SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for a new Community Choices Waiver 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 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 Support Coordination Agency Freedom of Choice form.

The applicant must complete and return the packet to indicate interest in receiving a Community Choices Waiver opportunity and to determine if he/she meets 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, 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 parish office.

Once it has been confirmed 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 reasonably assure health and welfare and to maintain the person 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 providers 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 provider's 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 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 and Post Authorization

All services under the Community Choices 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 and waiver 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:

- 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 specified in Section 7.8 – Record Keeping 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, if required.

- 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.

Some services require post authorization before the provider is able to bill for services rendered. 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.

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 agency 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.

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

Environmental Accessibility Adaptation

When the data management contractor receives a Plan of Care (provisional, initial or revised) that indicates a need for an environmental accessibility adaptation, an authorization is issued for a basic assessment to the assessor/inspector/approver, hereafter referred to as the assessor. After the data management contractor receives documentation that the assessor has completed the assessment, the PA for the **basic assessment and approval services** is released.

If the basic assessment indicates the need for an environmental accessibility adaptation, the data management contractor will issue the following two authorizations upon receipt of the revised Plan of Care:

- An authorization for the final assessment and approval to the assessor, and
- An authorization for the installation/completion of the adaptation to the contractor.

Upon receipt of documentation that these tasks have been completed, the data management

contractor will release the PAs for payment.

NOTE: If an assessor provider is not available, the OAAS regional office is responsible for giving prior approval for both installation/completion of the adaptation and for satisfactory completion of the adaptation.

Personal Assistance Services

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

A unit of service is:

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

The authorization, which is based on the prior authorized weekly cap, is released on a daily basis after service is provided and documented in the LAST system. The prior authorized week begins on Sunday at 12:00 a.m. and ends on the following Sunday at 12:00 a.m. Unused portions of the prior authorized allotment may not be saved or borrowed from one week for use in another week.

NOTE: Recipients receiving self-directed services should refer to the *Louisiana Department of Health and Hospitals Office of Aging and Adult Services Self-Direction Option Community Choices Waiver Employer Handbook.* (See Appendix B for information on accessing this handbook)

Adult Day Health Care

Authorization of adult day health care (ADHC) services is issued for the full plan of care year. The service unit is 15 minutes. Depending on the number of units being authorized, the authorization may be issued in two or more PAs. The PA is released for reimbursement after services are provided and documented in the LAST system.

Caregiver Temporary Support

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

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

PAs for assisted living centers, nursing facilities and respite care centers are automatically released at the time of issuance. These providers do not utilize the LAST system to document the provision of services.

Assistive Devices and Medical Supplies: Personal Emergency Response Systems (PERS) and Telecare

Authorization for assistive devices and medical supplies will be authorized upon receipt of the Plan of Care (initial, provisional, or revised). A PA is issued for the one-time installation of PERS and Telecare. An annual PA, comprised of a monthly unit of service, is issued for the monthly monitoring and maintenance. The monthly unit of service is automatically released at the time of issuance. These providers do not utilize the LAST system to document the provision of services.

Home Delivered Meals

Authorization for home delivered meals is issued according to the Plan of Care. 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. These PAs are simultaneously released upon issuance. These providers do not utilize the LAST system to document the provision of services.

Nursing Services

A nursing service assessment and/or ongoing nursing services are authorized upon receipt of the Plan of Care (provisional, initial or revised). Authorization is issued for no more than six months of service and is automatically released at the time of issuance.

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 Plan of Care (provisional, initial or revised). Authorization is issued for no more than six months of service and is automatically released at the time of issuance.

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

Housing Transition or Crisis Intervention Services and Housing Stabilization Services

Authorization for these housing support services is made upon receipt of the Plan of Care (initial, provisional, or revised). These providers do not utilize the LAST system to document the provision of services.

Changing Providers

Changing Support Coordination Providers

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

- A recipient moving to another region in the state,
- The recipient and the support coordination agency have unresolved difficulties and mutually agree to a transfer,
- The recipient's health or welfare have been compromised, or
- The support coordination agency 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 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 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:

- Most current Plan of Care,
- Current assessments on which the Plan of Care is based,
- Number of services used in the Plan of Care year, and
- Most recent six months 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 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 agency. In the month the transfer occurs, the receiving agency 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 agency 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 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.

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 agency 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 Service Providers

Recipients may change service providers based on the following schedule:

- Personal Assistance Service providers - once every quarter (three months) of the calendar year with the effective date being the beginning of the following quarter of the calendar year.

- All other service providers (except Transition Services) – once every six months.

Providers may be changed for good cause at any time as approved by the OAAS or its designee.

Good cause is defined as:

- A recipient moving to another region in the state where the current service provider does not provide services,

- The recipient and the service provider have unresolved difficulties and mutually agree to a transfer,
- The recipient's health or welfare has been compromised, or
- The provider has not rendered services in a manner satisfactory to the recipient.

Recipients must contact their support coordinator to change service providers.

The support coordinator will provide the recipient with the current Freedom of Choice (FOC) list of service providers in his/her 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 recipient, both the transferring provider and the receiving provider 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, and records tracking recipient's progress towards Individualized Service Plan goals and objectives (if applicable),
- 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 service provider agency and forward copies of the following to the new service provider:

- Most current Plan of Care,
- Current assessments on which the Plan of Care is based, and

- All other waiver documents necessary for the new service provider to begin providing services.

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 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 agency's PA number will expire on the end date as indicated on the Plan of Care revision.