1915(i) Policy

Service Authorizations 510-08-55

Required Training on MMIS Service Authorizations for Traditional Members:

1. *In addition to this policy, providers must utilize the Part I and II Training PowerPoints available on the 1915(i) website for specific instructions on submitting service authorizations into MMIS.*

2. *In addition to this policy, providers must visit the Managed Care Organization's (MCO) website to obtain additional service authorization requirements specific to Expansion members.*

Definitions applicable to this section:

1. **Medicaid Management Information System (MMIS):** A claims processing and information system that State Medicaid programs must have to be eligible for Federal Medicaid funding. The system controls Medicaid business functions, such as service authorizations, claims, and reporting. 1915(i) providers will enter all service authorizations and claims into MMIS.

2. **1915(i) Request for Service Provider Form:** Completed by the care coordinator to relay an individual's request to their provider of choice to provide a service contained in the POC. The form contains the name of the service(s) requested, as well as the amount, frequency, and duration of the service requested.

3. **ND Medicaid:** Also referred to as the Medical Service's Division or State Medicaid Agency (SMA) within the North Dakota Department of Health and Human Services. ND Medicaid administers the 1915(i) for individuals eligible for Traditional Medicaid.

4. **Place of Service (POS) Codes:** The POS codes identify the location a provider delivers a service to an individual. When submitting a service authorization request, the provider is required to identify the one POS code where they expect to deliver the majority of the services at. Later, when submitting the claim, the provider will list the correct

POS code for each of the services they provided and are submitting a claim for reimbursement. A Place of Service Codes document listing commonly used codes is located on the 1915(i) website. For a complete list of POS codes visit: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

5. **Plan of Care (POC) Submission:** The process in which the care coordinator submits the individual's POC to the SMA or the MCO. The POC contains the services which the provider(s) will later submit Requests for Service Authorization. Providers must also attach the POC each time they submit a service authorization.

6. **Service Authorizations:** All 1915(i) services must be prior authorized by the SMA or the MCO. Providers will not be reimbursed for services provided prior to the service authorization approval date. Providers submit a Request for Service Authorization for each service to the SMA for 1915(i) eligible Traditional members and to the MCO for 1915(i) eligible Expansion members.

7. **Service Limits and Codes Document:** This document, located on the 1915(i) website, identifies the limits for each service, as well as codes the provider will need to complete the service authorization request.

Relevant Information for Submitting Service Authorization Requests

1. Providers will use one of two separate service authorization processes depending on whether they are serving a Traditional Medicaid member or an Expansion Medicaid member.

    a. Traditional Members: Providers will use the SMA's process when submitting service authorizations for Traditional Medicaid members. This policy contains the process providers will follow for Traditional Medicaid members.

    b. Expansion Members: Providers will use the MCO's process when submitting service authorizations for Expansion Medicaid members. Providers are to contact the MCO or visit their website to obtain their service authorization policy and process.

2. One service authorization request per 1915(i) provider is required.

3. Multiple 1915(i) services can be included on one service authorization request.

4. The POC must be submitted with all service authorization requests.

5. Service authorization approval also indicates POC approval.

6. The service authorization number must be on all provider claims.

7. Only one service authorization number per claim is allowed.

8. Providers will not be reimbursed for services provided prior to the service authorization approval date.

Service Authorization Requested Begin Date and Requested End Date for Traditional Medicaid Members. (Contact the MCO for information pertaining to Expansion Members.)

Requested Begin Date: Providers will enter the anticipated start date of services. The requested begin date cannot be dated prior to the submission date of the service authorization request. Retroactive or back-dating of service authorization requests is not allowed for any service other than the initial care coordination request.

The care coordination service is the only service that may initially request a retroactive begin date of up to thirty (30) calendar days from the date of initial contact with the individual. Initial contact is defined as the first call or contact between the individual, or anyone assisting with the initial contact on behalf of the individual, and the care coordination agency. The 30-day grace period allows for completion of the initial POC, in its entirety, before submission of the initial care coordination service authorization request.

Retroactive requests for initial care coordination past 30 calendar days from initial contact will be approved the date the authorization was submitted in MMIS. Providers will not be reimbursed for services provided prior to the service authorization approval date.

Retroactive requests for subsequent care coordination will not be approved.

Service authorization approval or denial will be dated the date the authorization was submitted in MMIS by the provider, regardless of the requested begin date, for all requests other than the initial care coordination request. Providers will not be reimbursed for services provided prior to the service authorization approval date.

Requested End Date: The maximum time period a service authorization can be requested is to the end of the individual's 1915(i) eligibility period. The date of the end of the individual's 1915(i) eligibility period is obtained from the Zone.

Request Extending into Two Calendar Years: When the service authorization dates extend into two calendar years (i.e. 12/1/2022 - 11/30/2023), two service lines are required for the service requested with the calculated units requested.

For example: Line one dates of service: 12/1/2022-12/31/2022. Line two dates of service: 1/1/2023-11/30/2023.

SA Approval or Denial Date for Traditional Members: (Contact the MCO for information pertaining to Expansion Members.)

The SMA will use the date the service authorization request was submitted in MMIS as the approval or denial date for all service authorization requests other than the initial care coordination request.

The care coordination service is the only service that may initially request a retroactive begin date of up to thirty (30) calendar days from the date of initial contact with the individual. Initial contact is defined as the first call or contact between the individual, or anyone assisting with the initial contact on behalf of the individual, and the care coordination agency. The 30-day grace period allows for completion of the initial POC in its entirety before submission of the initial care coordination service authorization request.

Retroactive requests for initial care coordination past 30 calendar days from initial contact will be approved the date the authorization was submitted in

MMIS. Providers will not be reimbursed for services provided prior to the service authorization approval date.

Retroactive requests for subsequent care coordination will not be approved.

Providers who receive a denial for a service authorization request due to a submission error can resubmit an entirely new request with necessary corrections; denied requests cannot be amended. The SMA will use the original date the service authorization request was submitted as the approval or denial date for all service authorization requests other than the initial care coordination request.

Notification of SA Approval or Denial for Traditional Members:
(Contact the MCO for information pertaining to Expansion Members.)

MMIS will generate a notification letter indicating approval or denial of the service authorization request. The notification letter is generated in the evenings and mailed to the provider and to the individual the next business day. Prior to receiving the mailed notification letter, providers have the option of checking the approval or denial status of the service authorization request in the web portal. If the web portal indicates a denial for the service authorization request, the provider will not see the reason for the denial in the web system. Instructions for checking status in the web portal is available in Part II of the Service Authorization Training Power Point available on the 1915(i) website.

1915(i) Fee Schedule for Traditional Members: (Contact the MCO for information pertaining to Expansion Members.)

See the current 1915(i) Fee Schedule located here: https://www.hhs.nd.gov/medicaid-provider-information/medicaid-provider-fee-schedules

1915(i) Service Limits & Codes Spreadsheet for Traditional Members:
(Contact the MCO for information pertaining to Expansion Members.)

See the Service Limits and Codes Spreadsheet located on the 1915(i) website for information you will need to complete service authorization requests.

The spreadsheet identifies the following for each of the 1915(i) services:

- **Description** – Brief description of the service.

- **Age -** Each service has specific age requirements.

- **Rate Type -** Each service has one or more rate types associated with it. Unit, monetary, or per service are examples of the various rate types.

- **Code and Modifier -** The "code" is referred to as the procedure code when entering service authorizations into MMIS.

  Each rate type within a service will have a code, and sometimes a modifier, associated with it. When there are multiple components to a service, each component will have its own code. For example, the Training and Supports for Unpaid Caregiver service is Code H0039 and Modifier UK for the 15 minute unit rate; and an additional Modifier "UA" must be added if the service is provided in a group setting. The rate code T2025 is for the "per service" component of the service.

- **Medicaid Fee/Rate -** This is the dollar amount per rate type. For example, services with a 15 minute unit rate type have a Medicaid fee or rate dollar amount per unit assigned.

- **Service Limits -** Each service has one or more limits assigned to it.

- **Remote Support/Telehealth Limits, Codes & Modifier -** The majority of services allow remote service delivery with the established limits. See the 1915(i) Remote Support Service Delivery policy for additional requirements.

- **Provider Type -** The provider type for 1915(i) services is 049.

- **Specialty Code -** Each service has a specialty code associated with it.

- **Group Taxonomy -** A group taxonomy code is assigned to the group provider of each service.

- **Individual Taxonomy -** An individual taxonomy code is assigned to the individual provider of each service.

- **NPI Number -** Each group and individual provider must obtain a National provider ID (NPI).

Electronic Visit Verification (EVV) requirements for Traditional Members: (Contact the MCO for information pertaining to Expansion Members.)

EVV regulations are applicable to the respite service. See the Respite Service Policy for special instructions on the use of the Therap system for providers submitting service authorizations and claims for the respite service.

Provider Confirmation of Individual Eligibility

It is the provider's responsibility to confirm the individual's 1915(i) eligibility, as well as Medicaid Traditional or Expansion status, for the individual on a daily basis prior to providing the service. Medicaid reimbursement will not occur for services provided to individuals not eligible for the 1915(i) on the date of service provision. (There must also be a prior approved SA.)

- Traditional Members: Providers are to call the AVRS line to check eligibility for Traditional Medicaid members.

- Expansion Members: Visit the MCO's website for instructions on checking individual eligibility for Expansion members.

Standard Service Authorization Process for Traditional Members: (Contact the MCO for information pertaining to Expansion Members.)

Providers will follow these steps to complete the standard service authorization process:

1. Following the development of the Plan of Care (POC), the care coordinator submits the completed POC and their service authorization request for the care coordination service via MMIS to the SMA for 1915(i) eligible Traditional members or to the MCO via

their process for 1915(i) eligible Expansion members. The service authorization request must match the POC.

2. The SMA or MCO approves or denies the POC and service authorization. For Traditional members, MMIS generates a notification letter to the provider and to the individual. The denial letters contain client rights and appeals information. If denied, the care coordinator will make the necessary revisions to the service authorization request and resubmit.

3. Upon receipt of the POC from the care coordinator, each provider submits their service authorization with the POC attached via MMIS for 1915(i) eligible Traditional members and to the MCO via their process for 1915(i) eligible Expansion members.

4. The SMA or MCO compares the service amount, frequency and duration of each service authorization request to the POC to ensure they match.

5. The SMA or MCO approves or denies the service authorization. . For Traditional members, MMIS generates a notification letter to the provider and to the individual. If the service authorization request doesn't match the POC, the request will be denied. If denied, the provider will make the necessary revisions to the service authorization request and resubmit an entirely new request; denied requests cannot be amended.

Non-Standard Service Authorization Processes

The following scenarios require steps in addition to the standard process identified above. See the MCO's website for any instructions relating to these scenarios.

1. **Individual's Traditional Medicaid Eligibility Changes to Medicaid Expansion.** The care coordinator informs each of the individual's 1915(i) service providers of the change in eligibility status. The care coordinator, as well as all other service providers, must submit a new service authorization request to the MCO using the steps of the standard process above.

All former service authorization approvals from the SMA are no longer valid and MMIS will deny any claims improperly submitted as there is not a 1915(i) benefit plan to pay against.

1915(i) service limit maximums start over on the effective date of the individual's change from Traditional Medicaid to Expansion.

When a provider discovers a change in an individual's 1915(i) eligibility, or discovers an individual's Medicaid eligibility status has changed from Traditional Medicaid to Medicaid Expansion, or vice versa, the provider will inform the care coordinator, who in turn will inform each of the other service providers and others who need to know to ensure the new required service authorizations are submitted; all future claims are submitted to the appropriate entity; and to ensure all are aware of the change in eligibility status for system updates to occur.

Retroactive Eligibility Allowance for Individuals Transitioning between Traditional Medicaid and Medicaid Expansion

The SMA will allow for retroactive eligibility to occur within a 12 month period. SMA will honor those circumstances in which a retro-period of Medicaid eligibility has changed from a Traditional or Expansion coverage type to the other and in which the previous coverage type had a plan of care and authorization(s) in place for 1915(i) services as appropriate. In such circumstance, either coverage type shall be bound by the plan of care and authorizations as determined by the previous coverage type for a retro-period of up to one year.

For example: A provider confirms the individual's Expansion eligibility on February 1st, using the MCO's established eligibility confirmation process. The provider completes the MCO's POC and service authorization submission process. The provider continues to check the Expansion member's eligibility prior to providing each service and provides services through April 1st.

On April 1st, in spite of the MCO's system confirming for the past two months that the individual is Expansion eligible, it is discovered that the individual's eligibility status had actually

changed from Expansion to Traditional on March 1st. The Retroactive Eligibility Allowance will allow for the provider to submit the POC and service authorizations dated back to March 1st to the SMA for authorization. The provider will then submit claims for services dating back to March 1st when the individual became Medicaid Traditional eligible to the SMA for reimbursement.

See the Service Authorization Process Flow located on the 1915(i) website for the steps necessary in the event an individual's Traditional Medicaid changes to Medicaid Expansion.

The Zones are responsible for entering any Medicaid status changes into SPACES and the 1915(i) Web System when an individual's coverage transitions from Traditional Medicaid to Medicaid Expansion and vice versa.

2. **Individual's Medicaid Expansion Eligibility Changes to Traditional Medicaid.** The care coordinator informs each of the individual's 1915(i) service providers of the change in their eligibility status. The care coordinator, as well as all other service providers, must submit a new service authorization request to the SMA using the steps of the standard process above. All former service authorization approvals from the MCO are no longer valid.

   1915(i) service limit maximums start over on the effective date of the individual's change from Expansion to Traditional Medicaid.

   When a provider discovers a change in an individual's 1915(i) eligibility, or discovers an individual's Medicaid eligibility status has changed from Medicaid Expansion to Traditional, or vice versa, the provider will inform the care coordinator, who in turn will inform each of the other service providers, and others who need to know to ensure the new required service authorizations are submitted; future claims are submitted to the appropriate entity; and to ensure all are aware of the change in eligibility status for system updates to occur.

   Retroactive Eligibility Allowance for Individuals Transitioning between Medicaid Expansion and Traditional Medicaid

The SMA will allow for retroactive eligibility to occur within a 12 month period. SMA will honor those circumstances in which a retro-period of Medicaid eligibility has changed from a Traditional or Expansion coverage type to the other and in which the previous coverage type had a plan of care and authorization(s) in place for 1915(i) services as appropriate. In such circumstance, either coverage type shall be bound by the plan of care and authorizations as determined by the previous coverage type for a retro-period of up to one year.

For example: A provider confirms an individual's Traditional Medicaid eligibility on February 1st, using the SMA's AVRS established eligibility confirmation process. The provider completes the SMA's POC and service authorization submission process. The providers continue to check the Traditional member's eligibility prior to providing each service and provides services through April 1st.

On April 1st, in spite of the SMA's system confirming for the past two months that the individual is eligible for Traditional Medicaid, it is discovered that the individual's eligibility status had actually changed from Traditional to Expansion on March 1st. The Retroactive Eligibility Allowance will allow for the provider to submit the POC and service authorizations dated back to March 1st to the MCO for authorization. The provider will then submit claims for services dating back to March 1st when the individual became Expansion eligible to the MCO for reimbursement.

See the Service Authorization Process Flow located on the 1915(i) website for the steps necessary in the event an individual's Expansion eligibility changes to Traditional.

The Zones are responsible for entering any Medicaid status changes into SPACES and the 1915(i) Web System when an individual's eligibility transitions from Medicaid Expansion to Traditional or vice versa.

3. **Change in Service Name, Amount, Frequency, or Duration.** The care coordinator updates the POC to reflect the new service name, amount, frequency, and duration. The care coordinator forwards the updated POC to the provider(s) impacted by the change, informing

them of the change in the service. A new service authorization request and attached POC is required from the impacted provider(s) using the standard service authorization process above. Providers will reference the former service authorization number on the new service authorization request.

The new service authorization will only contain the service(s) impacted by the change. If the provider's initial service authorization contained multiple services, all services not impacted by this current change will remain on the initial service authorization and the provider will now have two active service authorizations for the individual. The service(s) impacted by the change will no longer be valid on the initial service authorization request.

State Responsibility: Upon receipt of the new service authorization request, the SMA will force the duplicate exception should an exception occur. The exception number will likely be 1008. The initial service authorization will not be voided, terminated, or end dated.

Multiple Active Service Authorizations and Impact on Future Claims. Since each claim can only have one service authorization number, in the event this change results in the provider having two active service authorizations, the provider will be required to submit separate claims for services and include the correct service authorization number on each claim.

See the Service Authorization Process Flow located on the 1915(i) website for the steps necessary in the event there is a change in service name, amount, frequency, or duration.

4. **Individual Requests a Transfer from One Service Provider to Another.** All requests made by individuals to transfer to a new service provider must go through the care coordinator.

Care Coordinator Responsibility: The care coordinator completes the Request for Service Provider form and sends to the sending service provider and to the receiving service provider. Release of Information requirements apply.

Following the receiving service provider's acceptance of the service transfer request, the care coordinator updates the POC with the receiving service provider's information and service(s) they've agreed to provide and forwards the POC to the receiving service provider.

Sending Service Provider Responsibility: Upon receipt of the Request for Service Provider form, it is best practice for the sending provider to forward the receiving provider a summary of the individual's progress, any relevant service-related information that would benefit the individual's future service, and the service authorization number from the current service authorization. Release of Information requirements apply.

Receiving Service Provider Responsibility: Upon receipt of the Request for Service Provider form, the receiving provider must respond within two (2) business days to the care coordinator with an acceptance or denial by signing the Request for Service Provider form and submitting to the care coordinator.

In the event the sending provider has not provided a summary of the individual's progress, relevant service-related information that would benefit the individual's future service, and the service authorization number from the current SA, it is best practice for the receiving provider to request this information. Release of Information requirements apply.

Upon acceptance of the request, the care coordinator forwards the revised POC to the receiving service provider who submits a service authorization request and the POC using the standard service authorization process above. The receiving provider will reference the former service authorization number on the new service authorization request if the former service authorization number is available from the sending provider. The service authorization from the sending provider will no longer be valid upon approval of the receiving provider's new service authorization.

The receiving provider has five (5) business days from the approval date of the service authorization to schedule an initial meeting with the individual.

State Responsibility: Upon receipt of the service authorization request from the receiving service provider, the SMA will force the duplicate exception should an exception occur. The exception number will likely be 1008. The former service authorization will not be voided, terminated, or end dated.

See the Service Authorization Process Flow located on the 1915(i) website for the steps necessary in the event an individual requests a transfer from one service provider to another.

5. **Individual Requests a Transfer from One Care Coordinator Provider to Another.**

Sending Care Coordinator Responsibility: The sending care coordinator must complete the Request for Service Provider form and submit to the receiving care coordinator. Release of Information requirements apply. Upon the receiving care coordinator's acceptance, the sending care coordinator updates the POC and forwards to the receiving care coordinator.

Receiving Care Coordinator Responsibility: The receiving care coordinator must sign the Request for Service Provider form within two (2) business days with an acceptance or denial by signing the form and submitting to the sending care coordinator.

Upon acceptance of the request, the sending care coordinator forwards the revised POC and the current service authorization number to the receiving care coordinator who submits a service authorization request and the POC using the standard service authorization process above. The receiving care coordinator will reference the former service authorization number on the new service authorization request. The service authorization from the sending care coordinator will no longer be valid upon approval of the receiving care coordinator's new service authorization.

The receiving care coordinator has five (5) business days from the approval date of the service authorization to schedule an initial meeting with the individual.

State Responsibility: Upon receipt of the service authorization request from the receiving care coordinator, the SMA will force the duplicate exception should an exception occur. The exception number will likely be 1008. The former service authorization will not be voided, terminated, or end dated.

See the Service Authorization Process Flow located on the 1915(i) website for the steps necessary in the event an individual requests a transfer from one care coordinator provider to another.

6. **Individual Requests to Discontinue All 1915(i) Services.** If an individual requests to discontinue all 1915(i) services, the current service authorization(s) and eligibility will remain open should the individual need 1915(i) services in the future.

7. **Service Authorization Requests to Exceed the Established Service Limit.** Service limits cannot be exceeded except in the following circumstance: It is determined additional service amounts are necessary to prevent the individual from being placed in a higher level of care, i.e. institution or other non-community-based setting.

   The care coordinator must document the needs of the individual and justify the additional amount of support the individual needs to remain in their home and community-based setting in the "Exceeding the Service Limit" section of the POC.

   The POC is submitted to the SMA for 1915(i) eligible Traditional members via email for review. At this time, the SMA will submit a heat ticket requesting an adjustment be made in MMIS to allow for authorization of the upcoming service authorization request to exceed the limit. When the heat ticket is complete, the SMA will inform the care coordinator by email of pre-approval or denial of the request to exceed the limit. If approved, the care coordinator will inform the provider to submit a new service authorization, referencing the former service authorization number, and POC via MMIS to request to exceed the limit. The SMA will authorize the request and the additional services may be provided.

See the Service Authorization Process Flow located on the 1915(i) website for the steps necessary in the event there is a need for a request for a service to exceed the maximum limit.

See the Plan of Care policy for process details and responsibilities.

8. **Individual's 1915(i) Eligibility Closes Due to a Change in Living Arrangement.** In the event a living arrangement change results in an individual's 1915(i) eligibility ending, any existing service authorizations are no longer valid.

   If a provider discovers a change in living arrangement, the provider will inform the care coordinator, who in turn will inform all providers, Zone eligibility worker, and others who need to know.

   The Medicaid Living Arrangement Reference Hard Card is located here for your reference:
   http://www.nd.gov/dhs/policymanuals/51003/51003.htm#510-03-105-10.htm%3FTocPath%3DEligibility%2520factors%2520for%2520ACA%2520Medicaid%2520510-03%7CReference%2520Hard%2520Cards%2520510-03-105%7C_____2

   If an individual is later determined re-eligible for 1915(i) services, a new POC will be developed and the standard service authorization process will be implemented.

   The Human Service Zones are responsible for entering all Medicaid and 1915(i) eligibility changes into SPACES and the 1915(i) Web System.

9. **Termination of Service (Other Than Care Coordination).** If a service provider terminates or discontinues any 1915(i) service other than care coordination (See #10 below for termination of care coordination) for an individual, it is the care coordinator's responsibility to identify other service providers for the individual to choose from.

   Care Coordinator Responsibility: The care coordinator completes the Request for Service Provider form and sends to the

terminating service provider and receiving service provider. Release of Information requirements apply.

Following the receiving service provider's acceptance of the service request, the care coordinator updates the POC with the receiving service provider's information and service(s) they've agreed to provide and forwards the POC to the receiving service provider.

Terminating Service Provider Responsibility: Upon receipt of the Request for Service Provider form, it is best practice for the terminating provider to forward the receiving provider a summary of the individual's progress, any relevant service-related information that would benefit the individual's future service, and the service authorization number from the current service authorization. Release of Information requirements apply.

Receiving Service Provider Responsibility: Upon receipt of the Request for Service Provider form, the receiving provider must respond within two (2) business days to the care coordinator with an acceptance or denial by signing the Request for Service Provider form and submitting to the care coordinator and terminating provider.

In the event the terminating provider has not provided a summary of the individual's progress, relevant service-related information that would benefit the individual's future service, and the service authorization number from the current SA, it is best practice for the receiving provider to request this information. Release of Information requirements apply.

Upon acceptance of the request, the care coordinator forwards the revised POC to the receiving service provider who submits a service authorization request and the POC using the standard service authorization process above. The receiving provider will reference the former service authorization number on the new service authorization request if the former service authorization number is available from the terminating provider. The service authorization from the terminating provider will no longer be valid upon approval of the receiving provider's new service authorization.

The receiving provider has five (5) business days from the approval date of the service authorization to schedule an initial meeting with the individual.

State Responsibility: Upon receipt of the service authorization request from the receiving service provider, the SMA will force the duplicate exception should an exception occur. The exception number will likely be 1008. The former service authorization will not be voided, terminated, or end dated.

See the Service Authorization Process Flow located on the 1915(i) website for the steps necessary in the event there is a change in service name, amount, frequency, or duration.

10. **Termination of the Care Coordination Service.** If a care coordination provider terminates or discontinues the care coordination service for an individual, it is the terminating care coordinator's responsibility to identify other care coordination providers for the individual to choose from.

    Terminating Care Coordinator Responsibility: The terminating care coordinator must complete the Request for Service Provider form and submit to the receiving care coordinator. Release of Information requirements apply.

    Following the receiving service provider's acceptance of the service request, the terminating care coordinator updates the POC with the receiving service provider's information and forwards the POC to the receiving service provider.

    Receiving Care Coordinator Responsibility: The receiving care coordinator must sign the Request for Service Provider form within two (2) business days with an acceptance or denial by signing the form and submitting to the terminating care coordinator.

    Upon acceptance of the request, the terminating care coordinator forwards the revised POC and the current service authorization number to the receiving care coordinator who submits a service authorization request and the POC using the standard service

authorization process above. The receiving care coordinator will reference the former service authorization number on the new service authorization request. The service authorization from the terminating care coordinator will no longer be valid upon approval of the receiving care coordinator's new service authorization.

The receiving care coordinator has five (5) business days from the approval date of the service authorization to schedule an initial meeting with the individual.

State Responsibility: Upon receipt of the service authorization request from the receiving care coordinator, the SMA will force the duplicate exception should an exception occur. The exception number will likely be 1008. The former service authorization will not be voided, terminated, or end dated.