Support Level Review Request Desk Guide

August 2022

COLORADO
Department of Health Care Policy & Financing

Introduction

The *Request for Support Level Request Review Form* must be completed by case managers to initiate a Department review of the current Support Level to determine if the member's support needs merit a temporary increase in Support Level. A request is submitted when there is a temporary change in needs requiring a higher level of daily support than what has been established for the member associated with the request. A request can only be initiated by the member, an authorized representative, or the case management agency. The *Request for Support Level Review Form*, when completed as outlined, will provide a comprehensive account of the Member's support needs. This desk guide is intended as reference document explaining the information required on the *Request for Support Level Review* form to ensure the Support Level Review panel has all pertinent information available to make a decision.

Member, Supports Intensity Scale (SIS) & Support Information

The first page of the form provides a snapshot of the Member and serves as the administrative portion of the request. Be sure to include all information and verify accuracy prior to submitting your request.

<table>
<tr><th colspan="4">Member Information</th></tr>
<tr><td>Last Name:</td><td>First Name:</td><td colspan="2">M.I.:</td></tr>
<tr><td>Medicaid ID#:</td><td>SSN:</td><td colspan="2">Date of Birth:</td></tr>
<tr><td colspan="4">Mailing Address:</td></tr>
<tr><td colspan="4">Date of most recent SIS Assessment:</td></tr>
<tr><td colspan="4">Risk Factors Impacting Support Level: ☐ Extreme Safety Risk to Self ☐ Public Safety Risk: Convicted
☐ Public Safety Risk: Non-Convicted ☐ No Risk Factors</td></tr>
<tr><td>Calculated Support Level:</td><td>Current Support Level:</td><td>Requested Support Level:</td><td>Review Type:</td></tr>
<tr><td colspan="4">Support Level 7 Budget Sheet Completed by Provider(s) and Included with Request: ☐ Yes ☐ No ☐ N/A</td></tr>
</table>

Risk Factors Impacting Support Level

Indicate whether the CMA in conjunction with the IDT pursuant to 10 CCR 2505-10 8.612.3[1] has determined that the member meets the definition of Public Safety Risk (Convicted or Non-Convicted) or Extreme Safety Risk to Self and has been documented in the Bridge.

[1] **The Safety Risk Factor Determination Process is outlined in 10 CCR 2505-10.8.612.3.D as follows:** *The CMA in conjunction with the IDT shall make a determination whether a Client meets the definition of Public Safety Risk or Extreme Safety Risk to Self through the following process: 1. The decision shall be made by a case management supervisor. He or she shall: a. Document the rationale to support the decision which shall be kept in the Client's record; b. Document that the Client meets the definition in the Department required data system; and c. Review the Client at least annually or when significant changes occur to assure that the Client continues to meet the definition. 2. At the point when a Client no longer meets the definition, his or her status must be changed in the Department-required data system and his or her Support Level must be re-calculated.*

Calculated Support Level
Provide the member's calculated Support Level under algorithm level (calculated score, including Risk Factors, if applicable). This information can be found within the "Client Information" section in the Bridge.

Current Support Level:
Indicate the Support Level at which the member is currently served. If this is an initial request, this should be the same as the Calculated Support Level. If this is a Re-Exam, the previously approved Override Level should be indicated. If a Support Level Review is still in effect, the Current Support Level can be found under the Override Tab on the "Client Information" section of the Bridge.

Requested Support Level
Indicate the Support Level that the IDT is requesting based on the identified plan to support the member at a higher support level.

Review Type
Select the review type (Initial or Re-Examination) from the drop-down options; select Initial if this is a new SLR request or Re-Examination if the member currently has a Support Level Override in place. When a member is changing waivers and a *Request for a Support Level Review* form is completed, Initial will be selected regardless if there is an approval from a previous waiver.

SL7 Budget Sheet Completed by Provider(s)
Case managers must ensure the *Request Form for Negotiated Level 7 Residential Daily Rate for HCBS-DD* has been completed by the current Residential Habilitation provider and is included when submitting a Level 7 SLR request. If provider(s) associated with a Support Level 7 requests are in place but do not complete this document, it will not be reviewed. For situations in which a request for Support Level 7 is warranted but no providers are in place, you may submit a Request for Support Level Review without the *Request Form for Negotiated Level 7 Residential Daily Rate for HCBS-DD*; however, once a potential provider(s) have been identified, one must be submitted.

Individual Services and Supports Information		
Residential Setting: ☐ Host Home ☐ Group PCA ☐ 3-Bed PCA ☐ Privately Leased/Owned Home ☐ Family Home	HCBS Waiver: Select One	Certification Period Start: End:
Residential Habilitation Agency:	Day Habilitation Agency:	
Other Provider Agency:	Other Provider Agency:	

Individual Services and Supports Information
Indicate the primary residential and/or day habilitation supports in place. If multiple day habilitation agencies or supportive providers are a part of the IDT, specify within "Other Provider Agency" spaces.

Review of Request Form & IDT Planning

The Member, authorized representative, family member, or CMA may request a review of the assigned Support Level in order to adequately meet needs at any time, as appropriate.[2] The Member/authorized representative/family member must be provided an opportunity to review the request prior to submitting request form. **The name in this box must never be a representative of the provider agency; review and approval is obtained from: the individual, legal guardian, authorized rep, or family member.**

Name of individual, legal guardian, authorized representative, or family member that reviewed this information (This information will be used for the decision letter, which is addressed to the individual or their guardian)	
Name:	Relationship:
Email:	Date Reviewed and Approved:
Mailing Address:	

Date Reviewed and Approved
The Date Reviewed and Approved is included to serve as evidence that the Member/ authorized representative was involved and approved the request.

[2] **The Request for Support Level Review planning and submission process is outlined in 10 CCR 2505-10, Sections 8.612.4.A-B as follows:** *The client, his or her legal guardian, authorized representative, family member, or CMA, as appropriate, may request a review regarding the Support Level assigned to meet the client's needs. […] The CMA shall complete the information required by the Department to request that the client's assigned Support Level be reviewed. Prior to submitting the request, the CMA shall provide an opportunity for the client, his or her legal guardian, authorized representative, or family member, as appropriate.*

Case Management Information	
Case Management Agency:	Contact Name:
CM Completing Form:	Date Submitted:
Email:	Phone:

Case Management Information

The CMA must complete the information required by the Department to request that the member's Support Level be reviewed. The Department will only accept requests submitted by a CMA.[3]

Contact Name
Provide the name of the person at your agency that serves as the point of communication for SLR requests.

CM Completing Form
Indicate the Member's assigned Case Manager.

Date Submitted
The exact date the *Request for Support Level Review* form was submitted to the Department's dedicated email inbox.

Email
Indicate the email address to which communication regarding the request should be directed.

[3] **Case Management Agencies are responsible for submitting the Support Level Review Request Form as outlined in 10 CCR 2505-10 8.612.4B. as follows:** *The CMA shall complete the information required by the Department to request that the client's assigned Support Level be reviewed. Prior to submitting the request, the CMA shall provide an opportunity for the client, his or her legal guardian, authorized representative, or family member, as appropriate, to review and provide additional information that will be submitted to the Department.*

Section 1: Interdisciplinary Team (IDT)[4] Information

1. Indicate IDT members who were a part of the Support Level Review planning process; check all that apply.	
☐ Member	☐ Day Habilitation (administration)
☐ Legal Guardian	☐ Day Habilitation (staff)
☐ Parent(s)	☐ Residential Habilitation (administration)
☐ Other Family Member(s)	☐ Residential Habilitation (staff)
☐ Friend(s)	☐ Job Coach
☐ Other Natural Support	☐ Respite Provider
☐ Advocate	☐ Behaviorist
☐ Mentor	☐ Personal Care/Homemaker Staff
☐ Regional Center Admin or Staff	☐ Case Manager
☐ Other:	☐ Other:
If any applicable participants were not involved in the planning process, please explain why.	
Conflict of interest evaluated: ☐ Yes ☐ No	

Participants Not Involved in the Planning Process

The Request for Support Level Review planning process will ideally involve all IDT members, regardless of if they will benefit from an approval. Knowing who participated, as well who did not participate provides additional context in reviewing requests. Be sure to note if a member did not participate in their own planning process and the reasoning for this.

Conflict of Interest Evaluated

The case manager must ensure that the IDT is focused on the Member's needs as they relate to an increased Support Level that would enable them to receive appropriate services and supports, and that the process is not driven by any other factors.

[4] **"Interdisciplinary Team" is outlined 10 CCR 2505-10 Section 8.600.4 as follows:** *[…] a group of people convened by a Community Centered Board which shall include the person receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by such person's needs and preferences, who are assembled in a cooperative manner to develop or review the individualized plan.*

Section 2: Overview of Utilization

2. Provide authorized and utilized waiver services outlined in the Support Plan. Explain any over/under utilization.							
Service	**Utilized**	**Authorized**	**%**	**Service**	**Utilized**	**Authorized**	**%**
Res. Hab.				Homemaker (Enhanced)			
SCC Tier I/II				Homemaker (Basic)			
SCC Tier III				Personal Care			
Spec. Hab. Tier I/II				Mentorship			
Spec. Hab. Tier III				Unit Respite			
Prevocational Services				Per Diem Respite			
Behavioral Assessment				Camp/Group Respite			
Behavioral Consultation				Job Development			
Individual Counseling				Job Coaching			
Group Counseling				Group Supported Emp.			
Behavioral Line Staff				Disposable Supplies			
Hippotherapy				Spec. Med Equipment			
Movement Therapy				Mileage Band			
Massage Therapy				CDASS Health Maintenance			
Personal Emergency Response							

Indicate each service category and associated units authorized on the member's current PAR. Document the number of units utilized to date. Case Managers will need to calculate the percentage of utilization relative to the percentage of the certification period that has elapsed. This will indicate if services are being utilized and the anticipated frequency.

Underutilized & Overutilized HCBS Services

If a Member is enrolling into Waiver services through a discharge process with the Regional Center or other higher levels of care, please identify the anticipated services to be authorized. There are instances when services may be authorized but not implemented according to the plan for various reasons. This applies to both overutilization and underutilization. Address any overutilization and/or underutilization in this section. This serves as a reference point for how needs have changed leading up to the request.

CDASS Utilization

If a Member receiving CDASS services has homemaker or personal care services, use the corresponding rows on the list. Health Maintenance is listed as a separate service, as there is not a corresponding waiver service.

Certification Period & Months Elapsed

Enter the number of months of the certification period along with the number of months that have elapsed. This information must be entered for the utilization percentage to auto-calculate.

Number of Months in certification period:	Number of Months that have elapsed:

Section 3: Overview of Services & Supports

3. Indicate State Plan Benefits currently in place, as well as additional or enhanced supports associated with the increase in care needs. If no State Plan Benefits or Additional Supports are indicated, please explain why.								
State Plan Benefits								
Service	**Temp**	**Ongoing**	**Service**	**Temp**	**Ongoing**	**Service**	**Temp**	**Ongoing**
Private Duty Nursing	☐	☐	Behavioral Health	☐	☐	Specialist I	☐	☐
LTHH	☐	☐	EPSDT	☐	☐	Specialist II	☐	☐
Hospice	☐	☐	Dental	☐	☐	Specialist III	☐	☐
Speech Therapy	☐	☐	Physical Therapy	☐	☐	Occupational Therapy	☐	☐
Additional Supports								
Service	**Temp**	**Ongoing**	**Service**	**Temp**	**Ongoing**	**Service**	**Temp**	**Ongoing**
Exceptional Travel Time	☐	☐	LOS Supervision	☐	☐	CDASS	☐	☐
Specialized Medical Protocols	☐	☐	1:1 Support	☐	☐	Family Caregiver	☐	☐
Specialized Medical Care	☐	☐	2:1 Support	☐	☐	Medication Management	☐	☐
Specialized Non-Medical Training	☐	☐	Awake Overnight Support	☐	☐	Other:	☐	☐
Duplication of services evaluated: ☐ Yes ☐ No								

This section provides an overview of additional supports in place to help the panel understand the case in its entirety. Use this section to note if the member is struggling to find a provider or facing other barriers to access these services. If a Member is enrolling into Waiver services through a discharge process with the Regional Center or other higher levels of care, please identify the anticipated services to be authorized and if they are anticipated to be temporary or ongoing.

NOTE: Temporary supports are the supports associated with the condition leading up to the request; some services may be both "temporary" and "ongoing." Explain how the temporary support is different from the ongoing support that is provided.

State Plan Benefits

Each item listed reflects services and supports that may be available to the Member through their Medicaid State Plan. While primary care is not listed, an overview of any additional medical providers would be indicated as a "specialist." For example, if a Member is diagnosed with uncontrolled diabetes and is associated with the SLR request, he or she may be receiving temporary support from an endocrinologist as well as a nutritionist. These would be indicted as Specialist I and Specialist II, respectively. The narrative would provide information about the service provided by each specialist.

Additional Supports

The items listed under Additional Supports are services or delivery methods that could be associated with waiver services, depending upon the type of support and current waiver. Identifying what is new versus ongoing helps the panel to understand the

situation. Providing this information for SLS service recipients is critical because there may be not a support system to sustain temporary needs if not approved.

Duplication of Services Evaluated
When submitting SLR requests in which complex medical needs are a factor, services through State Plan Benefits may be available that were not initially considered during the support planning process. In cases where the Support Level does not adequately address a member's needs, accessing State Plan Benefits may alleviate the need for an SLR.

Section 4a: Overview of Assessments & Discrepancies

The remainder of the form shifts focus from establishing baseline to creating a case for an increased Support Level. Section #4 is the starting point in establishing a basis for an increased Support Level.

4a. Provide an overview of discrepancies between the SIS Assessment and current ADL/care needs. This summary must **clearly explain** how the circumstances and needs were not properly captured by the SIS Assessment and Support Level determination process.				
Changes in ADL/Daily Care Needs				
☐ Bathing	☐ Dressing	☐ Transfer	☐ Mobility	☐ Receptive Language
☐ Paralysis/Loss of Limb	☐ Psychiatric Care	☐ Behavioral Intervention	☐ Toileting	☐ Expressive Language
☐ Eating	☐ Memory	☐ Decision-Making	☐ Self-Regulation	☐ Planning/Follow-Through
Summary of discrepancies between care needs and SIS Assessment, and why reassessment is not being pursued; if no discrepancies, please explain why:				

The primary objective of submitting a *Request for Support Level Review* is to create a case as to why a Member's daily care needs differ from the algorithm score and how those needs temporarily reflect a higher Support Level. Outside of Exceptional Medical and Behavioral Support, there are three domains that are used in the Support Level algorithm: Home Living, Community Living, and Health and Safety. Use these domains as a framework for articulating changes in daily care needs not captured by the SIS.

- Provide specific information on discrepancies between the ADL needs and the SIS Assessment when completing the first portion of this section;
- Give clear examples of person-specific supports and needs not captured by the SIS Assessment and Support Level determination process;
- Explain clearly why a SIS Reassessment is not being pursued.

Section 4b: Exceptional Need & Factors Impacting Need

4b. Summarize the member's exceptional need and factors impacting need:	
Projected timeline for increased support: __ years __ months	Does this request extend beyond the certification period? ☐ Yes ☐ No

Use this section to summarize interventions needed to meet the needs of the member. This section should include:

- Detailed description of the Member's need(s). Give specific examples of what staff do to support the member, particularly supports that go beyond reminders and verbal prompts;
- Onset date of new diagnosis (if applicable) or changes in condition, and how this has affected the Member's needs;
- Interventions associated with the Member's needs (hands-on assistance, full dependence, supervision and staffing ratios determined by the IDT, Restrictive Procedure, Rights Modifications, intensive instruction/skill building);
- Time dedicated each day/week to meeting person-specific needs;
- Specific details on current and/or significant life changes;
- How pre-existing supports may be enhanced with additional funding.

Clearly document the anticipated duration of the person-specific need. For cases in which the Member's condition is unlikely to improve, an override period beyond one year may be approved. Evidence to support an extended approval period should be presented in this section. Provide a concise answer; ensure that any historical information provided is relevant to the Member's current situation.

Unexpected Medical Needs or Changes to Medical Needs

A request that involves additional support for temporary medical needs is a common occurrence. The primary determining factor is the extent of *exceptional* medical need. For instance, an essential component of Residential Habilitation entails supporting ongoing medical needs. A new diagnosis or temporary injury may or may not be grounds for an SLR request; it is up to the IDT to determine whether the need is above and beyond the norm.

Skill-Building and Transitional Periods

SLR requests are most often associated with debilitating conditions; however, a request may be justifiable if the intent is to develop skills when facing a major life change. Examples of skill-building and transitional support may include but are not limited to:

- transitioning to a less restrictive setting;
- maintaining services in the community when at risk of being in a more restrictive setting; and

- providing targeted support through a formal behavior plan to increase independent skills or extinguish interfering behaviors.

For instance, a request may be justified if the increased funding would be used to support growth when transitioning to an independent living situation. Conversely, an SLR may be appropriate to help someone maintain their living situation if at risk of losing an independent lifestyle in the community. Time, frequency, and duration are the three factors assessed when Section 2 of the SIS assessment is scored. Through a coordinated effort across the IDT, an SLR can be used to make someone's life better if they wish to live a more independent life.

Section 5: Support Planning & Notable Case Developments

5. Provide a summary of steps taken to meet support needs leading up to this request.			
IDT Planning			
Meeting Date(s):			
Critical Incident Reporting (check all that apply, including reports as witness):			
☐ Mistreatment	☐ Abuse	☐ Neglect	☐ Exploitation
☐ Displacement	☐ Death	☐ Criminal Activity	☐ Excessive Property Damage
☐ Emergency Medical Treatment	☐ Medication Management	☐ N/A	☐ Other:
Referrals & Complaints in Past Year:			
☐ APS	☐ RFP	☐ RAE	☐ HCPF Escalations
☐ CDPHE	☐ Advocate	☐ Provider Integrity	☐ New HRC Submission
☐ Community Support Team	☐ Emergency DD Enrollment Request	☐ Medicaid Fraud Control Unit	☐SLS Exceptions Process
☐ Tier 3 Day Hab	☐ Other:		
Summary/Outcomes/Recommendations:			

A concise summary of IDT planning, incidents, referrals, and complaints that are relevant to the request will provide essential context and background.

IDT Planning

Outline the collaborative effort of the IDT and how incidents have impacted the Member:

- Note dates in which the Member and team have met to discuss concerns.
- Outline short-term action steps. Discuss referrals and interactions with other agencies.
- Document the other options that have been exhausted.

Section 6 – Additional Funding Documentation

6. If approved, how will the additional funds be utilized?		
Indicate the nature of the action plan to justify the additional funds for a Support Level increase. (check all that apply)		
☐ Aging Out Transition	☐ Progressive/Neurocognitive Diagnosis	☐ Community Transition
☐ Short-Term Injury/Illness	☐ Long-Term Injury/Illness	☐ Other:

Present a detailed proposal of how additional funds will be utilized to meet needs from a person-specific, person-centered perspective. Give specific information on what action steps will be taken and how success will be measured and determined. Cite which team members will be accountable for meeting these measures of success.

Action Steps
Summarize any new services that will be pursued and/or pre-existing services that will be fortified with additional funding. Outline how these plan changes/new services will be implemented during the override period, and a projected timeline for carrying out the action plan.

Measuring Success, Shared Accountability
Clearly state the end goal(s), and how supports in place will enable the member to meet their goal(s). Provide information on which team member will be responsible for each action step in the plan to help ensure that the objectives of the Request follow the timeline.

Re-Examination Requests
If you are completing a re-examination please give a detailed explanation regarding the overview of progress, additional supports that were put in place, barriers to finding additional supports or meeting the short-term goals in the past year. Give specific details on how a continued Support Level override will be utilized differently to meet the Member's need. If the re-exam indicates that the supports outlined in the previous request were not put in place, address why they were not and whether the previously identified needs were essential. Provide a step-down plan that enables the transition to the assigned Support Level.

Indicate the Nature of the Plan
Aging Out Transition
Pertains to Members transitioning from a children's waiver to an adult waiver.

Progressive/Neurocognitive Diagnosis
Diseases that are progressive or neurocognitive disorders imply the inability to recover. These cases are presented when needs are clearly misaligned with Support Level, but with the potential to decline unpredictably.

Community Transition
Members entering waiver services after a period of institutionalization often require enhanced supervision with a step-down approach.

Short-Term Injury/Illness
There is a clear prognosis and timeline for recovery is within a year.

Long-Term Injury Illness
Prognosis is not clear; these include cases in which a short-term illness becomes complicated by unforeseen circumstances or recovery that fell below expectations.

Other
Any special circumstances outside of the action plans described above.