SERVICE AUTHORIZATION PROCESS

Recipients who have been presumptively determined to meet nursing facility level of care and imminent risk requirements by the Level of Care Eligibility Tool (LOCET) will have a Minimum Data Set-Home Care (MDS-HC) assessment performed by the Office of Aging and Adult Services (OAAS) or its designee. The assessment and any other documentation are reviewed to determine if the recipient meets nursing facility level of care and qualifies for other program requirements. The Plan of Care is developed based on the results of the MDS-HC.

Provider Selection

If approved for services, an approval notice is sent to the recipient with a copy of the Plan of Care, a list of enrolled Medicaid long term-personal care services (LT-PCS) agencies that provide services in his/her area, and an Agreement to Provide Services form. The recipient is instructed to select and contact a provider to arrange for services. Providers will need to meet with the recipient to review the Plan of Care and discuss provision of the services.

If the provider agrees to provide the services, the contractor should be contacted and the appropriate documentation must be sent to them within 14 calendar days. (Refer to Appendix F for contractor information)

If the chosen provider declines to serve an individual, the provider must furnish to the entity that developed the Plan of Care written documentation that supports an inability to meet the individual's health and welfare needs, or all previous efforts to provide services and supports have failed and there is no option but to refuse services. The individual will then be asked to choose another provider.

Prior Authorization

All services for LT-PCS must be prior authorized. It is the responsibility of the provider to verify current prior authorizations (PAs) before services begin for a recipient. 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.

A PA number is assigned, and approved units of service are released on a weekly basis to the provider. The approved units of service must be used for the specified week. Units of service approved for one week cannot be combined with units of service for another week. For prior authorization purposes, a week is defined as beginning midnight Sunday and ending midnight Saturday.

A PA number will be issued to providers for the service authorization period, unless the recipient changes providers. Providers must use the correct PA number when filing claims for services rendered. Claims with the incorrect PA number will be denied.

All requests for changes in services and/or service hours must be made by the recipient or his/her responsible representative. A status change assessment will be performed for all requests where a change in the recipient's level of functioning is reported. The status change assessment may be done by telephone or in person, at the discretion of OAAS or its designee.

Reassessments will be conducted at least once every 18 months to determine ongoing qualification for services.