request a change in support coordination providers every six months. Good cause is defined as:

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

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

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

- Most current Plan of Care,
- Current assessments on which the Plan of Care is based,
- Number of services used in the calendar year, and
- Most recent six months progress notes.

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

The transferring support coordination provider shall 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 provider. In the month the transfer occurs, the receiving provider shall begin services within three 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 provider must submit the required documentation to the data contractor to obtain prior authorization.

Prior Authorization for New Support Coordination Providers

A new PA number will be issued to the new support coordination provider 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 provider's PA number will expire on the date of the transfer of the records.

The OAAS or its agent 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 provider receives the records and admits a recipient in the middle of a month, they cannot bill for services until the first day of the next month.

Changing ADHC Providers

Recipients may change ADHC providers once every six months. ADHC providers may be changed for good cause at any time as approved by the OAAS regional office or its designee.

Good cause is defined as:

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

Recipients must contact their support coordinator to change ADHC providers.

The support coordinator will provide the recipient 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 recipient, both the transferring and receiving providers share responsibility for ensuring the exchange of medical and program information which includes:

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

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 a Plan of Care revision form 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 Plan of Care revision. The transferring provider's PA number will expire on the end date as indicated on the Plan of Care revision.