Long-term services and supports (LTSS) Provider orientation

IAPEC-0177-15 December 2015

Waiver services overview

Iowa supports the following programs:

- Acquired immune deficiency syndrome (AIDS)/human immunodeficiency virus (HIV) Waiver
- Brain Injury Waiver
- Children's Mental Health Waiver
- Elderly Waiver
- Health and Disability Waiver
- Intellectual Disability Waiver
- Physical Disability Waiver
- Habilitation Services Waiver

Waiver services overview

AIDS/HIV Waiver program

The AIDS/HIV Waiver offers services for those who have been diagnosed with AIDS or HIV.

Brain Injury Waiver program

The Brain Injury Waiver offers services for those that have been diagnosed with a brain injury. Members must be at least one month old; there is no age maximum.

Children's Mental Health Waiver program

The Children's Mental Health Waiver offers services for children who have been diagnosed with serious emotional disturbance.

Elderly Waiver program

The Elderly Waiver provides services for elderly persons. Individuals must be at least 65 years of age for this waiver.

Waiver services overview

Health and Disability Waiver program

The Health and Disability Waiver provides services for persons who are blind or disabled.

Intellectual Disability Waiver program

The Intellectual Disability Waiver provides services for persons who have been diagnosed with an intellectual disability, or a mental disability equivalent to an intellectual disability, as determined by a psychologist or psychiatrist.

Physical Disability Waiver program

The Physical Disability Waiver provides services for persons who have a physical disability determination. An applicant must be at least 18 years of age, but less than 65 years of age.

Habilitation Services Waiver

The Habilitation Services Waiver is designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Continuity of care – LTSS services

Upon enrollment with Amerigroup Iowa, Inc.:

- LTSS services will be authorized until a new comprehensive needs assessment is completed, or up to one year in the absence of a completed assessment.
- Members receiving LTSS will be permitted to see all current providers on their approved service plan, including any non-network providers, until an assessment and service plan is completed and either agreed upon by the member, or resolved through the appeals or fair hearing process and implemented.
- LTSS services will not be reduced, modified or terminated in the absence of a new/up-to-date needs assessment that would support any service reduction, modification or termination.

Continuity of care – LTSS services

- We'll extend the authorization of current LTSS providers as necessary to ensure continuity of care through the end of 2017.
- We'll facilitate a seamless transition to new services and/or providers, as applicable, in the plan of care/service plan we developed – without any disruption in services.

Continuity of care – LTSS services

Amerigroup members using a residential provider at the time of enrollment will have continued access to that residential provider for up to two years, even on a non-network basis. Members can't be forced to move to another residential provider unless the following conditions are met:

- The member or his/her representative specifically requests the transition.
- The member or his/her representative provides written consent to the transition, based on quality or other concerns raised by Amerigroup.

Note: Any Amerigroup issues regarding the current residential provider's rate of reimbursement, or contracted vs. noncontracted status, shall not be grounds for moving a member to another residential provider.

Nursing facilities (NFs)

- Authorization must be in place prior to services being rendered.
- If the member leaves the NF, notification to our Case Manager and the DHS is required.
- Custodial claims can be billed with the following revenue codes:
  - 0120: Room and board/semi-private
  - 0190: Subacute care – general classification
- Bedhold claims can be billed with revenue code 0185 (hospital bedhold); this will let us know that a member has left understanding that it is a nonreimbursable in Iowa.

NFs – ventilator-dependent members

- It's important that the nursing NF accurately indicate when the criteria for skilled needs include ventilator care for at least six hours a day.
- Members in NFs that meet criteria for skilled and ventilator care will receive a special rate.
- To receive accurate claim payment for ventilator care, providers must include an applicable diagnosis code that indicates ventilator dependency, including:
  - Z99.11 – dependence on ventilator
  - J95.850 – mechanical complication of ventilator
  - J95.851 – ventilator-associated pneumonia
  - J95.859 – other complications of ventilator

Preadmission screening and residential review (PASRR)

- Prior to admission to a nursing facility, and any time there is a significant change in status, members will receive a preadmission screening and resident review (PASRR) by the state or its designee. We will work with the state or its designee responsible for implementation and oversight of the PASRR.
- The PASRR process must be completed prior to a facility admission.

PASRR (continued)

- Members entering a nursing facility must have a completed level I PASRR screening tool. If positive, Amerigroup will ensure the level II evaluation is completed by the state mental health and/or developmental authority.
- If the level II evaluation determines the member requires specialized services, our Community-Based Case Manager will ensure the nursing facility complies with federal PASRR requirements and all applicable Iowa law governing admission, transfer and discharge policies to provide, or arrange to provide, specialized services.

PASRR (continued)

- A copy of all PASRR documentation (i.e., level I screening tool and level II evaluation, if required) will be maintained in the member's electronic medical record in our clinical management system.
- Our Community-Based Case Manager will monitor members in accordance with contract visits and inform members of their right to return to the community.
- The Community-Based Case Manager educates members on the available settings, and ensures members have the option to receive home and community-based services (HCBS) in more than one residential setting appropriate to their needs.

Member liability/client participation

- Some members have a member liability, also referred to as client participation, which must be met before Medicaid reimbursement for services is available.
- The Iowa Department of Human Services (DHS) has the responsibility for determining the member liability amount. This includes a portion of members eligible for Medicaid on the following bases:
  - Members in an institutional setting
  - 1915(c) HCBS Waiver enrollees

Member liability/client participation

- Through the DHS eligibility and enrollment files, the state will notify us of any applicable member liability amounts. This information will be made available to providers. Providers will be required to collect this amount from the member.
- Provider will bill gross/full charges. We'll adjudicate the claim and deduct the member liability amount. In the event the sum of any applicable third-party payment and a member's financial participation equals or exceeds the reimbursement amount established for services, we'll make no payment to the provider.

Consumer-directed attendant care

Consumer-directed attendant care (CDAC)

- Under the HCBS Medicaid waiver program, there is an opportunity for members to have help in their own homes.
- CDAC is available for members in the following waiver programs:
  - AIDS/HIV Waiver
  - Brain Injury Waiver
  - Elderly Waiver
  - Health and Disability Waiver
  - Intellectual Disability Waiver
  - Physical Disability Waiver
- The services are designed to help members do things that they would normally do for themselves.

CDAC (continued)

- There are two types of CDAC services – **unskilled** and **skilled**:
- Unskilled services include help with normal daily activities such as:
  - Housekeeping
  - Fixing meals
  - Shopping
  - Running errands
  - Getting dressed/undressed
  - Getting in and out of bed
  - Taking a bath
  - Scheduling appointments
- Skilled services are more medical in nature and might include:
  - Monitoring medications
  - Tube feedings
  - Colostomy care
  - Recording vital signs
  - Intravenous therapy
  - Catheter care
  - Post-surgical nursing care
  - Therapeutic diets

CDAC (continued)

Requirements to become a CDAC provider are as follows:

- Complete the CDAC application with the IME
  - Complete the criminal history and abuse background check
  - Obtain NPI number (obtained once background check is completed)
  - Brain injury waiver providers must complete the online brain injury training course modules one and two within 60 days from the beginning date of service provision.
- Participate in a team meeting with an Amerigroup representative and eligible member, authorizing the provider to perform services
- Sign and date the CDAC agreement with the eligible member

CDAC provider responsibilities

- Providers are required to keep records of all completed service activities using the CDAC Daily Services Record form.
- Records must be kept for five years and be available (if selected to be audited).
  - Failure to maintain and provide adequate records could result in the provider refunding payments.

CDAC major incident reporting

- When a major incident occurs, CDAC providers are required to report it to us within 24 hours of the discovery of the incident.
- Major incidents are ones that:
  1. Result in a physical injury to or by the member that requires a physician's treatment or admission to a hospital.
  2. Result in the death of any person.
  3. Require emergency mental health treatment for the member.
  4. Require the intervention of law enforcement.
  5. Require a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3.
  6. Constitute a prescription medication error or a pattern of medication errors that leads to the outcome in bullets 1-3 above.
  7. Involve a member's location being unknown by provider staff who are assigned responsibility for oversight.

CDAC minor incident reporting

- When a minor incident occurs, CDAC providers are not required to report it to the IME, but they should be documented in any format designated by the provider. The report shall be maintained in a centralized file with a notation in the member's file.
- Minor incidents are ones that:
  - Result in the application of basic first aid.
  - Result in bruising.
  - Result in seizure activity.
  - Result in injury to self, to others, or to property.
  - Constitute a prescription medication error.
- Situations requiring physician's treatment or admission to a hospital for symptoms of an illness, disease process or seizure activities **ARE NOT** considered a major incident and should not be reported as such.

CDAC billing

- Providers can only be paid for services **after** the CDAC agreement is approved.
- Members work with their Provider and Case Manager to determine services needed and rate for those services.
- Agreement outlines the specific services the provider agrees to provide for the member – it outlines the amount of time/units allotted per month for each agreed upon service

CDAC billing

- Providers should bill using the following HCPCS codes:

	Agencies	Individuals
Nonskilled attendant care	S5125	T1019
Skilled attendant care	S5125 with U3 modifier	T1019 with U3 modifier

- Submit the Targeted Medical Care Claim form to us to receive payment. Claims can be submitted as frequently as weekly in the following ways:
  - Via fax (*fax number pending*)
  - Via mail at:

    Amerigroup Iowa, Inc.
    Claims Department
    4800 Westown Parkway, Suite 200
    West Des Moines, IA 50266

Top 10 things providers need to know

Top 10 things providers do that slow down authorizations	Solution
Submitting an authorization request: • Without the Amerigroup member ID number • With the member's name spelled incorrectly • Without the member's date of birth	Always include the: • Member's Amerigroup subscriber ID number • Member's name (spelled correctly) • Member's date of birth
Submitting an authorization request with missing date spans.	Always include first and last date through which you are requesting the authorization request, not to exceed 12 months.
Submitting an authorization request missing the provider ID.	Make certain that the provider ID is always included on the authorization request.
Sending the entire list of Amerigroup members instead of sending ONLY the members who need a new authorization.	Please only send those members for whom an authorization is required.

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Top 10 things providers need to know

Top 10 things providers do that slow down authorizations	Solution
The nursing facility will request a copy of the authorization when a copy has already been sent to the nursing facility's home office, or does not send a copy of the authorization to the DHS.	Nursing facilities should coordinate authorization requests with their home offices, and also send a copy to the DHS.
The facility does not provide notification when the member transfers to another facility or is discharged. In this case, the new facility requests an authorization when we still show the member as being in the original facility.	Send notification when a member leaves a nursing facility or transfers to another facility.
Submitting an authorization request that has illegible handwriting.	Ensure that the authorization request is legible.
Submitting an authorization request that does not contain a contact phone or fax number.	Ensure that the authorization request has a phone or fax number to facilitate a return of the authorization and clarifications as necessary.

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10 things providers need to know

Top 10 things providers do that slow down authorizations	Solution
Submitting an authorization request with a provider name that is not consistent with the provider name indicated on the contract and credentialing application.	Please be sure the authorization request is in the legal name as represented on the contract.
Nursing facility providers call Amerigroup utilization managers with claim issues. The utilization managers redirect the providers to Provider Services. This takes utilization manager's time.	Call your Provider Relations representative for assistance with claims issues or questions.
A home health agency or PCO provider requests an authorization for services at home when we show the member as still being in the nursing facility.	Please send notification when a member leaves the nursing home.

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