SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for an additional New Opportunities Waiver (NOW) opportunity or an existing opportunity is vacated, the next individual on the Request for Services Registry (RFSR) will receive a written notice indicating that a waiver opportunity is available. That individual will be evaluated for a possible NOW assignment.

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.

Prior to linkage to a support coordination agency, the applicant must have provided the Medicaid data contractor with a current 90-L form that has been completed, signed and dated by his/her Louisiana licensed primary care physician. 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 and 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. The following must be addressed in the Plan of Care:

- The applicant's assessed needs,
- 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 service (including waiver and all other services), and
- The average cost of services per day 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 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 service.

- Requesting the provider sign and return the following:
  - Section IX of the Plan of Care and/or the individual support plan,
  - Emergency Plan, and
  - Individualized Staffing Back-up Plan.
- Forwarding the Plan of Care packet to the Office for Citizens with Developmental Disabilities (OCDD) regional waiver office or Human Services Authority or District for review and approval.

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

Prior Authorization

All services in the NOW program 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. Prior authorizations are issued in quarterly intervals directly to the provider, with the last quarterly authorization ending on the Plan of Care end date.

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 prior authorization are not eligible for reimbursement.

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 direct service worker's timesheet 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 and progress notes 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 DHH fiscal intermediary with each payment.

- Checking billing records to ensure that the appropriate payment was received. (Note: Service providers have a one-year timely filing billing requirement under Medicaid regulations.)

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

NOTE: Authorization for services will not be issued retroactively unless a person leaving a facility is involved with special circumstances.

Post Authorization

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 unit 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.

One Time Transitional Expenses

The support coordinator must develop a plan to include the transition expenses for individuals who are moving from an Intermediate Care Facility for people with Developmental Disabilities

(ICF/DD) into their own residence in the community. No funds will be disbursed without prior authorization of expenditures. The following procedure must be followed to access these funds:

- The support coordinator must complete the "Transitional Expenses Planning and Approval (TEPA) Request Form," with input from the recipient and his/her circle of support, to document the need for transitional expenses, identify the designated purchaser, and estimate the cost of the items or services that are needed. The recipient may choose to be the designated purchaser or may select his/her authorized representative, support coordinator, or provider to act as the designated purchaser. (See Appendix D for a copy of this form)

- The support coordinator must request pre-approval from the OCDD regional waiver office or Human Services Authority or District by submitting the TEPA request form and the Plan of Care packet, including the Plan of Care budget sheet identifying the estimated TEPA cost, procedure code, provider and provider number, at least 10 working days prior to the recipient's actual move date.

- The OCDD regional waiver office or Human Services Authority or District sends the completed pre-142 approval letter and pre-approved TEPA request form to the support coordinator and OCDD Central Office Fiscal Section. A copy of the pre-142 approval letter will also be sent to the Medicaid parish office. The purchasing process cannot begin until the pre-142 approval letter is issued to the support coordinator.

- The support coordinator assists the designated purchaser with obtaining the items on the pre-approved TEPA request form.

- After purchases are made, the support coordinator is responsible for:

    - Obtaining the original receipts from the designated purchaser,
    - Identifying the pre-approved items to be reimbursed,
    - Notating the actual cost of the pre-approved items on the TEPA request form,
    - Summarizing all items purchased by the designated purchaser on the "NOW TEPA Invoice Form,"
    - Completing the "Request for Taxpayer Identification Number and Certification" (W-9 form) if the designated purchaser is not established as a state vendor, and
    - Informing the designated purchaser of the timeframes and procedures to be followed in order to obtain reimbursement.

- The support coordinator must submit the pre-approved TEPA request form,

original receipts, W-9 form (if applicable), and the TEPA Invoice form to the OCDD regional waiver office or Human Services Authority or District at least 10 working days following the pre-certification home visit.

- The OCDD regional waiver office or Human Services Authority or District reviews the purchased items with the recipient/authorized representative at the pre-certification home visit for approval.

- The OCDD regional waiver office or Human Services Authority or District mails the 18-W form, original receipts, pre-approved TEPA request form, and NOW TEPA Invoice Form to the OCDD Central Office Fiscal Section upon receipt. Payment will not be authorized until the OCDD regional waiver office or Human Services Authority or District gives final Plan of Care approval upon receipt of the 18-W form.

- The OCDD Central Office Fiscal Section establishes a transition expense record for the recipient and utilizes the pre-approved TEPA request form to ensure that only the item/services listed are reimbursed to the designated purchaser.

- The support coordinator must submit to the OCDD regional waiver office or Human Services Authority or District a revised Plan of Care budget sheet if there are any cost differences between the approved estimated TEPA cost and the actual TEPA cost.

- The OCDD Central Office Fiscal Section sends the "OCDD Verification of Actual TEPA Costs" form to the OCDD regional waiver office or Human Services Authority or District for service authorization.

- The OCDD regional waiver office or Human Services Authority or District gives final approval on the "OCDD Verification of Actual TEPA Costs" form and faxes it to the Medicaid data contractor along with the approved TEPA request form and accompanying Plan of Care budget sheets. A copy of the "OCDD Verification of Actual TEPA Costs" form is faxed back to the OCDD Central Office Fiscal Section for documentation in the OCDD payment record.

- Service authorization is issued to the OCDD Central Office Fiscal Section for the actual cost of items as identified on the approved TEPA request form. Any new items not on the original approved TEPA Request Form will not be reimbursed.

- The OCDD Central Office forwards the reimbursements to the designated purchaser upon payment from Medicaid.

All billing must be completed by the Plan of Care end date in order for the reimbursement to be

paid. OCDD central office Fiscal Section maintains documentation for accounting and monitoring purposes of each recipient's TEPA request including original receipts and record of payments to the designated purchaser

Additional requests for One Time Transitional Expenses must be requested by the recipient and submitted by the support coordinator on a new TEPA request form to the OCDD regional waiver office or Human Services Authority or District following the above procedure. Requests may be submitted up to 30 calendar days after the stamped receipt date of the 18-W in the OCDD regional waiver office or Human Services Authority or District.

Changes

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

Changing Direct Service Providers

Recipients may change direct service providers once every service authorization quarter (three months) with the effective date being the beginning of the following quarter. Direct service providers may be changed for good cause at any time as approved by the OCDD regional waiver office or Human Services Authority or District.

Good cause is defined as:

- A recipient moving to another region in the state where the current direct service provider does not provide services,
- The recipient and the direct service provider have unresolved difficulties and mutually agree to a transfer,
- The recipient would like to share supports with another recipient who has a different provider agency, regardless of the recipients' relationship,
- The recipient's health, safety or welfare have been compromised, or
- The direct service provider has not rendered services in a manner satisfactory to the recipient or his/her authorized representative.

Recipients and/or their authorized representative must contact their support coordinator to change direct service providers.

The support coordinator will assist in facilitating a support team meeting to address the recipient's reason for wanting to terminate services with the current service provider(s).

Whenever possible, the current service provider should have the opportunity to submit a corrective action plan with specific timelines, not to exceed 30 days, to attempt to meet the needs of the recipient.

If the recipient/authorized representative refuses a team meeting, the support coordinator and OCDD regional waiver office or Human Services Authority or District determines that a meeting is not possible or appropriate, or the corrective action plan and timelines are not met, the support coordinator will:

- Provide the recipient/ authorized representative with a current FOC list of service providers in his/her region.
- Assist the recipient/authorized representative in completing the FOC list and release of information form,
- Ensure the current provider agency is notified immediately upon knowledge and prior to the transfer, and
- Obtain the case record from the releasing provider which must include:
    - Progress notes from the last two months, or if the recipient has received services from the provider for less than two months, all progress notes from date of admission,
    - Written documentation of services provided, including monthly and quarterly progress summaries,
    - Current Individualized Service Plan (ISP),
    - Records tracking recipient's progress towards ISP goals and objectives, including standardized vocational assessments and/or notes regarding community or facility-based work assessments, if applicable,
    - Records of job assessment, discovery, and development activities which occurred, and a stated goal and objective in the most current ISP for the recipient to obtain competitive work in the community, if stated,
    - Copies of current and past behavior management plans, if applicable,
    - Documentation of the amount of authorized services remaining in the Plan of Care, including applicable time sheets, and

- Documentation of exit interview.

The support coordinator will 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,
- Number of services used in the calendar year,
- Records from the previous service provider, and
- All other waiver documents necessary for the new service provider to begin providing service.

Transfers must be made seven days prior to the end of the service authorization quarter in order to coordinate services and billing, unless the OCDD regional waiver office or Human Services Authority or District waives this requirement in writing due to good cause.

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

A new PA number will be issued to the new provider with an effective starting date of the first day of the new quarter or the first day of the first full calendar month following a good cause change. The transferring agency's PA number will expire on the date immediately preceding the PA date for the new provider.

Neither OCDD 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 recipient 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 OCDD regional waiver office or Human Services Authority or District when the reason for change is due to good cause as specified above.

Changing Supported Independent Living Providers

Changes in Supported Independent Living (SIL) providers will be effective on the Sunday following the approved request to change agencies. The agency the recipient is leaving will be

responsible for completing all three required contacts in the last week. The new provider agency will be responsible for completing these requirements beginning the week the transfer is effective. In instances where there is a need for an emergency change in providers at any other day during the week, the new provider agency will be responsible for meeting the weekly requirements.

If a new recipient begins receiving SIL services on a day other than Sunday due to an emergency, the provider will also be required to meet all weekly requirements in order to receive payment.

Changing Support Coordination Agencies

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. 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, safety or welfare have been compromised, or
- The support coordination provider has not rendered services in a manner satisfactory to the recipient.

Participating support coordination agencies should refer to the Case Management Services manual chapter which provides a detailed description of their roles and responsibilities.