LAPEER COUNTY COMMUNITY MENTAL HEALTH **Date Issued** 02/21/2002
Date Revised 02/28/12; 12/28/12; 03/23/15; 08/25/15

CHAPTER Fiscal Management	**CHAPTER** 06	**SECTION** 003	**SUBJECT** 85
SECTION Reimbursement	**DESCRIPTION** Adult Services Authorized Payments (ASAP) Definitions; Title XIX		
WRITTEN BY Michael K. Vizena, M.B.A. Executive Director	**REVISED BY** Andrea Schroeder, M.S.A. Residential Supervisor	**AUTHORIZED BY** Dr. Robert M. Sprague, CEO 8/26/15	

APPLICATION:

- All Staff

POLICY:

ASAP is an established Department of Health and Human Services (DHHS) payment program, which is automated, and on-line to interface with the client information system (CIS) which edits ASAP data against Medicaid (MA) eligibility data on CIS.

In order for the ASAP to run efficiently at Lapeer County Community Mental Health, it is important that all staff working with the system are familiar with the following definitions:

DEFINITIONS:

ADMINISTRATIVE DESIGNEE: A person(s) designated by each RMHA to coordinate ASAP related services of Agency.

ADULT SERVICES AUTHORIZED PAYMENT: Adult Services Authorized Payment (ASAP) is an online payment system which interfaces with three computerized data systems: Client Information System (CIS), Bureau of Regulatory Services (BRS), and the Michigan Department of Treasury. This on-line payment system, which makes payments to several types of providers, requires the provider to be enrolled, the care or services to be authorized, and the provider to submit electronic billing or call ASAP with billing information to produce a payment.

APPROVAL OF PERSONAL CARE SERVICES: Occurs after a Medicaid designated Case Manager (QIDP/QMHP) has ordered personal care services, which must be documented on Form DHHS-3803 and written in the IPOS.

AUTHORIZATION: request for personal care / supplemental services for a specified period of time from a specified provider. The Authorization is entered on ASAP using data from Form DHHS-3803.

COUNTY: 44 / number required to identify DHHS/CMH.

CONTINUOUS PERSONAL CARE NEEDS: Frequency (daily, weekly, monthly, etc.), in which personal care services are required to be administered to a person served.

a) Persons served must need "ON-GOING personal care services to be Title XIX eligible.

b) Personal care services do not have to be given each day for a payment, but needs and care must be continuous during that month.

DHHS-3803: Incorporates several of the documentation requirements for Title XIX personal care, such as "RMHA's ASSESSMENT OF NEED", "PHYSICIAN'S PRESCRIPTION", "RN's REVIEW AND APPROVAL OF SERVICE PLAN" and "SERVICE PLAN".

NOTE: A new DHHS-3803 is required in cases where there has been substantial change in needs.

NOTE: DHHS-3803 meets all DHHS Licensing requirements.

ELIGIBLE CARE PROVIDERS: The provider of the non-specialized residential services must be licensed and meet minimum requirements of DHHS as defined in Act 117, Public Acts of 1973, and Act 218, Public Acts of 1979, as amended. In addition, provider must have license on ASAP's licensing file.

ELIGIBILITY TYPE CODE: A number identifying the type of service a provider is authorized on ASAP. Also see back of DSS-2355X.

EMERGENCY SITUATION(S):

a. Hospitalization for any reason.

b. Special placement needs -- e.g., person served living with parent(s) and parent dies suddenly; person served is released from jail and last provider refuses to take him/her back, and

c. Any other related unplanned situation, e.g. protective service placement, court, etc.

END DATE: Last full day means person served in home at midnight (12:00 a.m.).

EXTENDED AUTHORIZATION: An Authorization of personal care services can be one day or up to twelve months. If a RMHA intends to continue that Authorization beyond the end date, then the RMHA staff must reauthorize services or extend the pay end date. RMHA staff must submit Reauthorization / Extensions 15 days prior to Authorization ending. In addition, end date cannot exceed Title XIX eligibility.

GENERAL FUNDS / GENERAL PURPOSE (GF/GP) STATE MONIES: 100% state funds.

HA: Home for the Aged.

HOSPITALIZATION FOR "MEDICAL REASONS": Medical situations, e.g., person served falls and breaks a hip; has pneumonia, delivery (pregnancy), or has a disease, etc. In addition, this definition does include mental health related issues as "medical reasons" and emergency situations.

INDIVIDUAL PLAN OF SERVICE (IPOS): Means a detailed written plan which identifies personal care needs and services, mental health services (including residential, treatment and/or training) and ancillary services needs (including assistance with personal finances and third-party benefits) of a person served and summarizes the habilitation and rehabilitation goals, objectives, methodologies and expected outcomes for specified service periods.

IN-HOME MENTAL HEALTH SERVICES: Treatment, (re)habilitation or training and/or behavior management programs carried out within the specialized mental health residential setting according to an IPOS and provided by CMH/DHHS. The ASAP payments must not be authorized for the same period that these services are provided.

LAST FULL DAY: The last day that the person served was in the provider's care at midnight (12:00 a.m.).

MEDICAID DESIGNATED CASEHOLDER: A case holder who is either a QIDP or QMHP as defined in 42CFR483.430 or Medicaid Chapter III.

NON-SPECIALIZED RESIDENTIAL SETTING: A licensed dependent living arrangement providing room, board and supervision, but not providing in-home mental health services.

PERSONAL CARE SERVICES (TITLE XIX): Qualifying services must be provided in accordance with the IPOS. These services assist persons served by hands-on assistance, guiding, directing or prompting in at least one of the following activities each day.

1. Eating/Feeding: The process of getting food by any means from receptacle (plate, cup, glass) into the body. This item describes the process of eating after food is placed in front of an individual.
2. Toileting: The process of getting to and from the restroom for elimination of feces and urine, transferring on and off the toilet, cleansing self after elimination, and adjusting clothes. A commode in any location may be considered the "restroom" only if in addition to meeting the criteria for "toileting", the individual empties, cleanses and replaces the receptacle without assistance from another person(s).
3. Bathing: The process of washing the body or body parts, including getting to or obtaining the bathing water and /or equipment, whether this is in bed, shower or tub.
4. Dressing: The process of putting on, fastening and taking off all items of clothing, braces and artificial limbs that are worn daily by the individual, including obtaining and replacing the items from their storage area in the immediate environment. Clothing refers to the clothing usually worn daily by the individual. Individuals who wear pajamas or gowns with robe and slippers as their usual attire are considered dressed.
5. Grooming: the activities associated with the maintaining personal hygiene and keeping one's appearance neat, including care of teeth, hair, nails, skin, etc.
6. Transferring: The process of moving horizontally and/or vertically between the bed, chair, wheelchair and/or stretcher.
7. Ambulation: The process of moving about on foot or by means of a device with wheels.
8. Taking Medication: The process of assisting the person served with medications which are ordinarily self-administered, when ordered by the person's physician.

PAMA CODE: Payment Assistance-Medical Assistance Code.

PASSWORD: A confidential and personalized word assigned to each designee and back-up designee. DHHS's State Operator may request security check for designee to obtain data from ASAP. Designee must also use Security Matrix for access through DHHS.

PEND/PND: Pended for further action –DHHS must review the billing

PERSON SERVED: A person (child, adult, or aged) who receives mental health services from RMHA.

PRE-AUTHORIZATION CHECK: The case manager or administrative designee must verify Medicaid eligibility through OASIS before a new Authorization is submitted. Case manager or administrative designee gives the case number, recipient ID number and provider ID number. ASAP will verify MA eligibility, conflicting authorizations, and provider data.

PROVIDER: The provider of service who is providing personal care services in a non-specialized residential setting.

PROVIDER ENROLLMENT: All AFC / HA facilities must be enrolled as a provider on ASAP before services can be authorized.

PROVIDER ID NUMBER: A seven-digit number assigned by ASAP to identify each provider.

QUALIFIED MENTAL HEALTH PROFESSIONAL (QMHP): A professional with specialized training or one or more years experience working directly with people mental health or other developmental disabilities. These may include physicians, social workers, psychologists, physical therapists, speech therapists, or occupational therapists and others as defined in 42CFR483.430 or Medicaid Chapter III. The QMHP is often the same as the CMH case manager or Medicaid Designated Case holder.

QUALIFIED INTELLECTUAL DISABILITIES PROFESSIONAL (QIDP): A professional with specialized training or one or more years of experience treating or working directly with people with an intellectual disability. These may include physicians, social workers, psychologists, physical, speech, or occupational therapists and others as defined in 42CFR483.430 or Medicaid Chapter III. The QIDP is often the same as the CMH case manager or the Medicaid Designated Case holder.

QUALIFIED PERSON SERVED: The person served has ACTIVE Medicaid during effective dates of service and has an eligible PAMA code.

RATE SET CODE: Determines which program on ASAP, payment should be calculated for. DHHS/CMH rate set code is "1". Rate set code is printed on DSS-2353 and must be manually written on DSS-2353X forms.

REAUTHORIZATION: Authorization will be ending, person served will be remaining in foster care and Authorization is being extended.

REEVALUATION OR REVIEW OF PERSONAL CARE SERVICES: This must occur within a calendar year of the last plan for Personal Care Services or the last re-evaluation. This can only be done based upon a face-to-face contact with the person served. A Medicaid designated Case Manager shall initiate a re-evaluation or review on Form DHHS-3803.

RESPONSIBLE MENTAL HEALTH AGENCY (RMHA): Centers for developmental disabilities and special facilities operated by or under contract with the Department of Health and Human Services; and Community Mental Health Boards, and their contract agencies, which are responsible for providing persons served services management.

R.N. / CASE MANAGEMENT SUPERVISOR REVIEW: Face-to-face contact with person served or an administrative review of service plan and the need for personal care services. This review is performed annually or within twelve months of the physician certification of need for personal care service or the initial R.N./Case Management Supervisor Review, whichever occurred last. A CMH-3803 form must be used by RMHA for review purposes.

SPECIALIZED COMMUNITY RESIDENTIAL SETTING: A licensed dependent living arrangement operated by or under contract to DHHS/CMH and providing room, board, supervision and in-home treatment, (re)habilitative and/or behavior management programs.

SHARED PROVIDERS: When both DHHS and CMH are using the same facility for persons served.

SINGLE PAYMENT': The maximum payment amount determined per calendar month. NOTE: Amount is subject to SSI or SSA legislative changes.

SPEND DOWN: Applies to Medicaid recipients who meet all eligibility factors except income. Persons with income in excess of local Medicaid protected income level may incur sufficient medical expenses to meet their monthly spend down requirements for Medicaid eligibility.

SUBSTANTIAL CHANGE: Any increase (additional) or decrease (reduction) in personal care activity or activity change from provide / assist, guide / direct or vice versa, within 364 days of most recent physician certification date or QIDP/QMHP review date; and as clinically determined by Case Manager(s) of the person served.

TEMPORARY ABSENCE OTHER THAN HOSPITAL: Absences up to eight days a month or 104 days a year are permissible without an adverse effect on the AFC/CCI/HA personal care / supplemental payment. Providers will need to record the dates of absences in the facility record of the person served. Case Managers shall monitor this at the time of the quarterly and annual reviews. Absences of more than eight days a month but less than 104 days a year MUST BE APPROVED IN WRITING BY THE CASE MANAGER AND/OR SUPERVISOR.

> NOTE: Plan of Services or QIDP/QMHP Reviews upon renewal of change(s) must include the number or what days / time absences are permissible. This is only necessary if authorized absences are not presently noted or documented.

TITLE XIX: Medicaid (state/federal) funding used when the RMHA has determined that the person served is in need of personal care services and a physician has completed and signed a Plan of Service certifying personal care need(s). A QIDP/QMHP must have approved this Plan of Service for personal care service(s).

VERIFY / INPUT DATA: RMHA case managers and designees must furnish timely and correct data to be communicated to DHHS-PCS regarding the person served and providers as required and/or changes occur.

Questions regarding this policy and procedure may be addressed to the Chief Executive Officer or any member of the management team.

AS:mgr

This policy supersedes
#02/02008 dated 02/21/2002.
