Colorado Utilization Review / Utillization Management

Provider User Guide

Includes updates effective 3/2/2022

Contents

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 portion 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.

Support and Help

For assistance with submitting to Qualitrac or questions on requests, please contact Telligen's support center:

833-610-1052
Or
ColoradoSupport@telligen.com

Updates

Beginning March 2022, the follow items in the review process are new. Please see details below for each item and within each request type section:

1. **Submitting Procedures, Modifiers and Total Average Daily Costs**: for each request being entered into Qualitrac: Submitters will be required to enter the procedures, up to two modifiers (see details below) and the expected total average daily cost at time of submission. NOTE: Please use the modifiers included in the attached appendix for each request/review type to ensure correct tracking. **Pre-prior approval PAR screenshots WILL NOT be required when entering procedure codes, modifiers, and total average daily costs.**

2. **Overlapping Reviews**, where one review can be submitted when two types of reviews are required. These review types are:

- IHSS/OCC
- CDASS/OCC
- IHSS/CHCBS

Documentation submitted will be used for both reviews while submitters will only have to submit one review.

3. **SLS Exceptions Reviews**, for members on the HCBS – SLS waiver who are in need of additional services and supports in excess of current SPAL and/or service unit limitations, in order to maintain the member's health and safety in the community.

4. **Qualitrac features added** (see details below)

- Reason for Request – users will be required to choose one option.
- Overlapping Reviews Review Type Selection – new review types added for HMA, OCC and CHCBS.

5. **Express Reviews** for IHSS, CDASS, OCC and Overlapping HMA reviews (IHSS/OCC and CDASS OCC) may be submitted when there are no changes (per the HCPF Express Review Qualification Attestation form) from the previous review completed by Telligen.

**IHSS/CHCBS Overlapping reviews are not eligible for Express Reviews.

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)

Important Information/Details (existing and new features)

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.

Submitting Reviews with Procedure Codes, Modifiers and Total Average Daily Costs

**Change from previous process – please review carefully!

- All OCC, CDASS, IHSS, and Overlapping Reviews require procedure codes and the corresponding modifiers to be submitted for each service area.
- Procedure codes can be found on the HCBS Rates Sheet or on the service lines on the Bridge PAR. Please see the Appendix which includes a list of procedure codes and applicable modifiers to use for all submissions to Telligen.
- Submission of a Pre-Prior Authorization (PPA) Screenshot will no longer be required.

- Incomplete information will result in an RFI to be issued by Telligen and may lead to a delay in review.

Overlapping Reviews

Beginning March 2022, submission of reviews when HCBS UR/UM reviews overlap will be completed by selecting the appropriate overlapping review type. These types will be:

- IHSS/OCC
- CDASS/OCC
- IHSS/CHCBS

Submitters may choose the overlapping review type if both reviews happen at the same time or may still submit separately if needed if both requests are not needed at the same time

When submitting overlapping reviews, you will choose only one review type indicating the overlapping reviews needed. The rest of the process will be the same.

When submitting multiple types of reviews at the same time or reviews that relate (such as an IHSS request for a previously approved CHCBS review), the CM should notify Telligen through the notes section of the review request, stating what additional reviews have also been submitted or submitted in the past. 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. If a PAR has HMA services and is OCC, the CM will select the overlapping review type (IHSS/OCC or CDASS OCC) and submit only one request.

- HMA/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 may submit an IHSS/CHCBS overlapping review type. If IHSS is added any time after the member is approved for CHCBS an individual IHSS review may be submitted.

The CHCBS review may be completed first as the member is not eligible for IHSS HMA services until they have been approved for CHCBS. If an overlapping review is submitted and the individual does not qualify for initial CHCBS eligibility, both CHCBS and IHSS will be denied. The overlapping review is recommended for IHSS/CHCBS at CSR.

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 using the overlapping review option, the Cost Containment form should include the HMA.

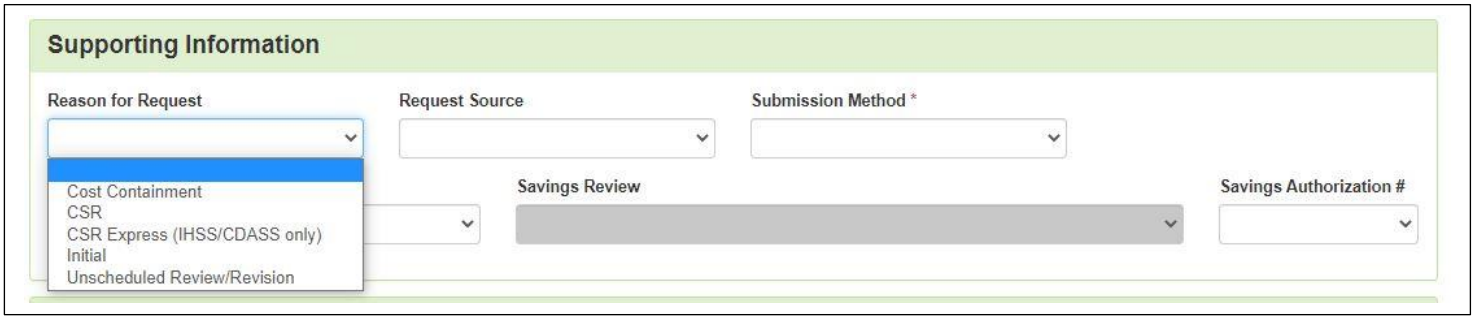
SLS Exception Reviews

For details on submitting SLS Exception Reviews, please see the detailed separate section below that includes the quick reference table.

Qualitrac Features

Reason for Request

Qualitrac has a new feature that will require a selection in the Reason for Request item in the Support Information area.



When submitting a review to Qualitrac, case managers will be required to select a Reason for Request option. Please select one of these:

Cost Containment – for CHCBS only

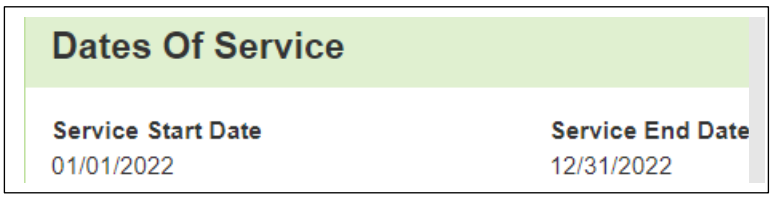
CSR – Continued Stay Review for annual recertification

CSR Express – for reviews for IHSS/CDASS and OCC when nothing has changed from the previous year. This is only to be used after Telligen has completed a full review the previous year and may only be used one time following a full review. Please do NOT select this option unless using the Extend feature in Qualitrac and submitting an Express Review. (See details below)

Initial – first time individual is being considered for the waiver/program

Unscheduled Review/Revision - If you are submitting a review when a revision has occurred in the member's service plan, please select Unscheduled Review/Revision in the Reason for Request field. (See snip above)

When submitting a request that involves a revision, please use the requested revision start date as the service start date under Dates of Service. This is typically the date the revision is submitted to Telligen. (See snip below)



Please be sure to submit all documentation including the revised IHSS Care Plan Calculator or CDASS Task Worksheet.

Overlapping Reviews – When selecting a review type, you will now have the option of selecting the overlapping reviews described above for submitting IHSS/OCC, CDASS/OCC and IHSS CHCBS requests. All other review types will remain available.

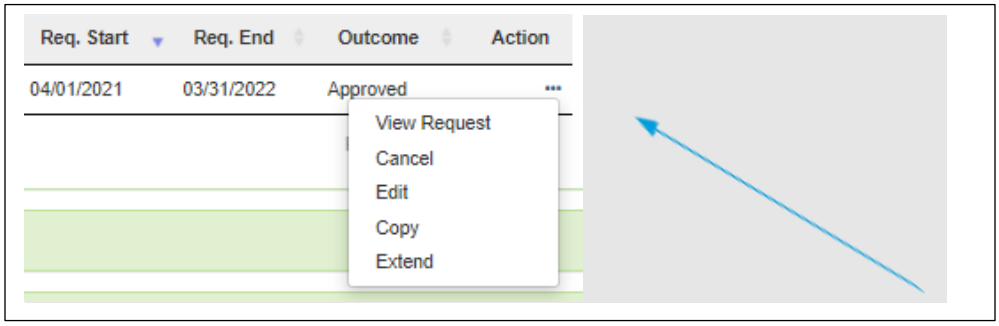
Express Reviews

Express reviews will be available for OCC and CDASS/IHSS requests as well as for HMA Overlapping Reviews. An express review may be requested one year after a full CSR request, or an initial request has been completed by Telligen.

Express reviews may ONLY be submitted if/when there are no significant changes for the member within the past year following Telligen's review. If Telligen has completed a full review (Initial or CSR) and a revision review within the certification span, an express review may be submitted for the new CSR period if there have been no significant changes resulting in a change in services. Please see the HCPF Express Review Qualification Attestation form for requirements.

NOTE: Express Reviews are not eligible for Requests for Information. If you submit an express review and more information is needed, the express review will be denied, and you will be asked to submit a standard request.

To request an Express review, the case manager will select the option to "Extend" in the most recent review completed in the Member Hub, Utilization panel.



The following documents must be submitted at the time of the request:

- Express Review Qualification Attestation form
- Outcome Letter from Telligen's previously completed CSR/Initial or Revision review
- Current certification care plan calculator and agency care plan (IHSS)
- Current certification CDASS task worksheet (CDASS)
- Current certification LTHH 485 (for LTHH services

The Express Review Qualification Attestation form will be distributed by the Department and will be available on the HCPF web site here:

hcpf.colorado.gov/long-term-services-and-supports-case-management-tools

The time frame for completing Express Reviews will be two business days from submission.

As with all HMA and OCC requests, procedure codes, modifiers and total average daily costs will need to be entered for express reviews.

Details on submitting Express Reviews can be found in the Telligen's Tip Sheet #4 – Express Reviews which will be distributed to CMAs and posted on the HCPF Web site here:

hcpf.colorado.gov/long-term-services-and-supports-training

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".

**Requests that include certification start dates prior to the start of the month of submission cannot be accepted.

- 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 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 Support Center for guidance prior to submitting the review request.

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.

Note: for Express Reviews, a Reconsideration may be used to submit any missing documentation following at denial or partial denial for missing documents only since no RFI will be issued for these requests. If the denial/partial denial is for any other reason a reconsideration may not be used and a standard request should be submitted.

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.

NOTE: If reopening a case, be sure to submit the documentation requested in the RFI and complete the reopen process by clicking the submit button. If you do not click this button, the request will not be moved to the review queue and the reopen review will not occur.

NOTE: Cases may be reopened one time following Technical Denial. If the case is reopened and another RFI issued, and the CM does not respond to the RFI within 10 business days, the case will be moved to Technical Denial. If an attempt to reopen the case is made again, the case will be denied.

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. Currently, 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) 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	5 Business Days
Outcome of no response to RFI	Technical Denial
TAT for UM Reconsideration	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. 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 in a +/- $50, CM does not need to submit for any review.

Non-HMA service changes that do result in a +/- $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. Currently, 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 (See required document if submitting IHSS or IHSS/CHCBS overlapping request in the sections below.)

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	5 Business Days
Outcome of no response to RFI	Technical Denial
TAT for UM Reconsideration	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). 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.***
Procedure Code	Submitters will need to enter Procedure Codes, applicable modifiers, and estimated total average daily costs at submission time for each OCC and HMA review, including Overlapping Reviews. See Appendix for Procedure Codes/Modifiers to use. Please see Tip Sheet # 5 for details on entering procedure codes, modifiers, and total average daily costs, available on the HCPF web site here: https://hcpf.colorado.gov/long-term-services-and-supports-training

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 • 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/Rapid Reviews

	IHSS Standard Reviews	IHSS Rapid Reviews*
TAT for UM review	4 Business Days	2 Business Days
TAT for Urgent UM review	4 Business Days	2 Business Days
Request for Information Response	10 Business Days	10 Business Days
TAT of UM review after RFI response received	5 Business Days	5 Business Days
Outcome of no response to RFI	Technical Denial	Technical Denial
TAT for UM Reconsideration	5 Business Days	5 Business Days
Documentation requirement	No additional requirements for standard TAT	Must include reason rapid review is being requested

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). 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.**
Procedure Code	Submitters will need to enter Procedure Codes, applicable modifiers, and estimated total average daily costs at submission time for each OCC and HMA review, including Overlapping reviews. See Appendix for Procedure Codes/Modifiers to use. Please see Tip Sheet # 5 for details on entering procedure codes, modifiers, and total average daily costs, available on the HCPF web site here: https://hcpf.colorado.gov/long-term-services-and-supports-training
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 **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

	CDASS Standard Review	CDASS Rapid Review
TAT for UM review	4 Business Days	2 Business Days
TAT for Urgent UM review	4 Business Days	2 Business Days
Request for Information Response	10 Business Days	10 Business Days
TAT of UM review after RFI response received	5 Business Days	5 Business Days
Outcome of no response to RFI	Technical Denial	Technical Denial
TAT for UM Reconsideration	5 Business Days	5 Business Days
Documentation requirement	No additional requirements for standard TAT	Must include reason rapid review is being requested

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, either a separate HMA review shall be conducted and approved, or an Overlapping review must be submitted. 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.***
Procedure Code	Submitters will need to enter Procedure Codes, applicable modifiers, and estimated total average daily costs at submission time for each OCC and HMA review, including Overlapping reviews. See Appendix for Procedure Codes/Modifiers to use. Please see Tip Sheet # 5 for details on entering procedure codes, modifiers, and total average daily costs, available on the HCPF web site here: https://hcpf.colorado.gov/long-term-services-and-supports-training
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) **CDASS Specific Requirements** • CDASS Task Worksheet • CDASS Monthly Allocation Worksheet

	• If applicable, HMA Review Case ID when cases are submitted separately **IHSS Specific Requirements** • IHSS Care Plan Calculator • IHSS Agency Plan of care • If applicable, HMA Review Case ID when cases are submitted separately **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

	OCC Standard Review	OCC Rapid Review
TAT for UM review	4 Business Days	2 Business Days
TAT for Urgent UM review	4 Business Days	2 Business Days
Request for Information Response	10 Business Days	10 Business Days
TAT of UM review after RFI response received	4 Business Days	5 Business Days
Outcome of no response to RFI	Technical Denial	Technical Denial
TAT for UM Reconsideration	5 Business Days	5 Business Days

Overlapping Reviews

Consumer-Directed Attendant Support Services (CDASS)/Over Cost Containment (OCC) Overlapping Review

Case managers may select the overlapping review for CDASS/OCC when both are submitted at the same time. Documentation for both portions of the review will be needed. Requirements/documentation are the same for the overlapping review as for the individual reviews

Review Type in QT	CDASS/OCC
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.**
Procedure Code	Submitters will need to enter Procedure Codes, applicable modifiers, and estimated total average daily costs at submission time for each OCC and HMA review, including Overlapping reviews. See Appendix for Procedure Codes/Modifiers to use. Please see Tip Sheet # 5 for details on entering procedure codes, modifiers, and total average daily costs, available on the HCPF web site here: https://hcpf.colorado.gov/long-term-services-and-supports-training
Examples of clinical documentation to support PA criteria	**Required for all reviews:** • ULTC 100.2 (can be accessed in the BUS by reviewers - upload to Qualitrac optional) **CDASS Specific Requirements** • CDASS Task Worksheet • CDASS Monthly Allocation Worksheet

	• CDASS Exercise Orders (If applicable) **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

Timing of CDASS/OCC Review

	CDASS/OCC Standard Review	CDASS/OCC Express Review
TAT for UM review	4 Business Days	2 Business Days
TAT for Urgent UM review	4 Business Days	2 Business Days
Request for Information Response	10 Business Days	Not Available for Express Reviews
TAT of UM review after RFI response received	5 Business Days	N/A
Outcome of no response to RFI	Technical Denial	N/A
TAT for UM Reconsideration	5 Business Days	N/A

In-Home Support Services (IHSS)/Over Cost Containment (OCC) Overlapping Review

Case managers may select the overlapping review for CDASS/OCC when both are submitted at the same time. Documentation for both portions of the review will be needed. Requirements/documentation are the same for the overlapping review as for the individual reviews

Review Type in QT	IHSS/OCC
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.**
Procedure Code	Submitters will need to enter Procedure Codes, applicable modifiers, and estimated total average daily costs at submission time for each OCC and HMA review, including Overlapping reviews. See Appendix for Procedure Codes/Modifiers to use. Please see Tip Sheet # 5 for details on entering procedure codes, modifiers, and total average daily costs, available on the HCPF web site here: https://hcpf.colorado.gov/long-term-services-and-supports-training
Examples of clinical documentation to support PA criteria	**Required for all reviews:** • ULTC 100.2 (can be accessed in the BUS by reviewers - upload to Qualitrac optional) **Required:** • IHSS Care Plan Calculator • IHSS Agency Plan of Care **Optional:** • 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 **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

Timing of IHSS/OCC Review

	CDASS/OCC Standard Review	IHSS/OCC Express Review
TAT for UM review	4 Business Days	2 Business Days
TAT for Urgent UM review	4 Business Days	2 Business Days
Request for Information Response	10 Business Days	Not Available for Express Reviews
TAT of UM review after RFI response received	5 Business Days	N/A
Outcome of no response to RFI	Technical Denial	N/A
TAT for UM Reconsideration	5 Business Days	N/A

Express Review for HMA, OCC requests

An Express Review may be requested when Telligen has completed an Initial or CSR review, or if an Initial/Revision or CSR/Revision has been completed. These reviews will allow for an additional year of approved services without submitting a full CSR request to Telligen.

Please see Tip Sheet #4 – Express Reviews for details on submitting these requests in Qualitrac.

NOTE: When an Express review is submitted, the documentation and information from original request are copied to a new request within the same Case ID.

Express reviews can only be requested when a previous full review has been completed by Telligen.

Review Type in QT	Extend available on previous request in Qualitrac, Member Hub, Utilization Management tab
Place of Service	Community
Type of Service	Home and Community Based Services
Timing	Will be transferred from original submission to new request. May be Concurrent or Prospective
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.**
Procedure Code	Any procedure codes on the original request will be moved to the Express Review automatically. All additional procedure codes, modifiers and total average daily cost estimates at submission will need to be added to the new Express Review request. See Appendix for Procedure Codes/Modifiers to use. Please see Tip Sheet # 5 for details on entering procedure codes, modifiers, and total average daily costs, available on the HCPF web site here: https://hcpf.colorado.gov/long-term-services-and-supports-training

Examples of clinical documentation to support PA criteria	Required for all reviews: • Express Review Qualification Attestation form • Outcome Letter from Telligen's most recently completed CSR/Initial or Revision review • Current certification care plan calculator and agency care plan (IHSS) • Current certification CDASS task worksheet (CDASS) • Current certification LTHH 485 (for LTHH services)

Timing of IHSS/OCC Review

	HMA/OCC Express Review
TAT for UM review	2 Business Days
TAT for Urgent UM review	2 Business Days
Request for Information Response	Not Available for Express Reviews
TAT of UM review after RFI response received	N/A
Outcome of no response to RFI	N/A
TAT for UM Reconsideration	N/A
Reconsiderations (1st Level Appeal in Qualitrac)	Reconsiderations are only available if/when a required piece of documentation is missing. The Express review will be denied if a Reconsideration is requested for any other reason, and the CM will be requested to submit a standard request.

In-Home Support Services (IHSS)/Children's Home and Community Based Services (CHCBS) Overlapping Review

Review Type in QT	IHSS/CHCBS
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.**
Procedure Code	Submitters will need to enter Procedure Codes, applicable modifiers, and estimated total average daily costs at submission time for each OCC and HMA review. (and Overlapping reviews) See Appendix for Procedure Codes/Modifiers to use. Please see Tip Sheet # 5 for details on entering procedure codes, modifiers, and total average daily costs, available on the HCPF web site here: https://hcpf.colorado.gov/long-term-services-and-supports-training See Appendix for Procedure Codes to use
Examples of clinical documentation to support PA criteria	**Required for all reviews:** • ULTC 100.2 (can be accessed in the BUS by reviewers - upload to Qualitrac optional) **IHSS Required:** • IHSS Care Plan Calculator • IHSS Agency Plan of Care • Signed and completed LTHH PAR if applicable (for LTHH) • LTHH Agency 485 and plan of care (for LTHH) **IHSS 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 **CHCBS Required:** • PMIP (initial only) • CHCBS Cost Containment Form **CHCBS Optional:** • Therapy Notes • Medical Records • Medication List

Timing of IHSS/CHCBS Overlapping Review

TAT for UM review	7 Business Days
Request for Information Response	10 Business Days
TAT of UM review after RFI response received	5 Business Days
Outcome of no response to RFI	Technical Denial
TAT for UM Reconsideration	5 Business Days

SLS Exceptions Reviews

SLS Exceptions reviews will be accepted through Telligen's Qualitrac system. If also submitting for CDASS, please submit a separate CDASS request and note that it is associated with the SLS Exceptions Review by including the Case ID for the SLS request.

Review Type in QT	SLS Exceptions
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 application	**Required for all reviews:** • SLS Exceptions Review Request Form • ULTC 100.2 (can be accessed in the BUS by reviewers - upload to Qualitrac optional) • Screen shot of authorized PAR **HMA approval Case Id from Telligen, if applicable.** **CDASS Specific Requirements (when CDASS is requested with SLS)** • CDASS Task Worksheet • CDASS Monthly Allocation Worksheet • CDASS Exercise Orders (If applicable) **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

Additional Information:

When an outcome letter for the SLS Exceptions Review request has been obtained from Telligen, the CM shall attach the outcome 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 SLS Exceptions Review

TAT for UM review	5 Business Days
TAT for Urgent UM review	5 Business Days
Request for Information Response	10 Business Days
TAT of UM review after RFI response received	5 Business Days
Outcome of no response to RFI	Technical Denial
TAT for UM Reconsideration	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

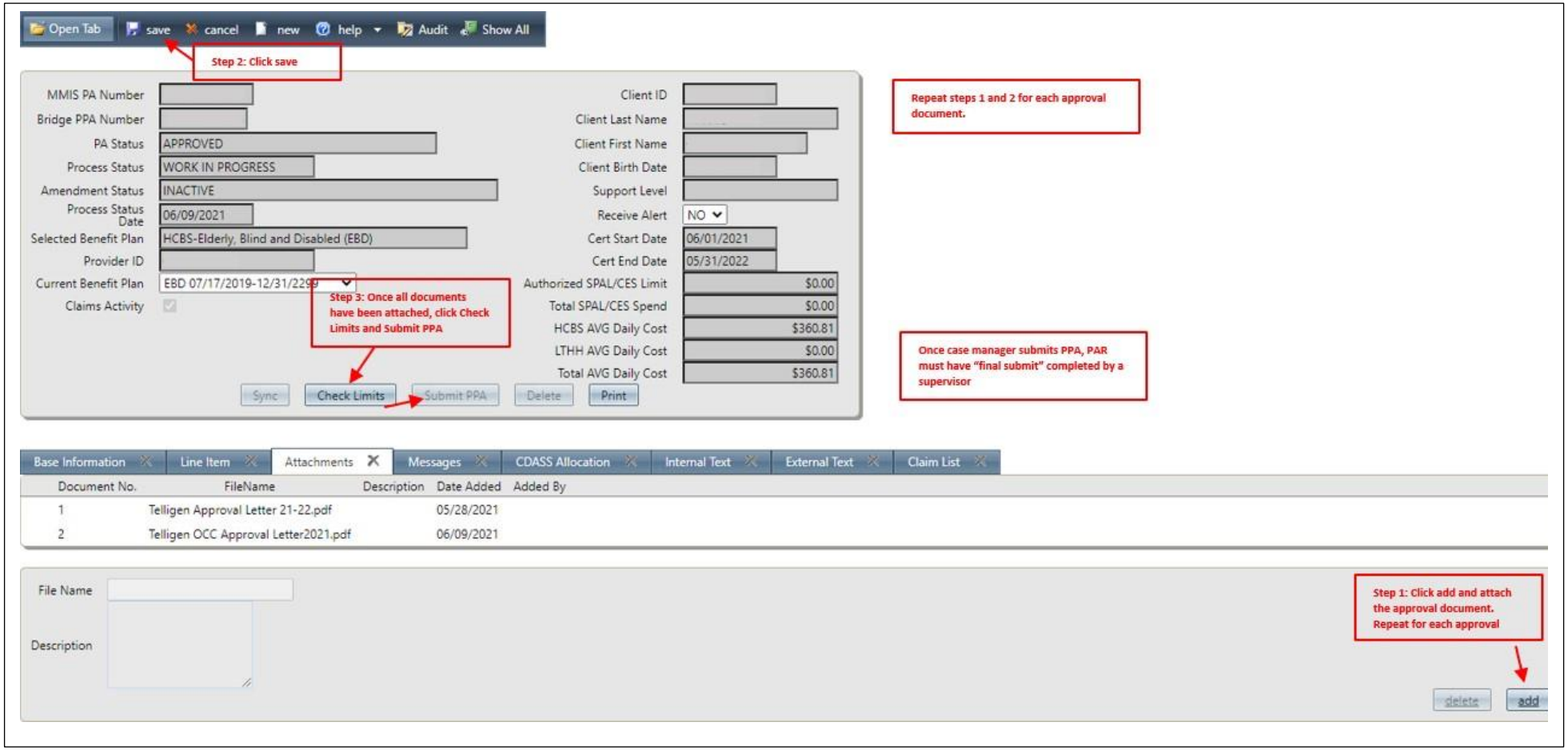
- HMA Documentation Guide
- Telligen Training Links
- Long-Term Services and Supports Case Management Tools
- HCPF Memo Series can be accessed online: hcpf.colorado.gov/memo-series
- Example of PPA for Review Submission (see attachment below)
- Example of a PPA ready for submission after Telligen review

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

Example of PPA for Review Submission



Appendix: Procedure Codes, Modifiers and Costs

For all submissions involving HMA or OCC (IHSS, CDASS, OCC, Overlapping Reviews: IHSS/OCC, CDASS/OCC, IHSS/CHCBS, SLS/CDASS) and any corresponding Express Reviews, CMs will be required to enter procedure codes, applicable modifiers per the following list provided by HCPF, and the estimated costs per code at submission. **Each service should have a corresponding procedure code and costs**. Modifiers should be added as needed.

This information should correlate to the procedure codes entered in the PAR, though fewer modifiers will be entered into Qualitrac. **PLEASE USE THE LIST OF PROCEDURE CODES/MODIFIERS BELOW FOR ALL SUBMISSIONS TO TELLIGEN** – only a maximum of 2 modifiers will be used at this time.

NOTE: The screenshot of the Pre-Prior Approval PAR will no longer be required for these reviews.

For details on selecting procedure codes and modifiers, and entering costs, in Qualitrac please see Tip Sheet #5 which is being distributed to all CMAs and posted to the HCPF web site here:

hcpf.colorado.gov/long-term-services-and-supports-training