POLICIES AND PROCEDURES State of Tennessee Department of Intellectual and Developmental Disabilities	Policy #: 80.3.4	Page 1 of 7
	Effective Date: December 7, 2015	
	Distribution: B	
Policy Type: Community/Waiver	Supersedes: 80.3.4 (8/15/13)	
Approved by: Debra K. Payne, Commissioner	Last Review or Revision: July 2, 2015	
Subject: Authorization of Services		

I. **AUTHORITY:** 42 CFR 441.301(b) (1) (i), Bureau of TennCare Rules Chapter 1200-13-01; Tennessee Code Annotated (TCA) 33-1-303, TCA 4-3-2708, TCA 71-5-144, Tennessee Home and Community Based Waivers, and DIDD Protocols.

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 ISPs, and state Case Managers (CM), Independent Support Coordination (ISC) agencies responsible for developing and monitoring the implementation of the ISP and approved providers of waiver services responsible for implementation of the ISP.

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 DIDD unit responsible for issuing notices of any adverse action to persons supported by DIDD.

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 or designee for the purpose of guiding medical necessity determinations.

F. **Enrollee** shall mean a Medicaid enrollee (i.e. person supported) 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. **Individual Cost Neutrality Cap** shall mean a financial limit on the total annual cost (i.e., ISP year and waiver year) of a person's Medicaid waiver services in the Statewide Waiver, equal to the average cost of private ICF/IID as determined by the Tennessee Office of the Comptroller.

I. **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.

J. **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 their vision of a preferred life in the setting in which they reside.

K. **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.

L. **Medical Necessity** shall mean the quality of being "medically necessary" as defined by Tennessee Code Annotated 71-5-144 and applies to TennCare enrollees.

M. **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.

N. **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.

O. **Plan of Care** shall mean the Individual Support Plan.

P. **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**.**

Q. **Section C** shall mean the part of the ISP that details the projected annual amount, frequency, and duration of waiver services.

R. **State Funded Service** shall mean a service reimbursed with funds appropriated to the Department by the Tennessee State legislature.

V. **POLICY:** The department ensures the health and welfare of enrollees through review and approval of the Individual Support Plan. The ISP must contain sufficient justification for services requested. In accordance with DIDD Protocols, the department authorizes covered waiver services that are medically necessary and within the scope of the annual individual cost neutrality cap, as applicable. Medical items or services that are not medically necessary shall not be paid for by the department. The ISC/CM is responsible for ensuring that, in the development of the ISP, HCBS DIDD Waiver services do not supplant benefits that are available to the waiver enrollee through their Managed Care Organization (MCO), Vocational Rehabilitation or services under a 504 Plan or Individual Education Program (IEP).

VI. **PROCEDURES:**

A. Individual Support Plan Review

1. Upon enrollment, covered services shall be provided in accordance with the physician's initial plan of care section of the Pre-Admission Evaluation (PAE) application.

2. 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.

3. The combined date range of the initial 60 day plan of care and the comprehensive ISP shall not exceed the total number of days in a calendar year.

4. The total projected cost of waiver services listed on the initial 60 day plan of care and on the comprehensive ISP shall not exceed the annual individual cost neutrality cap budget in either the ISP year or waiver year.

5. All waiver services for an enrollee shall be provided in accordance with an approved ISP. The department reviews and approves all ISPs to ensure that covered waiver services are authorized prior to payment.

6. Where required by state law, certain covered services shall be ordered by a licensed physician, nurse practitioner, physician assistant, dentist, or other appropriate healthcare provider.

7. The ISC/CM shall review the ISP 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.

8. The ISC/CM is responsible for ensuring that the ISP is amended (i.e., updated or revised) when warranted by changes in the needs or medical condition of the person supported.

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 TennCare 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.

   c. Within the limits established by the person's annual individual cost neutrality cap budget, as applicable.

3. The Plans Review Unit and designees as applicable, consistently and reliably apply the DIDD Protocols to each service request in order to make medical necessity determinations prior to authorizing or denying covered waiver services.

C. Approval of Annual ISPs and ISP Amendments

1. A team consisting of the person supported, legal representative, ISC/CM and other appropriate participants as identified by the person supported shall develop, review and update the ISP when needed, but at least annually (i.e., within 365 or 366 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.

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 twenty-one (21) calendar days prior to the effective date of a new ISP or amendment. The Department may issue sanctions against ISC agencies for failure to abide by ISP submission timelines. Department CMs who fail to abide by ISP submission timelines may face disciplinary action.

3. Amended ISPs shall be effective upon approval. Written notice must be provided for any adverse actions pertaining to an initial request for a waiver funded service and advance written notice must be provided for an adverse action regarding continuance of a waiver funded service. Advance written notice of adverse action shall be issued by the regional office a minimum of ten (10) days prior to the date that the adverse action takes place.

4. In order to meet the changing 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 and designees as appropriate 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 Plans Review Unit shall ensure that services are authorized within the person's individual cost neutrality cap, if applicable.

    c. The plan's reviewer's signature on the ISP section C shall serve as evidence that the requested medical items and services were authorized or denied. A copy of the ISP section C shall be transmitted to the ISC/CM and provider(s).

D. Appeals

1. The Plans Review unit may fully or partially deny a request for medical items and services. The appeals unit shall notify the enrollee (and conservator/ legal representative) in writing within fourteen (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.

E. ISP Denials Due to the Individual Cost Neutrality Cap

1. The Plans Review unit shall fully deny any ISP or amendment that is submitted in which the projected total cost of services exceeds the annual individual cost neutrality cap budget, if applicable.

2. Persons supported and the conservator/legal representative who receives a denial due to the individual cost neutrality cap will be provided written notice in accordance with the Grier Revised Consent Decree.

3. Upon denying an ISP or amendment due to the individual cost neutrality cap, the Plans Review unit shall return the ISP to the ISC within 24 hours of determining the cost of services exceeds the cap. The ISC shall work with the person supported, and conservator/legal representative and other appropriate parties as identified by the person supported to revise the ISP with alternative services in order to meet the needs of the person within the scope of the individual cost neutrality cap.

4. The ISP shall be resubmitted to the Plans Review unit according to the timeline established in section VI.C.2 of this policy. If an ISP within the scope of the individual cost neutrality cap is not submitted timely then the person may be disenrolled from the waiver.

5. If it is determined that the person's health and safety cannot be ensured through alternative services to keep the person under the individual cost neutrality cap, the person may no longer be able to receive waiver services and may be disenrolled from the waiver.

VII. **CQL STANDARDS:** none

VIII. **REVISION HISTORY:** May 26, 2015

IX. **TENNCARE APPROVAL:** July 2, 2015; September 15, 2015

X. **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
D. ISP Signature Sheet