

2004 SERVICE AUTHORIZATION

REVISION DATE: 6/10/2016, 7/3/2015

EFFECTIVE DATE: July 31, 1993

All services funded by the Division require authorization prior to delivery. Support Coordinators may authorize services in certain circumstances. Some services may require authorization in addition to that of the Support Coordinator, such as physician prescribed services, which require prior authorization by Health Care Services (HCS). Other services may require authorization by the Assistant Director or designee.

Authorization by the Division Support Coordinator shall be documented by the Support Coordinator's signature on the service plan.

For members who are eligible for Arizona Long Term Care System (ALTCS), the Support Coordinator shall authorize long term care services only when the assessment and planning process outlined in this policy manual determines the services to be medically necessary, cost effective, and federally reimbursable. Services are cost effective when the total cost does not exceed 100% of the cost of an Intermediate Care Facility for Persons with an Intellectual Disability (ICF/IID). Non-covered services and services provided to members who are not ALTCS-Long Term Care shall be authorized only when the same processes determine them to be developmentally necessary and cost effective and state funding is available.

Prior to authorization, the Support Coordinator shall ensure that other potential resources for meeting the identified needs have been explored, and are either not available or not sufficient to meet the documented need for both ALTCS and non-Long Term Care services. The Support Coordinator shall also ensure that the service will be provided in accordance with the service definitions and parameters outlined for each service in this policy manual.

Support Coordinators shall follow the steps outlined below in authorizing services:

- A. Members who are eligible for ALTCS receive identified services within thirty (30) days of eligibility. The Focus system will be updated within 5 days of the team meeting, unless a Utilization Review is required;
- B. A Utilization Review is required for any new or increase in service including Attendant Care, Respite, Habilitation and Day Treatment and Training. This Utilization Review process must be completed within 10 days;
- C. Entry of approvals in Focus shall be approved or denied following Support Coordinator authorization, other District management staff authorization if needed, and HCS authorization or other Division staff, if needed; and,
- D. Within five days of approval by the appropriate authority, the Support Coordinator ensures authorization information for the needed service, the amount of units, the start/end dates, and the preferred provider are entered in Focus.

Other Authorizations

Therapies require prior authorization through the District Administration and the Central Office. Home Health Aide, Home Health Nurse, Hospice, and Respiratory Therapy services require prior authorization through Health Care Services. Home modifications require prior authorization through the Home Modification unit.