

PROVIDER BULLETIN

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HOME AND COMMUNITY BASED SERVICES CARE PLAN CHANGES

- CARE PLAN CHANGES IN WEB TOOL

AUTHORIZATION OF CARE PLAN CHANGES IN HOME AND COMMUNITY BASED SERVICES WEB TOOL

Effective immediately, the process for completing authorization changes to existing care plans in the Home and Community Based Services' (HCBS) Web Tool has been revised to help prevent billing errors when care plans require changes on a date other than the first of the month.

When an existing care plan requires a **decrease** in authorized services, Division of Senior and Disability Services' (DSDS) staff will enter the effective date of change in the HCBS Web Tool as the first day of the first month following the date the change is made. This change applies regardless of whether the need for decrease is identified in mid-authorization or at reassessment. This also applies when there is a need for a decrease due to cost cap adjustment.

If there are **no changes** required to the care plan upon reassessment, DSDS staff will enter the effective date of change in the HCBS Web Tool as the first day of the first month following the date of reassessment.

While all efforts will be made to avoid mid-month care plan changes as described above, certain circumstances may require the authorization change to be made during the month. In these circumstances, providers shall not bill more units than the higher of the two authorizations for the month and providers shall not bill for units not delivered. Units billed in excess of the higher of the two authorizations or for services not delivered are subject to recoupment.

DSDS will continue to follow current protocol for care plans when a need for an **increase** is identified during reassessment or following a request for a care plan change. This means the effective date may fall during the middle of the month. When this happens, two authorizations are active at the same time for that month. However, one authorization **ends** on the date prior to the increase and one authorization begins on the date of the increase through the end of the

month. Again, providers must not bill more than the total units of the higher of the two care plan authorizations, and provider shall not bill for units not delivered. Units billed in excess of the higher of the two authorizations or for services not delivered are subject to recoupment.

Provider Bulletins are available on the MO HealthNet Division (MHD) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.mo.gov/mhd/> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the MO HealthNet card or by calling the Provider Communications Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the MO HealthNet ID card.

**Provider Communications Hotline
573-751-2896**