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 waiver opportunity is available. The applicant will receive a waiver offer packet that includes a CCW Services Decision form and a Support Coordination Agency (SCA) Freedom of Choice (FOC) and Release of Information form.

If interested in accepting the CCW opportunity, the applicant must complete and return the packet to determine if they meet the preliminary level of care criteria and/or any additional program requirements.

If the applicant meets the preliminary level of care and/or additional program requirements, they will be linked to a SCA. A support coordinator will be assigned to conduct an in-home assessment with the applicant and inform them 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:

1. Types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the beneficiary 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 (SC) 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:

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, (for adult day healthcare (ADHC), SC will also obtain completed assessment and/or plans written by the provider); and

4. Forwarding the POC packet to the Office of Aging and Adult Services (OAAS) regional office 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 CCW must be prior authorized. 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 provider is 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 one-year timely filing billing requirement under Medicaid regulations. See Section 1.4, Timely Filing Guidelines in the General Information and Administration Chapter of the Medicaid Services Manual at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

Support Coordination

Authorizations for support coordination service are issued by the data contractor 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 the month, after the SCa 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

Authorization for transition intensive support coordination (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 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 $1500. 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 (TSF)*"* 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.

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 assessment indicates the need for an EAA, the data contractor will issue the following two authorizations upon receipt of the revised POC:

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 assessor 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 one 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.

NOTE: Beneficiaries receiving self-directed PAS should refer to the *Community Choices Waiver Self-Direction Employer Handbook.* (See Appendix B for information on accessing 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 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.

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 Louisiana Service Reporting System (LaSRS®) to retrieve PAs, but do not utilize LaSRS® to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

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 LaSRS® to retrieve PAs, but does not utilize LaSRS® 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	One 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

PERS installation and monthly units of service use LaSRS® to retrieve PAs, but do not utilize LaSRS® 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 prior authorization will be released for payment once the data contractor receives documentation from the support coordinator confirming the purchase/rental/repair/procurement. (Refer to Appendix B for the OAAS Assistive Devices and Medical Supplies form).

Home Delivered Meals

Authorization for home delivered meals is issued according to the POC. The PA must be for a minimum of four meals per week, up to a maximum of 14 meals per week, not to exceed the limit of two meals per day. A service unit is one meal.

This provider type uses LaSRS® to retrieve PAs, but does not utilize LaSRS® 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 is 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 one meal.

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

The provider type uses LaSRS® to retrieve PAs, but does not utilize LaSRS® to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

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 six months of service and in the amount indicated in the POC.

This provider type uses LaSRS® to retrieve PAs, but does not utilize LaSRS® 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.

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).

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 six 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 LaSRS® to retrieve PAs, but does not utilize LaSRS® 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.

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 LaSRS® to retrieve PAs, but does not utilize LaSRS® to document the provision of services. The provider may bill, using the proper PA, after services are delivered.

Assistive Technology

Authorization for the assistive technology (AT) 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 AT services, is submitted to the data management contractor (DMC). The DMC 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 SCA 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 DMC.

The DMC issues and releases the PA to the SCA upon receipt of complete and accurate information.

Units of service:

Type of Delivery Method	Unit of Service
Purchasing Assistive Technology (AT) 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 prior authorization will be released for payment once the DMC receives documentation from the SC confirming the purchase/set-up visit. (Refer to Appendix B for the OAAS Assistive Technology form).

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
Personal Assistance Service (PAS)	Skilled Maintenance Therapies
Adult Day Health Care (ADHC)	Assistive Devices and Medical Supplies (excluding PERS)
Caregiver Temporary Support In-home	Nursing
Caregiver Temporary Support ADHC and center based (not overnight)	MIHC Intake and Assessment
	Transition Services
	Environmental Accessibility Adaptation

The DMC 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 to the 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, Freedom of Choice of Providers, for details 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:

1. 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;

2. Written documentation of services provided, including monthly and quarterly progress summaries (if applicable);

3. Current individualized service plan (ISP), current assessments upon which the ISP is based (if applicable);

4. Documentation of the amount of authorized services remaining in the POC including direct service case record documentation; and

5. 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.

NOTE: The new provider must bear the cost of copying, 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

Beneficiary(s) may request a change in SCA through the support coordinator or by contacting OAAS regional office. (Refer to 7.4-Beneficiary Rights and Responsibilities, Freedom of Choice 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 Transfer of Records 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 six months of Support Coordination Documentation (SCD).

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 must 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 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.