

Home and Community Based Services Manual

10.10
HCBS WEB TOOL
CARE PLAN CHANGE

Changes to an existing posted care plan within the HCBS Web Tool require the following:

- Copy the current posted Prior Authorization - Care Plan to a new pending Prior Authorization – Care Plan in order to make the necessary modifications;

Note: The ‘Copy to new PA’ functionality will end date (close) all of the current services in the Prior Authorization – Care Plan including those not requiring a modification and create a new pending PA;

- Review/modify all services in the new pending Prior Authorization – Care Plan and determine if the priority risk in the PA Type box accurately reflects the participant’s current situation; and
- Submit the new Prior Authorization – Care Plan to the Missouri Medicaid Information System (MMIS).

Log In

<https://www.cyberaccessonline.net>

Use your assigned User Name and Password.

Review the End User License Agreement and select ‘I Accept’.

Search

- Enter the participant’s ID (DCN) and birth date or last name in the ‘Search for Participant’ panel and select ‘Search’; or
- Select the participant from the ‘Site Patients’ panel. Participants **only** display in the panel when a user from the same ‘practice’ and ‘site’ have searched, from the CyberAccess Home screen, for that participant within the last 90 days.

Note: An additional participant specific search feature is available within the screens of the HCBS Web Tool by selecting the  at the top right of each screen. Utilizing this search navigates the user to the Participant Case Summary screen for the newly selected participant and closes the record for the current participant. Utilizing this search feature is the preferred method to access another participant’s record.

MO HealthNet Demographics screen

This information is populated from the MMIS and can only be changed by contacting Family Support Division.

Select ‘HCBS’ from the dropdown box on the screen menu bar labeled HCBS to navigate to the Participant’s record.

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Participant Case Summary Screen

Demographics

The information shall be reviewed, updated and saved as needed. Select 'Save'  if any information has been changed.

Physician Information

Review and update physician information as needed.

Eligibility

The 'HCB Medicaid Referral' checkbox is utilized, by the DSDS Call Center staff to facilitate access to the HCBS Web Tool for *new* referrals. Selection of the checkbox enables the Prescreen for those participants who are eligible for Medicaid spenddown but not in an active period of eligibility and are requesting an Aged and Disabled Waiver service (see Chapter 2). *This checkbox should not be utilized at reassessment.*

The 'CDS Restricted' checkbox shall be utilized to denote participants who have been determined at the conclusion of an investigation to no longer be eligible for authorization of Consumer Directed Personal Care Services (see Policy 3.25). Selection of this checkbox will restrict the authorization of 'Personal Care Consumer Directed Model' throughout the web tool application.

Review the Eligibility section to verify the participant's Medicaid eligibility. Additional information on the 'HCBS Eligibility' tab will provide ME code, age and applicable spenddown messages. Medicaid eligibility in the HCBS Web Tool may not reflect 'real time' information, as updates to the system require an overnight transaction. Additional Medicaid information may be accessed through use of LFAM and associated screens within the Mo. Dept. of Social Services Network.

Other Information

Review 'Other Responsible Person' and 'Formal Supports' and update as necessary. Select  to save each category.

Case Items

Expand Case Items related to a specific case by selecting .

Locate the Prior Authorization – Care Plan to be modified from the case items list and select the . The posted Prior Authorization – Care Plan to be modified can be identified by a unique number, which corresponds to the header number in the top right corner on the Prior Authorization (header) screen. Upon selection of the  for the posted Prior Authorization – Care Plan to be modified, the user will be navigated to the Prior Authorization (header) screen.

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Prior Authorization (header) Screen



On the Prior Authorization (header) screen of the care plan to be modified, select Prior Authorizations in the blue menu at the top of the screen. From the drop down list, select ‘Copy to New PA.’

The user will get a pop up box requiring entry of the end date for the current PA. A message will display: ‘The original PA will become a duplicate and must be end dated.’ Enter the actual date the current PA is to end (this should be the day before the effective date of the new prior authorization). Staff shall ensure prior authorizations to the same provider for the same service and authorization periods shall not contain overlapping dates. Any need to overlap authorization periods shall be thoroughly documented in case notes. The end date entered **cannot** be prior to the current date. Select . This will end date all of the services in the current Prior Authorization – Care Plan and **create** a new pending Prior Authorization – Care Plan to be modified.

The user will be navigated to the Prior Authorization Detail screen for the newly created pending Prior Authorization – Care Plan.

Prior Authorization Detail Screen



All open services from the previous posted Prior Authorization – Care Plan will be displayed in the ‘Authorized Services Summary’ in a **pending** status. The effective dates for the newly copied Prior Authorization – Care Plan will default to the next calendar day. Services copied with a future effective date (e.g. Nurse Visit for General Health Evaluations) will retain the future effective date. Effective dates can be modified if necessary. **All** services in the ‘Authorized Services Summary’ of the Prior Authorization Detail screen – even those requiring no change – must now be reviewed and have a status other than ‘pending’ from the Prior Authorization Line Item before the modified care plan can be submitted to the MMIS for reimbursement.

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- **To add a new service**

- Select 'Add a New Service' from the 'Prior Authorizations' drop down menu at the top of the screen. This will navigate the user to the Prior Authorization Line Item screen (below).

If the delete function  is present, it may be used to delete the associated service if it is no longer needed in the new modified care plan. Adverse Action may be required prior to any deletion of a previously authorized service.

To complete the review and update the status, select the  for each service in the Authorized Services Summary. This will navigate the user to the Prior Authorization Line Item screen.

Prior Authorization Line Item Screen



Prior Authorization Line Item

Review the service type and authorization (effective and end) dates and modify as necessary. Dates are editable if needed to meet the needs of the participant. Edits will not allow the effective date to precede the date of level of care determination and will not allow the end date to exceed the last full month within 365 days from the level of care determination.

Total Units/Month – auto populates based on information entered from the Task Detail Line Item.

- ILW (Independent Living Waiver) checkbox will only display when 'Personal Care – Consumer Directed' is selected as a service. This checkbox shall be utilized as outlined in the Independent Living Waiver Policy 3.55.
- Amended Authorization checkbox will display when either 'Personal Care – Consumer Directed' or 'Personal Care – Agency Model' are selected. This functionality requires supervisory approval and is to be used infrequently. The checkbox shall be utilized in situations when the participant has needs identified at the cost cap but the task and frequency selections do not calculate to the exact cost cap. When approved, a DSADS administrator user can select the checkbox and enter the cost cap units in the adjacent box. This amended unit amount will display on all other screens as the total units/month and will be transmitted to MMIS when the Prior Authorization is submitted. When a care plan containing an amended Prior Authorization is copied, the amended units do not display. If there is an ongoing need for the new plan to be amended, it will again need supervisory approval.

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Enter any necessary Service Delivery Comments to reflect participant specific service delivery instructions to assist the provider. These comments will be available to the provider on the Participant Case Summary screen and denoted by a .

Upon review and change (if necessary) of the Task Detail Line Item and the Provider Search, update the Status in the Prior Authorization Line Item Section to 'Approved.'

Select  to save the HCBS information. Close the line item.

Task Detail Line Item

Task Detail provides a view of the tasks and frequency from the previously copied Prior Authorization – Care Plan.

- **Add a new service**
 - Select the tasks requested on a regular basis (Note: some HCBS will have no tasks associated with the authorization.)
 - Enter the frequency (units/minutes/day) for the service or selected task (Note: various HCBS have different unit definitions.)
 - Select 'Save'  for each Task or Unit entry.
 - As tasks and frequencies are saved, the total monthly units will auto calculate and populate to the field above.
- **Increase/Decrease in current services**
 - Tasks and frequency may be edited in this section for the needed increase/decrease.
 - To modify a previously chosen task, 'Select' the task to be modified from the list at the bottom of the Task Detail Line Item section. Make the necessary changes to the frequency and select .
 - If a previously chosen task is no longer needed it may be deleted from the list.
 - To add a new task, select the task from the drop down list and enter the associated frequency and select .
 - As tasks and frequencies are saved, the total monthly units will auto calculate and populate to the 'Total Units/Month' field above.

Note: All actions shall be in compliance with the adverse action policy prior to any decrease or deletion in services (see Chapter 5).

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Provider Search

- Provider selection is required.
- A provider may be added by either selecting ‘Provider List’ or searching for the provider by entering the provider name and selecting . **Do not search for a provider by using the ID feature.**

Note: If the chosen provider cannot be found in the ‘Provider List’, check to ensure the correct county has been chosen for the participant and the correct service has been selected. If both of these are correct and the provider does not display contact DSDS Central Office.

- Select the chosen provider from the displayed list by selecting the . The chosen provider will be populated in the provider field in the Prior Authorization Line Item section above.

Following a status update of all services within the Prior Authorization – Care Plan, the authorization must be submitted to MMIS.

To submit the Prior Authorization, navigate to the ***Prior Authorization (header)*** screen. Select ‘Go to Prior Authorization Header’ at the top of the ***Prior Authorization Detail*** screen.

Prior Authorization (header)

PA Type (middle of the screen)

The priority risk previously selected and saved is displayed and is editable. After review of supporting documentation in the HCBS Web Tool, a change may be made if necessary. Select the appropriate risk from the drop down. The priority risk displayed is stored upon review and approval of the service line(s) and selection of the ‘Submit Prior Authorization’ button at the bottom.

Finalized Services Summary (at the bottom of the screen)

Services finalized on the Prior Authorization Line Item will be populated here. All services must have a status from the Prior Authorization Line Item section in order to display in the Finalized Services Summary. Until all services have been given a status, the ‘Submit Prior Authorization’ button at the bottom right of the screen will not be enabled.

This view provides a final review for all services and authorized dates. If any changes are needed, navigate back to the Prior Authorization Detail screen to make the identified changes.

Authorization Status

Select ‘Submit Prior Authorization’ in the bottom right hand corner. This sends the services to the MMIS for authorization. A unique PA number will be assigned and displayed at the end of each ‘Service Type’ line in the ‘Finalized Services Summary’.

The ‘Service Prior Authorization Posted’ box at the bottom left of the Prior Authorization screen will auto populate with a check.

Navigate to the Participant Case Summary.

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Participant Case Summary Screen

Case Items

Expand the appropriate case by selecting the  sign.

The newly created Prior Authorization – Care Plan will now display with an associated identification number and the status will be ‘Posted.’

Note: Ensure all providers have been contacted regarding the change in the care plan including those providers no longer authorized for HCBS. Case Notes shall thoroughly document all actions/contacts related to the newly modified care plan. Any attachments related to the care plan change shall be uploaded in the Attachments section of the Case Activity screen.