Title: **BSW 403**
Section: **ELIGIBILITY FOR SERVICES**
Subject: **Prior Authorizations by the Community Services Bureau**
Reference: **Big Sky Waiver (BSW) Application 01-01-2018; ARM 37.40.1407,.1420,.1421**
Supersedes: **BSW 403 (01/01/2019)**

DEFINITION

The Community Services Bureau (CSB) may require approval by the Regional Program Officer (RPO) and/or CSB prior to the member receiving specific services. 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. Services authorized by the CMT that do not meet Prior Authorization criteria are subject to repayment.

NOTE: Refer to BSW 605 (Payment Processing), for 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.

4. 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;
5. The service must provide a direct medical or curative benefit to the member; and
6. The service is an approved service listed in the BSW Application.

PRIOR AUTHORIZATION SITUATIONS

The CMT must request prior authorization for 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 plans;
3. Environmental Accessibility Adaptations in excess of $5,000. Refer to BSW 711 (Environmental Accessibility Adaptions);
4. Vehicle Modifications in excess of $5,000. Refer to BSW 737 (Vehicle Modifications);
5. Service Plan over cost limit; Refer to BSW 899-5 (Service Plan Cost Limits);

6. Specialized Medical Equipment or Supplies in excess of $2,500. Refer to BSW 733 (DME Specialized Medical Equipment, Supplies and Technology);
7. 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;
8. 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.
9. Amendment to an existing Prior Authorization;
10. Out-of-state non-medical transportation. Refer to BSW 718 (Non-Medical Transportation);
11. 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);
12. Non-medical transportation exceeding 50 miles/bi-weekly. Refer to BSW 718 (Non-Medical Transportation);
13. Pass-through payments. Refer to BSW 605 (Payment Processing); and
14. 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 requests.

BASIC SLOT AUTHORIZATION OF OVER COST

The RPO is responsible for reviewing and approving requests for costs over the Service Plan cost limit. Refer to BSW 809-4 Service

Plan Costs. Authorization for over cost will be made with consideration of the following criteria:

1. The service causing the member to exceed costs is a one-time purchase, e.g., specialized medical equipment or environmental modification;
2. The service causing the member to exceed costs is for intensive services required for 90 days or less:
    a. to resolve a crisis situation which threatens the health and safety of the individual;
    b. to stabilize the individual following hospitalization or an acute medical episode; or
    c. to prevent institutionalization during the absence of the unpaid caregiver.
3. The service causing the member to exceed costs is required to avoid institutionalization.

CARE CATEGORY 3 (CC3) SLOT AUTHORIZATION OF OVER COST

The RPO is responsible for reviewing and approving requests for costs over the Service Plan cost limit, including authorization of CC3 slot amendments and over costs; final approval may be required by Community Services Bureau (CSB). CC3 slots may be provided to a member whose services exceed cost limits due to his/her acuity and to prevent institutionalization. A referral for a CC3 slot may be submitted in this situation, although the CMT may continue to provide over cost services in a basic slot as long as the services can be maintained within the member's budget or until a CC3 slot becomes available. The CMT must provide thorough documentation supporting the need for over cost services. When the member has been placed on a wait list for a CC3 slot, the CMT must provide written notification to the member.

DEADLINES

PA requests must be submitted to the Department for review with sufficient advance notice to:

1. Provide the Department with at least 10 days to review the prior authorization prior to the need for services and/or the end of the current Service Plan; and

2. 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, clarification from the BSW Program Manager (PM).

PROCEDURES

Requests for prior authorization must be forwarded to the RPO/PM prior to implementation of services. In addition, approval of CC3 initial plans and amendments require both RPO and Central Office approval; a copy of the Service Plan and Service Plan cost sheet must accompany the Prior Authorization for CC3 (SLTC-148) form. Services cannot be authorized retroactively.

The following actions must be taken prior to the implementation of services:

1. Completion of the Prior Authorization form (SLTC-149) or Request for Initial Prior Authorization for CC3 (SLTC-148) form:
    a. The CMT will forward the completed form to the RPO/PM for review and authorization.
    b. Upon receipt of the form, the RPO/PM will review the form for accuracy and compliance to BSW policies.
        i. If the RPO/PM concurs, the RPO/PM will indicate the approval, sign and date the form and return the completed form to the CMT.

            NOTE: CC3 initial Plans require both RPO and Central Office prior approval. Central Office will

review the request and complete, sign and date the form and return the form to the RPO.

ii. If the RPO/PM does not concur with the Prior Authorization request, the RPO will indicate the reason for denial and return the form to the CMT.

c. The CMT will mail the member a Termination, Denial or Decrease of Services form (SLTC-150) indicating the reason for the service denial as indicated on the prior authorization by the RPO/PM.