COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

# HCBS-CIH Waiver Case Manager FAQ

*Frequently Asked Questions* *September 2022*

## What is the Home and Community-Based Services Complementary and Integrative Health Waiver (HCBS-CIH)?

The HCBS Spinal Cord Injury Waiver (HCBS-SCI) expanded to the HCBS Complementary and Integrative Health (HCBS-CIH) Waiver in July 2022. The HCBS-CIH Waiver is now available to eligible Coloradoans statewide. To be eligible, members must be 18 years of age or older and living with spinal cord injury, brain injury, cerebral palsy, spina bifida, muscular dystrophy, or multiple sclerosis that affects their ability to walk without a mobility device or support from someone assisting them at all times. Members must also meet financial eligibility (working adult buy-in available), level of care criteria, have a need for HCBS, and cost containment and service adequacy requirements. These regulations are outlined at 10 CCR 2505-10 8.517.5.

For more information about the waiver see the CIH web page, Informational Memo 22-016, and the SCI Waiver Expansion and Name Change FAQ.

## What are HCBS-CIH Services?

HCBS-CIH services include acupuncture, chiropractic, and massage therapy. These services are available through the HCBS-CIH Waiver. CIH Waiver members can access up to 408 (15min) units of these services over a 365-day certification period; however, a member may only receive 204 units of a single service. CIH service providers recommend the modality, frequency and scope of treatment related to the HCBS member's qualifying condition and inability to ambulate through a complementary and integrative health care plan (CIH care plan). Providers must also follow all general certification standards, conditions, and processes established at 10 CRR 2505-10 8.487.

## How do case managers document the targeting criterion for an eligible diagnosis?

An eligible diagnosis for the HCBS-CIH Waiver must be documented on the Professional Medical Information Page. The Colorado Department of Health Care Policy & Financing (Department) created the HCBS-CIH Waiver Eligible Person Targeting Criteria Guide for guidance.

If a case manager or member has further questions about broad diagnosis related to a qualifying condition, the member should work with their physician to document the most accurate ICD code that indicates spinal injury, brain injury, multiple sclerosis, spina bifida, muscular dystrophy, or cerebral palsy on the PMIP. They should then communicate with their case manager about this diagnosis.

## How do case managers document the "inablity for independent ambulation directly resulting from a qualifying diagnosis"?

If the member is unable to walk without assistance from a medical device or requires at least "touch assistance" from another person at all times because of their qualifying diagnosis, then the member meets targeting criteria for the HCBS-CIH Waiver. The member's inability for ambulation resulting from a qualifying diagnosis should be documented in the ULTC 100.2 Mobility ADL section. Example: "The member requires assistant from a medical device or person to walk at all times and their inability for independent ambulation directly results from their qualifying diagnosis documented on the PMIP."

## What is considered a mobility device?

A mobility device is equipment used to assist a person's mobility, like canes or walkers. Similar devices like prosthetics that support the member's ability to independently ambulate would be considered a mobility device. Permanent structures such as walls or furniture would only be used in temporary situations and would not be considered a mobility device.

## Does a score of "2" in the Mobility section of activities of daily living (ADLs) meet the HCBS-CIH targeting criterion of inability for independent ambulation?

The Level of Care (LOC) assessment and ADL mobility scoring ***are not part of the targeting criteria for HCBS-CIH Waiver***. Keep in mind that determining Level of Care and determining whether someone meets Targeting Criteria can overlap but they are two distinct processes. So, while responses from the LOC can inform the targeting criteria determination, you may still need to ask follow-up questions to determine if targeting criteria are met.

## What transportation is available for HCBS-CIH services?

Members may use Non-Medical Transportation (NMT) to access HCBS-CIH services. NMT services must be prior authorized by the case manager. Information on HCBS Non-Medical Transportation can be found on the NMT webpage. If a member needs additional NMT trips to CIH Services, please use this additional NMT request form before adding to the PAR. Members will work with their local NMT provider to set up transportation to and from CIH appointments for authorized services.

## What happens if a HCBS-CIH Waiver prior authorization request (PAR) is over cost containment?

HCBS-CIH Waiver PARs fall under all the same cost containment procedures, timelines, and regulations as the HCBS Elderly, Blind, and Disabled (HCBS-EBD) waiver. Case managers must ensure the need for these services and support is clearly documented. Rules and Regulations pertaining to cost containment on the HCBS-CIH Waiver can be found at 8.517.5.F COST CONTAINMENT AND SERVICE ADEQUACY. For more information surrounding the Over Cost Containment process, please review the UM Provider User Guide found on the LTSS Training webpage.

## How do case managers work with CIH providers?

Case managers play a vital role in the success of members receiving acupuncture, chiropractic, and massage therapy by working with providers to coordinate PARs, connect members to providers, and follow up with providers as a member's needs change.

During the support planning process for HCBS-CIH services, case managers will receive an HCBS-CIH Care Plan from each CIH provider. Providers will contact case management agencies to confirm the member is enrolled in the CIH Waiver, the member's certification date, and where to send the completed HCBS-CIH Care Plan. Providers will then complete an intake with the member (either in person or virtually) and send a completed HCBS-CIH Care Plan to the case manager. HCBS-CIH services may then be added to a member's PAR as recommended on the HCBS-CIH Care Plan and agreed to by the member. Once the case manager has completed the support planning process, please make sure the provider reviews the signed statement of agreement, and receives a copy of the current PAR.

As HCBS-CIH service providers enroll, the Department will notify local case management agencies. Case Managers may refer members to CIH providers by directing them to the HCBS-CIH webpage or HCPF Find a Provider Tool. They are also welcomed to keep an internal directory of providers in their area and who is taking patients.

## What is the Home and Community Based Services Complementary and Integrative Health Care Plan (HCBS-CIH Care Plan)?

The HCBS-CIH Care Plan is a required form that documents the recommendation of HCBS-CIH service provider(s) of the appropriate frequency, scope, and duration of the service they are providing as required by 10 CCR 2505-10 8.517.11.D. Providers will submit a completed and signed HCBS-CIH Care Plan to the member's Case Manager to use in the support plan process. Providers may recommend frequency, scope, and duration of services for the entire certification period regardless of remaining time in the certification period. No more than 204 (15 min) units of a single service or 408 (15min) units total can be authorized. Once authorized, CIH service units may be used at any time during the certification period.

## What if a case manager or member knows of an interested acupuncturist, chiropractor, or massage therapist?

If a case manager or member knows of qualified acupuncture, massage therapy, and/or chiropractic providers interested in enrolling as a CIH waiver provider, please encourage them to read the Complementary and Integrative Health Services Guide. Information for providers may also be found on the provider enrollment webpage. For further questions, providers can contact the Provider Services Call Center at 1-844-235-2387.

## Will CBMS, BUS, interChange or Bridge reflect the waiver name change?

The use of the term "the SCI Waiver" will be retained in the Benefits Utilization System (BUS), the Colorado Benefits Management System (CBMS), the Bridge, and eligibility verification/benefit plan information maintained in the Colorado interchange Medicaid Management Information System (MMIS) until the new Care and Case Management system goes live. The Department will send out further information as system changes occur.

## For more information contact

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