# Ohio Administrative Code

## Rule 5123-9-07 Home and community-based services waivers - request for prior authorization for individuals enrolled in the individual options waiver.

Effective: January 1, 2024

(A) Purpose

This rule establishes standards and procedures for prior authorization of waiver services when an individual funding level exceeds the funding range determined by the Ohio developmental disabilities profile for an individual enrolled in the individual options waiver.

(B) Definitions

For the purposes of this rule, the following definitions apply:

(1) "Cost projection tool" means the web-based analytical tool that is a component of the medicaid services system, developed and administered by the department, used to project the cost of home and community-based services identified in an individual service plan.

(2) "County board" means a county board of developmental disabilities.

(3) "Department" means the Ohio department of developmental disabilities.

(4) "Funding range" means one of the dollar ranges contained in appendix A to rule 5123-9-06 of the Administrative Code to which individuals enrolled in the individual options waiver have been assigned for the purpose of funding services other than adult day support, career planning, group employment support, individual employment support, non-medical transportation, vocational habilitation, waiver nursing delegation, and waiver nursing services. The funding range applicable to an individual is determined by the score derived from the Ohio developmental disabilities profile that has been completed by a county board employee qualified to administer the tool.

(5) "Individual" means a person with a developmental disability or for purposes of giving, refusing to give, or withdrawing consent for services, the person's guardian in accordance with section

5126.043 of the Revised Code or other person authorized to give consent.

(6) "Individual funding level" means the total funds, calculated on a twelve-month basis, that result from applying the payment rates in service-specific rules in Chapter 5123-9 of the Administrative Code to the units of all waiver services other than adult day support, career planning, group employment support, individual employment support, non-medical transportation, vocational habilitation, waiver nursing delegation, and waiver nursing services established by the individual service plan development process to be sufficient in frequency, duration, and scope to meet the health and welfare needs of an individual enrolled in the individual options waiver.

(7) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual.

(8) "Medicaid services system" means the comprehensive information system that integrates cost projection, prior authorization, daily rate calculation, and payment authorization of waiver services.

(9) "Ohio developmental disabilities profile" means the standardized instrument utilized by the department to assess the relative needs and circumstances of an individual compared to others. The individual's responses are scored and the individual is linked to a funding range, which enables similarly situated individuals to access comparable waiver services paid in accordance with rules adopted by the department.

(10) "Prior authorization" means the process to be followed in accordance with this rule to authorize an individual funding level for an individual enrolled in the individual options waiver that exceeds the maximum value of the funding range.

(11) "Service and support administrator" means a person, regardless of title, employed by or under contract with a county board to perform the functions of service and support administration and who holds the appropriate certification in accordance with rule 5123-5-02 of the Administrative Code.

(12) "Waiver eligibility span" means the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility redetermination date.

(C) Standards

(1) The county board will inform an individual, in writing, of the individual's right to request prior authorization whenever development or proposed revision of the individual service plan results in an individual funding level that exceeds the funding range assigned to the individual.

(2) Unless a request for prior authorization has been approved in accordance with this rule, the individual funding level for services will be within or below the funding range assigned to the individual.

(3) Approval of a request for prior authorization is valid only for the duration of the individual's waiver eligibility span for which the request was made.

(4) The department will not consider a request for prior authorization submitted after the end date of the waiver eligibility span for which the request is made.

(D) Procedures

(1) A request for prior authorization will be submitted to the department during the waiver eligibility span for which the request is made and as soon as possible after development or proposed revision of the individual service plan results in an individual funding level that exceeds the funding range assigned to the individual.

(2) An individual will initiate the prior authorization process by submitting a signed and dated request to the county board. A county board will assist in the preparation of the request when the individual requests assistance.

(3) The county board will submit the request for prior authorization with the current or proposed individual service plan and supporting documentation to the department through the medicaid services system within ten business days of receiving the individual's request. Supporting documentation will provide evidence that the requested services are medically necessary in accordance with the criteria set forth in paragraph (D)(7) of this rule.

(4) When the county board is unable to support the request based on the county board's documentation that the requested services do not meet the criteria set forth in paragraph (D)(7) of this rule, the county board will provide to the department:

(a) A detailed description of the county board's efforts to develop an individual service plan that results in an individual funding level within the funding range assigned to the individual; and

(b) An alternative cost projection that ensures the health and safety of the individual, including the date the alternative cost projection was reviewed and declined by the individual; and

(c) Supporting documentation evidencing that the requested services are not medically necessary in accordance with the criteria set forth in paragraph (D)(7) of this rule.

(5) Within ten business days of receiving the request, the department will notify the county board if additional information is needed to make a determination. The county board will submit the additional information to the department within five business days of receiving notification from the department.

(6) The department will review the request and make a determination within ten business days of receiving all necessary information.

(7) When reviewing a request, the department will determine whether the waiver services for which prior authorization is requested meet the waiver service definition and are medically necessary. The department will determine the services to be medically necessary if the services:

(a) Are appropriate for the individual's health and welfare needs, living arrangement, circumstances, and expected outcomes; and

(b) Are of an appropriate type, amount, duration, scope, and intensity; and

(c) Are the most efficient, effective, and lowest cost alternative that, when combined with non-waiver services, ensure the health and welfare of the individual receiving the services; and

(d) Protect the individual from substantial harm expected to occur if the requested services are not authorized.

(8) The department may limit its review to the individual's request in the medicaid services system and the cost projection tool that produced an individual funding level that exceeds the funding range assigned to the individual when the county board supports the request and:

(a) The costs exceed the funding range solely as a result of a payment rate increase taking effect during the individual's waiver eligibility span and not as a result of a change in the type, amount, duration, scope, or intensity of services authorized; or

(b) The projected individual funding level exceeds the funding range assigned to the individual by no more than ten per cent; or

(c) The request is for an individual for whom prior authorization has been approved for a previous waiver eligibility span and the request includes an attestation by the service and support administrator that the individual's needs, waiver services, and cost of waiver services have not changed since the preceding request.

(9) Based on its review, the department will:

(a) Approve the request if it finds that the services for which prior authorization is requested meet the criteria set forth in paragraph (D)(7) of this rule; or

(b) Deny the request; or

(c) Approve the request for a partial or full waiver eligibility span for all or some of the services provided the criteria set forth in paragraph (D)(7) of this rule are met.

(10) When the department makes a determination regarding a request for prior authorization, the department will:

(a) Issue written notification to the individual which sets forth the reason for denial or reflects the

total amount authorized for the current waiver eligibility span and includes the individual's right to request a hearing in accordance with section 5101.35 of the Revised Code and division 5101:6 of the Administrative Code; and

(b) Update the prior authorization status to reflect its determination in the medicaid services system.

(11) When the request for prior authorization is denied, the individual and the service and support administrator will meet to revise the individual service plan.

(12) If the individual requests a hearing in accordance with paragraph (D)(10)(a) of this rule, the county board will offer a county conference in accordance with rule 5101:6-5-01 of the Administrative Code and comply with applicable requirements of division 5101:6 of the Administrative Code.

(13) Failure by a county board or the department to comply with the timelines established in this rule will not constitute approval of a request for prior authorization.

(14) The Ohio department of medicaid reserves the right to review all requests for prior authorization submitted through the medicaid services system to ensure compliance with this rule.