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**900 – ONGOING ACTIVITIES**

# 900 - ONGOING ACTIVITIES

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| POLICY STATEMENT | Activities required by the CCSP are coordinated among the AAA, care coordination, and service providers. |
| POLICY BASICS | Activities discussed in this section are conducted regularly when working with CCSP clients. It is helpful to understand which activities are dealt with at the local level and those which require assistance from the Division of Aging Services or Division of Medical Assistance (DMA).<br><br>Activities include:<br><br>• Address changes - inside PSA and transfers<br><br>• Care coordination conferences<br><br>• Interruptions in service<br><br>• Medicare home health and CCSP<br><br>• Provider requests for changes in services<br><br>• SAF changes including:<br><br>  • Billing edits<br>  • Overrides<br>  • Prior approvals<br>  • Third party reimbursements.<br><br>• Terminations. |
| REFERENCES | Chapter 600, Assessment;<br>Chapter 700, Care Management;<br>Chapter 800, Reassessment;<br>Chapter 1100, CCSP AIMS;<br>Appendix 100, Forms and Instructions |

## 910 - CLIENT ADDRESS CHANGES

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| POLICY STATEMENT | Care coordinators, providers, and DFCS inform each other immediately when a client's address changes. |
| POLICY BASICS | • The care coordinator updates client address changes in Client Health Assessment Tool (CHAT) and AIMS. If data entry staff maintain information in AIMS, the care coordinator uses the Client Registration Report for AIMS to request an update of the client's address in AIMS.<br><br>• Care coordinators are responsible for care coordination activities for all CCSP clients who live within their assigned areas.<br><br>**NOTE:** When a client moves, a reassessment may be necessary. |
| PROCEDURES | Use procedures in Chart 910.1 when processing address changes for active CCSP clients: |

**Chart 910.1 - Address Changes**

| IF | THEN |
|---|---|
| Client plans to move or has already moved within the PSA | 1. Update CHAT with the new address, and print the revised Client Registration Report for AIMS.<br><br>2. Update AIMS or forward printed Client Registration Report for AIMS to data entry.<br><br>3. After data entry has keyed the changes, file the Client Registration Report for AIMS in client's case record.<br><br>4. Change care coordinator assignment in CHAT and AIMS, if applicable.<br><br>**5.** Notify provider of client's new address. |
| **IF (contd.)** | **THEN (contd.)** |

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| SSI Medicaid client moves | In addition to the steps 1-5 above, advise client to contact SSA to update the mailing address for Medicaid card. |
| MAO or PMAO client moves within the same or to another PSA | In addition to the steps 1-5 above, verbally notify MAO caseworker of new address.<br>• Within 3 business days after verbal notification, follow up with a completed CCC, Form 5590 to the county DFCS office. |
| Client moves to another PSA and care coordinator determines that client continues to need CCSP services in the new PSA | • Advise receiving PSA of client's new address.<br>• Complete case transfer procedures in CHAT and AIMS. |
| Client moves within the same PSA or out of the PSA but no longer wants services at new address | • Request letter from client or authorized representative stating that services are not wanted at the new address.<br>• Send completed Form 5382 to advise client of the termination because of the request to voluntarily terminate services.<br>• Terminate client from services using termination procedures. Do not continue services during the 30 day notice. |
| Client moves without notifying the care coordinator | Attempt to locate client through the following means:<br>• U. S. Postal Service (certified letter)<br>• Provider(s)<br>• DFCS<br>• Family members or neighbors |
| **IF (contd.)** | **THEN (contd.)** |

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| | Document efforts to locate client in client's case record. |
| Care coordinator unable to locate the client | • Use Form 5382 to send a termination notice to client's last known address and proceed with termination process.<br>• File returned mail in client's case record with envelope intact to verify attempt to deliver termination notice. |

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| REFERENCES | Appendix 100, Forms and Instructions<br>Chapter 1100, CCSP AIMS<br>Section 970, Terminations |

## 912 -TRANSFERS OUT OF PSA

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| POLICY STATEMENT | CCSP clients may transfer to another PSA and remain eligible for the CCSP. |
| POLICY BASICS | Care coordinators and providers work together to assure that CCSP clients successfully transfer from one PSA to another without experiencing unnecessary interruptions in services. |
| PROCEDURES<br><br>AIMS activities | Responsibilities of transferring care coordinator:<br><br>• Obtain the new address and name of the county where the client is moving or has moved.<br><br>• Notify the care coordination agency in the receiving PSA regarding the following:<br><br>  • Proposed date transfer will occur<br>  • Reason for transfer<br>  • Client's service needs<br>  • Other pertinent information<br>  • Obtain name of "receiving" care coordinator, if known.<br><br>• Complete the following activities to update AIMS information:<br><br>  • Complete the Client Transfer Form. If the "receiving" care coordinator's name is not known, write "unassigned and the name of the PSA" on the Client Transfer Form. This procedure expedites data entry.<br><br>  **EXAMPLE:** Write "unassigned ARC" on the Client Transfer Form.<br><br>  • Update AIMS or use the Client Transfer Form to ensure that information in AIMS is updated.<br><br>**NOTE:** The "receiving" care coordinator's name will appear on the "transferring" PSA's SAF Summary Report for the months/units provided in the "transferring" PSA. |

PROCEDURES (contd.)

The "transferring" PSA's SAF Summary Report will contain a note to indicate that the client was transferred to another PSA.

- Ensure completion of SAF changes.
  - Update units of service prior to transfer
  - Do not change the eligibility disposition code
  - Do not enter a service end date.

**NOTE:** Once the receiving care coordinator's name has been entered into AIMS, the transferring care coordinator will be unable to access SAFs for data entry.

CHAT activities

- Update the following information in CHAT:
  - Client's new address
  - Telephone number
  - Emergency contact
  - New PSA
  - Name of receiving care coordinator, if known
  - Add the "Transfer-out-of Region" status.
- Export CHAT files to the "receiving" PSA**.**
- If client moves to a PSA not served by current provider, transfer copies of provider clinical records or case summaries to the receiving care coordinator.
- Copy all documents in the original case record to create a duplicate case to retain.
- For MAO and PMAO clients, send CCC, Form 5590 to DFCS indicating date of transfer, client's new address, and county of residence. File a copy of the CCC in the original and duplicate case records.

Place completed Client Transfer Form on the original record. Transfer entire original record with the most recent printed SAF to the receiving care coordinator by certified mail with return receipt requested.

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| PROCEDURES (contd.) | <u>Responsibilities of the receiving care coordinator:</u><br><br>• Review Client Transfer Form.<br><br>• Arrange interim services, if needed.<br><br>• Determine if client needs to be reassessed, or has been reassessed within the last 30 days.<br><br>• Within five business days, conduct a face-to-face visit with client to complete a CCP or reassessment.<br><br>• Broker services with provider(s). |
| CHAT activities | • Review and update imported CHAT files including care coordinator's name.<br><br>• Change the "Transfer-out-of Region" status to "Transfer-into Region" status. |
| AIMS activities | • If the Client Transfer Form indicates the receiving care coordinator as "unassigned PSA" ensure that the name of receiving care coordinator is updated in AIMS.<br><br>• Ensure the update of units and months of service to SAFs in AIMS.<br><br>**NOTE:** The receiving PSA can make adjustments to all SAFs.<br><br>• Send CCC, Form 5590 to DFCS after receiving CCNF from provider advising that the MAO or PMAO client is receiving a waivered service in the county of residence.<br><br>• When received, review record to assure that all forms are in file. Contact transferring PSA for missing documents. |
| REFERENCES | Appendix 100, Forms and Instructions;<br>Section 672, Standards of Promptness;<br>Chapter 1100, CCSP AIMS |

## 920 - CARE COORDINATION CONFERENCES

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| POLICY STATEMENT | Care coordinators schedule conferences when changes in a client's situation call for special interventions. |
| POLICY BASICS | A care coordination conference is often the best approach to resolving a difficult situation. Participants assure that:<br>• Care coordination conferences result in group acceptance of each participant's role and responsibility for following through with an intervention plan.<br>• Agencies respect the position from which others act.<br>• Mutual agreement on the expected outcome results in successful problem resolution. |
| PROCEDURES | The care coordination agency leads the meeting and is responsible for the following activities:<br>• Defining the purpose and focus of the conference<br>• Deciding whether the client or the care giver attends. Depending upon the nature of the problem, it may not be possible to involve the client in the care coordination conference.<br>• Including all agencies and persons involved in the case<br>• Arranging a location for the conference<br>• Notifying participants to attend<br>• Determining what information about the client is shared with conference participants. The care coordinator shares only the information necessary to assist with the problem resolution.<br>• Arranging for official minutes to be taken and distributed within five days of the conference<br>• Clarifying the plans of action agreed upon during the conference |

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| PROCEDURES (contd.) | • Giving everyone present a chance to be heard<br>• Documenting care coordination conference results in the client's case record<br>• Advising each conference participant of the outcome of the intervention. |
| REFERENCES | Chapter 700, Care Management |

## 930 - INTERRUPTIONS IN SERVICES

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| POLICY STATEMENT | Temporary interruptions in service do not jeopardize a client's continued eligibility for participation in the CCSP. |
| POLICY BASICS | The following gives examples of interruptions in service which occur most frequently:<br><br>• Temporary visits to another PSA<br><br>Clients may visit an area where his/her current providers are not enrolled to serve. Except in emergencies, prior planning and coordination with the care coordinator, provider(s) and the client assures that medical needs will be met, either professionally or by an informal care giver.<br><br>• Client travel outside the state.<br><br>**NOTE:** CCSP Medicaid eligible clients must receive a waivered service within each calendar month to maintain Medicaid eligibility but SSI Medicaid clients do not.<br><br>• Client hospitalizations<br><br>Hospitalizations do not interfere with a client's Medicaid eligibility nor is the client in danger of being terminated from the CCSP even if the hospital stay is more than 60 days since no break in service occurs.<br><br>• Nursing home placement for less than thirty days<br><br>A client placed for less than 30 days in a nursing home does not lose CCSP eligibility but the client will need a new LOC before CCSP can continue. The most common reasons for temporary placements are convalescent care from a hospitalization and temporary absence or incapacity of the care giver.<br><br>**NOTE:** Failure of CCSP clients to communicate with care coordinators and providers may result in interruptions in service. |

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| PROCEDURES | Advise clients to always report changes in their situations. Use procedures in Chart 930.1 when clients have interruptions of service.<br><br>**NOTE:** Advise MAO clients to discuss their plans with DFCS so that interruptions in services do not result in CCSP Medicaid ineligibility. |

**Chart 930.1 - Interruptions in Service**

| IF | THEN |
|---|---|
| Client temporarily visits in another PSA<br>AND<br>Needs service(s) during the visit | Take the following action:<br><br>• Plan in advance with the client and the care giver.<br><br>• If the current provider is approved<br><br>to deliver services in the PSA where the client will visit, arrange for the provider to continue to deliver the client's services. If not, determine if the client is willing to choose another provider that delivers service in both PSAs. Explain to the client and providers that the services may resume with the current provider after the visit.<br>OR<br>• Transfer the case to the other PSA where services will be brokered with a provider.<br><br>• Remain in close contact with the care coordinator in the PSA where the client is visiting to assure that client needs are being met.<br><br>**NOTE:** Use CCC, Form 5590 to notify DFCS when a MAO client does not receive a waivered service for 30 days. |

| IF (contd.) | THEN (contd.) |
|---|---|
| Client travels outside the state | Advise client to use procedures shown on the back of the Medicaid card to obtain medical care. |
| Client is hospitalized | • Hospital discharge planners are responsible for knowing a client's medical and social situation and arranging services when discharged from the hospital.<br><br>• Inform discharge planners that the patient is a CCSP client to avoid any of the following:<br><br>  • Discharge planner referring client to a provider other than the CCSP provider currently serving client<br>  • Discharge planner ordering Medicare or Medicaid home health services without the knowledge of the CCSP provider or care coordinator<br>  • Client entering a nursing home without the knowledge of the provider or care coordinator<br>  • Client being discharged without care coordinator determining whether the medical condition warrants a reassessment prior to discharge. |

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|---|---|
| **IF (contd.)** | **THEN (contd.)** |
| Client placed in a nursing home for less than 30 days | Temporary placements in nursing home facilities do not affect eligibility for CCSP or Medicaid, provided the RN:<br><br>• Reassesses the client prior to discharge and assigns a new LOC<br>AND<br>• Care coordinator assures that services are in place when the client returns home. |

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| REFERENCES | Chapter 500, Eligibility Criteria;<br>Section 912, Transfers;<br>Section 628, Level of Care |

## 940 - MEDICARE HOME HEALTH SERVICES AND CCSP

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|---|---|
| POLICY STATEMENT | CCSP clients may receive Medicare home health services and remain eligible for CCSP services. |
| POLICY BASICS | Medicare services include the following:<br>▪ Skilled nursing visits<br>▪ Home health aide visits<br>▪ Physical therapy<br>▪ Medical social services<br>▪ Occupational therapy<br>▪ Speech therapy<br>Medicare services are the same services that a client would receive from home health in CCSP. Therefore, if an individual is receiving Medicare home health services at initial assessment, the client meets the CCSP Medicaid requirement of waivered service receipt.<br>**NOTE:** MAO clients terminated from CCSP may lose their eligibility for Medicaid. Care coordinators must refer MAO clients terminated from the CCSP to DFCS for Medicaid eligibility determination. Clients terminated from the CCSP may reapply when their situations change.<br>If a client receives Medicare or Medicaid home health services, they must be delivered by the same provider**.** |
| PROCEDURES | Medicaid home health providers:<br>▪ Use CCNF, Form 6500 to notify care coordinators whenever a client is receiving any of the above six services through Medicare.<br>▪ Indicate on CCNF, Form 6500 the anticipated duration of the Medicare covered services.<br>Communicate regularly with the Medicare provider to monitor |

PROCEDURES (contd.)

the duration of Medicare services.

Do not authorize Medicare home health services on the SAF. When Medicare home health services replace Medicaid home health services, adjust the SAF to reflect the change. When Medicare benefits end, the CCSP enrolled provider uses the CCNF to notify the care coordinator. If necessary, complete a reassessment to determine if the client will need additional services from CCSP.

When a CCSP client receives Medicare home health services from a provider not enrolled as a CCSP provider, the care coordinator:

- Contacts the Medicare provider
- Determines which Medicare services are provided
- Coordinates CCSP and Medicare care plan
- Requests verbal or written notification of any Medicare increase, decrease or termination.

When a client receives Medicare services, follow the procedures in Chart 940.1:

**Chart 940.1 - Medicare Status Changes**

| IF | THEN |
|---|---|
| Client receives only Medicare services for more than 60 days and provider expects Medicare services to continue indefinitely | Determine whether client needs additional CCSP services.<br>OR<br>If Medicare home health services alone meet the client's needs. |
| Medicare home health services alone will meet the client's medical needs indefinitely<br><br>**NOTE:** Do not keep this type of client in the CCSP to continue Medicaid eligibility. | Use Form 5382 to advise client of termination from the CCSP. |

REFERENCES

Appendix 100, Forms and Instructions;
Chapter 800, Reassessment

## 950 - PROVIDER REQUESTS CHANGE IN SERVICE UNITS

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|---|---|
| POLICY STATEMENT | CCSP providers may request from the care coordinator, an increase or decrease in the client's units of service. |
| POLICY BASICS | The care coordinator, who is responsible for managing clients' care, approves or disapproves all increases or decreases in a client's authorized units of service. |
| PROCEDURES | Use the procedures in Chart 950.1 when a provider requests a change in service: |

**Chart 950.1 - Provider Requests for Change in Service Units**

| IF | THEN |
|---|---|
| Provider notifies care coordinator of change in client's condition and requests an increase/decrease in the number of authorized service units<br><br>**NOTE:** A provider may not automatically make a change in service without prior approval from care coordinator. | Care coordinator completes the following activities:<br><br>▪ Contacts provider to determine reason for the request.<br><br>▪ Approves or disapproves the provider's request and documents in the case record the discussion with provider and reason for decision.<br><br>▪ Within three business days after receipt, signs, dates, and returns the CCNF, Form 6500 to the provider.<br><br>▪ Determines whether client needs a reassessment. |
| Care coordinator agrees with provider that client's situation has changed but the circumstances do not require a reassessment | Care Coordinator:<br><br>1. Uses CHAT to develop an interim Comprehensive Care Plan (CCP) that reflects changes in service units.<br><br>2. Completes SAF or provides revised SAF to data entry authorizing changes in services in AIMS. |

| IF (contd.) | THEN (contd.) |
|---|---|
| | 3. Sends interim CCP and SAFs to provider**.** |
| Care coordinator agrees with provider<br>AND<br>Client's situation has changed significantly; therefore, a reassessment is required<br><br>**NOTE:** Determine if situation requires an RN or social service worker to complete the reassessment. | Care coordinator:<br><br>▪ Discusses client's condition with provider and client's physician.<br><br>▪ Completes steps 1-3 above.<br><br>▪ Conducts reassessment.<br><br>**NOTE:** If care coordination's recommendation and the physician's care plan conflict, consult with the client's physician to resolve the situation. |
| Provider increases service units delivered without first obtaining care coordinator prior approval<br>AND<br>No reassessment is required.<br><br>**EXAMPLE:** Providers increasing services without talking to care coordinators for approval and then sending CCNF request after services are delivered. | If increase in service units is justified, care coordinator:<br><br>▪ Completes steps 1-3 above.<br><br>If increase in service units is unjustified, care coordinator:<br><br>▪ Sends CCNF back to the provider advising that increase was not approved.<br><br>▪ Does not amend CCP or generate SAFs. Provider cannot bill for the unauthorized services rendered.<br><br>**NOTE:** Report to the AAA any provider who repeatedly disregards this requirement. |

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| REFERENCES | Chapter 600, Care Coordination;<br>Appendix 100, Forms and Instructions;<br>Chapter 800, Reassessment |

## 960 - SAF CHANGES

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| POLICY STATEMENT | Service Authorization Forms (SAF) are initiated only by care coordinators to authorize services. |
| POLICY BASICS | Care coordinators use the SAF to authorize reimbursements for services rendered.<br><br>The AAA generates and maintains SAF data unless this activity is delegated to the care coordination agency. However, unique situations occur that require the assistance of the Division of Aging Services and/or DMA.<br><br>The most common situations which require Division assistance with the SAF are:<br><br>▪ Overrides:<br><br>The local level can update a SAF up to one year after service delivery. For adjustments of more than 12 months, an override is necessary from the Division of Aging Services.<br><br>▪ Billing edits:<br><br>The Aging Information Management System (AIMS) and the Division of Medical Assistance's Medicaid Management Information System (MMIS) use billing edits to block payment to claims. Both computer systems use automated processing and auditing. Billing edits in MMIS block payment of claims that have data inconsistent with the information in AIMS.<br><br>**EXAMPLE:** AIMS edits prevent authorizing more than 75 Medicaid home health visits and costs that exceed the cost limit and entering SAFs without a Medicaid number.<br><br>▪ Prior Approval Requests (PAR):<br><br>In AIMS the Prior Approval Requests billing edit automatically stops reimbursement of SAFs on clients whose cost of services exceed the established cost limit. When excess services are entered on the SAF, the SAF will "Pend". Until the Division approves the PAR and |

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| POLICY BASICS (contd.) | releases the "pended" SAF, the data will not transfer to EDS.<br><br>**NOTE:** If the Division does not approve the PAR, the SAF is declined and the PAR is returned to the care coordinator.<br><br>▪ Third party reimbursement:<br><br>Some CCSP clients have Medicare or private insurance coverage. The provider is responsible for billing for third party reimbursement first and then billing the balance to Medicaid. |
| PROCEDURES | When a provider requests an adjusted SAF because it reflects less units than actually provided, determine if an override is justified.<br><br>Use the procedures in Chart 960.1 to adjust an SAF when an override is justified: |

**Chart 960.1 - Override Procedures**

| IF | THEN |
|---|---|
| Override needed because service delivery date more than 12 months ago | The provider:<br><br>▪ Sends care coordinator CCNF, Form 6500 requesting the increase in units on the SAF.<br><br>The care coordinator:<br><br>▪ If the increase is justified, requests override from the Division of Aging Services.<br><br>▪ Sends copy of SAF with approved changes and writes a detailed explanation of the reason for request in the "client liability" section.<br>AND<br>Attaches a cover memorandum requesting an override and forwards it to the Division of Aging Services |

| IF (contd.) | THEN (contd.) |
|---|---|
| | within five business days of provider's request. |
| Division approves override request | ▪ Division staff initial the form and enters changes to SAF.<br>AND<br>▪ Care coordinator generates and signs SAF, forwards a copy to provider with CCNF, and files original in client file.<br><br>▪ Provider bills DMA for services. |
| The Division denies override request | ▪ Division staff return paperwork to care coordinator with the reason for denial.<br>AND<br>▪ Care coordinator uses CCNF to notify provider of Division decision.<br><br>**NOTE:** Division of Aging Services maintains file copies of all approved/denied overrides at the state level. |

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| REFERENCES | Appendix 100, Forms and Instructions;<br>Section 1130, Automated Deauthorization Process |

## 962 - BILLING EDITS

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| POLICY STATEMENT | DMA's fiscal agent processes Medicaid claims only if they are timely and correct. Billing edits are employed to block payment of claims that are inconsistent with the Medicaid Management Information System (MMIS). |
| POLICY BASICS | DMA's fiscal agent, Affiliated Computer Services (ACS), implemented the MMIS which processes and audits provider claims. The Medicaid billing form captures the necessary data for the MMIS.<br><br>DMA's fiscal agent pays claims only if they are received by the end of the sixth month following the month services are rendered. Claims over six months old and claims adjustments require special handling to pay a provider. |
| PROCEDURES | Upon receipt of CCNF from provider documenting that services have begun, the following activities occur:<br><br>1. Care coordinators authorize services for clients on the Service Authorization Form (SAF) in the Aging Information Management System (AIMS**).**<br><br>2. After the SAF information is entered into AIMS, SAF data is available to the Information and Technology (IT) Section of DHR's Office of Technology and Support.<br><br>3. From IT, SAF information is transferred to DMA's MMIS.<br><br>▪ DMA's MMIS contains client eligibility information that matches with Social Security Administration and DFCS client eligibility information.<br><br>▪ If SAF information does not match DMA's MMIS files, system audits and edits stop the SAF transfer to DMA's MMIS.<br><br>4. After delivering services, providers use the SAF received from the care coordinator to prepare their claims and submit them to EDS either electronically or by mail. The claim information submitted by the provider must |
| PROCEDURES (contd.) | |

also match the MMIS/DMA system for payment to be made.

Apply the deadlines in Chart 962.1 regarding CCSP provider payments submitted to EDS:

**Chart 962.1 - Billing Deadlines**

| BILLING SITUATION | TIMELINESS |
|---|---|
| Claim submitted for services rendered<br>AND<br>Client is Medicaid eligible | DMA allows 6 months from the end of service month to submit initial claim.<br>BUT<br>AIMS will deauthorize services 3 months after service month regardless whether the provider has billed.<br><br>**NOTE:** If a provider bills after the third month service was delivered and deauthorizations have occurred, the provider will need services authorized on a new SAF. |
| Claim submitted for client determined retroactively eligible for Medicaid | 6 months from month in which eligibility was determined. |
| Claim submitted with third party payers | 12 months following month of service. |
| Claim denied for Medicare, resubmitted for Medicaid | 3 months following date Medicare claim was denied. |
| Denied claim resubmitted | 6 months following month of service or by end of 3rd month following denial. |
| Claim submitted for adjustment | 3 months from month of payment, accompanied by adjustment request form and Remittance Advice. |

PROCEDURES (contd.)

If unable to resolve the provider's billing problem, ask the provider to use the following procedures:

- Complete the Provider Inquiry Form found in the Appendix of the DMA Billing Manual
- Attach the Remittance Advice

PROCEDURES (contd.)

- Attach copy of the SAF

| | |
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| | ▪ Mail all of the above to DMA, P.O. Box 38426, Atlanta, GA 30334. |
| REFERENCES | Appendix 100, Forms and Instructions;<br>Section 912, Transfers;<br>Section 970, Terminations;<br>Chapter 1100, CCSP AIMS;<br>Billing Manual for Community Care Services |

## 964 - PRIOR AUTHORIZATION / PREPAYMENT REVIEW REQUESTS

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| POLICY STATEMENT | The Division of Aging Services must authorize payment of client service costs exceeding the cost limits for CCSP. |
| POLICY BASICS | The Division of Aging Services provides cost edit information to the AAAs.<br><br>The care coordinator requests prior authorization requests (PAR) before a service is delivered or prepayment review requests (PPR) after services are delivered. The care coordinator sends these requests to the Division of Aging Services for approval.<br><br>The SAF pends if net services authorized exceed the cost edit per individual for the month. The AAA generates a computerized printout of the pended SAF for the care coordinator. This form is similar to the SAF except for the heading "Pended Service Authorization" at the top of the page, and there is no signature line for the care coordinator. The message at the bottom of the pended SAF states, “his service authorization has been pended until a DMA-80 has been approved by the Division of Aging Services.”<br><br>Close communication between care coordinators and providers is important in the prior authorization/prepayment request process. If there is a question concerning the client's need for increased services, the care coordinator consults with the care coordination team and/or completes a reassessment.<br><br>**NOTE:** Care coordinators approve initial and subsequent installations of emergency response systems even if the total cost for services exceeds the cost limits for the installation month.<br><br>Care Coordinators may assist clients in obtaining prior approval for prescription drug(s) requests. If a client requires more than 5 prescriptions in a month, cannot use generic drugs, or needs other medication, the pharmacy needs prior approval from DMA. Pharmacies may provide clients with the Prior Approval Drug(s) Request Form, DMA-614 for completion and submission to doctors. The doctor will send the form(s) to the following address: |
| POLICY BASICS | First Health Services |

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|---|---|
| (contd.) | P.O. Box 724387<br>Atlanta, Georgia 31139<br>Telephone: 1.800.547.0673<br>Fax: 1.800.547.1578 |
| PROCEDURES | When a client's service costs are expected to exceed the monthly cost limits set by the Division of Aging Services, the provider, care coordinator, and Division of Aging Services follow the procedures in Chart 964.1: |

**Chart 964.1 - Procedures for Prior Approval & Prepayment Review Requests**

| IF | THEN |
|---|---|
| Provider determines client services will exceed cost limits within 5 working days before the beginning of the month in which services are to be delivered | The provider advises the care coordinator that the client's cost of care is expected to exceed the limit for the current month and requests the care coordinator's prior authorization to increase services. |
| Emergency situation requires immediate delivery of services and provider is unable to contact care coordinator for verbal approval beforehand<br><br>**NOTE:** Since providers and care coordinators are required to be available by phone (pager) 24 hours a day, 7 days per week, such emergency situations are expected very rarely. | Provider initiates prepayment review request by contacting care coordinator as soon as possible to advise that a completed CCNF, Form 6500 is forthcoming. |
| Care coordinator agrees that increase in service is needed | Provider sends care coordinator a completed CCNF, Form 6500, within three business days of the verbal approval from care coordinator and attaches doctor's order or other relevant medical/social information, if applicable. |
| Community Care Notification Form (CCNF), Form 6500, reflects care coordinator's verbal approval | Care coordinator:<br><br>1. Verifies with other providers the number of units provided to be sure total services rendered did exceed cost limits. Deducts the client liability from service costs. |
| **IF (contd.)** | **THEN (contd.)** |

| | |
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| | 2. Completes the DMA-80 for each month that the cost exceeds the guideline.<br><br>3. Adjusts SAF to correspond to DMA-80.<br><br>4. Completes Care Coordination Transmittal form (CCT).<br><br>5. Within five business days of receipt of the CCNF, Form 6500, mails the following to the Division of Aging Services:<br><br>C completed DMA-80<br>C CCT<br>C copy of pended SAF.<br><br>6. Maintains copies of DMA-80 and CCT in tickler file until disposition. |
| PMAO client becomes Medicaid eligible | Care coordinator:<br><br>C Follows steps 1-6 above.<br><br>C Generates SAFs retroactively based on client's receipt of services and Medicaid eligibility.<br><br>**NOTE:** Review CCC, Form 5590 to determine if client is Medicaid eligible for retroactive months. |
| Submitted documentation contains insufficient information | Division of Aging Services contacts the care coordinator to request further information. |

| IF (contd.) | THEN (contd.) |
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| Division of Aging Services approves the service request on DMA-80 | Within five business days, Division of Aging Services:<br>▪ Signs and dates the DMA-80.<br>▪ Notifies the care coordinator of approval of DMA-80.<br>▪ Enters the DMA-80 serial number into AIMS.<br>▪ Releases the pended SAF to the local level with the DMA-80 number printed in the lower left corner.<br>▪ Notifies the care coordinator of the released SAF. |
| Care coordinator receives approval of DMA-80 from Division of Aging Services | Care coordinator:<br>▪ Reviews SAF to determine if it is correct.<br>▪ Sends copy of released SAF to provider within three business days.<br>AND<br>Provider:<br>▪ Bills with released SAF. |
| Division of Aging Services denies DMA-80 | Within five business days, Division of Aging Services:<br>▪ Signs and dates the DMA-80.<br>▪ Notifies the care coordinator of denied DMA-80. |
| **IF (contd.)** | **THEN (contd.)** |

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| | ▪ Sends copies of denied DMA-80 to provider and care coordinator.<br><br>▪ Declines SAF in AIMS to allow the care coordinator to update the SAF at the local level.<br><br>AND<br>Care coordinator:<br><br>▪ Within three business days, notifies the provider that the request was denied and sends updated SAF.<br><br>AND<br>Provider:<br><br>▪ Bills on updated SAF for month of service. |
| PROCEDURES (contd.) | Do not send a DMA-80 in the following situations if:<br><br>▪ Total cost of services less the cost share does not exceed the cost limits.<br><br>▪ The client is PMAO until Medicaid eligibility has been determined.<br><br>▪ ERS installation causes the cost of services to exceed the cost cap.<br><br>Enter cost share amount on the Care Coordination Prior Authorization Request Transmittal (CCT) for MAO clients. Enter "0" if the client has been assigned a "0" cost share.<br><br>**NOTE:** If a care coordinator causes the SAF to pend in error, call the Division's accounting technician to request release of the pended SAF. |
| REFERENCES | Appendix 100, Forms and Instructions:<br>Prior Authorization Request, Form DMA-80; |

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| REFERENCES (contd.) | Community Care Notification Form (CCNF), Form 6500;<br>Care Coordination Transmittal Form (CCT);<br>Community Care Communicator, Form 5590;<br>Prior Approval Drug(s) Request Form, DMA 614;<br>Chapter 800, Reassessment |

## 966 - THIRD PARTY REIMBURSEMENTS

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| POLICY STATEMENT | If a CCSP client's CCSP services are covered by any other third party insurance, the CCSP provider must first bill the third party insurance carrier before billing Medicaid. |
| POLICY BASICS | Some CCSP clients have health insurance policies which pay toward the cost of skilled health services provided by the CCSP. |
| PROCEDURES | For clients with third party insurance, the care coordinator lists on the Service Authorization Form (SAF) all services and units of service ordered on the initial plan of care.<br><br>The provider submits an invoice to DMA for reimbursement of the balance of the cost of services not covered by the CCSP client's third party insurance.<br><br>It is not necessary for the provider to send a CCNF to the care coordinator to deauthorize third party units that were reimbursed. DMA coordinates third party insurance payments for Medicaid clients. |
| REFERENCES | Chapter 1100, CCSP AIMS |

## 970 - TERMINATIONS

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| POLICY STATEMENT | CCSP clients who no longer meet the eligibility requirements or no longer wish to participate in the CCSP are discharged from the CCSP program. |
| POLICY BASICS | The care coordinator terminates clients from the CCSP. DMA's Utilization Review Team (UR) and providers may discharge a client's service. Clients may appeal care coordinator and UR adverse action decisions.<br><br>Care coordinators use the following termination reasons/status codes in AIMS and in CHAT to indicate the reason for terminations.<br><br>1. Client no longer meets level of care criteria: After reassessment, care coordinator determines that the client no longer meets the LOC.<br><br>**NOTE:** CHAT includes this code but in AIMS use the code listed in #2 below.<br><br>2. Client no longer eligible: Care coordinator determines client is no longer eligible for CCSP for reason other than LOC.<br><br>3. UR recommends discharge/termination: UR recommends the client discharge from service and this recommendation is upheld in the UR appeal process.<br><br>4. No services provided for 60 consecutive days: The enrolled client has not received a waivered service for 60 consecutive days, including those paid for by Medicare and indicated on the Comprehensive Care Plan.<br><br>**EXCEPTION:** When the client is hospitalized.<br><br>5. Death of client: The client dies.<br><br>6. Client refused service/requested termination: The client refuses service and/or requests termination from the CCSP. |
| POLICY BASICS (contd.) | 7. Moved out of state: The client moves out of state. |

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| | **NOTE:** In AIMS, use "Client Moved from Service Area" to indicate that the client moved out of state.<br><br>8. Client entered nursing home/facility: The client enters a long-term care facility on a permanent basis.<br><br>**NOTE:** If a client enters a nursing facility for a temporary stay, the care coordinator does not send a termination notice until notified the placement is permanent.<br><br>9. Other: In CHAT, use this code for terminations that do not fit the other reasons or status codes. |
| PROCEDURES | Use the procedures in Chart 970.1 when discharging clients from the CCSP: |

**Chart 970.1 - Termination Procedures**

| IF | THEN |
|---|---|
| Provider sends 30 day discharge notice advising client of the reason and effective date of discharge<br>AND<br>Sends care coordinator a CCNF advising of client□s proposed discharge. Provider attaches a copy of the discharge notice sent to client and a copy of the final summary report.<br><br>**NOTE:** If a provider discharges a client who exhibits and/or allows illegal behavior in the home or client or others living in the home have inflicted or threatened bodily harm to another person within the past 30 calendar days, the provider does not have to provide services through the effective date of discharge notice. | If care coordinator determines client continues to need the service, care coordinator uses client choice or rotation to broker the service with another provider.<br><br>If no provider is willing to accept the client and the client is no longer receiving a service, care coordinator sends a completed Form 5382 advising client of termination from CCSP. |
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| IF (contd.) | THEN (contd.) |
|---|---|
| Provider discharges client who fails to pay cost share | Care coordinator attempts to re-broker services with another provider.<br>BUT<br>No provider is willing to accept the client and the client is no longer receiving a service.<br>Care coordinator sends a completed Form 5382 to the client. |
| Provider sends 30 day discharge notice advising client of reason and effective date of discharge<br>AND<br>Care coordinator determines client is no longer eligible for service(s) | Care coordinator sends a completed Form 5382, stating the reason for termination in service<br>AND<br>Provides care coordination services until the termination date. |
| Client is in an acute care hospital more than 60 days | If client plans to return to CCSP, care coordinator does not send adverse action notice<br>BUT<br>Completes a reassessment when the client is discharged from the hospital. |
| Client is discharged from the hospital<br>AND<br>No longer receives services from providers participating in CCSP<br><br>**NOTE:** Give client the option of choosing a CCSP provider. | Care coordinator sends adverse action notice, Form 5382, advising client of termination from the CCSP.<br><br>**NOTE:** A non-approved provider cannot request reimbursement from CCSP. To ensure coordination of appropriate service delivery, notify hospital discharge planners when a CCSP client enters the hospital. |
| A MAO or PMAO client is terminated from the CCSP | Care coordinator sends CCC, Form 5590, to DFCS on the same day that the Form 5382 is mailed to client.<br><br>**NOTE:** If client entered a nursing home, include the name of the facility on the CCC. |
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| IF (contd.) | THEN (contd.) |
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| MAO or PMAO client requests a fair hearing | Care coordinator and DFCS coordinate the hearing request with LSO.<br>AND<br>Care coordinator notifies provider(s) of the client's appeal. |

PROCEDURES (contd.)

To close a case record, complete the following activities in CHAT and AIMS:

CHAT:

1. Enter last day of services on Comprehensive Care Plan

2. Delete care coordinator's name

3. Document information pertinent to termination

4. Add status code for termination at end of 30-day notice.

   **EXCEPTION:** If client appeals the adverse action, the case remains active during the hearing process.

AIMS:

1. Update the following:

   - End Date which is final service date
   - Eligibility/Change in Status with reason for termination.

2. Revise SAF in AIMS to delete units of service not provided to client prior to termination date.

   **NOTE**: AIMS automatically deauthorizes any services authorized after the termination date.

3. Send copies of revised SAFs to a provider.

4. File original SAF in case record.

5. Change care coordinator to unassigned.

REFERENCES

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| | Chapter 1000, CCSP Appeals;<br>Section 660, Documentation;<br>Chapter 1100, CCSP AIMS;<br>Section 606, Provider General Manual |