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SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for a new Community Choices Waiver (CCW) opportunity or an existing opportunity is vacated, the individual who meets the criteria for one of the priority groups, or whose date is reached on the CCW Request for Services Registry (RFSR) shall receive a written notice indicating that a CCW opportunity is available. The applicant will receive a CCW offer packet that includes the following:

1. A CCW Services Decision form; and
2. A Support Coordination Agency Freedom of Choice (FOC) and Release of Information form.

If the applicant is interested in accepting the CCW opportunity, they must complete and return the packet, selecting a support coordination agency.

After the packet is returned, if the applicant meets the waiver offer criteria, they will be linked to a support coordination agency. A support coordinator will be assigned to the applicant.

The support coordination must:

1. Conduct a face-to-face, in-home assessment with the applicant to determine medical eligibility;
2. Inform them of all available services under the CCW program; and
3. Assist the applicant as needed with the application process for Medicaid's determination of the financial eligibility process.

Once the assessment has been completed and it has been determined that the applicant meets the Nursing Facility Level of Care (NFLOC) requirements for the CCW program, the support coordinator may continue with the plan of care (POC) development. The POC development may be completed on the same day as the assessment or the support coordinator may schedule a 2nd meeting to finalize the POC.

NOTE: The support coordinator may conduct the assessment and POC development at the same meeting, as long as the support coordinator has the equipment/capability to finalize the assessment and obtain the results while during the visit.

The following must be addressed in the POC:

1. Types and number of services (including waiver and all other services) necessary

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to reasonably assure health and welfare and to maintain the beneficiary safely in the community;

2. Individual cost of each waiver service; and
3. 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, quarterly upon request, and annually thereafter for each identified waiver service.

The support coordinator is responsible for:

1. Notifying the selected providers that they have been chosen by the beneficiary to provide the necessary services;
2. Completing assessment and POCs;
3. Obtaining an agreement from the selected provider(s) to provide services;
4. Obtaining copies of any completed assessments and/or plans written by the Adult Day Health Care (ADHC) provider (if the beneficiary is receiving ADHC services); and
5. Forwarding the POC packet to the Office of Aging and Adult Services regional office (OAAS RO) or its designee 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 CCW program 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. PA does not guarantee payment for the service as payment is contingent upon the passing of all edits contained within the claims payment process,

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the beneficiary's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

The PA is generated by the data contractor and is specific to a beneficiary, provider, service code, established quantity of units, and for specific dates of service.

The 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.

If the beneficiary is receiving ADHC services, the ADHC provider is responsible for developing an Individualized 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.).

The providers are responsible for the following activities:

1. Checking PAs to verify that all PAs for services match the approved services in the beneficiary's POC. Any mistakes must be immediately corrected;
2. Verifying that services were documented as specified in Section 7.8 – Record Keeping and are within the approved service limits as identified in the beneficiary's POC prior to billing for the service;
3. Verifying that services were delivered according to the beneficiary's approved POC prior to billing for the service;
4. Proper use of the Electronic Visit Verification (EVV) system (if applicable);
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 delivered to the beneficiary and are approved in the beneficiary's POC;
7. Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary with each payment; and
8. Checking billing records to ensure that the appropriate payment was received.

NOTE: Providers have 1-year timely filing billing requirement under Medicaid regulations. See Section 1.4, Timely Filing Guidelines in the General

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Information and Administration Chapter of the Medicaid Services Manual at the following:

<http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf>

Support Coordination

The data contractor issues authorizations for support coordination services for the POC year. A service unit is 1 month, and each authorization covers a maximum of 7 months, or 7 service units. Typically, two PAs will be issued for a 1-year POC. At the end of the month, after the support coordination agency fulfills the service requirements and inputs the required documentation in the data contractor's database, the data contractor will release 1 service unit of the PA.

Transition Intensive Support Coordination

Authorization for transition intensive support coordination (TISC) is issued upon receipt of the POC (provisional or initial).

A service unit is 1 month. The authorization includes a unit of service for each month with a maximum of 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 data contractor's database, the data contractor will release one service unit of the PA.

NOTE: Authorization for services will not be issued, retroactively, unless an individual 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 \$1500. The authorization period is the effective date indicated on the POC or POC 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 (TSF)" are sent to the data contractor. (See Appendix B for the link to the 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.

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Environmental Accessibility Adaptation

When the data contractor receives a POC (provisional, initial or revision) that indicates a need for an environmental accessibility adaptation (EAA), an authorization is issued for a basic assessment to the assessor. After the data contractor receives documentation that the assessor has completed the assessment, the PA for approval services is released.

If the basic assessment indicates the need for an EAA, the data contractor will issue the following 2 authorizations upon receipt of the POC revision:

1. Authorization for the final inspection and approval to the assessor; and
2. Authorization for the installation/completion of the EAA to the provider/contractor.

Upon receipt of documentation (either from the support coordination agency or OAAS) that these tasks have been completed, the data contractor will release the PAs for payment.

Personal Assistance Services

An annual authorization of personal assistance services (PAS) is issued upon receipt of the POC (initial or revision). The authorization is based on the approved POC.

Units of service:

Type of Delivery Method	Unit of Service
A.M./P.M.	Per visit
Traditional	15 minutes

Approved units of service are calculated on a weekly basis to the provider and must be used for the specified week.

PAs are released on a daily basis after services are provided and documented in the EVV system. Units of service approved for 1 week cannot be combined with units of service for another week. For PA purposes, a week is defined as beginning at 12:00 am Sunday and ending at 11:59 p.m. the following Saturday. Payment for services is capped for each week.

Unused portions of the prior authorized allotment may not be saved or borrowed from one week for use in another week.

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NOTE: Beneficiaries receiving self-directed PAS should refer to the “OAAS CCW Self-Direction Employer Handbook.” (See Appendix B for the link to this handbook).

Adult Day Health Care

ADHC service units are 15 minutes. ADHC services are assigned a PA number for the year. Approved units of service are issued on a quarterly basis. PAs are released after services are provided and documented in the EVV system. Units of service approved for 1 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.

Caregiver Temporary Support Service

Authorization for caregiver temporary support service is issued for no more than 30 calendar days or 29 overnight stays per POC year. Each PA is capped at 14 calendar days or 13 overnight stays and no contiguous PAs are issued.

Units of service:

Type of Delivery Method	Unit of Service
In the home	15 minutes
Assisted Living Facility; Nursing Facility; Respite Care Center (ALL overnight)	Daily
ADHC center (not overnight)	15 minutes (maximum of 40 units/day)

PAs are released for personal care attendant (PCA) providers, ADHC centers and home health agencies after the service has been provided and documented in the EVV system.

Assisted living centers, nursing facilities and respite care centers use the data contactor’s database to retrieve PAs, but do not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

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Monitored In-Home Caregiving Services

Authorization for monitored in-home caregiving (MIHC) services is issued upon receipt of the POC (initial, provisional, or revision).

Units of service:

Type of Delivery Method	Unit of Service
MIHC (Level 1 and Level 2 services)	Per day
Intake and assessment	Per service

This provider type uses the data contractor's database to retrieve PAs, but does not utilize the database to document the provision of services.

The intake and assessment PA will be released once the MIHC Services Form is submitted to the data contractor by the support coordinator. "Per day" units may be billed using the proper PA, after services are delivered.

Assistive Devices and Medical Supplies

Authorization for assistive devices and medical supplies will be issued upon receipt of the POC (initial, provisional, or revision).

Units of service:

Type of Delivery Method	Unit of Service
PERS Installation Telecare Installation	1-time fee
PERS Maintenance Telecare Maintenance	Per month
Medication Dispensing and Monitoring	Per month
Equipment Rental and Repairs	Pay as approved
Equipment Purchase Medical Supply Purchase Procurement	Per service/Pay as approved

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PERS installation and monthly units of service use the data contractor's database to retrieve PAs, but do not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

For all other "per month", "per service" or "pay as approved" units, the PA will be released for payment once the data contractor receives documentation from the support coordinator confirming the purchase/rental/repair/procurement. (See Appendix B for the link to the OAAS Assistive Devices and Medical Supplies form).

Home Delivered Meals

Authorization for home delivered meals (HDMs) is issued according to the POC. The PA must be for a minimum of 4 meals per week, up to a maximum of 14 meals per week, not to exceed the limit of 2 meals per day. A service unit is 1 meal.

This provider type uses the data contractor's database to retrieve PAs, but does not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

Medically Tailored Meals (MTMs) and Nutritional Counseling

Authorization for medically tailored meals (MTMs) and nutritional counseling services are issued according to the POC.

The PA for MTMs must be for 14 meals per week, not to exceed the limit of two meals per day. MTMs can begin the day after the beneficiary is discharged from the hospital or nursing facility and is not to exceed 12 weeks. A service unit is 1 meal.

The PA for nutritional counseling services are limited to 3 sessions per 12 weeks of MTM home delivery post discharge. A service unit is 1 nutritional counseling session/service.

This provider type uses the data contractor's database to retrieve PAs, but does not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

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Units of service:

Type of Delivery Method	Unit of Service
Medically Tailored Meals	Per service/meal
Nutritional Counseling	Per service

Nursing Services

A nursing service assessment and/or ongoing nursing services are authorized upon receipt of the POC (provisional, initial or revision).

Units of service:

Type of Delivery Method	Unit of Service
Assessment	Per service
Nursing Care	Per visit

Authorization is issued for no more than 6 months of service and in the amount indicated in the POC.

This provider type uses the data contractor's database to retrieve PAs, but does not utilize the database to document the provision of services. The PA will be released for payment once the data contractor receives the Nursing/Therapy Payment Authorization form from the support coordinator confirming the service/visit. (See Appendix B for the link to this form).

Skilled Maintenance Therapy Services (Physical Therapy, Occupational Therapy, Speech/Language Therapy)

A skilled maintenance therapy assessment and/or ongoing therapy services are authorized upon receipt of the POC (provisional, initial or revision).

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Units of service:

Type of Delivery Method	Unit of Service
Evaluation Re-evaluation	Per service
Therapy Home Care Training (Out-Patient)	Per Visit

Authorization is issued for no more than 6 months of service and in the amount indicated in the POC. The POC revision is based on the recommendations from the professional evaluation and as reflected on the CCW Nursing/Therapy Evaluation form. (See Appendix B for link to this form).

This provider type uses the data contactor's database to retrieve PAs, but does not utilize the database to document the provision of services. The PA will be released for payment once the data contractor receives the Nursing/Therapy Payment Authorization form from the support coordinator confirming the service/visit. (See Appendix B for the link to this form).

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

Authorization for these permanent supportive housing (PSH) services is made upon receipt of the POC (initial, provisional, or revision).

Units of service:

Type of Delivery Method	Unit of Service
Housing Stabilization	Per 15 minutes (maximum of 72 units per POC year)
Housing Transition or Crisis Intervention	Per 15 minutes (maximum of 96 units per POC year)

These provider types use the data contactor's database to retrieve PAs, but does not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

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Assistive Technology

Authorization for the assistive technology service is limited to a one-time lifetime purchase amount for the AT device (including protective case for the device) and a one-time lifetime amount for the AT procurement/set-up visit. The authorization period is the effective date indicated on the POC or POC Revision through the POC end date. The POC or POC revision, including the applicable assistive technology services, is submitted to the data contractor. The data contractor issues a PA for the requested services placing a hold on the PA until verification of receipt of services. After the approved device purchase is made by the agency and the set-up visit completed, the POC/POC revision, the receipt(s) for the purchases and the Assistive Technology form are sent to the data contractor. (See Appendix B for the link to this form).

The data contractor issues and releases the PA to the support coordination agency upon receipt of complete and accurate information.

Units of service:

Type of Delivery Method	Unit of Service
Purchasing Assistive Technology Device/Item(s)	Per service (one-time lifetime maximum payment)
Procurement for Set-Up Visit in the home	Per service (one-time lifetime maximum payment)

The PA will be released for payment once the data contractor receives documentation from the support coordination agency confirming the purchase/set-up visit. The support coordination agency is responsible for reimbursing the purchaser (beneficiary, family, provider, own agency, etc.) upon receipt of reimbursement. (See Appendix B for the link to OAAS Assistive Technology form).

Financial Management Services

Authorization for Financial Management Services (FMS) will be issued upon receipt of the POC (initial, provisional or revision).

Units of service include the following:

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Type of Delivery Method	Unit of Service
Financial Management Service (FMS) Monthly Administrative Fee for the Self-Direction Option	Per month

This provider type uses the data contractor's database to retrieve PAs, but does not utilize the database to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

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 through documentation submitted by the support coordinator as follows:

EVV	Additional Documentation
<ol style="list-style-type: none"> PAS ADHC Caregiver Temporary Support Services (In-home) Caregiver Temporary Support Services (ADHC and center based, not overnight) 	<ol style="list-style-type: none"> Skilled Maintenance Therapies Assistive Devices and Medical Supplies (excluding PERS) Nursing Services MIHC - Intake and Assessment Transition Services EAA Assistive Technology

The data contractor checks the information reported against the prior authorized units of service. Once post authorization is granted, the 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 Providers

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

All requests for changes in providers require a new FOC by the beneficiary or their responsible representative (Refer to 7.4 - Beneficiary Rights and Responsibilities, FOC of Providers, for details

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on “good cause” criteria and timelines.)

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

1. Progress notes from the last 6 months, or if the beneficiary has received services from the provider for less than 6 months, all progress notes from date of admission;
2. Written documentation of services provided, including monthly and quarterly progress summaries (if applicable);
3. Current ISP, (if applicable);
4. Current assessments upon which the ISP is based, (if applicable);
5. A summary of the beneficiary’s behavioral, social, health, and nutritional status, (if applicable);
6. Records tracking the beneficiary’s progress towards ISP goals and objectives, (if applicable);
7. Documentation of the amount of authorized services remaining in the POC including direct service case record documentation; and
8. Documentation of exit interview.

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

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

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

Prior Authorization for New Providers

The support coordinator will complete a 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(s) may request a change in their support coordination agency through the support coordinator or by contacting OAAS RO. (Refer to 7.4-Beneficiary Rights and Responsibilities, FOC of Providers, for details on "good cause" criteria and timelines).

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 "Support Coordination Transfer of Records form". (See Appendix B for the link to this form). The new agency must obtain the case record and authorized signature from the transferring agency.

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

1. Most current POC;
2. Current assessments on which the POC is based;
3. Number of services used in the POC year; and
4. Most recent (6 months) of Support Coordination Contact Documentation (SCD) forms.

NOTE: The new support coordination agency must bear the cost of copying the documents 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 RO 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.

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In the month the transfer occurs, the receiving agency must begin services within 3 days after the transfer of records and is eligible to bill for services the 1st 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 PA.

Prior Authorization for New Support Coordination Agencies

A new PA number will be issued to the new support coordination agency with an effective starting date as the 1st day of the 1st 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 1st 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 1st of the next month.