

Topic:	Direct Nursing MMIS Authorization and Payment Procedures
Date Issued/Updated:	11/10/2016

Overview

Description: Direct Nursing Service (DNS) authorization and payment instructions.

Purpose/Rationale: In order to comply with federal and state requirements the department must assure an authorization and payment process for local Case Management Entities. Under OAR 411-380, DNS providers are issued Prior Authorizations and payments through the Medicaid Management Information System (MMIS).

Applicability: Case Managers who support adults (21 years and older) who reside in foster care homes (DD58) or their own homes (DD49/DD149), and who qualify for Direct Nursing Service (shift care) as determined by ODDS criteria, need to know to authorize and approve payment for the Direct Nursing Service.

Procedure(s) that apply:

For MMIS authorization and payment the following procedures apply:

- All Direct Nurse providers must be [qualified/enrolled DNS providers](#)
- For individuals receiving DNS in an In-Home setting (DD49/149), Case Management Entities should assure current ISP's and Direct Nursing Assessment Results Memorandum are attached in the eXPRS Plan of Care system. For those in Adult Foster Care, the current ISP must be sent to Suzi Drebes or Ken Ralph at ODDS.RNsupport@state.or.us
- No hours of service will be paid before the start date of a Prior Authorization. Direct Nursing hours identified on ISP cannot exceed the number of hours identified on Direct Nursing Criteria. Direct Nursing Hours that exceed the Prior Authorized amounts or exceeding the monthly allotted (as identified on Criteria) nursing hours will not be paid.
- For the DNS authorization and payment procedures, four different entities are responsible for clearly communicating and coordinating information to assure prior authorization and payment. These groups are:

- Individuals, family, legal representatives, AFH providers
- DNS Providers (Home Health or In Home Agencies and Self-employed RN's or LPN's)
- Case Management Entities (CDDP or Brokerages)
- ODDS Central Office

Self-employed or Agency Providers must:

1. After discussion with individual, family or AFH provider, enter or load a request for Prior Authorization (PA) of hours into MMIS no later than the 25th of the month prior to anticipated service month
2. Send a secure request to ODDS.RNSupport@state.or.us and the case management entity, requesting to pend the authorization.
 - a. Request must include:
 - i. Individuals name, hours requested, prime number, and prior authorization number
 - b. ODDS will pend the prior authorization for that next month
3. After the full month of delivered services, invoices/timesheets are signed by the DNS provider, and individual, family or AFH provider
4. Submit invoice/timesheets to the case management entity (contact varies depending on program) and
5. After ODDS approves payment status of hours worked (verified by CME) make claim for release of payment.

Following receipt of the Prior Authorization into MMIS, ODDS will:

1. Pend the authorization until they receive verification from the case management entity that invoice/timesheet is accurate
2. Wait for the case management entity to email ODDS.RNSupport@state.or.us with verification of approved invoice/timesheet at the end of the month.
3. Convert the pending authorization in MMIS into approved status
4. ODDS will confirm approved status in email to the case manager

Following receipt of the Email from the self-employed or Agency Provider, the Case Management Entity(CME) must:

1. Verify accuracy of invoice/timesheets with ISP and approved hours.
2. Email the Provider and ODDS.RNSupport@state.or.us indicating that the hours authorized/worked are 'approved', with the PA number, individual's name and prime number.

In Addition:

- The provider must notify the CME immediately if hours (already Prior Authorized) need to be adjusted during the month of service. The CME must approve and send notification to ODDS/Central Office (ODDS.RNSupport@state.or.us). ODDS/Central Office will make the adjustment to the Prior Authorized total hours. For example: Nurse Provider X has 250 hours Prior Authorized and Nurse Provider Y has 250 hours Prior Authorized for the month of June: If Nurse Y becomes unavailable to work during the month of June, ODDS (after receiving email approval from the CME) can increase Nurse Provider X authorized hours as long as:
 - (i) It occurs in the same month of service
 - (ii) It was prior approved by CM
 - (iii) And total hours worked by the nurse providers do not go over the total monthly allowed by the ISP/Criteria.

Form(s) that apply:

Provider Invoice/Timesheets

Definition(s):

Case Management Entity- "Case Management Entity" means a CDDP or Support Service/Brokerage.

Direct Nursing Services- "Direct Nursing Services" mean the services described in OAR 411-380-0050 determined medically necessary to support an individual with complex health management support needs in their home and community. Direct nursing services are provided on a shift staffing basis.

Home Health Agency - "Home Health Agency" has the meaning given that term in ORS 443.005

In Home Care Agency- "In-Home Care Agency" has the meaning given that term in ORS 443.305.

MMIS- "MMIS" means "Medicaid Management Information System". MMIS is the automated claims processing and information retrieval system for handling all Medicaid transactions. The objectives of the system include verifying provider enrollment and individual eligibility, managing health care provider claims and benefit package maintenance, and addressing a variety of Medicaid business needs.

Prior Authorization for Services- "Prior Authorization for Services" means payment authorization for direct nursing services given by the Department or contracted agencies of the Department prior to provision of the service. A physician referral is not a prior authorization for services.

Reference(s):

OAR 411-380-0030 DNS eligibility; OAR 411-380 – 0030(2) DNS Criteria-
OAR 411-380 – 0090 Provider Billing and payment; OAR 410-120 – 1300 Timely submission of claims; OAR 410- 120-1320 Authorization of payment; OAR 410 – 120-1340 Payment; OAR 410-120-1380 Compliance with Federal and state statutes.

Frequently Asked Questions:

Q. As the Case Management Entity are we responsible for authorization, review and approval of hours?

A. The Case Manager is responsible for the initial authorization of DNS services. The Case Management Entity is responsible:

- To assure the accurate monthly prior authorization of hours against the total allowable hours identified in the ISP,
- Review of the provider signed timesheets or invoices to verify no overlapping nursing hours, and that providers (individually and collectively) did not exceed total authorized hours,
- The delivery (in a timely manner) of e-mail confirming hours to the ODDS central office.

Q. Do CMs have to wait for all provider timesheets to be sent in before reviewing, approving and sending each provider's confirmation e-mail to ODDS?

A. No. Each Provider may submit for payment and be paid when all steps have been accurately completed. CMEs are responsible for reviewing the total tally of provider hours submitted. If the total hours authorized are exceeded, the CME should contact ODDS Central office.

Q. Do the CMEs have to send to central office copies of timesheets or invoices as part of the payment process?

A. No. However all documentation (signed timesheets or invoices, confirmation e-mails to ODDS and any other authorization and payment communication) must be kept for auditing purposes. Providers must also maintain their own records per OARs 411-380-0080(6).

Q. Must providers use both a timesheet and invoice?

A. No. Providers may use either a timesheet or invoice as long as it contains all of the following information:

- Name of the individual
- Date: month/day/year
- Daily start and end time entries for hours worked for the month
- Name of DNS Provider (Agency or Self-Employed)
- Signature line for Provider
- Signature line for individual, family, foster care provider

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