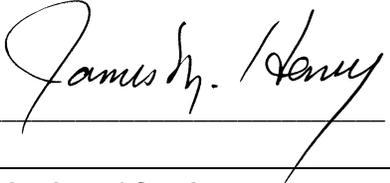


	POLICIES AND PROCEDURES State of Tennessee Department of Intellectual and Developmental Disabilities	Policy #: 80.3.4	Page 1 of 5
Policy Type: Community/Waiver		Effective Date: March 15, 2013	
Approved by:  <hr/> Commissioner		Supersedes: N/A Last Review or Revision: N/A	
Subject: Authorization of Services			

- I. **AUTHORITY:** 42 CFR 441.301(b) (1) (i), Bureau of TennCare Rules Chapter 1200-13-01; DIDD Protocols, Tennessee Code Annotated (TCA) 33-1-303, TCA 4-3-2708, TCA 71-5-144, Tennessee Home and Community Based Waivers.
- II. **PURPOSE:** The purpose of this policy is to establish guidelines for review and approval of Individual Support Plans (ISP), amendments, waiver services, and state-funded individuals.
- III. **APPLICATION:** This policy applies to all Department of Intellectual and Developmental Disabilities (hereinafter "DIDD" or "Department") staff responsible for reviewing and approving independent support plans (ISP) and amendments, waiver services, and state funded individuals; state Case Managers (CM), Independent Support Coordination (ISC) agencies; and approved providers of waiver services.
- IV. **DEFINITIONS:**
 - A. **Adverse Action Affecting TennCare Services or Benefits** as it relates to actions under the Grier Revised Consent Decree shall mean, but is not limited to, a delay, denial, reduction, suspension or termination of TennCare benefits, as well as any other act or omission of the TennCare program, which impairs the quality, timeliness, or availability of such services.
 - B. **Appeals Unit** shall mean the department unit responsible for issuing notices of any adverse action to persons supported by the department.
 - C. **Bureau of TennCare or TennCare** shall mean the single state Medicaid agency that is responsible for the administration of the state's Medicaid program.
 - D. **Covered Services or Covered Waiver Services** shall mean services which are available through Tennessee's Home and Community Based Services Waiver, when medically necessary, and when provided in accordance with the waiver as approved by the Centers for Medicare and Medicaid Services.
 - E. **DIDD Protocols** shall mean guidelines approved by the TennCare Chief of Long Term Services and Supports or designee and the department Director of Health Services for the purpose of guiding medical necessity determinations.

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- F. **Enrollee** shall mean a Medicaid enrollee who is enrolled in a Home and Community Based Services waiver.
- G. **Home and Community Based Services (HCBS) waiver or Waiver** shall mean a waiver approved for Tennessee by the Centers for Medicare and Medicaid Services, to provide services to a specified number of Medicaid eligible individuals who have an intellectual disability, and who meet criteria for Medicaid reimbursement in an Intermediate Care Facility for Individuals with Intellectual Disabilities. The HCBS waivers for people with intellectual disabilities in Tennessee are operated by the Department of Intellectual and Developmental Disabilities with oversight from TennCare, the state Medicaid agency.
- H. **Independent Support Coordinator (ISC) or Case Manager (CM)** shall mean a person who provides support coordination services to an enrollee; who is responsible for developing, monitoring, and assuring the implementation of the Plan of Care; who assists the enrollee in identifying, selecting, obtaining, coordinating, and using both paid services and natural supports to enhance the enrollee's independence, integration in the community, and productivity as specified in the ISP.
- I. **Individual Support Plan (ISP)** shall mean a person-centered document that provides an individualized comprehensive description of the person-supported, as well as, guidance for achieving unique outcomes that are important to and for the person in achieving a good quality of life in the setting in which they reside.
- J. **Medical Item or Service** shall mean an item or service that is provided, ordered, or prescribed by a licensed health care provider, and is primarily intended for a medical and or behavioral purpose.
- K. **Medical Necessity** shall mean the quality of being "medically necessary" as defined by Tennessee Code Annotated 71-5-144 and applies to TennCare enrollees.
- L. **Medical Necessity Determination** shall mean a decision made by the department Director of Health Services or Plans Review Unit regarding whether a requested medical item or service satisfies the definition of medical necessity contained in Tennessee Code Annotated 71-5-144, and satisfies the definition of services specified in the approved waiver, otherwise not available to enrollees under the approved Medicaid state plan.
- M. **Medically Necessary** shall mean medical items and services as defined in Tennessee Code Annotated 71-5-144. No enrollee shall be entitled to receive and the department shall not be required to pay for any items or services that fail fully to satisfy all criteria of "medically necessary" items or services as defined in this statute or the approved waiver.
- N. **Plan of Care** shall mean the Individual Support Plan.
- O. **Plans Review Unit** shall mean the department unit responsible for reviewing individual support plans (ISP) in accordance with approved DIDD protocols to pre-authorize or deny covered waiver services.
- P. **Section C** shall mean the part of the ISP that details the projected annual amount, frequency, and duration of waiver services.

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V. **POLICY:** The department ensures the health and welfare of enrollees through review and approval of the Individual Support Plan. The department authorizes ISPs that are person-centered, i.e., identifies services and supports important to and for the person-supported, reflects the choices and desires of the person-supported, as well as, the outcomes the person has chosen to achieve. The department authorizes covered waiver services that are medically necessary. Medical items or services that are not medically necessary shall not be paid for by the department.

VI. **PROCEDURES:**

A. Individual Support Plan Review

1. All waiver services for an enrollee shall be provided in accordance with an approved Individual Support Plan. The department reviews and approves all ISPs to ensure that covered waiver services are authorized prior to payment.
2. Prior to development of the initial ISP, covered services shall be provided in accordance with the physician's initial plan of care section of the Pre-Admission Evaluation (PAE) application.
3. Each enrollee shall have a comprehensive individualized written ISP that shall be developed within sixty (60) calendar days of the enrollee's admission to the waiver.
4. Where required by state law, covered services shall be ordered or reordered by a licensed physician, nurse practitioner, physician assistant, dentist, or other appropriate healthcare provider.
5. The ISC/CM shall review the ISP when needed, but no less frequently than once each calendar month, and shall document each review on the Support Coordination/Case Management Monthly Documentation Form with a dated signature.
6. The ISC/CM is responsible for ensuring that the ISP is amended (i.e., updated or revised) when warranted by changes in the needs of the person-supported.
 - a. A team consisting of the person supported, legal representative, ISC/CM and other appropriate participants in the development of the ISP shall review and update the ISP when needed, but at least annually (i.e., within 365 days of the previous review). The ISC/CM shall document such review on the Annual ISP Review and Update Documentation Form with a dated signature.
 - b. The ISC/CM shall submit the ISP with amendments or the annual ISP to the applicable regional Plans Review Unit.
 - c. The Plans Review Unit shall review and approve amended and annual ISPs when needed, but no less frequently than once every twelve (12) calendar months, and shall document such review with dated signatures.

B. Medical Necessity Determinations

1. Covered services are authorized in accordance with the approved waiver definitions and in accordance with the DIDD protocols.
2. Waiver enrollees are eligible to receive, and the department shall provide payment for, only those medical items and services that are:
 - a. Within the scope of benefits defined in the waiver.
 - b. Determined by the department to be medically necessary.
3. The Plans Review Unit consistently and reliably applies the DIDD protocols in order to make medical necessity determinations prior to authorizing covered waiver services.

C. Approval of Annual ISPs and ISP Amendments

1. The person supported, legal representative, ISC/CM, and other appropriate participants shall develop the ISP and any amendments.
2. To ensure continuity of waiver services and approval of the ISP prior to the provision of services as required by federal and state law and regulation and the State's approved Section 1915(c) waiver applications, the ISC/CM shall submit the ISP to the department regional office at least thirty (30) calendar days prior to the effective date of a new ISP and upon completion of any amendment.
3. Amended ISPs shall be effective upon approval; however, advance notice must be provided for any adverse actions pertaining to an initial request or continuance of waiver-funded services.
4. In order to meet the service and support needs of the person supported, the ISC/CM may send an amended ISP to the department regional office at any time.
5. The Plans Review Unit shall review the ISP and amendments in accordance with the approved waiver definitions and DIDD protocols.
 - a. The Plans Review Unit shall complete the protocol checklist for each medical item or service requested on the ISP or amendment.
 - b. The applicable regional Plans Review Unit may fully or partially deny a request for medical items and services. The appeals unit shall notify the enrollee (or conservator/legal representative) in writing within 14 calendar days of any adverse action in accordance with the Grier Revised Consent Decree. All other applicable parties will also be notified within this timeframe, such as the ISC/CM and the service provider(s).
 - c. All medically necessary items and services shall be approved. The plans reviewer's signature on the ISP section C shall serve as evidence that the requested medical items and services were authorized. A copy of the ISP section C shall be transmitted to the ISC/CM and provider(s).

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D. Appeals

1. The applicable regional Plans Review unit may fully or partially deny a request for medical items and services. The appeals unit shall notify the enrollee (or conservator/legal representative) in writing within 14 calendar days of any adverse action in accordance with the Grier Revised Consent Decree. All other applicable parties will also be notified within this timeframe, such as the ISC/CM and the service provider(s).
2. Upon an adverse action affecting TennCare Services or Benefits all enrollees are afforded advance notice, the right to appeal an adverse decision, and the opportunity to have a fair hearing in accordance with requirements of the Grier Revised Consent Decree.

VII. ATTACHMENTS:

- A. Individual Support Plan With Person-Centered Prompts
- B. Annual ISP Review and Update Documentation Form
- C. Support Coordination/Case Management Monthly Documentation Form

VIII. TENNCARE APPROVAL DATE: December 5, 2012