Colorado Utilization Review / Utilization Management

Provider User Guide

Updated 5/5/2021

Overlaps and Timing of Review Types
Children's Extensive Services Waiver
Children's Home and Community-Based Services
In-Home Support Services Review—Standard and Rapid
Consumer-Directed Attendant Support Services Review—Standard and Rapid
Over-Cost Containment Review—Standard and Rapid
PASRR

Effective 3/1/2021

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Purpose

The purpose of this guide is to provide Case Managers (CMs) process and requirement clarification for Home and Community-Based Services (HCBS) Utilization Review/Utilization Management (UR/UM) Reviews submitted to Telligen. It also provides information to review submitters regarding the Qualitrac portal. It will be a quick reference tool for important information about review types and the associated timelines for each.

The first potion of this guide will outline important tips and general information. Specific information for each review type will be outlined in their own sections further into the guide. Lastly, additional resources and Department contacts to help users are provided at the end of this guide.

Background

Telligen began the following UR/UM reviews on March 1, 2021:

- Over Cost Containment (OCC) for the following waivers: Elderly, Blind, and Disabled (EBD), Spinal Cord Injury (SCI), Brain Injury (BI), and Community Mental Health Supports (CMHS)
- Children's Extensive Support (CES) waiver eligibility reviews
- Children's Home and Community-Based Services (CHCBS) waiver eligibility and Cost Containment reviews
- Participant-Directed Programs Health Maintenance Activities (HMA) UR/UM reviews
    - Consumer Directed Attendant Support Services (CDASS) for the following waivers: BI, EBD, SCI, CMHS, and Supported Living Services (SLS)
    - In-Home Support Services (IHSS) for the following waivers: EBD, CHCBS, and SCI.
- Pre-admission Screening and Resident Review (PASRR)

Acronyms List

Acronym	Definition
ASAM	American Society of Addiction Medicine
BD	Business Days
BPS	Biopsychosocial (Comprehensive clinical assessment)
CDASS	Consumer-Directed Attendant Support Services
CES	Children's Extensive Services Waiver
CHCBS	Children's Home and Community Based Services Waiver
CMH	Children's Mental Health Bureau
CSR	Continued Stay Review
Ext Req	Extension Request – another way of saying CSR for specific outpatient services within QT
H&P	History and Physical
IHSS	In-Home Support Services
MH	Mental Health
MI	Mental Illness
OCC	Over Cost Containment
PAR	Prior Authorization Request
PASRR	Pre-admission Screening and Resident Review
PR	Physician Review
PRFT-AS	Psychiatric Residential Treatment Facility Assessment
QT	Qualitrac (Online UM portal)
RFI	Request for Information
SDMI	Severe and Disabling Mental Illness
SED	Severe Emotional Disturbance
SUD	Substance Use Disorder
TAT	Turn Around Time
UM	Utilization Management
UR	Utilization Review

Important Tips

When to submit for HMA Reviews

Case managers (CMs) are required to submit all PARs that include HMA to Telligen for approval. This includes all initial IHSS or CDASS reviews with HMA requested; Continued Stay Reviews (CSRs) with PARs that include HMA; and PAR revisions that include increases to HMA. The Telligen approved determination letter must be uploaded to the attachments tab prior to submitting the PPA. CMs are not required to submit PAR revisions for Telligen review when decreasing HMA services. The CM should upload the approved determination letter for the PAR being revised to decrease HMA units.

Overlaps and Timing of Review Types

There are times when the HCBS UR/UM Reviews overlap. In these cases, CMs are required to submit separate reviews for each of the review types. When submitting multiple types of reviews at the same time, the CM should notify Telligen through the notes section of the review request, stating what additional reviews have also been submitted. Please include the Case ID of the related review when submitting if possible.

IHSS/CDASS HMA and OCC

When HMA services are added or increased resulting in a cost per day of $285/day or more, an OCC review is required. The CM will submit both an HMA review and an OCC review.

- The HMA review should be completed first, as approval of HMA services might result in the services being OCC limits.
    - The CM can choose to submit both reviews at the same time and add a note in the request about there being two reviews, one HMA and one OCC.
- Both HMA and OCC reviews must be submitted at least annually at the time of Continued Stay Review (CSR).

CHCBS and HMA

When a CM submits an initial CHCBS review and the member plans to utilize IHSS HMA services, the CM will submit both a CHCBS review and an HMA review.

- The CHCBS review should be completed first as the member is not eligible for IHSS HMA services until they have been approved for CHCBS.

    - If the CM intends to request an IHSS HMA review at a later date (after initial CHCBS review), the Cost Containment form included in the initial CHCBS review should not include the IHSS HMA. When the CM is prepared to submit an HMA review, the updated Cost Containment form should be completed and submitted, including the HMA reflecting a +/-$50 daily cost change along with the required documents for the IHSS HMA review. A note indicating that the prior Cost Containment form was submitted for

the CHCBS review should be added with the submission so Telligen's reviewers can reference it as needed.

- If the CM chooses to submit both reviews at the same time, the Cost Containment form should include the HMA services and a note should be added in the request about there being two reviews, one CHCBS and one HMA.

Tips for Submissions for CES, CHCBS, OCC, IHSS, CDASS

- For reviews submitted in these categories, please use "Concurrent" for any reviews that have a Requested Certification Start Date prior to the date the review is entered into Qualitrac. For those that have a Requested Certification Start Date the same day or after the request is submitted, please use "Prospective".
- Selecting Providers for non-PASRR reviews: Please select your case management agency for both Treating Provider and Ordering Provider. Also select your case management agency in the Visibility panel to allow other users from your agency to see the reviews you submit.
- **IMPORTANT:** Be sure to select the listing of your case management agency that displays the same NPI or Other ID that was used to register your agency for Qualitrac. Contact your agency leader if you need this information.

Standard Review vs. Rapid Review

- For OCC, CDASS, and IHSS reviews, a "Standard Review" or "Rapid Review" may be requested. Standard Reviews have a turnaround time of 4 business days, while Rapid Reviews have a turnaround time of 2 business days. Rapid Reviews may only be requested when there is potential for an interruption or disruption in services for the member if a review is not completed within the Standard Review turnaround time.
- If a Rapid Review is requested and the review can be completed prior to the certification start date within the Standard Review turnaround time, Telligen will deny the review request. Telligen will direct the CM to resubmit the review as a Standard Review. If a CM is unsure whether a review request qualifies for a Rapid Review, please reach out to Telligen's Call Center for guidance prior to submitting the review request.

Pre-Prior Authorization (PPA) Screenshot Requirement

- All OCC, CDASS, and IHSS reviews require the CM to submit a screen shot of the PPA from the bridge as part of the documentation required for review. The PPA reflects current and proposed service authorization. Telligen reviews the PPA to determine there is no duplication of services and that the individual's needs and service plan support the costs. Incomplete information will result in an RFI to be issued by Telligen and may lead to a delay in review.

- **It is very important that the "Submit PPA" button is not utilized during this process.** Once the "Submit PPA" button is utilized, the PPA will be submitted as a Prior Authorization Request (PAR) and cannot be revised. The Bridge does not have the functionality to adjust a PAR without completing a service revision. Therefore, services that are submitted in the Bridge must be accurate and have necessary approval prior to clicking on the "Submit PPA" button.
- CMs should only utilize the "Save" button during this process. Any information (such as start dates, units, line items, etc.) can be updated and changed prior to the PPA being submitted. Once the CM obtains an approved determination letter from Telligen for the request, the CM must make any necessary changes to the PPA and upload the determination letter to the attachments tab. The CM then must review the PPA for accuracy and submit by clicking the "Submit PPA" button. In the case of OCC, a supervisor with supervisor credentials is required to complete the PPA submission.

Outcomes

Reconsiderations

CMs may request a "reconsideration" by Telligen within 5 business days of a denial/partial denial of a review. The reconsideration process within Qualitrac is called "Reconsideration/First Level Appeal". Reconsideration is used when denials or partial denials have occurred. Information will be copied from the original request to a new request within the same Case ID. CMs will attach additional documentation to the new review to support the reconsideration of the previous denial. If the CM is unable to obtain additional information required for a reconsideration within the 5-business day timeframe, the CM can resubmit a new request at a future date once additional information is obtained.

Reopens

Reopen is used only for reviews that have a technical denial status. If a Request for Information (RFI) is issued on a review, the CM has 10 business days to provide the requested information. If the CM does not respond to the RFI within 10 business days, a Technical Denial is automatically generated from the Qualitrac system. Once the review has been technically denied, the CM can "reopen" the review once additional information for the RFI is obtained. When reopened, information will be copied from the original request to a new request with the same Case ID.

Appeals

A reconsideration or a reopen is not an official appeal. It does not negate the Department's official appeal process through a Notice of Action (LTC-803). The complete regulations for Recipient Appeals are found at 10 CCR 2505-10 8.057. CMs are required to issue a Notice of Action (LTC-803) for all denials.

Children's Extensive Services Waiver (CES)

CES waiver reviews are conducted by Telligen to determine that the individual meets the additional targeting criteria for eligibility outlined in 10 CCR 2505-10 8.503.30.A.8. CMs submit CES reviews for all Initial enrollments and CSR. The submission should include the completed CES application.

All Case Management Agencies (CMAs) should use the most up to date CES application found on the Long-Term Services and Supports Case Management Tools webpage. Please see OM 19-018 for the updated appendix information. Appendix B Behavioral Interventions is a quick and easy way to document interventions; however, it is not, on its own, sufficient to justify a human intervention in a person-centered manner. For example, – intervention titled "parent vigilance at night" does not adequately describe what type of actual intervention is taking place, what the parents are being vigilant about, what actions are they taking etc. If Telligen receives a review request and there is no additional information in the LOC assessment or application about the specific human interventions that are taking place, Telligen will request additional information from the CM prior to an approval or denial. Numbers associated with the previous version of Appendix B should not be used within the application.

CMs should provide Telligen with any relevant documentation that can inform the review. Third Party documentation regarding behaviors and interventions is no longer required as part of the CES application, however, if the information/documentation is available, the CM should provide it for the review.

Level of Care (LOC) & Targeting Criteria Information for CES Reviews

Both LOC criteria and targeting criteria must be met prior to waiver enrollment. It is possible that a youth attempting to access the CES or CHCBS waiver, may meet LOC criteria, but not meet targeting criteria. In this instance the youth would not be eligible for waiver enrollment. At this time, the contracted entities to evaluate and determine LOC criteria for the CHCBS and CES waivers, prior to waiver enrollment, are CMAs. LOC criteria is assessed using the LOC assessment. CMs are trained to complete and score this assessment which results in the determination of LOC/functional eligibility.

Telligen is trained by the Department to review and ensure the targeting criteria for CES and CHCBS identified in the approved waiver application and the Code of Colorado Regulations (CCR) is met, before waiver enrollment is authorized. Approved CES and CHCBS waiver applications may be reviewed on the Center for Medicare & Medicaid Services (CMS) CMS website or by visiting the Department's website under "Approved HCBS Waiver Documents," where the full text of approved waivers can be reviewed. Regulation regarding Level of Care Screening guidelines for the HCBS-CES and C-HCBS waivers is found at 10 CCR 2505 – 10 8.400. HCBS-CES targeting criteria is found at 10 CCR 2505 – 10 8.503.30 under Client Eligibility. C-HCBS targeting criteria is found at 10 CCR 2505 – 10 8.506.6 under Client Eligibility.

The start date for services shall not be prior to the submission date to Telligen for CES and CHCBS reviews.

Review Type in QT	Children's Extensive Services Waiver
Place of Service	Community
Type of Service	Home and Community Based Services
Timing	Prospective, Concurrent
Selecting Providers	Select your case management agency for both Treating Provider and Ordering Provider. Also select your CMA in the Visibility Panel. ***Be sure to select the listing of your agency that shows the same NPI or Other ID that was used to register for Qualitrac.***
Suggested Procedure Code	H2014: Community HCBS Habilitation
Examples of clinical documentation to support PA criteria	**Required:** • ULTC 100.2 **(**can be accessed in the BUS by reviewers - upload to Qualitrac optional) • PMIP (initial only) • CES Application **Optional:** • Clinical Notes • Other Documents demonstrating need • Therapy Notes • Medical Records • Provider/physician orders/clinical notes/letters and any other supporting documentation • Medication List

Timing of CES Review

TAT for UM review	10 Business Days
TAT for Urgent UM review	10 Business Days
Request for Information Response	10 Business Days
TAT of UM review after RFI submitted	10 Business Days
Outcome of missing RFI	Technical Denial
TAT for UM Appeal/ peer to peer	5 Business Days

Children's Home and Community-Based Services (CHCBS)

CHCBS waiver reviews are conducted by Telligen to determine that the individual meets the additional targeting criteria for eligibility outlined in 10 CCR 2505-10 8.506.6. CMs submit CHCBS reviews for all Initial enrollments and CHCBS Cost Containment reviews when there is a change in the daily cost per day for the individual +/-$50.

For the CHCBS waiver, within the Level of Care (LOC) assessment, CMs shall include information that demonstrates targeting criteria for the CHCBS waiver. This includes identifying elements of the youth's care and/or condition that would demonstrate medical fragility. This can be documented in the activities of daily living narratives, in the demographic summary narrative, and/or by providing additional documentation (medical provider's notes, etc.) to Telligen for review.

Initial enrollment review request should include the Cost Containment form. Telligen has access to the Departments IMS to review the LOC assessment.

A CHCBS Cost Containment review (submitted under CHCBS with a note stating the cost containment review required) is only required upon initial enrollment and any time that a revision to the Cost Containment form results in a +/- $50 change. This change could be the result of additional IHSS HMA hours, significant increase in Case Management services or State Plan Benefits. In an effort to avoid an RFI, please submit previous cost-containment form as well as newly updated cost containment form for comparison.

Regardless of a +/-$50 change in Cost Containment, all CHCBS waiver members who have HMA through IHSS will need to submit an IHSS HMA review to Telligen at CSR.

Approval of the Cost Containment form does not constitute approval of Medicaid reimbursement for authorized services identified within the record.

Quick Reference for HMA (IHSS) and CHCBS

- HMA increases that do not result in a +/- $50, CM submits for HMA review only.
- HMA increases that do result in a +/- $50, CM submits HMA review and CHCBS Cost Containment review.
- HMA decreases that do not result in a +/- $50, CM does not need to submit for any review.
- HMA decreases that do result in a +/- $50, CM submits for CHCBS Cost Containment review only.
- Non-HMA service changes that do not result +/- $50, CM does not need to submit for any review.
- Non-HMA service changes that do result +/- $50, CM submits for CHCBS Cost Containment review only.
- All CSRs that include HMA regardless of changes that have occurred, CM submits HMA review.

Level of Care (LOC) & Targeting Criteria Information for CHCBS Reviews

Both LOC criteria and targeting criteria must be met prior to waiver enrollment. It is possible that a youth attempting to access the CES or CHCBS waiver, may meet LOC criteria, but not meet targeting criteria. In this instance the youth would not be eligible for waiver enrollment. At this time, the contracted entities to evaluate and determine LOC criteria for the CHCBS and CES waivers, prior to waiver enrollment, are CMAs. LOC criteria is assessed using the LOC assessment. CMs are trained to complete and score this assessment which results in the determination of LOC/functional eligibility.

Telligen is trained by the Department to review and ensure the targeting criteria for CES and CHCBS identified in the approved waiver application and the Code of Colorado Regulations (CCR) is met, before waiver enrollment is authorized. Approved CES and CHCBS waiver applications may be reviewed on the Center for Medicare & Medicaid Services (CMS) CMS website or by visiting the Department's website under "Approved HCBS Waiver Documents," where the full text of approved waivers can be reviewed. Regulation regarding Level of Care Screening guidelines for the HCBS-CES and C-HCBS waivers is found at 10 CCR 2505 – 10 8.400. HCBS-CES targeting criteria is found at 10 CCR 2505 – 10 8.503.30 under Client Eligibility. C-HCBS targeting criteria is found at 10 CCR 2505 – 10 8.506.6 under Client Eligibility.

The start date for services shall not be prior to the submission date to Telligen for CES and CHCBS reviews.

Review Type in QT	Children's Home and Community Based Services
Place of Service	Community
Type of Service	Home and Community Based Services
Timing	Prospective, Concurrent
Selecting Providers	Select your case management agency for both Treating Provider and Ordering Provider. Also select your CMA in the Visibility Panel. ***Be sure to select the listing of your agency that shows the same NPI or Other ID that was used to register for Qualitrac.***
Suggested Procedure Code	H2014: Community HCBS Habilitation
Examples of clinical documentation to support PA criteria	**Required:** • ULTC 100.2 (can be accessed in the BUS by reviewers - upload to Qualitrac optional) • PMIP (initial only) • CHCBS Cost Containment Form **Optional:** • Therapy Notes • Medical Records • Medication List

Timing of CHCBS Review

TAT for UM review	10 Business Days
TAT for Urgent UM review	10 Business Days
Request for Information Response	10 Business Days
TAT of UM review after RFI submitted	10 Business Days
Outcome of missing RFI	Technical Denial
TAT for UM Appeal/ peer to peer	5 Business days

In-Home Support Services (IHSS) Review

Telligen conducts Utilization Review/Utilization Management (UR/UM) activities for IHSS and CDASS authorizations requesting skilled health maintenance activities (HMA). This new UR/UM review process includes a review of all Prior Authorization Requests (PARs) that include HMA for CDASS and IHSS. The last step of authorizing IHSS and CDASS services that include HMA is to submit a request for review to Telligen to determine there is no duplication of services, appropriate level of service is authorized to meet the care needs, and the individual's needs and/or service plan support the costs.

Review Type in QT	IHSS
Place of Service	Community
Type of Service	Home and Community Based Services
Timing	Prospective, Concurrent
Selecting Providers	Select your case management agency for both Treating Provider and Ordering Provider. Also select your CMA in the Visibility Panel. ***Be sure to select the listing of your agency that shows the same NPI or Other ID that was used to register for Qualitrac.***
Suggested Procedure Code	99509: Home visit for assistance with activities of daily living and personal care
Examples of clinical documentation to support PA criteria	**Required:** • ULTC 100.2 (can be accessed in the BUS by reviewers - upload to Qualitrac optional) • IHSS Care Plan Calculator • IHSS Agency Plan of Care • Screen shot of PAR (prior to PPA submission) • Signed and completed LTHH PAR if applicable (for LTHH) • LTHH Agency 485 and plan of care (for LTHH) **Optional:** • PDN Plan of Care and schedule • Verification of exercise Plan • Therapy Notes • Medical Records • Previous service plans including previous provider agency care plan and/or previous Consumer Directed Service task worksheet • Comparative data on similar individuals if available. • Provider/physician orders/clinical notes/letters and any other supporting documentation • Medication List

Timing of IHSS Standard Review

TAT for UM review	4 Business Days
TAT for Urgent UM review	4 Business Days
Request for Information Response	10 Business Days
TAT of UM review after RFI submitted	4 Business Days
Outcome of missing RFI	Technical Denial
TAT for UM Appeal/ peer to peer	5 Business Days

Timing of IHSS Rapid Review

Documentation requirement	Must include reason rapid review is being requested
TAT for UM review	2 Business Days
TAT for Urgent UM review	2 Business Days
Request for Information Response	10 Business Days
TAT of UM review after RFI submitted	2 Business Days
Outcome of missing RFI	Technical Denial
TAT for UM Appeal/ peer to peer	5 Business Days

Consumer-Directed Attendant Support Services (CDASS) Review

Telligen conducts Utilization Review/Utilization Management (UR/UM) activities for IHSS and CDASS authorizations requesting skilled health maintenance activities (HMA). This new UR/UM review process includes a review of all Prior Authorization Requests (PARs) that include HMA for CDASS and IHSS. The last step of authorizing IHSS and CDASS services that include HMA is to submit a request for review to Telligen to determine there is no duplication of services, appropriate level of service is authorized to meet the care needs, and the individual's needs and/or service plan support the costs.

Review Type in QT	CDASS
Place of Service	Community
Type of Service	Home and Community Based Services
Timing	Prospective, Concurrent
Selecting Providers	Select your case management agency for both Treating Provider and Ordering Provider. Also select your CMA in the Visibility Panel. **Be sure to select the listing of your agency that shows the same NPI or Other ID that was used to register for Qualitrac.**
Suggested Procedure Code	99509: Home Visit for assistance with activities of daily living and personal care
Examples of clinical documentation to support PA criteria	**Required:** • ULTC 100.2 (can be accessed in the BUS by reviewers - upload to Qualitrac optional) • CDASS Task Worksheet • CDASS Monthly Allocation Worksheet • Screen shot of PAR (prior to PPA submission) **Optional:** • Verification of exercise Plan • Medical Records • Provider/physician orders/clinical notes/letters and any other supporting documentation • Medication List

Timing of CDASS Standard Review

TAT for UM review	4 Business Days
TAT for Urgent UM review	4 Business Days
Request for Information Response	10 Business Days
TAT of UM review after RFI submitted	4 Business Days
Outcome of missing RFI	Technical Denial

TAT for UM Appeal/ peer to peer	5 Business Days

Timing of CDASS Rapid Review

Documentation requirements	Must include reason rapid review is being requested
TAT for UM review	2 Business Days
TAT for Urgent UM review	2 Business Days
Request for Information Response	10 Business Days
TAT of UM review after RFI submitted	2 Business Days
Outcome of missing RFI	Technical Denial
TAT for UM Appeal/ peer to peer	5 Business Days

Over-Cost Containment (OCC) Review

The OCC review is required when the average daily cost of HCBS and LTHH services exceeds $285/day for the EBD, BI, CMHS, and SCI waivers. Telligen is the designated reviewer for OCC. The review is conducted to ensure there is no duplication of services and the services requested reflect the needs identified in the LOC. If a member's OCC PPA contains HMA, a separate HMA review shall be conducted and approved by Telligen prior to OCC review submission. Should a revision of the service plan increase the cost per day to $285 or higher, an OCC review shall be submitted prior to revised services being authorized.

Review Type in QT	Over-Cost Containment
Place of Service	Community
Type of Service	Home and Community Based Services
Timing	Prospective, Concurrent
Selecting Providers	Select your case management agency for both Treating Provider and Ordering Provider. Also select your CMA in the Visibility Panel. ***Be sure to select the listing of your agency that shows the same NPI or Other ID that was used to register for Qualitrac.***
Suggested Procedure Code	H2014
Examples of clinical documentation to support PAR criteria	**Required for all reviews:** • ULTC 100.2 (can be accessed in the BUS by reviewers - upload to Qualitrac optional) • Screen shot of PAR (prior to PPA submission) signed by CM Supervisor **CDASS Specific Requirements** • CDASS Task Worksheet • CDASS Monthly Allocation Worksheet • If applicable, HMA Review Case ID **IHSS Specific Requirements** • IHSS Care Plan Calculator • IHSS Agency Plan of care • If applicable, HMA Review Case ID **PDN Specific Requirements** • PDN Plan of Care and schedule **LTHH Specific Requirements** • LTHH Signed and completed LTHH PAR if applicable

	• LTHH Agency 485 and plan of care **Optional:** • Therapy notes • Medical Records • Previous service plans including previous provider agency care plan and/or previous Consumer Directed Service task worksheet • Provider/physician orders/clinical notes/letters and any other supporting documentation • Medication List

When OCC approval has been obtained from Telligen, the CM shall attach the OCC approval letter and the HMA approval letter, if applicable, to the PAR in Bridge prior to submission of the PPA. If the PAR indicates "Pending State Approval" for longer than 10 business days, CMs may email LTSSOCC@STATE.CO.US requesting the PAR to be approved at the State level.

Timing of OCC Standard Review

TAT for UM review	4 Business Days
TAT for Urgent UM review	4 Business Days
Request for Information Response	10 Business Days
TAT of UM review after RFI submitted	4 Business Days
Outcome of missing RFI	Technical Denial
TAT for UM Appeal/ peer to peer	5 Business Days

Timing of OCC Rapid Review

TAT for UM review	2 Business Days
TAT for Urgent UM review	2 Business Days
Request for Information Response	10 Business Days
TAT of UM review after RFI submitted	2 Business Days
Outcome of missing RFI	Technical Denial
TAT for UM Appeal/ peer to peer	5 Business Days

PASRR

As of 3/1/2021, please create all requests for PASRR reviews in Qualitrac (www.myqualitrac.com). Previously used PASRR Level 1 screening forms (PAL/PAS) will not be accepted via secure email/fax. ONLY supporting documentation for PASRR Level 1 reviews already created in Qualitrac may be submitted by secure email/fax when the user is unable to upload to Qualitrac. Please inform a Telligen team member if/when you cannot submit to the portal. If you send your supporting documentation via fax or secure email, please include the following information:

1. Date
2. Submitter First Name and Last Name
3. Submitter Organization
4. Submitter Phone
5. Submitter Email Address
6. Qualitrac Case ID
7. Type of documentation being submitted: H&P and/or Medication List

Fax: 720-554-1747

Email: ColoradoReviews@telligen.com

Review Type in QT	PASRR Level 1
Place of Service	Nursing Facility
Type of Service	Long Term Care
Timing	Prospective, Concurrent
Suggested Procedure Code	T2010
Examples of clinical documentation to support PA criteria	**Required:** • H&P or other documentation of physical review of systems and vitals from within the last 6 months • Current Medication List

Timing of PASRR Review

TAT for UM review	6 Business Hours
TAT for Urgent UM review	6 Business Hours
Request for Information Response	5 Business Days
TAT of UM review after RFI submitted	6 Business Hours
Outcome of missing RFI	Technical Denial
TAT for UM Appeal/ peer to peer	N/A

Additional Resources

- HMA Documentation Guide
- Telligen Training Links
- Long-Term Services and Supports Case Management Tools
- HCPF Memo Series can be accessed online: https://www.colorado.gov/hcpf/memo-series
- Example of PPA for Review Submission (attachment)

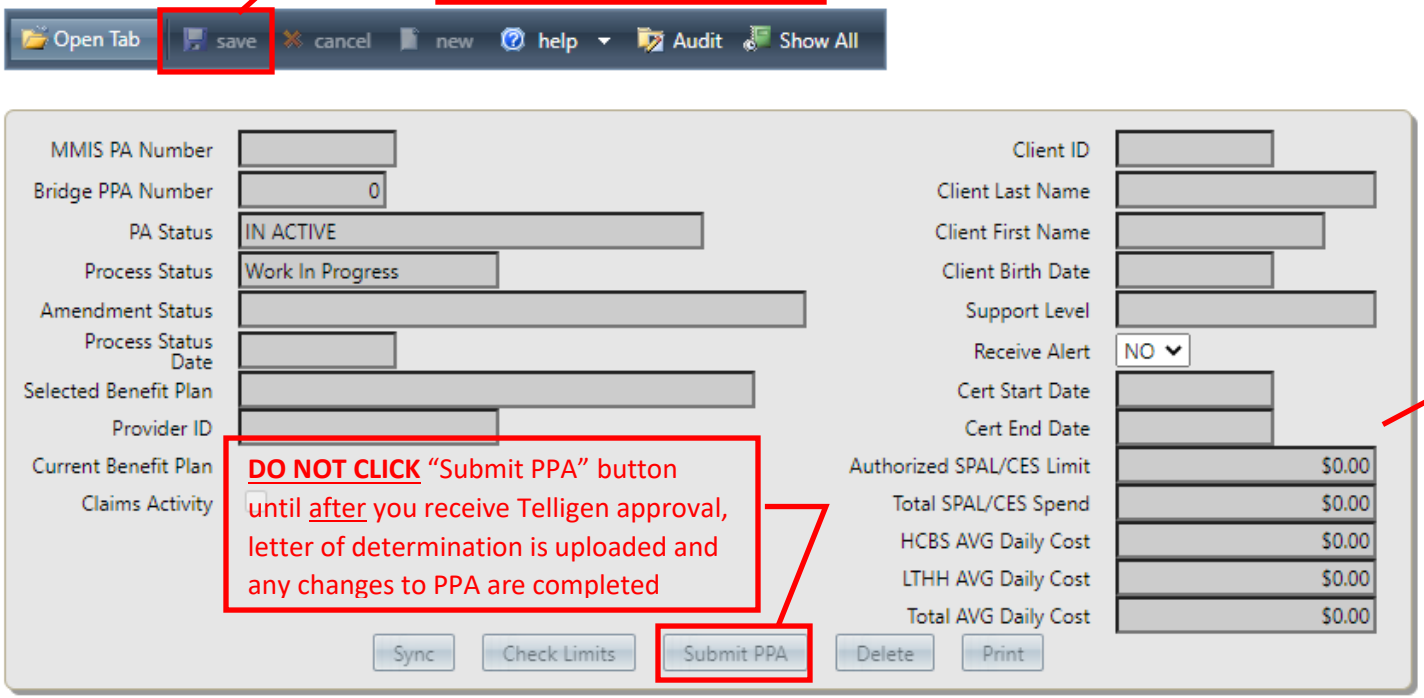
Department Contact

All email communications to the following email in boxes should include "Telligen" or "UR/UM" in the subject line to ensure timely response by the Department.

- Over Cost Containment: LTSSOCC@state.co.us
- Participant Directed Programs: HCPF_PDP@state.co.us
- CHCBS and CES: HCBS_HCBS_Questions@state.co.us

Sample PPA Screen Shot for Review Purposes

Save button should be used while awaiting review determination from Telligen



DO NOT CLICK "Submit PPA" button until after you receive Telligen approval, letter of determination is uploaded and any changes to PPA are completed

Screenshot must include the Daily Cost Information

Base Information | Line Item | Attachments | CDASS Allocation | Claim List | External Text | Internal Text | Messages

Line	Status	Service Description	Units	Dollars	Eff Date	End Date
01	APPROVED	T1019 -PERSONAL CARE SER PER 15 MIN U1	2066.000	$10,701.88	05/22/2020	07/21/2020
02	APPROVED	T1019 -PERSONAL CARE SER PER 15 MIN U1	17843.000	$92,426.74	07/22/2020	04/30/2021

Screenshot must show all line items