CCC Plus PDN Workflow
CCC Plus Waiver
Transfer Cases

1	Member or Primary Care Giver (PCG) (and in special circumstances the provider) calls the MCO and requests a transfer to another provider. The MCO care coordinator (CC) ensures the Member's choice of provider is honored whenever possible. A list of available providers can be given to the PCG or Member if a new provider has not been chosen.
2	MCO contacts the requested provider to verify the transfer, the new provider's availability to staff the authorized PDN hours, and the start of care date.
3	MCO provides the screening packet (which includes the UAI, DMAS 96 and 97, DMAS 108/109) and a copy of the current or last CMS 485 to the new service provider.
4	New provider submits DMAS 116 (the initial RN Home Visit), start of care date and CMS 485 to MCO within 48 hours of beginning services. The ***CMS 485 must include:*** the new agency/provider information that is receiving the Member; and the physician signature ordering the skilled services. Orders for skilled nursing services will include a specific number of nursing hours per day (i.e., not a range of hours)*.
	Reminders: • If physician is not available to sign the authorization order, the receiving agency/RN may take a verbal order from the physician ordering the PDN services. • If physician is not available to provide a verbal order, the physician's currently signed orders may be used until the new CMS 485 is signed by the physician to avoid delay in access to care. The current orders must be in effect and both service providers must verify the expiration date. • The receiving agency is not permitted to bill for any service rendered until the physician signature is obtained on the new CMS 485 containing their provider information.
5	CC will review the CMS 485 for accuracy. Service Authorization is entered by MCO. MCO provides authorization info to the PDN provider and Member. MCO sends DMAS 225 to DSS when appropriate. *Note: The length of the authorization may vary between the MCO health plans.* Often as points of education, if a CC reviews the CMS 485 they may note that the provider has missing or incomplete orders and should direct the provider to get a supplemental order to the CMS 485 to close that gap. The CC must follow-up to ensure the supplemental order is received. The authorization should not be denied if supplemental orders are needed for the CMS 485, if documentation shows the services are medically necessary.
6	If MCO does not authorize all requested services and hours, appeal rights are provided by the MCO.
7	The MCO care coordinator reassessments will continue according to CCC Plus contract.
8	Service provider home visits and documentation requirements continue according to manual and regulatory requirements.

*Please refer to the 485 provider update for detailed information.