SUBJECT: Medicaid 1915(c) Home and Community Based Services (HCBS) Case Management: Service Authorizations	**REFERENCE NUMBER:** CM-001
TARGET AUDIENCE: Providers of HCBS Case Management and Participant Directed Case Management	**EFFECTIVE DATE:** 11/25/2019
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APPROVAL DATE: 11/19/19	**SIGNATURE:** *Pam Smith*

PURPOSE:

The purpose of this document is to provide formal guidance to 1915(c) waiver case managers on minimum standards for activities related to service authorization. Service authorization includes:

- Defining required services needed to meet participant identified goals and desired outcomes
- Submitting the service authorization for approval

This document serves as an ongoing source of guidance regarding what the Department for Medicaid Services (DMS) requires for high-quality case management delivery. This SOP is intended to offer broad guidance on case management practices throughout the Commonwealth and should be used to develop a provider's internal policies and procedures. For more specific requirements and procedures, please refer to your organization's policies and procedures.

CHANGES SINCE LAST REVISION:

- N/A

DOCUMENTS/ASSOCIATED RESOURCES:

- Service authorization training
- Service authorization crosswalk

Respective parties shall complete the following activities in accordance with the descriptions within this document. If you have any questions regarding any of the steps below, contact the Cabinet for Health and Family Services (CHFS) Department for Medicaid Services (DMS) 1915(c) Waiver Help Desk, 844-784-5614 or by emailing 1915cwaiverhelpdesk@ky.gov.

Section 1: Acronyms and Definitions

Term/Abbreviation	Definition	Reference
CM	Case Manager	N/A
DMS	Department for Medicaid Services within Kentucky's Cabinet for Health and Family Services	N/A
Guardian (for a minor)	An individual, agency, or corporation appointed by the District Court to have care, custody, and control of a minor and to manage the minor's financial resources.	KRS 387.010(3)
Guardian (for an adult)	A person appointed by the court to make decisions regarding the person of an adult.	KRS 387.812(3)
MMIS	Medicaid Management Information System	N/A
MWMA	Medicaid Waiver Management Application	N/A
Natural supports	Individuals who provide unpaid support, training, companionship, or supervision for the purpose of accomplishing or improving the participant's quality of life. Natural supports include family members, friends, neighbors, coworkers, community members, and the participant's responsible party (if applicable).	Appendix C-1/C-3, SCL waiver application (Natural Supports Training)
Participant	Waiver service recipient	N/A
PCSP	Person-centered service plan	N/A
PDS	Participant Directed Services	N/A
Prior authorization	Previous term used to describe the required action to obtain approval from the quality improvement	N/A

	organization (QIO) for waiver services based upon medical necessity. Authorization for services must be approved for payment to be made by the Medicaid Program on behalf of both the categorically and the medically needy. MWMA will generate a 'prior authorization' number upon service approval.	
Service authorization	Term used to replace "prior authorization." Determination of appropriate services to meet participant's assessed goals and desired outcomes. For some services this may include a determination of medical necessity or clinical appropriateness of benefits and services. Other services require a determination of appropriateness based upon needs within other domains (environmental, social, financial, emotional etc.) for which payment shall be made by the Medicaid Program on behalf of both the categorically and the medically needy.	N/A
SOP	Standard Operating Procedure	N/A

Section 2: Prepare to authorize services

Step	Action	Responsible Party
Conduct service planning and determine authorized service level with the participant		
1.	Review the functional assessment to be informed of the participant's needs to ensure that an appropriate level of service can be delivered.	Case Manager (CM)
2.	Provide information and education to the participant, guardian, and authorized representative, if applicable, to facilitate their understanding of how the assessed level of need influences the level of services appropriate to authorize. Ensure that there is a thorough review of all relevant community resources and that both waiver and non-waiver services are explored for a comprehensive plan.	CM
3.	Complete the PCSP in the Plan of Care (POC) Module in MWMA. The PCSP must have the following mandatory sections completed: • Goals • Objectives • Waiver service details • Non-waiver service details	CM
4.	Evaluate the amount of services required based upon the identified need within the assessment to estimate the service type, frequency, scope, and duration. For example, if the participant only needs and requests assistance to prepare for bathing and dressing following bathing, consider: • The number of times per week the participant wishes to bathe • The specific amount of time needed to prepare for bathing • The amount of time needed to dress following bathing • Any additional practical factors that may influence the time required to complete care or deliver services safely and in a person-centered manner (e.g. participant's preferred method of bathing, anticipated resistance with care delivery, cueing and prompting required vs. direct assistance)	CM
5.	If the participant consents to the agreed upon scope, amount, and duration of service, follow the remaining steps in sections 3-4 of this SOP.	CM

Step	Action	Responsible Party
	If the participant disagrees with the scope, amount, and duration, the CM should provide the participant with necessary information to file a grievance. Refer to the Service Authorization Training Guide for additional information.	

Section 3: Entering Service Authorization in MWMA

Step	Action	Responsible Party
Submitting the service type, amount, scope, and duration into MWMA		
6.	Enter the service type, frequency, and scope of services into the POC module in MWMA to complete documentation of needed services to meet the participant's goals and objectives in the "MWMA Plan Details" screen.	CM
7.	Review the entire PCSP, ensure all fields are filled in completely and accurately, save the PCSP, and submit it within MWMA.	CM

Section 4: Case Management Supervisor Review (if applicable)

Step	Action	Responsible Party
Case Management Supervisor Review		
8.	In certain situations, the CM will request a case management supervisor review. If applicable, the CM will check the box in MWMA, "case supervisor review required." The case management supervisor will receive an automated task in MWMA to review the PCSP. ***NOTE**: CM agencies are strongly encouraged to have CM Supervisors review the PCSP to monitor utilization and ensure proper allocation of services. Case management supervisor review will ensure PCSPs are aligned with participant goals and needs identified in the functional assessment and other participant specific information. Specifically, supervisory review of PCSPs will focus on:* • *Use of 1915(c) waiver or non-waiver services* • *Frequency of services* • *Amount of services* • *Appropriateness of goals*	CM

Step	Action	Responsible Party
9.	If the CM Supervisor requires a revision, the CM will receive an automated task via MWMA. Once an automated task is received, the CM needs to review the case management supervisor's comment(s), address needed changes, save and complete re-submission of the PCSP. ***NOTE**: MWMA will require all fields to be complete; however, if a functional error is displayed the CM must address the error (i.e., inaccurate date).*	CM
10.	Any services not requiring a Cabinet-level review and approval will be marked as approved in MWMA. Once all services are in the 'approved' status, including services requiring Cabinet-level review, MWMA will interface with the Medicaid Management Information System (MMIS) and a prior authorization number will be generated. ***NOTE**: MMIS may return an error message. If this occurs, the error will include instructions for resolving the error and help desk contact information for additional follow-up as needed.*	N/A

Section 5: Cabinet-level review of service authorization

Step	Action	Responsible Party
Updating the service status		
11.	DMS or its designee will review service authorization(s) designated as requiring a Cabinet-level review.	DMS or its designee
12.	MWMA will display the status of the service. Please proceed according to the instructions below with the corresponding status. Service statuses include, but are not limited to: • Prior Authorized, • Approved, • Pended, • Denied, • Cancelled • Voided (used only on a previously approved services) Please refer to the MWMA Service Authorization Quick Reference Guide for additional information regarding service statuses.	CM

Step	Action	Responsible Party
13.	**If a service is approved**: Enter start and end date. MWMA will send the service to MMIS, which will return a prior authorization number. ***NOTE**: The prior authorization number(s) will be generated after **ALL** services on the plan have been approved.*	CM
14.	**If a service is pended**: The CM receives an automated task for revisions requested. Once the task is received, the CM is required to review the comment in MWMA, address needed changes and complete re-submission of the PCSP.	CM
15.	**If a service is denied**: A denial reason should be entered into the notes, saved and submitted through MWMA. ***NOTE**: Within 10 calendar days a CM may request reconsideration by navigating through the reconsideration screen and completing required information.*	DMS or its designee
16.	**If a service is cancelled**: The cancelled service status is only used on services that were already entered / approved. ***NOTE**: Services can only be cancelled before the prior authorization number is issued.*	CM
17.	**If a service is voided:** The voided service status is only used on services that have been issued a prior authorization number**.**	N/A