Title: **AB-CFC/PAS 417**
Section: **Eligibility for Services**
Subject: **Temporary Authorizations**
Reference: **ARM 37.40.1005 and 37.40.1114**
Supersedes: **AB-CFC/PAS 417 (April 1, 2018)**

PURPOSE

Temporary authorizations are intended to allow an enrolled Medicaid Community First Choice/Personal Assistance Services (CFC/PAS) provider agency the ability to temporarily authorize CFC/PAS in order to meet the health and safety needs of CFC/PAS members. A temporary authorization enables a provider agency to deliver services on a temporary basis without a Service Profile from Mountain Pacific Quality Health (MPQH) or to expand service authorization in either scope or duration from the MPQH Service Profile. The temporary authorization is limited in duration to 28 days.

A temporary authorization may be used in the following situations:

1. High Risk Intake;
2. Short-term Intake; and
3. Change in Service Need.

A provider agency must meet the temporary authorization guidelines in order to bill services without a MPQH Service Profile. If a provider agency does not follow the temporary authorization process to deliver services, repayment will be required.

GENERAL GUIDELINES

1. The service scope and service limits outlined in AB-CFC/PAS 403 and 404 apply to all temporary authorizations. If a provider agency authorizes services that are not allowed in the CFC/PAS program or beyond the service limits of the CFC/PAS program a repayment will occur.
2. The provider agency must document the temporary authorization for services on the member's Service Plan (SLTC-170). The only exception is temporary authorizations that are short-term (i.e. less than seven

days). In those circumstances the authorization may be documented on the Service Delivery Record and/or case notes.

3. A provider agency cannot authorize CFC-only tasks (i.e. community integration, correspondence assistance, and yard hazard removal or skill acquisition) on a temporary authorization.
4. The only tasks that may be authorized are ADL tasks, medical escort, shopping, laundry and household tasks.
5. A provider agency cannot authorize meal preparation and exercise if a member is already at the cap. If a member is at the cap it will be indicated on the MPQH Service Profile (STLC-154).
6. ➢The Plan Facilitator signature and member signature are not required for temporary authorizations. If the Plan Facilitator is known at the time the temporary authorization is completed, the agency must send a copy of the temporary authorization form to the Plan Facilitator within 48 hours.
7. ➢The provider agency must provide the member with a copy of the Service Plan, with the temporary authorization, within 48 hours of completing the temporary authorization. The temporary authorization serves as the member's notice of the implementation of services for High Risk and Short-Term intakes and the change in service authorization when there is a change in need.

HIGH RISK INTAKE PROCESS

The high risk intake process is outlined in AB-CFC/PAS 414. The provider agency must complete all of the steps outlined in policy in order to deliver services prior to receiving the MPQH Service Profile (SLTC-155).

SHORT-TERM INTAKE

1. A short-term intake is an intake for a member who will

need services for 28 days or less. In this case the provider agency does not need to complete a referral to MPQH. If there is any question whether a member will need services for more than 28 days the standard intake process outlined in AB-CFC/PAS 411 should be followed. The provider agency must document the reason why services are expected to be delivered for 28 days or less. If a provider agency fails to justify why a short-term intake is warranted a repayment will occur.

2. ➢The provider agency Nurse Supervisor completes an on-site in-person visit with the member and completes the Service Plan, including the Service Plan Schedule, the comments and special instruction for service plan implementation, and the temporary authorization date span and total authorized time. The provider agency and member must sign the Service Plan. The Plan Facilitator does not need to be present at the intake or sign the Service Plan.

   NOTE: A Person Centered Plan Form (SLTC-200) is not required for a short-term admit.

3. A provider agency can only authorize PAS for short-term admits on the Service Plan. PAS is limited to ADL services, medical escort, shopping, laundry and household tasks. Members cannot receive CFC services on a short-term intake.

4. The Service Plan must justify the medical and functional need for services. If a Service Plan does not document the medical and functional need for services, a repayment will occur.

5. If the member's situation changes during the implementation of the temporary authorization and there will be a need for services for more than 28 days, a referral must be sent to MPQH and the provider agency must follow the process for High Risk intake (Refer to CFC/PAS 414).

CHANGE IN SERVICE NEED

1. Short-term change: If the change is needed for less than seven days, the provider agency may document the change in service need on either the Service Delivery Record and/or case notes.
2. Temporary Change: If the change in need is expected to last seven days or more, the provider agency Nurse Supervisor or Qualified Designee must complete the Temporary Authorization section on the member's current Service Plan or use a new Service Plan form to complete the Temporary Authorization section. The Temporary Authorization section must be completed as follows:
    a. Mark the temporary authorization/amendment box for whatever change is appropriate. If the change is longer than 28 days, the provider agency should complete an amendment to MPQH (Refer to AB-CFC/PAS 719).
    b. Describe the ADL/IADL change. The provider agency should review the current Service Profile and Service Plan and use this box to document the Service Plan Schedule changes that are necessary based on the member's change.
        i. The provider agency should mark whether they believe the change will be short-term (90 days or less) or permanent.
        ii. In the box provided, the provider agency should document the change that occurred and provide details about the change that is needed from the current Service Plan Schedule to meet the member's needs. The provider agency should be specific and describe any change in tasks, am/pm and weekly frequency, and increase in time related to these changes.

iii. The provider agency should indicate the intended start date, end date and total time in units that service will be delivered per bi-weekly period. The provider agency may only deliver a change in services for the time period indicated. A temporary authorization cannot exceed 28 days. The provider agency may only bill for the total units indicated on the temporary authorization for the time period indicated as substantiated by the Service Delivery Records.

c. ➢The provider agency Nurse Supervisor, or Qualified Designee, must complete and sign the Temporary Authorization section. If the Qualified Designee completes the temporary authorization, the Nurse Supervisor must review and sign-off on the temporary authorization section within ten days.

d. Once the temporary authorization span ends, the provider agency must revert back to the current MPQH Service Profile.

e. If a provider agency needs to extend the temporary authorization, the agency must fax an amendment request to MPQH prior to the end date indicated on the temporary authorization span (Refer to CFC/PAS 719).

i. If the provider agency faxes an amendment to MPQH prior to the end date, they must indicate the date the amendment was faxed to MPQH. Once this is completed, the provider agency may continue to provide services as outlined on the temporary service authorization until MPQH completes the amendment request.