SERVICE ACCESS AND AUTHORIZATION

Office of Citizens with Developmental Disabilities (OCDD) waivers has been operationalized to a tiered waiver system of service delivery, which will allow individuals to be supported in the most appropriate waiver. Home and community based opportunities will now be provided based on the individual's prioritized need for support, which was identified in their Request for Services Registry (RFSR) Screening for Urgency of Need (SUN). Instead of first come, first served, individuals with the most emergent and urgent need for support will have priority. When funding is appropriated for a new Children's Choice Waiver opportunity, or an existing opportunity is vacated, the next individual on the RFSR 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 the person-centered planning process. At the conclusion of that process, it will be determined which waiver is the most appropriate for the individual in the tiered waiver process. A Children's Choice Waiver slot will be extended if the individual is between the ages of 0-20 and if this is the most appropriate waiver. An offer will not be extended if the individual is seeking employment and/or day habilitation services.

The applicant will receive a waiver offer packet that includes a Support Coordination Agency Freedom of Choice 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 be linked to a support coordination agency.

Once linked, the support coordinator will assist the applicant in gathering the documents which 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 freedom of choice of enrolled waiver providers, the availability of services as well as the assistance provided through the support coordination service.

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:

1. The applicant's assessed needs;

2. The types and number of services (including waiver and all other services) necessary to maintain the applicant safely in the community;

3. The individual cost of each waiver service (including waiver and all other services); and

4. The total cost of 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 Freedom of Choice (FOC) form initially and annually thereafter for each identified waiver service.

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;

3. Requesting the provider sign and return the:

    a. Provider Agreement form and budget pages;

    b. Emergency plan; and

    c. Individualized staffing back-up plan.

4. Forwarding the POC packet to the local Human Services Authority or District for review and approval.

NOTE: The authorization to provide service is contingent upon approval by the Human Services Authority or District.

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 that is requested is medically necessary and meets 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 contractor and is specific to a beneficiary, provider, service code, established quantity of units, and for specific dates of service. Prior authorizations 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 prior authorization. Services provided without prior authorization are not eligible for reimbursement.

The service provider is responsible for the following activities:

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

2. Verifying 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 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;

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 LDH fiscal intermediary with each payment; and

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

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

In the event that reimbursement is received without a 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 the service delivery information is reported accurately in the post authorization 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 unit(s) of service. Once post authorization is granted, and the billing is correctly submitted by the service provider, reimbursement for the appropriate units of service will occur.

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

Changing Direct Service Providers

Beneficiaries/authorized representatives may change direct service providers once every twelve months. All requests for changes in services and/or service hours must be made by the beneficiary/authorized representatives.

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

Good cause is defined as:

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/authorized representatives 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 to by the beneficiary/authorized representatives. 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/authorized representative 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/authorized representative with the current Freedom of Choice (FOC) list of service providers in his/her region;

2. Assist the beneficiary/representative 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 two months, or if the beneficiary has received services from the provider for less than two 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 calendar 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 Human Services District or Authority 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.

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 submit the revision request to the Human Services Authority or District for approval. Upon approval, a new PA number will be issued to the new provider with the effective starting date. The transferring agency's PA number will expire on the date immediately preceding the PA date for the new provider.

Neither the Human Services Authority or District nor its agent will backdate the new PA period to the first day of the first full calendar month in which the FOC and transfer of records are completed. If the new provider receives the records and admits a beneficiary in the middle of a month, the new provider cannot bill for services until the first day of the next month. New providers who provide services prior to the begin date of the new PA period will not be reimbursed.

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

Changing Support Coordination Agencies

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. Good cause is defined as:

1. A beneficiary/authorized representatives' 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 Case Management Services manual chapter in the *Louisiana Medicaid Provider Manual* which provides a detailed description of their roles and responsibilities.

Changes in Authorized Services

Any change or revision to the POC must be prior approved by the Human Services Authority or District. Requests for changes to the POC must be made by the beneficiary/authorized representative to the support coordinator. Changes will not be made solely on the request of the service provider.

The beneficiary/authorized representative may not authorize services or authorize direct service workers to work hours or services not included in the approved POC.