1915(i) Service Authorization Process Flows
This process is completed upon the initial Care Coordination Plan of Care (CC-POC).

Care Coordinator (CC) and individual have completed the initial Care Coordination Plan of Care (CC-POC).

Individual’s Medicaid: Traditional or Expansion?

Expansion
CC follows Managed Care Organization (MCO) Service Authorization (SA) process.

Traditional
CC submits CC-POC and Service Authorization (SA) for CC service to State via MMIS for authorization. Service, Amount, Frequency, and Duration must match CC-POC.

State authorizes CC service which also acknowledges CC-POC approval?

MCO authorizes CC service which also acknowledges CC-POC approval?

MMIS generates approval letter to CC provider and individual.

MMIS generates denial letter and right to appeal to CC provider and individual.

Yes

CC services can now be billed starting from SA approval date.

Comprehensive Plan of Care (CC-POC) can be developed.

No

Follow MCO SA process.

Follow MCO SA process.

CC-POC and/or SA is revised; CC-POC and SA are re-submitted by CC provider OR process ends.
Care Coordinator (CC) and individual have completed the Comprehensive Plan of Care (C-POC). C-POC identifies individual’s choice of service providers.

CC completes Request for Service Provider form and sends form to each provider identified on the C-POC.

- Individual’s Medicaid: Traditional or Expansion?
  - Traditional
    - CC attaches finalized C-POC to CC Service Authorization (SA) in MMIS previously submitted and approved.
    - Service, Amount, Frequency, and Duration must match C-POC.
    - CC forwards finalized C-POC to all service providers on the C-POC.
    - CC changes C-POC to individual’s next choice of provider.
  - Expansion
    - CC sends C-POC to Managed Care Organization (MCO).

- Each individual provider accepts request?
  - YES
    - Provider(s) accepts request and informs CC.
  - NO
    - Provider(s) deny request and inform CC.

- Each service provider submits SA and C-POC to State via MMIS for authorization. Service, Amount, Frequency, and Duration must match C-POC.

- State authorizes services?
  - YES
    - Services begin.
  - NO
    - SA is revised; C-POC and SA are re-submitted by provider OR process ends.

MMIS generates approval letter to provider and individual.

MMIS generates denial letter and right to appeal to provider and individual.

This process is completed upon the initial Comprehensive Plan of Care (C-POC).
Care Coordinator (CC) and individual complete the Comprehensive Plan of Care (C-POC). C-POC identifies individual’s choice of service providers.

CC completes Request for Service Provider form and sends form to each provider identified on the C-POC.

Each individual provider accepts request?

YES

Provider(s) accepts request and informs CC.

NO

Each individual provider requests?

YES

Individual’s Medicaid: Traditional or Expansion?

Traditional

CC submits C-POC and Service Authorization (SA) for CC service to State via MMIS for authorization. Service, Amount, Frequency, and Duration must match C-POC.

Follow MCO SA process.

NO

MCO authorizes CC service which also acknowledges C-POC approval?

NO

MMIS generates denial letter and right to appeal to CC provider and individual.

YES

State authorizes CC service which also acknowledges C-POC approval?

State authorizes services?

NO

Services begin.

YES

CC forwards approved C-POC to all service providers on the C-POC.

MMIS generates approval letter to CC provider and individual.

Expansion

CC follows Managed Care Organization (MCO) Service Authorization (SA) process.

Follow MCO SA process.

NO

MCO authorizes CC service which also acknowledges C-POC approval?

YES

CC forwards approved C-POC to all service providers on the C-POC.

Service providers follow MCO SA process.

Expansion

CC follows Managed Care Organization (MCO) Service Authorization (SA) process.

Follow MCO SA process.

NO

MCO authorizes CC service which also acknowledges C-POC approval?

YES

CC forwards approved C-POC to all service providers on the C-POC.

Service providers follow MCO SA process.

NO

MMIS generates denial letter and right to appeal to CC provider and individual.

NO

C-POC and/or SA is revised; C-POC and SA are re-submitted by CC provider OR process ends.
This process is completed when an individual’s 1915(i) eligibility ends OR a member’s Traditional Medicaid changes to Medicaid Expansion.

Service providers check individual’s 1915(i) eligibility and Traditional Medicaid eligibility before providing services.

- Individual’s 1915(i) eligibility ends or the individual’s Traditional Medicaid changed to Expansion?
  - NO: Continue providing services.
  - YES: Service provider informs each of the other providers on Comprehensive Plan of Care (C-POC) of change.

If 1915(i) eligibility ended, no services can be provided and process ends.

If Traditional Medicaid changed to Expansion, Care Coordinator submits the C-POC to Managed Care Organization (MCO).

MCO service authorization process is implemented for the new 1915(i) Expansion member.
This process is completed when individual’s Medicaid Expansion changes to Traditional Medicaid.

- Service providers check individual’s 1915(i) eligibility and Medicaid Expansion eligibility before providing services.

  - Individual’s Medicaid Expansion changed to Traditional?
    - NO: Continue providing services.
    - YES: Service provider informs each of the other providers on Comprehensive Plan of Care (C-POC) of change.
      - Service providers implement Managed Care Organization’s (MCO) process to cancel existing Service Authorizations (SA).
      - When the member’s Medicaid status has changed from Expansion to Traditional, Care Coordinator (CC) submits new SA and C-POC to State via MMIS for authorization.

        - C-POC and/or SA is revised; C-POC and SA are re-submitted by CC provider OR process ends.
          - MMIS generates denial letter and right to appeal to CC provider and individual.

    - MMIS generates approval letter to CC provider and individual.
      - CC forwards C-POC to all service providers on the C-POC.
        - State authorizes C-POC services?
          - YES: Each service provider submits SA and C-POC to State via MMIS for authorization.
          - NO: SA is revised; C-POC and SA are re-submitted by provider OR process ends.

        - MMIS generates denial letter and right to appeal to CC provider and individual.

    - MMIS generates approval letter to provider and individual.
      - Services begin.
Individual requests a transfer from one Care Coordinator (CC) provider to another.

Sending CC completes the Request for Service Provider form and sends to the receiving CC along with the most recent Comprehensive Plan of Care (C-POC).

The receiving CC must sign the Request for Service Provider form within 2 business days.

Receiving CC accepts transfer?

The receiving CC updates the C-POC with receiving CC information.

Individual's Medicaid: Traditional or Expansion?

Receiving CC follows Managed Care Organization service authorization process.

Receiving CC submits a Service Authorization (SA) and updated C-POC to State via MMIS.

State authorizes receiving CC?

Traditional

MMIS generates approval letter to receiving CC and individual.

Receiving CC has 5 business days to schedule an initial meeting with the individual.

SA is revised; C-POC and SA are re-submitted by receiving CC OR process ends.

Expansion

MMIS generates denial letter and right to appeal to receiving CC and individual.

Receiving CC must inform sending CC of denial within 2 business days.

Member chooses another CC provider.

Receiving CC informs sending CC of denial.

Services begin.

This process is completed when a individual transfers from one care coordinator provider agency (sending) to a different care coordinator provider agency (receiving).
Individual requests a transfer from one service provider agency to another.

Care Coordinator (CC) completes the Request for Service Provider form and sends to the sending and receiving provider.

The receiving provider must sign the Request for Service Provider form within 2 business days and send to the CC and sending provider.

Member choices another provider.

Receiving service provider informs CC and sending service provider of denial.

The receiving provider accepts transfer?

NO

Receiving service provider informs CC and sending service provider of denial.

YES

CC updates the Comprehensive Plan of Care (C-POC) with receiving provider information and sends to receiving provider.

Individual's Medicaid: Traditional or Expansion?

Traditional

The receiving provider submits a Service Authorization (SA) and C-POC to State via MMIS.

State authorizes receiving provider?

YES

Traditional

The receiving provider submits a Service Authorization (SA) and C-POC to State via MMIS.

State authorizes receiving provider?

YES

MMIS generates approval letter to receiving provider and individual.

Receiving provider has 5 business days to schedule an initial meeting with the member.

Services begin.

NO

Expansion

Receiving provider follows Managed Care Organization service authorization process.

Expansion

Receiving provider follows Managed Care Organization service authorization process.

State authorizes receiving provider?

NO

Receiving provider must inform CC of denial within 2 business days.

MMIS generates denial letter and right to appeal to receiving provider and individual.

Receiving provider must inform CC of denial within 2 business days.

Services end.

MMIS generates denial letter and right to appeal to receiving provider and individual.

MMIS generates denial letter and right to appeal to receiving provider and individual.

SA is revised; C-POC and SA re-submitted by receiving provider OR process ends.

This process is completed when an individual transfers from one service provider agency (sending) to a different service provider agency (receiving).
There is a change in service(s) based on need.

Care Coordinator (CC) updates the change(s) in service(s) on the Comprehensive Plan of Care (C-POC) and sends to service provider(s) with the change(s).

Individual Medicaid: Traditional or Expansion?

- **Traditional**
  - Service provider(s) submit a new Service Authorization (SA) to match C-POC. SA and C-POC are submitted to State via MMIS with a comment referencing the prior SA number and indicating change(s) in service.

  - State authorizes service(s)?
    - YES: MMIS generates approval letter to provider and individual. Services begin.
    - NO: MMIS generates denial letter and right to appeal to provider and individual. Provider is to inform CC of denial within 2 business days.

  - MMIS generates denial letter and right to appeal to provider and individual. Provider is to inform CC of denial within 2 business days.

- **Expansion**
  - Service provider(s) follow Managed Care Organization service authorization process.

This process is completed when there is a change in service name, amount, frequency, or duration on the POC.
This process is completed when there is a request for a service to exceed the maximum service limit.

Care Coordinator (CC) updates the Comprehensive Plan of Care (C-POC) to increase service(s) and includes justification for exceeding the limit.

Individual Medicaid: Traditional or Expansion?

Traditional

CC submits updated C-POC to State via email at nd1915i@nd.gov referencing service(s) that will exceed limit.

State approves request?

YES

State submits HEAT ticket to allow for excess service.

NO

State informs CC of denial.

C-POC is revised and re-submitted by CC OR process ends.

NO

Expansion

Follow Managed Care Organization process.

State informs CC when HEAT ticket is complete.

CC sends updated C-POC to service provider exceeding limit and informs them HEAT ticket is completed.

Provider exceeding the limit submits Service Authorization (SA) and updated C-POC to State via MMIS with a comment referencing the prior SA number and indicating increase in service.

MMIS generates denial letter and right to appeal to provider and individual.

State authorizes service?

YES

Services begin.

NO

State informs CC when HEAT ticket is complete.

Provider is to inform CC of denial within 2 business days.

SA is revised; C-POC and SA are re-submitted by provider or process ends.

Individual Medicaid: Traditional or Expansion?