# SERVICE ACCESS AND AUTHORIZATION

When funding is appropriated for an additional OCDD waiver opportunity or an existing opportunity is vacated and funded, the next individual on the Developmental Disability Request for Services Registry (DDRFSR) 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 a person centered planning process. At the conclusion of that process, if it is determined that the New Opportunities Waiver is the most appropriate waiver for this individual, a NOW offer will be extended.

The applicant will receive a waiver offer packet that includes a Support Coordination Agency Freedom of Choice (FOC) 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 and the availability of services as well as the assistance provided through the support coordination service.

Once it has been determined that another OCDD waiver will not meet the needs of the applicant, and the New Opportunities Waiver (NOW) is the most appropriate waiver, another home visit is made to finalize the plan of care (POC). The following must be addressed in the POC:

- The applicant's assessed needs;
- The types and quantity of services (including waiver and all other services) necessary to maintain the applicant safely in the community;
- The individual cost of each waiver service; and
- The 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 form initially and annually thereafter for each identified waiver service.

### Initial Plan of Care

The support coordinator will take the following actions:

- Notify the provider that the beneficiary has selected their agency to provide the necessary service;
- Schedule a meeting with the provider and the beneficiary to discuss services needed by the beneficiary;
- After the meeting, forward a copy of the draft POC to the provider and request the provider sign and return the following:
  - Budget pages; and
  - Required POC provider attachments (e.g. Attachments B through I) as indicated in the POC.
- Forward the initial POC packet, including provider attachments to the Human Services Authority or District for review and approval.

### Annual Plan of Care

Annual POCs follow the same process as an initial POC except for the following:

- Support Coordinator supervisors are allowed to approve an annual POC based on OCDD policy; and
- A copy of any POC approved by the Support Coordinator supervisor will be forwarded to the Human Services Authority or District.

**NOTE**: New Opportunities Waiver services cannot begin prior to the Human Services Authority/District or Support Coordinator supervisor approval of the POC.

## 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 beneficiary 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, compliance with all policy and rules for the covered services, 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, which means that only the service codes and units specified in the approved POC 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 beneficiary's POC. Any mistakes must be immediately corrected to match the approved services in the POC;
- Verifying that the direct service worker's timesheet or electronic clock in/out is completed correctly and that services were delivered according to the beneficiary's approved POC prior to billing for the service;
- Verifying that services were documented and provided as evidenced by timesheets or electronic clock in/out and progress notes and are within the approved service limits as identified in the beneficiary's POC prior to billing for the service;
- 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;
- Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system:
    - It is the provider's responsibility to ensure that billing information for the dates of service, procedure codes, and number of units delivered is correct and matches the information in LaSRS. Inconsistencies between LaSRS and the provider's billing system may result in recoupment.
- Billing only for the services that were delivered to the beneficiary and are approved in the beneficiary's POC;

- Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary with each payment; and

- 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 approved due to special circumstances by the OCDD Waiver Director/designee.

## Post Authorization

To receive post authorization, a service provider must ensure that service delivery information is reported accurately in the post authorization system maintained by the Medicaid data contractor. The Medicaid data contractor checks the service delivery information located in the post authorization system against the prior authorized units of service. Once post authorization is granted, and billing is correctly submitted by the service provider, reimbursement for the appropriate units of service will occur.

Providers of NOW services must ensure that the service provided, quantity of services, and dates of service billed align with actual delivery of services. Span date billing for services is acceptable as long as the dates align with the services being billed. Services billed and paid in excess of the services provided **on a specific date** will be recouped.

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

## IFS Supplemental Payment for Complex Needs

The provider agency is responsible for completing the OCDD Behavioral and Non-Complex Tasks Review screening tool which is required to determine if the individual requires additional support in order for the provider to receive the supplemental payment. In addition, the provider must obtain all required documentation per the screening tool in addition to preparing and submitting the required provider documents.

The Support Coordination Agency will submit the screening tool and the provider documents to the LGE for review and approval. Initially approval will be required from the OCDD Central

Office. However, this approval may be re-directed to the Human Services Districts and Authorities in the future.

## 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 Individuals with Intellectual Disabilities (ICF/IID) or other institution 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 beneficiary 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 beneficiary 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 link to this form);

- The support coordinator must request pre-approval from the Human Services Authority or District by submitting the TEPA request form and the POC packet, including the POC budget sheet identifying the estimated TEPA cost, procedure code, provider and provider number, at least 10 working days prior to the beneficiary's actual move date;

- The 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. The beneficiary must be provided choice in the items being purchased on his/her behalf;

- 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 Human Services Authority or District within 90 calendar days following the pre-certification home visit;
- The Human Services Authority or District reviews the purchased items with the beneficiary/authorized representative at the pre-certification home visit for approval;
- The 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 Human Services Authority or District gives final POC approval upon receipt of the 18-W form;
- The OCDD Central Office Fiscal Section establishes a transition expense record for the beneficiary 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 Human Services Authority or District a revised POC 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 Human Services Authority or District for service authorization;
- The 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 POC 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; and

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

All billing must be completed by the POC end date in order for the reimbursement to be paid. OCDD central office Fiscal Section maintains documentation for accounting and monitoring purposes of each beneficiary'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 beneficiary and submitted by the support coordinator on a new TEPA request form to the Human Services Authority or District following the above procedure. Requests must be approved 60 calendar days prior to the expiration of the original POC.

## Changes

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

### Changing Direct Service Providers

Beneficiaries 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 Human Services Authority or District.

Good cause is defined as:

- A beneficiary moving to another region in the state where the current direct service provider does not provide services;

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

Beneficiaries 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 beneficiary'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 calendar days, to attempt to meet the needs of the beneficiary.

If the beneficiary/authorized representative refuses a team meeting, the support coordinator and 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 beneficiary/ authorized representative with a current FOC list of service providers in his/her region;
- Assist the beneficiary/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 beneficiary 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 POC provider documents;
- Records tracking beneficiary's progress towards POC 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 beneficiary 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 prior authorization periods for the current POC 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 calendar days prior to the end of the service authorization quarter in order to coordinate services and billing, unless the 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. If the existing provider charges a rate that exceeds the competitive copying rate, then the provider should contact the Support Coordinator to resolve the issue.

**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 date agreed to by the new provider. The transferring agency's PA number will expire on the date immediately preceding the PA date for the new provider. New providers who provide services prior to the start date on the new Prior Authorization 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 change is due to good cause.

## 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 beneficiary is leaving will be responsible for completing all 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 beneficiary 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 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 its maximum number of beneficiaries. Good cause is defined as:

- A beneficiary moving to another region in the state;
- The beneficiary and the support coordination provider have unresolved difficulties and mutually agree to a transfer;
- The beneficiary's health, safety or welfare have been compromised; or
- The support coordination provider has not rendered services in a manner satisfactory to the beneficiary.

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.