COLORADO
Department of Health Care Policy & Financing

INFORMATIONAL MEMO

TITLE:	**OVER COST CONTAINMENT PROCESS AND EXPECTATIONS**
SUPERSEDES NUMBER:	**N/A**
EFFECTIVE DATE:	**DECEMBER 17, 2019**
DIVISION AND OFFICE:	**BENEFITS AND SERVICES MANAGEMENT DIVISION, OFFICE OF COMMUNITY LIVING**
PROGRAM AREA:	**OVER COST CONTAINMENT**
KEY WORDS:	**OVER COST CONTAINMENT, EQHEALTH, HCBS**
INFORMATIONAL MEMO NUMBER: HCPF IM 19-069 **ISSUE DATE: DECEMBER 17, 2019** **APPROVED BY: CANDACE BAILEY**	

HCPF Memo Series can be accessed online: https://www.colorado.gov/hcpf/memo-series

Purpose and Audience:

The purpose of this Informational Memo is to outline the Over Cost Containment (OCC) review process for specific Home and Community Based Services (HCBS) waivers and direct case managers of expectations with this process.

Background:

Beginning December 2018, eQHealth became the Department of Health Care Policy & Financing's (Department) designated reviewer for Over Cost Containment (OCC) requests. Case Managers must create an account in the eQSuite to submit a request. Below is an overview of the process and expectations of case managers. For more information regarding OCC processes, please referrer to prior Memo Series OM 19-001 and IM 19-025.

Information/Procedure:

Over Cost Containment (OCC) is a review of requested Home and Community Based Services (HCBS) and Long-Term Home Health (LTHH) services. A review by the Department, or its designated reviewer, is required when the average daily cost of

HCBS and LTHH services is $285 or more for the Elderly, Blind and Disabled (EBD), Brain Injury (BI), Community Mental Health Supports (CMHS), and Spinal Cord Injury (SCI) waivers. The review is conducted to ensure there is no duplication of services and the services requested reflect the needs identified in the ULTC 100.2 assessment.

Requirements

When submitting an OCC review request, the case manager must submit a copy of the Prior Authorization Request (PAR), including the service line items and units requested. Please refer to the attachment for an example of what should be sent. A copy of the Bridge Service Plan is not sufficient. Incomplete information may lead to a denial. Along with the copy of the PAR, case manager shall include the below additional information for the following areas:

- Consumer-Directed Attendant Support Services (CDASS)
  - PAR (dummy PAR or screenshot from the Bridge)
  - Task worksheet and explanation of allocated time
  - Allocation worksheet
  - Doctor orders, and any other supporting documentation

- In-Home Support Services (IHSS)
  - PAR (dummy PAR or screenshot from the Bridge)
  - Agency care plan
  - IHSS calculator
  - Doctor orders, and any other supporting documentation

- LTHH
  - Signed and completed LTHH PAR
  - Agency 485 and plan of care
  - Physician Orders

Approval Timeline

Initial Assessment

For an initial assessment with a subsequent OCC PAR developed during service planning, it is advised case managers submit the OCC review request as soon as possible. The Department is aware the submission date to eQHealth for these OCC requests may be after the initial certification start date.

Continued Stay Review (CSR)

For a CSR, it is advised case managers submit the OCC review request at least one

month prior to the certification start date. If a PAR is pended for an additional information request, that can greatly lengthen the process. A PAR may not be billed against until it has received OCC approval. If the provider is rendering services prior to receiving approval, they do so at the risk of not receiving payment. Providers cannot bill off a dummy PAR or screen shot. Failure to submit an OCC request in a timely manner may result in an individual's service needs not being met and could put the health and welfare of the individual in danger.

If you have completed an Initial Assessment or a Continued Stay Review (CSR), sent the OCC review request to eQHealth, and the PAR start date has already passed, and you have not received approval from eQHealth yet, you must continue to work with eQHealth on the OCC approval process. To facilitate the review, ensure all documentation is provided to eQHealth when the original request is submitted.

- Participants using CDASS are the employer of record for their attendants. They require an approved PAR on file with their FMS vendor by the 15th of the new certification period for payroll to be completed timely. The case manager must work with eQHealth to review and approve the OCC request before the new certification period/PAR start date. For circumstances where the submission or approval is delayed, and attendant payroll will be impacted, submit the OCC request to eQHealth and request the services to be approved while the review is being completed. Once the determination is completed the case manager will follow up on any changes needed to the services.

- A change in service authorization requires a notice of adverse action (803). If it is determined that the services requested on the PAR are not substantiated by the members assessment and case management documentation, the case manager will be referred to change the services. The member must be sent an 803 which outlines the service change and the members appeal rights. The service level previously authorized for the prior certification span will be continued into the new certification span until the effective date of the 803 is reached. In the event of a timely appeal filed with Office of Administrative Courts, the member can request to continue the current service level until the appeal process is completed.

<u>Denials/Request for more information</u>

One of the most common reasons for a denial is lack of information. As part of the submission, case managers are required to submit all necessary and supporting documentation. This includes a copy of the PAR and additional information as stated above. If eQHealth requests more information than what was included in the original request, the request will be placed in a "Pend Status" until the case manager provides

the necessary information. A case manager must respond to the pended review and provide the additional/requested information in order for eQHealth to complete their review. If the additional information provided to eQHealth is not sufficient and they still need additional information, the request will be denied. The case manager can submit a new request with the additional information if the original request is denied. It is important to note in the request what information was added/revised. If the case manager adds or subtracts time/units to any category after a pend, case managers need to document the rationale and update the assessment with the pertinent information. This can reduce the likelihood of the request once again being placed in "Pend Status".

A denial may be issued because the level of services requested do not meet the needs documented in the ULTC 100.2 assessment. For example: the IHSS Care Plan Calculator lists all skin care as skilled care; however, there is no skin integrity issue or open wounds listed anywhere in the assessment. Therefore, there is not a documented need for skilled skin care. In order to resolve this, either the assessment must be updated to ensure the task meets the definition, or the task can be changed to personal care.

Post-Approval Procedures

Once you have obtained an approval letter from eQHealth for your request, you must upload the approval letter to the attachments tab in the Bridge, prior to a supervisor completing the submit PPA. Once completed, submit the PAR in the Bridge. If you have keyed the PAR and submitted it to the InterChange and the status shows as "Pending State Approval", "Suspended" or "Work in Progress", please send an email to the LTSSOCC@state.co.us with the PAR number and your specific request for assistance. Please write in the subject line of your email "Bridge PAR Assistance Required". PARs that are pending for state approval that do not have the eQHealth approval letter uploaded will not be approved until completed.

For assistance with a review submission or technical assistance with the Portal, please contact eQHealth:
co.pr@eqhs.org
Customer Service Line 888-801-9355 (toll-free phone)

Attachment(s):

PAR Screenshot Example

Department Contact:

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