403 Eligibility for Services: Prior Authorization by the Community Services Bureau

Draft – March 15, 2021

DEFINITION

Prior authorizations provide approval to exceed payment limits for certain services before the services are provided. The Community Services Bureau ~~(CSB)~~ may require approval by the ~~Regional~~ regional ~~Program~~ program ~~Officer~~ officer ~~(RPO)~~ and/or Community Services Bureau ~~CSB prior~~before ~~to~~ a ~~the~~ member ~~receiving~~ can receive specific services or services valued above certain amounts. ~~Big Sky Waiver (BSW) is not an entitlement program and is subject to federal regulations requiring cost-effectiveness measures. The Case Management Team (CMT) is required to manage services within the Service Plan cost limit to keep the program from exceeding any state funding limitations. A Prior Authorization (PA) is limited to the authorization period indicated on the Prior Authorization form.~~

The Big Sky Waiver is not an entitlement program and is subject to federal regulations requiring cost-effectiveness measures. Case management teams manage services and budgets to keep the waiver program from exceeding state funding limits. ~~Services authorized by the CMT that do not meet Prior Authorization criteria are subject to repayment.~~

Prior authorization for services is different than authorizing provider payments by the case management team. ~~NOTE:~~

Refer to BSW 605 (Payment Processing) for more information~~information related to prior authorization completed by the Case Management Team for provider payment~~.

~~REQUIREMENTS~~

~~CMTs are required to provide justification that each prior authorization request meets all prior authorization criteria prior to submitting a request to the RPO; RPOs are required to confirm the prior authorization criteria has been met. Prior Authorizations are subject to the following criteria and require RPO approval:~~

1. ~~The service(s) must be medically necessary and relate specifically to the member's medical diagnosis or is necessary for the member to access the member's home and/or community. This must be documented in the member's service plan.~~
2. ~~The service must be such that without the services(s), the member would require institutionalization and/or results in the member's decreased access to their home and/or community.~~
3. ~~The service plan must include documentation supporting that each service is the most cost-effective option to meet the need of the member. Cost-effectiveness evaluation requires a~~

comparison of similar services and equipment/supplies and choosing the option that meets the member's specific need at the lowest cost.

4. The member must pursue all other potential third- party sources of coverage (including, but not limited to: natural supports, Medicare, EPSDT, CFC and State Plan). All third-party sources must be evaluated and exhausted prior to the authorization of services; documentation that needed items are not coverable by another payer source must be present in the member's case record;

NOTE:

If the individual is under the age of 21, EPSDT must have been pursued and a decision received for all services/supplies (with the exception of home modifications, vehicle modifications and/or service animals) and the documentation has been uploaded into CaseWave. If the request for services includes Personal Assistance Services, Specialized Child Care for Medically Fragile Children, and/or Private Duty Nursing:

a. The MPQH profile has been uploaded into CaseWave; and
b. a bi-weekly schedule of the hours currently utilized through State Plan therapies, CFC, EPSDT and/or Life Span Respite and the remaining hours of coverage requested through Big Sky Waiver has been uploaded into CaseWave

5. The service must be received after the client's enrollment into BSW and prior to termination from BSW. Payment will not be made for services rendered after the effective date of termination. Services that are incurred prior to the Prior Authorization request will not be approved and are subject to repayment. Services that are expected to be received or consumed over a period that exceeds the member's BSW enrollment period such as dietary supplements purchased in bulk which are expected to be consumed after the client's BSW termination date do not meet BSW service or Prior Authorization criteria;

6. The service must provide a direct medical or curative benefit to the member; and
7. The service is an approved service listed in the BSW Application.

Services authorized by the CMT that do not meet Prior Authorization criteria are subject to repayment.

PRIOR AUTHORIZATION SITUATIONS

Case management teams The CMT must request prior authorization for member services in the following situations:

1. Care Category 3 (CC3) Initial Service Plans. Refer to BSW 402 (Slot Categories);

   NOTE:

   CC3 Initial Plans are dependent on the CSB having sufficient funding for CC3 Plans.

2. Increase to CC3 cost plansservice plan amendments. ;

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3. Environmental Accessibility Adaptations in excess of $~~5~~25,000. Refer to BSW 711 (Environmental Accessibility Adaptions).~~;~~
4. Vehicle Modifications in excess of $25,000. Refer to BSW 737 (Vehicle Modifications)~~;~~.
   ~~a. Service Plan over cost limit; Refer to BSW 899-5 (Service Plan Cost Limits)~~
5. Specialized Medical Equipment or Supplies in excess of $~~2,~~5,000. Refer to BSW 733 (~~DME~~ Specialized Medical Equipment, Supplies and Technology)~~;~~.
~~6. Items specified in BSW 733-2 (DME Specialized Medical Equipment, Supplies, and Technology: Commonly Covered Items Under Big Sky Waiver) require written approval by the RPO;~~
~~7. Wait list placement for individuals under 21.~~

   ~~NOTE:~~

   ~~CMTs are required to verify an applicant meets all wait list criteria prior to submitting a Prior Authorization request to RPOs or Central Office staff.~~

~~8.~~6. An a~~A~~mendment to an existing ~~Prior~~ prior ~~Authorization~~authorization.~~;~~
~~9. Out-of-state non-medical transportation. Refer to BSW 718 (Non-Medical Transportation);~~
~~10. Social Supervision services (including Social Supervision under Personal Assistance Services or Specially Trained Attendants) exceeding 20 hours/bi-weekly. Refer to BSW 722 (Personal Assistance Services);~~
~~11. Non-medical transportation exceeding 50 miles/bi-weekly. Refer to BSW 718 (Non-Medical Transportation);~~
~~12. Pass-through payments. Refer to BSW 605 (Payment Processing); and~~
7. Grant funded slot (e.g., Money Follows the Person, etc.). NOTE: Prior Authorizations for services under the Money Follows the Person program (MFP) must meet the same criteria as non-MFP prior authorization requests.

Additionally, case management teams may request annual, blanket, multi-member authorizations for service providers receiving payments through a third-party biller.

~~DEADLINES~~TIMEFRAMES

A prior authorization is limited to the authorization period indicated on the prior authorization form.

~~PA~~ Prior authorization requests must be submitted to the Department for review with sufficient advance notice to ensure members receive services timely and, when necessary, receive timely notice of service denial or decrease. ~~:~~

When requesting and responding to a prior authorization:

~~Case management teams will provide~~
- ~~Provide~~ the Department with at least 10 business days to review the prior authorization ~~prior~~ before to the need for services and/or the end of the current ~~Service~~ service ~~Plan~~plan.~~; and~~
- The Department will respond to the prior authorization request with an approval, denial, or a request for additional information within 5 business days from the date the prior authorization is received.

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~~1.~~ If the request is not approved, case management teams will provide the member with timely notice of decrease, denial, or termination of services, which members can appeal, as outlined in BSW 412 (Adverse Action).

~~Provide the member with timely notice of a decrease, denial or termination of services as indicated in BSW 412.~~

~~Exceptions will be evaluated in the event of emergency situations. Emergent situations must be identified on the PA prior to submission. The Department will respond to the PA request with an approval or denial, or a request for additional information within 10 calendar days from the date the PA is received.~~ Departmental responses may be extended under certain circumstances, e.g.. clarification pursued through the Department's Legal Department, clarification pursued through the Centers for Medicare and Medicaid Services, or clarification from the ~~BSW~~ Big Sky Waiver Program Manager. ~~(PM)~~

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