

5123:2-9-07

Home and community-based services waivers - request for prior authorization for individuals enrolled in the individual options waiver.

(A) Purpose

The purpose of this rule is to establish standards and procedures for prior authorization of waiver services when an individual funding level exceeds the funding range determined by the Ohio developmental disabilities profile for individuals enrolled in the individual options waiver.

(B) Definitions

- (1) "Cost projection tool" means the web-based analytical tool, developed and administered by the department, used to project the cost of waiver services identified in the individual service plans of individuals enrolled in individual options and level one waivers.
- (2) "County board" means a county board of developmental disabilities.
- (3) "Department" means the Ohio department of developmental disabilities.
- (4) "Funding range" means one of the dollar ranges contained in appendix A to rule 5123:2-9-06 of the Administrative Code to which individuals enrolled in the individual options waiver have been assigned for the purpose of funding services other than adult day support, non-medical transportation, supported employment-community, supported employment-enclave, and vocational habilitation. The funding range applicable to an individual is determined by the score derived from the Ohio developmental disabilities profile that has been completed by a county board employee qualified to administer the tool.
- (5) "Individual" means a person with a developmental disability or for purposes of giving, refusing to give, or withdrawing consent for services, his or her guardian in accordance with section 5126.043 of the Revised Code or other person authorized to give consent.
- (6) "Individual funding level" means the total funds, calculated on a twelve-month basis, that result from applying the payment rates in service-specific rules in Chapter 5123:2-9 of the Administrative Code to the units of all waiver services other than adult day support, non-medical transportation, supported employment-community, supported employment-enclave, and vocational habilitation established by the individual service plan development process to be sufficient in frequency, duration, and scope to meet the health and welfare needs of an individual enrolled in the individual options waiver.
- (7) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual.

- (8) "Medicaid services system" means the comprehensive information system that integrates cost projection, prior authorization, daily rate calculation, and payment authorization of waiver services.
- (9) "Ohio developmental disabilities profile" means the standardized instrument utilized by the department to assess the relative needs and circumstances of an individual enrolled in the individual options waiver compared to others. The individual's responses are scored and the individual is linked to a funding range, which enables similarly situated individuals to access comparable waiver services paid in accordance with rules adopted by the department.
- (10) "Prior authorization" means the process to be followed in accordance with this rule to authorize an individual funding level for an individual enrolled in the individual options waiver that exceeds the maximum value of the funding range.
- (11) "Service and support administrator" means a person, regardless of title, employed by or under contract with a county board to perform the functions of service and support administration and who holds the appropriate certification in accordance with rule 5123:2-5-02 of the Administrative Code.
- (12) "Waiver eligibility span" means the twelve-month period following either an individual's initial enrollment date or a subsequent eligibility redetermination date.

(C) Standards

- (1) The county board shall inform an individual, in writing, of the individual's right to request prior authorization whenever development or proposed revision of the individual service plan results in an individual funding level that exceeds the funding range assigned to the individual.
- (2) Unless a request for prior authorization has been approved in accordance with this rule, the individual funding level for services shall be within or below the funding range assigned to the individual.
- (3) Approval of a request for prior authorization is valid only for the duration of the individual's waiver eligibility span for which the request was made.

(D) Procedures

- (1) An individual shall initiate the prior authorization process by submitting a signed and dated request to the county board. A county board shall assist in the preparation of the request when the individual requests assistance.
- (2) The county board shall submit the request for prior authorization with the

current or proposed individual service plan and supporting documentation to the department through the medicaid services system within ten business days of receiving the individual's request. Supporting documentation shall provide evidence that requested services are medically necessary in accordance with criteria set forth in paragraph (D)(6) of this rule.

- (3) When the county board is unable to support the request based on the county board's documentation that the services do not meet the criteria set forth in paragraph (D)(6) of this rule, the county board shall provide to the department:

 - (a) A detailed description of the county board's efforts to develop an individual service plan that results in an individual funding level within the funding range assigned to the individual; and
 - (b) An alternative cost projection that ensures the health and safety of the individual and the date the alternative cost projection was reviewed and declined by the individual.
- (4) Within ten business days of receiving the request, the department shall notify the county board if additional information is needed to make a determination.
- (5) The department shall review the request and make a determination within ten business days of receiving all necessary information.
- (6) When reviewing a request, the department shall determine whether the waiver services for which prior authorization is requested are medically necessary. The department shall determine the services to be medically necessary if the services:

 - (a) Are appropriate for the individual's health and welfare needs, living arrangement, circumstances, and expected outcomes; and
 - (b) Are of an appropriate type, amount, duration, scope, and intensity; and
 - (c) Are the most efficient, effective, and lowest cost alternative that, when combined with non-waiver services, ensure the health and welfare of the individual receiving the services; and
 - (d) Protect the individual from substantial harm expected to occur if the requested services are not authorized.
- (7) The department may limit its review to the individual's request in the medicaid services system and the cost projection tool that produced an individual funding level that exceeds the funding range assigned to the individual when the county board supports the request and:

- (a) The projected individual funding level exceeds the funding range assigned to the individual by no more than ten per cent; or
 - (b) The request is for an individual for whom prior authorization has been approved for a previous waiver eligibility span and the request includes an attestation by the service and support administrator that the individual's needs, waiver services, and cost of waiver services have not changed since the preceding request.
- (8) Based on its review, the department shall:
 - (a) Approve the request if it finds that the services for which prior authorization is requested meet the criteria set forth in paragraph (D)(6) of this rule; or
 - (b) Deny the request; or
 - (c) Approve the request for a partial or full waiver eligibility span for all or some of the services provided the criteria set forth in paragraph (D)(6) of this rule are met.
- (9) When the department approves a request for prior authorization, the department shall:
 - (a) Issue written notification to the individual which reflects the total amount authorized for the current waiver eligibility span and includes the individual's right to request a hearing in accordance with section 5101.35 of the Revised Code and division 5101:6 of the Administrative Code; and
 - (b) Update the prior authorization status to reflect its determination in the medicaid services system.
- (10) When the department denies a request for prior authorization, the department shall:
 - (a) Issue written notification to the individual which includes the individual's right to request a hearing in accordance with section 5101.35 of the Revised Code and division 5101:6 of the Administrative Code; and
 - (b) Update the prior authorization status to reflect its determination in the medicaid services system.
- (11) When the request for prior authorization is denied, the individual and the service and support administrator shall meet to revise the individual service plan.

- (E) If the individual requests a hearing in accordance with paragraph (D)(9)(a) or (D)(10)(a) of this rule, the county board shall offer a county conference in accordance with rule 5101:6-5-01 of the Administrative Code and comply with applicable requirements of division 5101:6 of the Administrative Code.
- (F) Failure by a county board or the department to comply with the timelines established in this rule shall not constitute approval of a request for prior authorization.
- (G) The department shall submit to the Ohio office of medical assistance, on a quarterly basis, a summary of requests for prior authorization received. The department shall also systematically evaluate compliance with prior authorization requirements by verifying that each individual funding level is maintained within the prior authorized amount and providing the results of this evaluation in writing to the Ohio office of medical assistance no less than quarterly.

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Certification

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