

Prior Authorization Review Process for HCBS Waiver Services

No.	Date	Question	Answer
GENERAL QUESTIONS			
1.	9/30/10	Is the median for each service going to be distributed?	The median for services were included in the Individualized Services Information System (ISIS) communication on 09/30/2010 and are posted on the website referenced in the letter (http://www.ime.state.ia.us/HCBS/HCBSindex.html) Any HCBS service that is authorized needs to be determined necessary by the case manager/service worker (CM/SW) and through the prior authorization process (PA).
2.	9/30/10	Is DHS mailing the changes in requiring a prior authorization for services to families who are receiving services?	It is the responsibility of the case manager / service worker to communicate any changes in the member's service plan as a result of the prior authorization process or any other changes in the member's service plan. Unless there is a need to decrease the hours or service, there would not be a need to notify families.
3.	10/6/10	Are we going to wait to issue notice of decision's (NOD's) until we have the result of the preauthorization?	Yes, the case manager / service worker should not send out an NOD until the prior authorization is completed.
4.	10/6/10	What will be the turnaround time on these prior authorization requests?	After all the necessary information has been received, the Iowa Medicaid Enterprise (IME) Medical Services unit is allowed 2 business days response time for an initial prior authorization process and 5 business days for a re-authorization.
5.	10/5/10	Where do we direct questions on the prior approval process?	Please direct questions via email to HCBSwaivers@dhs.state.ia.us
6.	10/5/10	Am I correct to say that the time it takes to fill out these forms and fax it falls under the billable documentation category?	Activities that are related to prior authorization would be considered planning activities and would be billable for case management. Completing forms (paper or electronic) that are required to ensure access to, or funding of, needed services (e.g. - entering service plan and specific service information in ISIS) are billable.
7.	10/5/10	Supporting documentation – is there an option of submitting the assessment as well as the service plan? Are we required to fax the entire assessment plus the service plan?	You will find documentation requirements that need to be submitted listed on the bottom of the prior authorization form. IME has copies of the level of care assessment. If there is additional information that would be helpful in determining a members need the CM/SW should send it in.
8.	10/7/10	How can these changes occur when we are already into the month?	The prior authorization process began October 1, 2010. Prior authorizations completed between the 1st –15th of the month will be implemented the first day of the following month. Prior authorization completed the 16th or after will be implemented the first day of the second month following authorization. For example: The prior authorization for a service is completed

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			<p>prior to the 15th of November the changes will be implemented on December 1, 2010</p> <p>The prior authorization for a service is completed after the 15th of November the changes will be implemented on January 1, 2011.</p>
9.		<p>What about the skilled levels of care, they need more help because they are at skilled; there is no accommodation for them.</p>	<p>The monthly service cap based on the level of care determination did not change. The median amounts used in the PA process took into consideration all levels of care for each specific waiver.</p>
10.	10/7/10	<p>Is the preapproval required as annual reviews are due or do we have to have current plans that exceed the median (for CDAC) go through the approval process immediately?</p>	<p>Prior authorization will occur anytime the Case Manager/ Service Worker makes a change to the service plan and the service exceeds the median cost or number of units for that service.</p>
11.	10/7/10	<p>Can the preauthorization be submitted before they are actually put in the ISIS service plan and get approved and then put in the service plan?</p>	<p>This would require a fair amount of process change and ISIS programming. It is recommended that the PA be processed through ISIS. The service can be entered prior to the needed start date.</p>
12.	10/6/10	<p>Should Targeted Case Manager's (TCM's) do this for everybody receiving these services beginning October 1st, or is October 1st the date to begin and as member's service plan changes occur throughout the year, it is done at the annual review?</p>	<p>This process is not retro back to 10/1. It started on 10/6/10 forward for initial and annual. ISIS will prompt the CM/SW if a review is needed. See the response to question #10.</p>
13.	10/7/10	<p>When I went to approve member's CDAC rate change from 10/1/10 to 10/21/10 (due to level of care change) I got the milestone that he needed authorization.</p> <p>Where do we fax the prior auth information to for the services beginning 10/1/2010 and who will review those?</p>	<p>ISIS is kicking out the workflow based on the median amounts like it is supposed to do. However, the department has determined that we will not do a prior authorization if the only change is a rate increase. If the only change in the service plan is due to a rate change then a statement to that effect may be entered into the ISIS comment section. Please fax to (515) 725-1388 and Medical Service reviewers will work on the review.</p>

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14.	10/7/10	Will we get the pre-auth forms for November and December ahead of time?	The implementation of the November and December services has been delayed. The effective date of adding additional services has not yet been determined. CM/SW's will be notified prior to adding on the new services for PA.
15.	10/7/10	Where do we fax the prior auth information to for the services beginning 10/1/2010 and who will review those?	Please fax to (515) 725-1388 and Medical Service reviewers will work on the review.
16.	10/8/10	At what point do they review? At level of care? What should I tell my providers and families now?	For service requests beyond the median they review at the initial and annual review or when the change initiated exceeds the median. For the initial application approval the Prior Auth review will occur after the level of care review has been completed.
17.	10/8/10	Isn't that determined by IME with the LOC form...that already qualifies them for a higher level of care/services?	The LOC form is used to establish Level of Care to institutional and facility care. The Prior Authorization process confirms the service needs that are beyond the median.
18.	10/8/10	Initial procedure: when a TCM puts in a service plan, and the units requested go over the median, will IME/ISIS tell the TCM what they need to submit, i.e. the Certificate of Medical Necessity, treatment plan etc. On the Certificate it asks if the TCM has attached other documentation, but how will the TCM know which documentation to submit?	The documentation that is needed is found at the bottom of each certification of medical necessity for prior authorization form found on the website. See the response to question #1.
19.	10/8/10	What do some of the unit medians mean? i.e. for Respite MR-HHA basic individual 31 does this mean 31 hours a month, and will the TCM have to do a PA every month?	The median amount will indicate at what threshold the service needs a prior authorization. Respite is 31 hours. CDAC is 17 days for the daily rate and 41 for hourly. For service requests beyond the median they review at the initial and annual review or when the change initiated exceeds the median. See response to question #10.
20.	10/8/10	Who and how many people are reviewing these PA's? Concern that if they are not approved timely, members will go without services.	To expedite the process, the case manager should submit the supporting documentation at the time the review is submitted. The PA reviewers are processing PA's in the order in which they are received.

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21.	10/8/10	Will all of this documentation have to be faxed in?	A process is currently being developed to assist with electronic submissions and additional information will be provided when it is ready to use. The required documentation which needs to be submitted is listed at the bottom of the certification of medical necessity prior authorization form.
22.	10/12/10	Will these forms be a one-time thing or will we send them with every funding renewal?	A certification of medical necessity form will need to be completed each time a service changes and is over the median or if there is a new service plan requiring a change.
23.	10/12/10	If IME will have to click off on everything before it goes to the Central Point of Coordination (CPC) administrator for approval, this could significantly delay the approval process.	IME suggests that the renewal of a service plan be initiated far enough in advance of the plan expiring to allow for timely completion of this process. A prior approval is completed within 2 to 5 days of receipt of all the required information requested. If all information is submitted, the review process will go faster.
24.	10/20/10	The service worker is not entering any new service authorizations on the plan until she receives something in writing from Medical Services.	For the prior approval to work, the service plan must be entered into ISIS to go through the PA process.
25.	10/20/10	Is Medical Services adding the 2.5% reduction to rates?	Medical Services is not entering the 2.5% rate decrease. The SW/CM must confirm and adjust the rates.
26.	10/19/19	Do you know if DHS has been contacted about the milestones in ISIS when prior authorizing pre voc.? Because when you get that milestone it does not allow you to authorize any other needed services until the pre voc prior auth is completed?	All services are tied to one milestone. You will not be able to approve a service plan until the prior authorization is completed. IME suggests that the renewal of a service plan be initiated far enough in advance to allow for timely completion of this process.
SUPPORTED COMMUNITY LIVING (SCL) SERVICE QUESTIONS			
27.	10/5/10	Case managers have a milestone that says the supported community living (SCL) – W1300 requires preauthorization and needs a form completed and sent to IME. What is the form?	SCL services are not currently included in the prior authorization process. If the case manager / service worker receives a milestone for SCL prior authorization they should respond to the milestone and comment that the prior approval (PA) is for SCL. SCL will be added to the PA process at a later date. A form for SCL prior authorization will be available prior to implementation.
28.	10/8/10	On informational letter (IL) 951, page 1 it states that SCL for members under 18 y/o will need a PA, on page 2, it states SCL for members under age 20 will have to have a PA. Which age is it	Under the age of 18 is the correct answer. The implementation of prior authorization for SCL services for this age group has been delayed to another time. Notification will be provided when this will resume.
29.	10/8/10	On the median unit list, there is the W1300 listed with 23 units. Does this mean all adults in a 24 hour waiver site	The implementation of prior authorization for SCL services for this age group has been delayed to another time. Notification and information regarding the criteria will be provided when this will

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		will need a PA?	resume.
CONSUMER DIRECTED ATTENDANT CARE (CDAC) QUESTIONS			
30.	10/6/10	I have a member whose CDAC rate restoration resulted in the member's total monthly cost of services exceeding the monthly service cap. I then received an ISIS milestone requesting a Prior Authorization form.	Anytime you attempt to authorize CDAC services over the median number of units or over the median cost per unit it will trigger prior authorization. The case manager / service worker should make adjustments to the service plan to accommodate the change as needed. In addition, if the increase in the CDAC rate did not result in exceeding the monthly cap but triggered the PA process, the case manager / service worker should answer the milestone that this was not an annual review but as a result of the rate restoration. IME Medical Services will not be reviewing changes to CDAC services as a result of the rate restoration.
31.	10/7/10	How do we justify only paying for 17 days of daily CDAC? What about the other days in the month?	Not all members receive daily CDAC 31 days of each month. Utilization should be based on medical necessity. The PA process uses the median amount of a service in a plan to identify what services will require a PA. It will not limit the amount of service to the median amount. For example if 31 units of daily CDAC are reviewed and are determined to be medically necessary, 31 units will be preauthorized by IME medical Services unit
32.	10/7/10	On one member, the CDAC provider will have used up her 41 hours in one week. Member is skilled level of care with 160 hours of care. We do not know what else to do for these members who need these hours.	This will only be a consideration when the service plan is changed or updated. If the service plan is changed to increase/decrease hours or a level of care (LOC) process has just occurred and it is time to renew your service plan; that is when ISIS looks to see if the service meets the threshold and a review is needed. If the service is medically necessary, then it will be approved. Please note that Medicaid has other services available that may be more appropriate to meet the member's needs.
33.	10/7/10	I was under the impression that if a client has a CDAC provider and the CDAC agreement/service plan has less than 41 units then there is no prior authorization needed. We have a new member and we put less than 41 units and the request for prior authorization came up. Can you please clarify for me?	ISIS staff is looking into this; it has to do with when the service plan was actually started. If the number of hours falls under the threshold, put a note in ISIS describing that and a review will not be needed. This should not be a long term problem.
34.		In order to continue with CDAC I have to reduce them all to 41 hours or do pre-authorizations on them? Is there a way to have the case plans approved as they are now and then at the next review I can re-evaluate the number of units?	The case manager or service worker should not be reducing a member's plan to below 41 units to avoid a prior authorization. If that member needs more than 41 then this needs to be requested. See question #8 regarding effective dates of any changes in the service plan because of the PA.

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35.	10/12/10	Do we need to be sending all the documents listed in Section D for every prior authorization request? The case managers do not get the daily log forms from the providers; we base our schedule of a representative week on the CDAC agreement and verbally discuss it.	<p>If the member has more than one provider who is completing ADL/IADL needs, a schedule of the services the member receives from each provider is needed. A time line indicating who is completing each task and when they are in the home should be included so that services are not duplicated by other providers.</p> <p>You do not need to send this if the member does not have multiple providers completing ADL/IADL cares.</p>
36.	10/12/10	We have a couple of situations where a member has CDAC (or other prior authorization services) that were already authorized in the plan. The Case manager has had to make other changes to the service plan in ISIS such as adding an additional service, adding units, etc. When doing so, it then brings up the prompt that the service requires prior authorization even though CDAC is not being newly authorized. In these circumstances, will we need to submit all prior auth documentation? What will prevent this milestone from then coming up each time we make a change to a service plan during a given year?	<p>If you are changing units or adding a service that requires a prior authorization, you will need to complete the review for that indicated service even if it is in the middle of a plan. The only exception to this is the 2.5% rate restoration for CDAC's at the present.</p> <p>If you are changing units or adding a service that does not require a prior authorization AND you are not changing anything on the services that would require a review, you will need to put a note in ISIS alerting the reviewer so they are aware of why you will not be submitting additional information.</p>
37.	10/15/10	I was told that a PA shouldn't be needed in this situation-but I was told by the ISIS help desk that they can't delete a milestone and that I needed to submit the PA. Who can delete the milestone? The only reason this got triggered was because of the 2.5% reinstatement.	The CM/SW would write a note in the comment section of the milestone that this is for a rate increase and click complete. Then the review coordinator will move the milestone along without a PA.
RESPIRE QUESTIONS			
38.	10/6/10	What will the respire need be based upon? (like the consumer directed attendant care (CDAC) need is based upon medical necessity only)	All waiver services, including respire, must be based upon medical necessity as determined by the assessed needs of the member. Respire PA will be implemented at a later date. Prior to implementation, instructions will be provided to CM/SW's.
39.	10/6/10	Why would respire have to be pre-authorized when this is a service that families should have control over when and how much they need?	Respire services must be medically necessary just as any other Medicaid service. There are criteria that must be met. Certainly family needs are considered as part of the criteria, but the CM/SW has control over the amount of respire authorized.

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40.	10/6/10	It looks like some of the respite median amounts are monthly, some are yearly, and there's no distinction between the waivers where it would be monthly vs. the Intellectual Disability (ID) waiver.	The annual and monthly amounts will be taken into consideration when prior authorization begins for respite. Please note the reply for question #38.
41.	10/7/10	As far as child care...what about respite being used while parents are attending college courses?	Please refer to Iowa Administrative Code (IAC) Chapter 441--78 for the respite service definition. The respite service definition has not changed.
42.	10/6/10	I see under in home family therapy (6) Family & Community Supports (10) Respite-Home Care Agcy & Non-Facility, Group (31) & Respite-Home Care Agcy & Non-Facility, Individual (31) which includes specific numbers identified. Are we not to authorize any more than what is allotted on this chart or is this just an average or assumed projection?	Services should be authorized based on the member's assessed needs. The median amounts are the threshold for prior authorization.
43.	10/15/10	Do we look at the respite hours on the CCO breakdown page and if they are over 31, will that trigger a PA? If they have traditional and CCO with the total over 31 hours of respite, will that trigger a PA?	Any traditional HCBS waiver service over the PA median that is entered to develop a CCO budget will require a PA. For example if a HVM or CDAC service is included in a CCO budget, a PA workflow will begin, just as it would if the service was in the traditional service plan. IME suggests that the renewal of a service plan be initiated far enough in advance to allow for timely completion of this process.
DEVICE QUESTIONS			
44.	10/5/10	For Assistive Devices -- does this apply to all Assistive Devices or ones above a certain cost?	At this time, the prior authorization process applies to all assistive devices.
PREVOCATIONAL SERVICE QUESTIONS			
45.	10/6/10	Why is the "median" for Pre-Voc identified as "all"?	We are reviewing all pre-vocational services to assure that progress is occurring as pre-vocational services are intended, to address specific work readiness skills.
46.	10/6/10	On the Pre-Vocational Certificate of Medical Necessity "Has a medical/mental health professional recommended this device?" I don't think that probably is supposed to be a question under pre-voc as it is not a device?	The forms are in the process of being corrected. Thank you for bringing this to our attention.
47.	10/8/10	Does Prevoc require the denial letter from Voc Rehab—is VR prepared to provide that and	The Department of Vocational Rehabilitation (DVR) provides components of prevocational services. A letter of denial from DVR is needed before

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		will the application process for VR funding have to be initiated to get the letter?	authorizing prevocational services under the waiver.
48.	10/19/10	The PA will not be done unless the TCM makes a change or puts in a new service plan, and is notified that the service needs a prior authorization. Some case managers are hearing from providers that they will require the NOD's for pre-voc services now.	Service plan prior authorizations are only needed when the services are entered into ISIS and it kicks off the waiver prior authorization work flow. IME suggests that the renewal of a service plan be initiated far enough in advance to allow for timely completion of this process. It is a best practice to send the provider timely, written notification when there is a change or cancellation in services.
CHILDREN'S MENTAL HEALTH WAIVER QUESTIONS			
49.	10/6/10	There are several lines on the chart that are services where CMH Waiver services do not provide. Is that correct?	Per schedule in Informational Letter 951, the services applicable to CMH will be reviewed.
CONSUMER CHOICES OPTION QUESTIONS			
50.	10/12/10	When you get the milestone requiring prior approval for CCO/CDAC- and they also have traditional services – can we go ahead and send the NOD to providers and member or do we have to wait until we hear back from IME?	An NOD cannot be sent out until all services have been approved. If the CCO budget is based on a service, or an amount of service, that will require a PA, then the NOD cannot be sent out until all services have been approved. New service plans should be initiated timely before the old plan expires. This should allow timely notification to providers.
51.	10/14/10	How will this authorization work for consumer choices option (CCO)? Will the 31 hours of respite also be the cut off? How will that be calculated? ALSO if a worker changes the broker for CCO, won't the milestone for authorization come up if it's over the mean amount? Will authorization be needed at that time?	The change in the Broker should not affect the PA, since it did not change any services. If we see that the broker change does start a PA, let Medical Services know and they will address it with the ISIS staff. Please see the respite section questions #38-43.
52.	10/28/10	What about services for Nov. with CCO, Veridian gets paid on the first of the month, so I take it that Veridian will not get paid and the providers will have to wait. The support brokers are the ones that set up the budgets...so they need to be informed to adjust those services. We just give them a \$\$ amount since we don't know all the fees involved. They are the ones that set up services; we just input the initial budget in the system.	The department will assure that there will not be an interruption of funds going to Veridian for the CCO budgets and services. If there is an adverse action taken in the reduction of services due to the PA process, any adjustments will be made to allow for the 10 day NOD process to notify the member of the change. If changes do occur, you will need to let the member know of the change in the budget and they will need to work with the ISB to adjust the CCO budget for future use in CCO. The PA's that are occurring now are for the services that make up the CCO budget, and are not a CCO PA. For example, if CDAC is the service that makes up the CCO budget, it is the CDAC service that is being PA'd, not CCO.

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		<p>My coworkers in the region all have CCO clients that have care plans due Nov. and we have to input them this month so they get paid in Nov. Does this mean no one will get paid CCO funds in November due to prior authorizations being needed? The informational letter did not state that CCO CDAC was being affected in Oct. It just listed CCO in December and that is how everyone read it. So, the support brokers need to go in and get these readjusted and we need to do PA's. So, will the money be released later for these people once the PA's are in? Either way, there are going to be some very angry providers...because all of us thought CCO was being changed in DEC.</p>	<p>CCO is scheduled to begin the PA process sometime in the future. At that time, IME Medical Services will begin to review the non-standard items that are being requested for purchase. This activity is currently being completed (prior authorized) by IME Long term Care staff. Switching over to Medical Services to complete this task will significantly decrease the turnaround time on purchase requests.</p>
53.	11/2/10	<p>When are we getting information on that...as we have several consumers waiting to get their funds approved. No one has yet informed us of the budget limitations that are being imposed on CCO and what those are going to be. We are getting milestones for CCO that Prior authorization is needed but no one has explained to us the limitations or usage that is being approved. Also, we as case managers do not set up the individual budget. We give them a set dollar and the support brokers handle the services that are directed by the client.</p>	<p>The prior authorizations (PA) are not for CCO, but rather the traditional service that makes up the CCO budget. If the service requires a PA based on the type and amount, it will be prior authorized whether it is a traditional service or part of the CCO budget. Once the PA is approved that amount of service will be authorized in the plan and the CCO budget will be adjusted, as applicable. The Department is working on making adjustments to ISIS to assure timely approval so that there is no delay in getting CCO budgets approved prior to the month of the change and to give a CM /SW appropriate time to issue a NOD with the 10 day notice time included if an adverse action should take place</p> <p>The CCO prior authorizations that will begin in December are review and approval of the non-standard items that currently get reviewed and approved by the Department. The only difference will be the IME Medical Services will be completing the approval. This will vastly increase the approval time to between 2-5 days once information is submitted.</p>
EXCEPTION TO POLICY QUESTIONS			
54.	10/8/10	How does exception to policy	Once an ETP is approved by the Director and sent

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		<p>fit with prior authorization? What is the process and order of process? For example, if someone's plan is at the max and they need a shower chair; do we have to do both the exception to policy and the prior authorization in order to get that for them? That is a long time to wait for a shower chair. How does this all fit together and work for big ticket items like a ramp or a walk-in shower?</p>	<p>out, Medical Services will receive a copy of the prior authorization approval. If you need to exceed the lifetime cap for HVM you will request an exception to policy (ETP). If the HVM will cause the member to exceed the monthly service cap of \$1,117.00 you will also need to request an ETP.</p> <p>In regard to your concern regarding possible delays in processing requests, you can assist to speed up the process by having the three itemized bids submitted with your ETP request or prior authorization request. If we have what we need when we receive the request the process flows much more quickly than when we have to chase information down.</p>
	12/1/10	<p>Is it possible that we might complete PA on someone one month and then need to change hours the next month or two. If that happens, it will generate another prior auth. Is there something that can be done to expedite the process in these cases if the time span between the two is really short? I would hate to have to repeatedly send all of the same information.</p>	<p>If a service is amended on the plan that goes above the mean a PA will still need to be completed even though the plan was reviewed in the last few months.</p>

HCBS Waiver Prior Authorizations-Completed 10/1/10 through 12/8/10					
Service Type	Pending	Total Reviewed	Approved	Modified	Denied
Assistive Devices	13	128	111/87%	0	17/13%
CDAC	77	435	298/68%	130/30%	7/2%
Environmental Modifications	3	1	0	0	1/100%
Home and Vehicle Mod	12	87	74/86%	0	12/14%
Prevocational	64	377	255/68%	4/1%	118/31%