**GOVERNMENT OF THE DISTRICT OF COLUMBIA**
**Department of Health Care Finance**

**Office of the Director**

DHCF Transmittal No. 09-25

TO: District of Columbia Medicaid Providers of EPD Waiver Services Utilizing Casenet Electronic Case Management System

FROM: Julie Hudman, Ph.D.
Director
Department of Health Care Finance

DATE: November 25, 2009

SUBJECT: Policies and Procedures for Delmarva Foundation to Prior Authorize Services in the Elderly and Individuals with Physical Disabilities (EPD) Waiver Program

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The Department of Health Care Finance (DHCF) has developed the following policies and procedures to provide guidance on the process that will be used for prior authorizing EPD Waiver services for providers utilizing Casenet electronic case management system. For EPD Waiver providers utilizing Casenet, DHCF has delegated responsibility for reviewing and prior authorizing EPD Waiver services to Delmarva Foundation, Inc., the Quality Improvement Organization (QIO) for the District of Columbia.

**Effective December 15, 2009, the QIO will review new applications, recertifications, change requests, and transfers for the EPD Waiver and begin authorizing EPD Waiver services as stated in the policies and procedures outlined below.**

The QIO will only undertake these responsibilities for beneficiaries who receive case management services from providers who utilize Casenet. DHCF will continue to perform these administrative functions for beneficiaries who receive case management services from providers not utilizing Casenet at this time. As additional case management providers transition to the Casenet system, responsibility for prior authorization of EPD Waiver services and other administrative functions will move to the QIO.

Transitioning prior authorization of EPD Waiver services and other administrative functions to the QIO will allow for a more efficient and timely review and authorization of EPD Waiver services.

Outlined on the following pages are the policies and procedures for prior authorization of EPD Waiver services for case management provider agencies utilizing Casenet.

# Policies and Procedures for Prior Authorization of EPD Waiver Services for Casenet Users

***Beneficiary or Authorized Representative Procedure***

An individual seeking home and community-based services shall contact DHCF or the Aging and Disability Resource Center (ADRC) for an EPD Waiver Provider Directory. The beneficiary shall select a case management provider agency from the directory and contact the agency to request EPD Waiver services.

***Case Management Provider Procedure***

After a beneficiary selects a case management provider agency, the provider agency shall search for the individual in the Casenet system to determine whether the beneficiary is currently receiving EPD Waiver services. If the beneficiary is found in the Casenet system, the provider agency must assign a case manager to that beneficiary. If the beneficiary is not found, the beneficiary must be added as a new recipient. **Case managers shall not have a case load greater than forty-five (45) EPD Waiver beneficiaries.**

After the case management provider agency assigns a case manager to the beneficiary, the assigned case manager shall schedule an appointment with the beneficiary to perform a comprehensive assessment of the individual's health, functional needs, home and social environment, and risks to the individual's well-being in order to complete the EPD Waiver application materials in Casenet.

The case manager shall complete the necessary waiver documents below directly in Casenet. In the event a signature cannot be obtained electronically or the form is not available in Casenet, scan and upload the forms into Casenet. If a form is available in Casenet and there is a paper signature but no electronic signature, upload the signed form but be sure to complete the electronic form in Casenet.

The following forms must be completed and entered into Casenet:

a) Form 30-AW (New Admissions) or 1209-W (Recertifications);
b) Waiver Beneficiary Freedom of Choice form with identified case management agency of choice, beneficiary's signature, and case manager's signature; and Client Bill of Rights and Responsibilities form with beneficiary's signature and case manager's signature. Note: These are separate forms in the paper world, but are the same form in Casenet;
c) Medicaid application (if applicable) with copy of supporting documentation including proof of income, bank statement, and insurance card (if beneficiary has

other health insurance such as Medicare, Kaiser Permanente, Blue Cross/Blue Shield, etc.) etc.;

d) Client Health History form with case manager's signature;
e) Risk Assessment form with signature of case manager (a signature from a registered nurse is required in the case of recertifications);
f) EPD 2010-1 Guidelines Worksheet for Determining PCA Service Hours;
g) Individualized Services Plan (ISP) with signature of case manager. Note: Case managers are required to complete the Waiver Costs and Services section in Casenet; and
h) Request for Medicaid Nursing Facility Level of Care form (Form 1728)*.

* The Request for Medicaid Nursing Facility Level of Care form (Form 1728) must include the signature of either a physician, physician assistant, or nurse practitioner and his/her NPI number. Physician assistants should include their supervising physician's NPI number. After entering Form 1728 into Casenet, the case manager shall task the QIO to complete the level of care (LOC) determination. The case manager shall check Casenet to confirm that an LOC determination has been made by the QIO.

***Timelines***

1. Within two (2) business days of completing the beneficiary's comprehensive assessment, the case manager shall enter all forms into Casenet.
2. All forms must be entered into Casenet before submitting the Request for Medicaid Nursing Facility Level of Care form (Form 1728).
3. Within two (2) business days after obtaining the signature on Form 1728 and submitting the form into Casenet, the case manager shall task the QIO to make the LOC determination.
4. Within three (3) business days, the QIO will complete the LOC determination.
5. DHCF shall forward the documents needed to determine financial eligibility to the Income Maintenance Administration (IMA) within five (5) business days.
6. IMA shall make the Medicaid financial eligibility determination within forty-five (45) calendar days.
7. Once financial eligibility is determined, DHCF shall task the QIO within two (2) business days to review requested services and complete the prior authorization request.
8. Upon receipt of the task notification from DHCF, the QIO staff shall conduct a review of the requested services and complete the prior authorization within five (5) business days.

The QIO will task the beneficiary's case manager as a means of notifying the case manager that services have been approved. The QIO will also generate and mail a letter to the beneficiary and case management provider agency identifying the approved provider(s) and services.

***Change Requests***

Within two (2) business days of the case manager assessing the need for the change in services, the case manager shall use the file import function to upload the Request for Change in Services form and the EPD 2010-1 Guidelines Worksheet for Determining Personal Care Aide Service Hours. The case manager shall task DHCF as a means of notifying DHCF that a request for change in services has been submitted.

DHCF shall task the QIO to review the Request for Change in Services form and EPD 2010-1 Guidelines Worksheet. Within five (5) business days, the QIO shall review and authorize the change request, as appropriate. QIO will task the beneficiary's case manager as a means of notifying the case manager that the services have been approved.

***Transfers (Inter-agency)***

Within two (2) business days of the beneficiary's request for transfer, the discharging agency shall begin the inter-agency transfer process. All aspects of the transfer, including the last and first day of services must be coordinated between and mutually agreed upon by both the discharging and receiving agency. The discharging agency shall upload the Discharge Summary form and the Inter-Agency Transfer form into Casenet five (5) business days prior to the first day of services provided by the receiving agency.

DHCF shall complete the transfer within five (5) business days and task the beneficiary's discharging case manager as a means of notifying him/her of the transfer. The receiving case management provider agency may only conduct the comprehensive case management assessment and start direct care services, if applicable, after receiving a task from DHCF notifying the receiving case management agency that the transfer has been completed and the beneficiary has been assigned to the receiving case management agency in Casenet.

No later than the day immediately following the last day of services provided by the discharging agency, the receiving case management agency must conduct a comprehensive assessment of the beneficiary and complete the following documents:

a. Individualized Services Plan (ISP);
b. Client Health History;
c. Risk Assessment;
d. Beneficiary Freedom of Choice and Bill of Rights; and
e. EPD 2010-1 Guidelines Worksheet for Determining PCA Service Hours

Within five (5) business days of the receiving case management agency assessment of the beneficiary, the case manager shall complete all necessary forms listed above in Casenet and use the file import function to upload documents, if applicable. DHCF will task the receiving agency a new prior authorization retroactive to the date services begin. In the interim, the receiving agency should begin services on the agreed upon start date to avoid any disruption in services.

*Appeals Process*

**Denial of Eligibility for EPD Waiver Program:**

If an individual is denied admittance into the EPD Waiver Program, the individual has the right to request a fair hearing. QIO staff will send a denial letter to the individual with information on how to access the fair hearing process.

**Denial of Request for EPD Waiver Services:**

If an individual disagrees with a denial of services or the number of PCA service hours approved, the case management provider agency may fax a letter requesting reconsideration to Karen Mesko, Director of Long-Term Care, Delmarva Foundation at 410-820-0164. The letter may include additional documentation to support the reconsideration request for the denied service(s) or number of approved PCA service hours.

The QIO will arrange for a reviewer, other than the reviewer who performed the initial review, to perform the reconsideration review, and issue the reconsideration decision within five (5) business days of the reconsideration request. Providers and beneficiaries will receive written notice within five (5) business days of the reconsideration determination. If approved, the QIO enters the approval data into the Prior Authorization Subsystem of the MMIS. If not approved, the QIO provides written notification of the denial to the provider and beneficiary including information on how to request a fair hearing from the DC Office of Administrative Hearings. A beneficiary or beneficiary's representative has ninety (90) calendar days from the postmark date of the QIO reconsideration letter to ask for a fair hearing.

*Contact Information*

**All questions regarding authorization of EPD waiver service requests submitted on or after December 15, 2009 should be directed to Karen Mesko, Director of Long-Term Care, Delmarva Foundation, at 410-763-6288.**

Concerns with this revised procedure should be directed to Robin Revels-Fitzhugh, Director of DC Medicaid Programs, Delmarva Foundation at 202-496-6564 or by email at fitzhughr@dfmc.org.

Questions regarding the revised process may also be directed to Ericka Walker, Program Analyst, DHCF, at 202-442-9054 or by email at ericka.walker@dc.gov.

CC: Delmarva Foundation for Medical Care, Inc.