Office Hours Q&A - Updated February 2024

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* = new / updated information

Terms in use:

IHSS – In-Home Support Services

CDASS – Consumer Directed Attendant Support Services

OCC – Over Cost Containment

CHCBS – Children's Home and Community Based Services

Overlapping Reviews: CDASS+OCC, IHSS+OCC, IHSS+CHCBS

HMA – Health Maintenance Activities (for IHSS, CDASS)

RFI – Request for Information

CES – Children's Extensive Supports Waiver

LTHH – Long Term Home Health

Procedure Codes

Should procedure code 99509 be using minutes instead of units? And what about frequency?

Please refer to the Procedure Codes Modifiers List found on the Utilization Review/Utilization Management (UR/UM) webpage to review the units and qualifiers to be entered. For 99509, the quantity will be 1 unit and the cost field will contain the Total Average Daily Cost as it appears in the Pre-prior Approval PAR. The Total Average Daily Cost includes HCBS and LTHH services. The frequency does not need to be entered.

Why is frequency visible in the Qualitrac portal if it doesn't need to be used when submitting reviews?

Frequency is part of the Qualitrac program. It is used by other states but is not required in Colorado.

Do Case Managers need to calculate the hours to minutes?

Please follow the Procedure Codes and Modifiers list when choosing the Units Qualifier and using either minutes or units. There is a new IHSS Calculator that calculates the minutes for you. It can be retrieved on the Consumer Direct of Colorado (CDCO) webpage under the IHSS Resources tab, then under IHSS Tools and Forms. The CDASS task worksheet already displays both the minutes and hours and can be found on the CDCO webpage under the CDASS Forms tab. Along with the SLS CDASS forms.

How are CDASS codes used? T2025?

When submitting a review in Qualitrac for a PAR that contains CDASS, the HMA minutes must be split off from the non-HMA minutes by using two service lines. The non-HMA (personal care and homemaker) minutes must be captured using the T2025 procedure code with no modifier. The HMA minutes must be captured using the T2025 procedure code with the SC modifier. The non-HMA minutes only need to be submitted with an OCC or CDASS-OCC Overlapping review.

If submitting an HMA request, is only the HMA procedure code needed?

When submitting an HMA review, only the applicable HMA procedure code and the 99509 code are required. The applicable HMA codes can be found in the Procedure Codes Modifiers List.

Does the 99509 code have to be submitted with every review?

The 99509 procedure code must be submitted for all HMA reviews, Over Cost Containment reviews, and Overlapping (CDASS + OCC, IHSS + OCC, or IHSS + CHCBS) reviews. The 99509 code does not need to be submitted with CHCBS only reviews, CES reviews, or SLS Exception reviews.

Note: Outcome Not Rendered will show up for codes where Telligen is not rendering an outcome on that item, such the 99509 procedure code with the Total Average Daily Cost submitted with each review. Telligen must record the requested daily cost but is only providing a determination on the services being requested.

Why are procedure codes being used?

Procedure codes are needed for reporting – they do not affect the review. This data will be shared in upcoming Office Hours meetings.

A short coaching on codes for HMA/OCC: Use 99509 with Total Average Daily Cost (as it appears in the Pre-prior Approval PAR/PAR) in the cost field. Use the Procedure Codes Modifiers List to find units/minutes to enter into the minutes/units field. Use the relevant procedure codes and modifiers in the code list for each request being made.

OCC Reviews: Codes for all services are needed for OCC Only (including overlapping reviews that include OCC)

CDASS/IHSS that are non-OCC do not need codes for non-HMA services.

Outcome Not Rendered – Qualitrac gives outcomes per procedure code, and this will be used on the 99509 code, so it does not affect the overall outcome.

Reminder: Many letters will be partial denials because of multiple procedure codes being used on requests. You don't need to have a letter that says Approved, Partial Denial indicates that at least some services were approved for the procedure code.

Why do case managers get comments that we need to add other procedure codes in addition to the two mentioned?

If the case is OCC, then all codes relevant to the PAR being OCC (they appear in the PAR) need to be entered.

Should the procedure code H2014 for CHCBS be used even if they do not have HMA?

Yes, it should still be used.

Overlapping Reviews

Overlapping reviews include: CDASS + OCC, IHSS + OCC, IHSS + CHCBS.

- CHCBS regulations were revised May 1, 2022, to eliminate cost containment criteria. In the place of CHCBS cost containment reviews, case managers are required to submit annual CHCBS reviews to Telligen to review for waiver targeting criteria. For a child who is on the CHCBS waiver and has IHSS, the CHCBS CSR must either be submitted to Telligen prior to or at the same time as the IHSS HMA review. Each review can be submitted independently or as one review as an IHSS + CHCBS Overlapping review. Both CHCBS and IHSS HMA must be reviewed annually and there are no rapid or express reviews available for IHSS+CHCBS. If submitted separately, the IHSS review may be an Express review if there are no changes from the previous year's IHSS review, however the IHSS request cannot be approved until the CHCBS CSR has been submitted/approved.

The URUM Provider User Guide (Provider Manual) is updated to reflect these changes and is available on the UR/UM webpage.

Is there more information needed when submitting a case for Targeting Criteria review at the CSR for CHCBS?

Any time a review is submitted for targeting criteria, please submit the same information needed for an initial review.

Are PMIPs required for CSR reviews?

A new PMIP is not needed for each review, but case managers must maintain one in the member's file. If the individual was enrolled in CHCBS while PMIPs were not required, one will be needed at CSR so that there is at least one on file. Once a PMIP is on file, no additional PMIPs will be required at future CSRs.

If there is a CHCBS case with IHSS, the IHSS did not change, how should a case management agency submit for this new year with the now required CHCBS review? Can the agency submit for an Express for the IHSS and submit CHCBS separately or should they do a joint CHCBS and IHSS review and show IHSS has not changed?

The case manager has the option to submit either way. They can submit an overlapping CHCBS + IHSS review at the time the CHCBS CSR is happening, or they can submit an Express IHSS review and a standard CHCBS review. If the case manager submits separate reviews, please ensure that a note is added to both related cases to identify they are being submitted concurrently. NOTE: The IHSS request cannot be approved until the CHCBS request has been approved, which can occur at the same time if both are submitted simultaneously.

Are there any plans to add a Rapid IHSS + OCC or a Rapid CDASS + OCC review choice?

Rapid IHSS + OCC and Rapid CDASS + OCC reviews were added to the review options in May 2023.

Recent Review Types added (Rapid and Express for Overlapping):

IHSS + OCC Rapid

IHSS + OCC Express

CDASS + OCC Rapid

CDASS + OCC Express

Express Reviews

Tip Sheet 4 outlines the submission process for Express reviews and is available on the UR/UM webpage.

The Express Review Qualification Attestation Form must be submitted with **all** Express Reviews.

There can be difficulty submitting Express Reviews because the system will not allow for the appropriate dates for the new certification to be entered. What should Case Managers do when this happens and is there a way to prevent it?

As of September 2023, Express Reviews with Concurrent timing can be submitted in Qualitrac with no special process. Dates for the start/end can be selected when submitting.

Exception for Express Reviews: Currently, Qualitrac cannot accept an Express Review (Extension option) on a case that was previously Reconsidered (1st Level Appeal in Qualitrac). In this case only, please submit "Rapid" case for OCC, IHSS, CDASS and include a note stating that Express Review is requested and could not submit using extend feature. Be sure to include all documentation needed for an Express Review.

"Reason for Request" – selecting Express in this dropdown helps Telligen know that you are submitting an Express Review but does not make the request an express review. To be an Express Review, the request must be submitted as an extension (with the exception above for cases where the extension is not available). The Express option in the Reason for Request box will be removed when Qualitrac is updated to allow extensions on previous cases that went to Reconsideration.

Note: A separate Express Review request is needed if separate requests were submitted the previous year (one each for OCC, IHSS and CDASS). Telligen will not be able to approve an Express review for a current submission if a standard or rapid request was not made the previous year.

Express Reviews Requirements and Process:

Documentation to attach:

1. Outcome Letter from previous case being extended. This can be downloaded from the previous case and attach it to the Express Review/Extension. The letter does not automatically attach to extension.

2. Complete Express Review Qualification Attestation form which needs to be completed (4 items) and signed.

3. IHSS Care Plan Calculator or CDASS Task Worksheet with current date. There should be no changes in time requested in the calculators/worksheets. If there were changes, the Express Review is not available, and you should submit a standard or rapid review. You can also choose to submit a new overlapping review.

Note: Most Express Reviews denied are due to missing documentation. The previous outcome letter and attestation are the most common items missing.

For questions or trouble submitting Express Reviews, contact Telligen's support center at:

- Phone: 833-610-1052
- Email: ColoradoSupport@telligensupport.com
    - Include the case ID
    - Do not include any PHI

If case managers are attesting that nothing has changed, why is it necessary to upload a new CDASS Task Worksheet or IHSS Care Plan Calculator for an Express Review?

Submitting the new CDASS Task Worksheet or IHSS Care Plan Calculator is necessary to validate that services have not changed from the previous year. Telligen is responsible for ensuring thorough utilization management reviews are completed and a comparison of the new documents to previous documents serves as a double check that service changes are not being missed. Updated Task Worksheets / Care Plan Calculators are required on an annual basis. It is important that the dates on the updated Task Worksheet / Care Plan Calculator are dated for the upcoming certification period that corresponds to the to the Express Review being completed by Telligen.

Note: Please do not remove any documentation that was added in the original review as it is needed for audits, records, and RFIs. For express reviews it is carried over into the extended request and is needed to complete the express review.

If there only is a Telligen review for HMA and the HMA has stayed the same, is there any give to have that still remain as an express review? What is being reviewed (HMA) has not changed, only potentially other services

If services have changed, that is an indicator that the members' needs have changed. Express reviews are intended only for members who have not had a change in needed services or functioning. If there has been any change to the members' services, a full review must be completed.

Rapid Reviews

How should a case manager submit a Rapid Review?

Rapid reviews can be submitted using the same process as all other reviews. Case managers may select an IHSS Rapid, CDASS Rapid, or OCC Rapid review. Rapid Reviews should be submitted within 12 business days prior to certification start date. Rapid Reviews may be denied, and a standard review requested when submitted prior to the 12-business day allowable review period. Rapid reviews are available to ensure the individual's services are not impacted by the review needing an RFI or Reconsideration. Case managers should try to submit all reviews prior to the Rapid Review period, if at all possible.

Can Rapid Reviews be done for initial reviews?

Yes, Rapid Reviews can be done for initial reviews if there is a set time for the cert date.

Can a rapid review be done for a CES case?

No, CES cases are not currently eligible for a rapid review.

Additional Topics Received

What procedure codes appear on letters?

Each procedure code will have its own section on the outcome letter and will receive an individualized outcome. The 99509 procedure code must be included with each review as it is a general indicator code that is used to capture the Total Average Daily Cost. While required, this code does not receive an outcome and the determination "Outcome Not Rendered" is provided. For all other procedure codes, partial denials are very common and could be for a simple error such as a miscalculation in the minutes/units field. As long as the partially approved units / minutes are the desired outcome, no additional submissions are required.

Are there common errors that can cause cases to be Denied or RFI'd?

Yes, Telligen is seeing some common errors in RFIs which may lead to a case being denied if they are not addressed in an RFI response. Most important is that all service areas should be addressed in the 100.2 and/or in any documentation submitted with the case. This should include a description of the individual's need in that area, what the caregiver is doing (what assistance is being provided), how often the assistance is provided (frequency – on average) and how long it takes (duration – on average). These can be short descriptions, but they should be specific to the person. For example, telling us that the person has a certain diagnosis does not tell us what the need is as people can have the same diagnosis and different abilities. We are looking to the case manager to paint a picture of the person, what they can and cannot do, what hands-on assistance is needed, etc.

Other reasons RFIs are generated is that information or forms may be missing from submissions. If LTHH is involved, the LTHH PAR and the LTHH care plan are needed. For IHSS, an agency care plan (with a current date, the agency name and the individual's name) are needed. For CDASS, an order/prescription for exercise from a qualified medical provider is needed. Case Managers can use UR/UM Provider User Guide to see exactly what is needed for each type of review. UR/UM Provider User Guide . The guide was updated in August 2023, so please be sure you have the latest version.

SLS Exceptions:

When submitting a SLS Exception request, what date should be used in the date of service panel?

The service start date cannot be a retroactive date meaning it has to be in the current month or forward. Requests must be for services to be delivered and cannot be approved for services already completed.

Updated SLS Exception Form should be used effective January 2024. Please go directly to the website each time to download the form in order to ensure the most up to date for is always being used.

Protective Oversight and Accompanying

Updated information is being included in the HMA guide around Protective Oversight and Accompanying. The Department of Health Care Policy and Financing (HCPF) along with Telligen are working on a supplemental document for the HMA documentation guide for Protective Oversight & Accompanying. This should be available soon.

Does Telligen use the same HMA guide?

Telligen uses the same HMA Documentation Guide as case managers.

How should accompaniment be handled for individuals that cannot communicate verbally?

If it is for a client under HMA, the attendant must be providing a skilled task. If it has to do with paperwork or communication, that will go under PCP accompaniment since it is not necessarily a skilled task. To determine if time for accompanying should be allocated as a skilled or unskilled task, please review the HMA Documentation Guide.

What is the best way to document protective oversight? What is/is not PO? Why are some hours approved and others not approved?

Protective Oversight is used to prevent or mitigate disability-related behaviors. For the review, please describe what is happening during the time protective oversight is requested. There cannot be more than one task occurring at the same time, for example, positioning during a seizure would be requested under positioning, not under protective oversight. Hours may not be approved if they do not meet the definition of protective oversight and/or if the requested time is not justified in the 100.2, or if activity should be in another task category. Each situation is unique so full descriptions and consideration of other tasks being done are best practice.

Can you explain if/how clients with a seizure disorder could get protective oversight?

As each case is unique, there is not a prescriptive way for a member to qualify for protective oversight hours for seizures. When submitting a review for protective oversight for members who experience seizures, best practice is to include documentation of what the seizure protocol looks like. Protective oversight can only be used to account for the time the

attendant is actively helping the member prevent harm to themselves. The seizure activity and subsequent aftercare could be documented in a variety of ways. First, it could be justified within protective oversight if the explanation shows how the attendant is preventing or mitigating a disability-related behavior such as self-harm, administration of emergency medication to stop seizing, or the aftercare tasks required. The other option is to document the tasks associated with seizure protocol within another category, such as positioning, medical management, or respiratory care. Each part of the seizure protocol can only be documented once, and duplicative tasks will be denied.

There have been some denials for seizure care saying it is not covered by CDASS. Reviewers are saying that seizures are unpredictable so we cannot allow time for seizure care.

In general, when something is not approved for protective oversight, the submitted documentation is unclear or more information is needed. It is important that Telligen understands what is happening and what assistance is being given. Often the description indicates that the assistance would be more appropriate in another task and at times the time has already been accounted for in another task.

Requests for Information (RFI)

Can there be more than one RFI on the same case?

Telligen will issue a second RFI if needed. A second RFI may also be used if new information is received on the response to the first RFI that was not previously provided. Occasionally, a second RFI may be issued if something was missing in the initial RFI.

Case Managers are seeing something in a new category i.e., nail care was not even asked about during the first RFI and then asked about in a second RFI.

This can happen occasionally, though Telligen works to ensure that RFIs have all questions the first time. As mentioned above, new questions can arise when responses to RFIs are received, and Telligen would rather RFI a second time than deny if it the item can be clarified.

Can denials be issued for something not in RFI?

Yes, it is possible. An RFI may clarify items which could be duplicative.

Does the same person review the RFI response?

Telligen aims to have the same reviewer look at the case after receiving the RFI response, and the clinical reviewers will always do a final review of the case. No matter who is completing the case, the documentation and notes on the case are all reviewed for completion of the request.

If case managers submit more info on cases after we submit for review, do you get notifications that more was submitted? Is there any way to have who reviewed the case name on the review, that way if we have questions about the RFI we can talk to them directly?

The case goes back into the queue once documents have been uploaded after an RFI. There is no notification of additional information when submitted and you will not be able to submit more information once the reviewer begins work on the request. All documentation submitted is available to the reviewer when working on the case after the RFI response.

Questions come through the support center to allow the reviewers to get reviews completed. Reviewers are consulted on specific cases when questions are asked by the individual responding to the ticket as needed. We prefer to keep the communication on the Telligen side to the people designated to respond so that the reviewers can focus on completing reviews, though, at times, a reviewer may contact a case manager to discuss a case.

Submitting Reconsiderations rather than new cases, reopens, new cases

Reminder: After a denial or partial denial, a Reconsideration (1st Level Appeal in Qualitrac) is available. You do not need to submit a new case – you can use Reconsideration. One Reconsideration is available per request. (If more info is needed during Reconsideration, an RFI will be issued for all standard/rapid (not Express) reviews). Reconsiderations must be submitted within 5 business days of the outcome being applied to the case.

Do you only have 5 days after the denial to request the reconsideration?

Yes, 5 business days.

Is there a way to re-open a case once it has been completed if additional units need to be added?

No, it cannot be re-opened, if there is a revision that needs to be done the case manager would need to submit a new request. Please include a note that the case is for a revision and specify what the revision is. The accompanying calculator should include the revised item and all other items approved in the previous initial/CSR review.

A "reopen" of a case is only allowed if there is not response to an RFI

Justification for Services/Documentation

Telligen is using the 100.2, all documents submitted, and the PAR for OCC in reviews. Telligen is looking for case managers to paint the picture of the member including their needs and the services being provided by attendants/caregivers. Telligen won't assume or infer based on diagnosis – each person's capabilities and needs can be different. Telligen is looking for what the caregiver is doing, how long it takes, and how often each task is being done. Please provide a description of the assistance that is being provided. HMA cannot be monitoring or watching.

Services cannot overlap – Telligen will look for this in the review and may request changes based on information provided. Most common areas where overlap seen is positioning during another service or time.

If LTHH is included, Telligen needs to know when LTHH is providing services, and when IHSS is providing services.

“In Conjunction” is for tasks that may be performed immediately next to each other and related to the needs for both tasks.

On the HMA Guide, “Special Considerations” are considerations – each one by itself does not make a task skilled, but all will be considered and should be part of documentation submitted or 100.2.

No need to attach previous years letter for express reviews.

Please attach the outcome letter to the PAR on the states system.

CDASS exercise letter needs to be from a qualified clinician, The order must be signed/completed by a licensed medical professional (Licensed Medical Professional means the primary care provider of the Client, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN), as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act). The documentation in the 100.2 or in a separate document submitted with the case will also need to include a description of the exercise along with a description of the hands on assist needed with each exercise.

The monthly allocation worksheet is not required to be submitted to Telligen.

Will Telligen accept Case Manager observations listed in 100.2 as justification for services?

Telligen will consider all documentation as part of the review. If there are questions after reviewing the 100.2, Telligen will issue an RFI with questions.

What is being done to resolve issues of reviewers not actually reviewing the 100.2 and all the provided docs to justify times and in turn issue RFIs which result in a huge waste of time because all the info was available it just wasn't reviewed?

The reviewers do read all the documentation submitted as well as the 100.2. Please send any concerns through the Telligen support center by submitting a ticket by calling 833-610-1052 during business hours or by emailing ColoradoSupport@telligen.com. This is the quickest way to get a response from the Telligen URUM review team. HCPF also looks into these, please send concerns to hcpf_pdp@state.co.us or hcpf_hcbs_casemanagement@state.co.us . Be sure to include the Case ID on each item in question.

LTHH PARS

Long-Term Home Health (LTHH) is not added to the PAR at the time of the Telligen submission, so we do not know the daily cost for the new cert period for LTHH services. Should the Case Manager add the LTHH daily cost from the previous cert in order to have an estimate?

Home health regulation allows for PARs to be submitted up to 11 days after the start of services, which means a case manager may not always have access to the new LTHH PAR until after the HCBS services are approved. If case managers do not have the new LTHH PAR and subsequently do not have the LTHH Cost Per Day, the case manager can use the previous certification period's LTHH Cost Per Day and submit the previous LTHH PAR and 485 to Telligen.

If case managers are using the previous year LTHH PAR / 485 as a guide, will Telligen take that as up to date documentation for review?

If case managers do not have access to the upcoming certification period's LTHH PAR / 485, Telligen will accept the previous year's LTHH documentation. Best practice is to inform Telligen that the new LTHH Documentation is not available at the time the review is submitted.

Are LTHH PARs required for review by Telligen if there are no other HCBS services being requested?

Only members with LTHH and HCBS that exceed $315 / day must be reviewed by Telligen. If a member only has LTHH, a Telligen review is not required.

What is the best way to communicate that there is not a new LTHH PAR?

The case manager should add a note to the case or may submit a separate document.

If the member has LTHH and the LTHH is ending the day prior to IHSS starting and the case manager is listing that in the comment box for the review, is it still necessary to add the cost for the LTHH even though it will be ending the day prior to the start of IHSS and technically will not be part of the daily cost moving forward?

If the member is no longer receiving LTHH and only requesting IHSS, the Case Manager would not need to include the LTHH cost per day in the review. It is best practice to inform Telligen that the LTHH services are ending, and that the LTHH cost per day is not being included in the Total Average Daily cost.

If HMA services have already been approved by Telligen and LTHH is added in the middle of a cert period does everything need to be rereviewed?

Yes, if services change mid-certification, this would be considered a revision to the Support Plan and a Telligen review would be required.

Children's Extensive Supports Waiver (CES)

On the CES application reviewers are looking for same breakdown as that listed for Medical Condition/Behavior for the interventions being performed:

1. Description of Intervention - can be more than one intervention at a time. Describe what is being done, where (the environment), who is there and what are they doing (caregiver/parent, etc.), what is needed (medical equipment, sensory inputs).
2. Frequency of Intervention – how often do the interventions occur?
3. Duration of Intervention – how long do the interventions last each time? (on average).
4. More "intense" – describe active interventions – how are caregivers engaging or interacting?
5. The risk associated if the intervention were not in place.

Reminders: Read/enter info on the application across. Columns related to medical condition/behavior are broken down by Frequency, Duration, Intensity (what could happen due to the medical condition or behavior).

Intervention is not broken down by Description, Frequency and Duration, but Telligen is looking for these same items as they relate to the interventions. The only interventions needed are those that are "more intense", but submitters are welcome to include others.

Interventions that are more intense must be active to be considered. One-to-one supervision or parent vigilance are not "more intense". More intense means active, hands on, etc. One-time interventions (locks on doors, doctor/PT appointments) are not caregiver interventions. School time isn't considered, and this should not be included in times given. For nighttime, co-sleeping isn't considered if/when child/parent are sleeping. Examples of active nighttime interventions are putting child to bed, reading, applying pressure, etc. Baby monitors are not considered.

* The application should be completed by a case manager, facilitating an interview with the guardians to fill out the application with them. The goal is a conversation and interview with the family about what their environment looks like, what they are doing, who is there, day to day, and, day and night.

* There should be no changes or edits made to the application format when submitting to Telligen. Include additional information on a separate Word or PDF document.

* Please don't leave any blanks in the application.

* Telligen is not reviewing for DD determination or validating developmental delay.

* Chrome is recommended for Qualitrac, Edge is second best.

* Digital signature (pdf Docusign signature, hand signature, typed out signature) is needed from parent or guardian, Telligen will send an RFI for this if it is not on the form.

Other Questions

When a case manager is completing an IHSS plan, and something is added to the HMA section is there any part that would not require a Telligen review?
Anytime there is HMA added to the PAR a Telligen review is needed.

If there is an IHSS re-certification and there is no HMA, does it need to be submitted to Telligen?

No, if the case does not contain HMA and is not Over Cost Containment you would not need to submit it for review.

Is there any chance that the Telligen Express Review Qualification Attestation will be built into the actual Telligen website?

At this time, there is no plan to incorporate the Qualification Attestation directly into Qualitrac. Telligen and HCPF will continue to explore new ways to make the Qualification Attestation form more usable for case managers.

Can the Telligen Support Center receive encrypted email?

The Support Center cannot receive encrypted emails, which means protected health information (PHI) cannot be sent to the Support Center. Case Managers can submit the Qualitrac Case ID or Medicaid ID without other PHI to the Support Center without breaking HIPAA requirements. The Case ID can be found in the Qualitrac portal in the upper left corner of the case after submitting the request and they are also listed in the Member Hub for each individual, in the Utilization Management tab.

Is there a way to provide feedback from case managers/agencies who are doing the assessments/submissions or just the stakeholders?

HCPF and Telligen encourage feedback from all stakeholders which include but are not limited to case managers / case management agencies, members, and advocates. Feedback about the URUM process can be sent to the Participant Directed Programs Unit (PDPU) inbox for feedback: hcpf_pdp@state.co.us

Regarding CDASS exercise, can we include orders/prescriptions from last year from the doctors rather than getting new doctor's orders each year?

As long as there has been no change in needs, previous orders/prescriptions can be submitted with each year's CSR and/or express review.

*** Should we not be describing the frequency of a behavior as "constantly" anymore? For example, vocalizing**

Constant is does not accurately reflect periods when the individual may not be doing the behavior, such as when eating, sleeping or engaged in another activity. If it is not every 15 minutes, it is not constant. Best practice is to describe how often and what the behavior is as well as when it happens.

*** As far as frequency for interventions, a family responds every time they have a behavioral/medical issue. So that is why often times the behavior and intervention look the same**

It is hard to fit a person's life into the form but that is why using medical condition/behavior and then intervention information helps to get the picture of what's happening. It is understood that it may seem constant or that a medical condition is constant (meaning it is something the child lives with all the time). In some medical conditions/behaviors, it is possible that it is not happening constantly, or interventions are not needed. We are looking to understand how often a behavior or condition occurs that requires an active intervention (or group of interventions) during the day and during the night and more information about the intervention (what the caregiver is doing). As each person is different, we look to the case manager to tell us what medical condition/behavior requires interventions that are more "intense" than verbal redirection, observation etc. This information should include a description of the intervention(s) with the frequency (how often does it occur – on average), duration (how long does the intervention take – on average), and what the caregiver is doing. This can be short description as long as all components are included in the description.

IHSS Plans of Care

When IHSS agency is not responding to CM request for information, send this to HCPF at this email address (HCPF_pdp@state.co.us) for assistance.

Outcome Letter Types

Approval – The outcome letter should be downloaded as a PDF and uploaded as an attachment to the PAR. If the PAR shows Pending State Review the case manager should email LTSSOCC@state.co.us to request PAR approval.

Partial Denial – Once an outcome letter is received for the request, the case manager will need to adjust the relevant lines on the PAR to reflect what was approved in the review. The outcome letter from the case in Qualitrac should be downloaded as a PDF and uploaded as an attachment to the PAR. If the PAR shows Pending State Review the case manager should email LTSSOCC@state.co.us to request PAR approval if the case is over cost. A Long-Term Care Notice of Action must be sent to the member.

Denial – If a denial is received, the case manager must remove the denied services from the PAR and send a Notice of Action to the member.

Official Appeals

An official appeal occurs when a member appeals their service change or denial through the Office of Administrative Courts upon receiving a Notice of Action from the case manager. Interim approval of services will occur if the member chooses to appeal the service change or denial. If services need to be temporarily approved on the PAR while the appeal is active, the case manager should document appeal to the Notice of Action and email LTSSOCC@state.co.us inbox for review and temporary approval of services. **Note:** Services may only be temporarily approved if there is an active appeal through the Office of Administrative Courts.

Additional Training Opportunities

Telligen Support Request Form – Use this form to submit a topic request for the next Telligen Open Office Hours or to request technical assistance from HCPF

Telligen Support: 833-610-1052 or ColoradoSupport@telligen.com

UR/UM Management web page

Sign Up for Case Manager's Corner newsletter to get email notifications directly

* HCPF Escalations Form