PRIOR AUTHORIZATION

All clients must be enrolled with Special Health Care Needs (SHCN) before services can be authorized.

All services must have prior authorization before provision of service.

All Prior Authorization requests must be submitted on the most current original Prior Authorization form. Prior Authorization requests may be sent to the Adult Head Injury (AHI) Service Coordinator via mail, fax or secure e-mail.

A written treatment/service plan is required for all services and must be submitted with the Prior Authorization request. The treatment plan must address goals that match the client's functional level for the time of the Prior Authorization request.

Client/family participation in development of the plan should be documented.

Providers will not be reimbursed for any services delivered before approval.

Neither SHCN nor the client/family shall be responsible for payment for a service when the Provider fails to complete the SHCN prior authorization process.

Approval of services is contingent upon the availability of funding.

Services will be approved for a definite period as indicated on the Prior Authorization form.

Written notification of approval or denial will be sent to the Provider.

The AHI Program will maintain fiscal responsibility in the following manner:

Available funds for rehabilitative services will be divided into fourths and allocated one quarter at a time.

Prior Authorization requests will be approved up to the amount available for each quarter.

Approval decisions will be made on a case-by-case basis, following the person-centered model, taking into consideration:

- The client and family's wishes;
- The health and safety of the client;
- Identified priorities listed in the client's Service Plan;
- Average costs for services (based on Program history) needed to reasonably assure completion of the plan; and
- Availability of other resources/support.

The AHI Program will monitor the difference between authorization requests and actual expenditures. When the demand for services exceeds available funds, the service will maintain a waiting list for services.

PRIOR AUTHORIZATION PROCEDURES

Prior Authorization forms shall be submitted to the AHI Service Coordinator by the 10th of the month before the beginning of the month for which services are planned. No authorization will be accepted after close of business on the 10th. When the 10th falls on a weekend, Prior Authorizations are due by close of business on the Friday before the 10th.

The individualized treatment plan for the current authorized period must be attached to the Prior Authorization that is sent to the AHI Service Coordinator. The treatment plan and goals must be developed by a Qualified Head Injury Professional, and:

- Reflect input from the client's planning team;
- Reflect services essential to the expected client outcome;
- Specify the frequency, expected duration of treatment;
- Specify the expected function the participant will achieve if service is approved;
- Specify the methods to be used or strategies to be taught to address the client's unique barriers to independence;
- Incorporate information from previous services received; and
- Document client/family participation in the plan.

NOTE: Refer to Treatment Plan and Progress Report section for specific requirements.

Prior authorization requests for clients that have ongoing service plans in place requiring services for an expected duration of a three-month period may be submitted on a quarterly basis.

Services will be approved for new clients if funds are projected to be available after funding has been allocated for clients whose rehabilitation programs are in progress. When the demand for services exceeds available funds, a waiting list will be maintained. **NOTE: New clients are defined as those who have not received SHCN services in the past.**

The date of the Prior Authorizations submitted should end on the final day of the month/quarter in which the service is planned.

For example, if a client is expected to begin services for the **month** on April 10, the Prior Authorization request would be dated April 10-April 30, the final day of the month. If a client is expected to begin services for the **quarter** on April 10, the Prior Authorization request would be dated April 10-June 30.

When services requested are also covered by MO HealthNet or another third party payer, a copy of the denial for coverage of the service must be attached to **each** Prior Authorization that is sent to the AHI Service Coordinator. The original denial or a fax copy of the denial is acceptable. If the third-party payer refuses to issue a written decision, a written statement dated and signed by the Provider documenting the third-party payer's verbal decision will be acceptable as evidence of no coverage for the requested service.

Upon receipt of the Prior Authorization, the client's AHI Service Coordinator will:

- Review the request;

- Ensure medical and financial eligibility are met;
- Ensure that all other payment resources have been utilized;
- Review the DHSS Treatment Plan and Monthly Progress Report (as applicable);
- Review the client's long-term goals; and
- Advocate for the client's needs as funding decisions are made by SHCN.

In order to promote statewide consistency in decision-making, the AHI Service Coordinator and the team of AHI Service Coordinators will meet quarterly in Central Office to process Prior Authorization requests. The AHI Program Manager is responsible for final approval.

Written responses to Prior Authorization requests will be sent to the Provider by SHCN no later than the first of the month following submission of the request.

PRIOR AUTHORIZATION REQUEST

The **Prior Authorization Request** must be submitted to obtain prior approval to provide any rehabilitation service. No payment will be made for services rendered without prior approval. The **original** form must be completed according to SHCN policies and procedures listed in this manual.

INSTRUCTIONS FOR COMPLETION

Complete as follows:

1.	CLIENT NAME	Enter the complete (LAST, FIRST, MI) name of the client who will receive services.
2.	DATE OF BIRTH	Enter client's date of birth.
3.	AGE	Enter client's age.
4.	DCN	Enter the departmental client number.
5.	ADDRESS	Enter client's complete address (STREET, CITY, STATE, ZIP).
6.	COUNTY	Enter client's county of residence.
7.	PROVIDER NAME	Enter complete name of the Provider as listed on participation agreement.
8.	TELEPHONE NUMBER	Enter Provider's telephone number.
9.	ADDRESS	Enter Provider's complete **payment mailing** address.
10.	CONTACT PERSON	Enter name of the contact person in Provider agency.
11.	SERVICES REQUESTED	Mark the box for the service requested. **Each service requested must have a separate Prior Authorization form.**
12.	DATES OF SERVICE REQUESTED	Enter the dates of when services will be provided upon approval.
13.	NUMBER OF UNITS PER WEEK	Enter number of units of service that will be provided each week.
14.	LIST MONTH AND NUMBER OF UNITS	Enter the month and number of units of service that will be provided per month.
15.	TOTAL UNITS REQUESTED	Enter total number of units requested on this form.
16.	FOR STATE USE ONLY	SHCN use only.

SIDE TWO:

17.	RELATED AHI PROGRAM SERVICE	Check the service title for which transportation is requested. *EXAMPLE:* Prevocational Training or Socialization Skills Training.
18.	INDIVIDUAL	Enter number of miles from client's residence to rehab program times two equals total mileage for the trip.
19.	GROUP-SAME LOCATION	Enter names of DHSS clients transported. Enter mileage from residence to rehab facility or recreational activity. Total number of miles one-way. Multiply by two for total round-trip mileage. Enter total in box. Approval will be prorated for each client.
20.	GROUP-DIFFERENT LOCATION	Enter name of DHSS clients transported. Enter mileage attributed to client from pick up point to next client pick up point. Multiply by two for total round trip for that client. Continue calculation process for each DHSS client transported. Complete a separate form for each client transported.

Prior Authorization Modification

If a participant's needs should change during the originally authorized time frame, it may be appropriate to request an increase or decrease in services as appropriate to the participant's situation. In this event, the Provider shall complete an Adult Head Injury Program Prior Authorization Modification form. This form is then submitted to the Service Coordinator for review. The Service Coordinator will submit the Modification form to the Program Manager for final approval of the modification request. This approval is based upon the recommendation of the Service Coordinator regarding appropriateness and the availability of funding if the modification requires an increase in services.

The Service Coordinator and Provider will receive a copy of the prior authorization modification form, once processed by the Program Manager.