Case Management Support

Utilization Review/Utilization Management Reviews

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UR/UM Reviews

What is a UR/UM Review?

The Department currently contracts with a vendor, Telligen, to conduct Utilization Review/Utilization Management (UR/UM) reviews on behalf of the Department. Reviews are conducted to ensure the services requested reflect the identified needs of the waiver member and that there is no duplication of services.

UR/UM Reviews

Required Reviews

The Department requires the HCBS UR/UM review of:

- Over Cost Containment (OCC)
- Participant-Directed Programs Health Maintenance Activities (HMA) UR/UM
  - Consumer Directed Attendant Support Services (CDASS)
  - In-Home Support Services (IHSS)
- SLS Exception Requests
- Pre-admission Screening and Resident Review (PASRR)*
- Children's Extensive Support (CES) waiver eligibility reviews*
- Children's Home and Community-Based Services (CHCBS) waiver eligibility and Cost Containment reviews*

* = Not covered in this training

UR/UM Reviews

Review Frequency

Reviews are completed annually and any time an increase in services are requested

- Express reviews are permitted for select reviews on a bi-annual basis

Express Review vs. Rapid Review

An Express review is an administrative approval in which Telligen does not complete a full review of the case and relies on the Express Review Qualification Attestation Form to validate that there have been no changes in need since the previous review.

A Rapid review is a full review that Telligen expedites if the member is at immediate risk of losing services should the services not get approved quickly.

Review Comparison

	Standard	Rapid	Express
When to use:	• This is the first review completed by URUM vendor (initial, CSR) • Changes to level of functioning have occurred since the previous review • Services have not yet started	• This is the first review completed by URUM vendor (initial, CSR) • Changes to the level of functioning have occurred since the previous review • Member is at risk of encountering a gap in services should the utilization management review not occur on a shortened timeframe	• A review has been conducted for the member by the URUM vendor within the past year • There have been no changes in functioning or service need since the previous review
Health Maintenance Activity (HMA) Reviews	Turnaround Time: 4 days	Turnaround Time: 2 days	Turnaround Time: 2 days
	Documents Required for Submission: • IHSS Care Plan Calculator (IHSS HMA Reviews only) • IHSS Agency Plan of Care (IHSS HMA Reviews only) • Signed and Completed LTHH PAR (IHSS HMA Reviews only, and if applicable) • CDASS Task Worksheet (CDASS HMA Reviews only) • CDASS Monthly Allocation (CDASS HMA Reviews only) • Any applicable supporting documentation to justify HMA utilization request	Documents Required for Submission: • IHSS Care Plan Calculator (IHSS HMA Reviews only) • IHSS Agency Plan of Care (IHSS HMA Reviews only) • Signed and Completed LTHH PAR (IHSS HMA Reviews only, and if applicable) • CDASS Task Worksheet (CDASS HMA Reviews only) • CDASS Monthly Allocation (CDASS HMA Reviews only) • Any applicable supporting documentation to justify HMA utilization request	• Documents Required for Submission: • 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 HMA Reviews only) • Current certification CDASS task worksheet (CDASS HMA Reviews only) • Current certification LTHH 485 (for IHSS HMA reviews only, and if applicable)

Review Comparison

	Standard	Rapid	Express
Over-Cost Containment (OCC) Reviews	Turnaround Time: 4 days	Turnaround Time: 2 days	Turnaround Time: 2 days
	Documents Required for Submission: • IHSS Care Plan Calculator (if applicable) • IHSS Agency Care Plan (if applicable) • CDASS Task Worksheet (if applicable)	Documents Required for Submission: • IHSS Care Plan Calculator (if applicable) • IHSS Agency Care Plan (if applicable) • CDASS Task Worksheet (if applicable) • CDASS Monthly Allocation (if applicable)	Documents Required for Submission: • Express Review Qualification Attestation form
	• CDASS Monthly Allocation (if applicable) • LTHH signed and completed LTHH PAR and 485 (if applicable) • Any applicable supporting documentation to justify OCC utilization request	• LTHH signed and completed LTHH PAR and 485 (if applicable) • Any applicable supporting documentation to justify OCC utilization request	• Outcome Letter from Telligen's most recently completed CSR/Initial or Revision review • Current certification IHSS Care Plan Calculator and IHSS Agency Care Plan (if applicable) • Current certification CDASS Task Worksheet (CDASS HMA Reviews only) • Current certification LTHH 485 (if applicable)

Review Comparison

	Standard	Rapid	Express
Overlapping Scope, HMA + OCC Review	Turnaround Time: 4 days Documents Required for Submission: • IHSS Care Plan Calculator (if applicable) • IHSS Agency Care Plan (if applicable) • CDASS Task Worksheet (if applicable) • CDASS Monthly Allocation (if applicable) • LTHH signed and completed LTHH PAR and 485 (if applicable) • Any applicable supporting documentation to justify OCC utilization request	Turnaround Time: 2 days Documents Required for Submission: • IHSS Care Plan Calculator (if applicable) • IHSS Agency Care Plan (if applicable) • CDASS Task Worksheet (if applicable) • CDASS Monthly Allocation (if applicable) • LTHH signed and completed LTHH PAR and 485 (if applicable) • Any applicable supporting documentation to justify OCC utilization request	Turnaround Time: 2 days Documents Required for Submission: • Express Review Qualification Attestation form • Outcome Letter from Telligen's most recently completed CSR/Initial or Revision review • Current certification IHSS Care Plan Calculator and IHSS Agency Care Plan (if applicable) • Current certification CDASS Task Worksheet (CDASS HMA Reviews only) • Current certification LTHH 485 (if applicable)
Supported Living Services Exception Process	Turnaround Time: 5 days Documents Required for Submission: • SLS Exception Request Form • Screen shot of authorized PAR • CDASS Review Case ID, if applicable • CDASS Task Worksheet, if applicable • CDASS Exercise Orders, if applicable • Any applicable supporting documentation to justify the request	Not Available	Not Available

Questions?

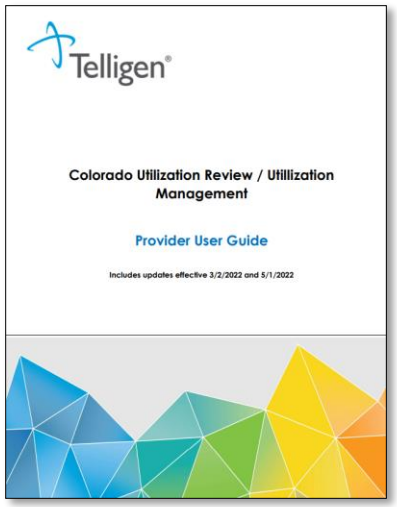
Preparing for a Review

Resources

- HCBS Utilization Review/Utilization Management Website
  - This website contains the following resources:
    - Office Hours Information
    - Training Materials
    - Forms and Templates
    - Memos and Guidance
    - Contacts
- UR/UM Provider User Guide
- Telligen Review Type Comparison
- Health Maintenance Activities (HMA) Documentation Guide
- Long-Term Services and Supports Case Management Forms and Tools

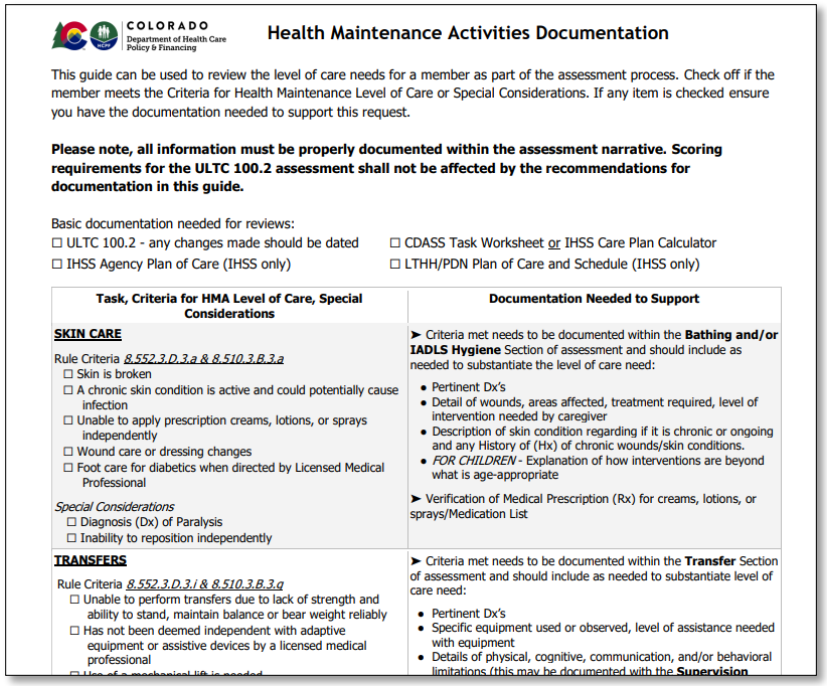
Preparing for a Review

- UR/UM Provider User Guide
  - Documentation - each review type has a list of both required and optional documentation to prepare for the submission process
    - Examples of clinical documentation to support Prior Authorization criteria
  - Timelines – associated timelines for each review type
  - Communication - collaboration among member, CMA, and agency (if applicable)



Preparing for a Review

- Health Maintenance Activities Documentation Guide
  - When submitting utilization management reviews for Health Maintenance Activities, the HMA Guide can prove to be a useful tool for determining the appropriate documentation to be submitted with each review



COLORADO
Department of Health Care Policy & Financing

Health Maintenance Activities Documentation

This guide can be used to review the level of care needs for a member as part of the assessment process. Check off if the member meets the Criteria for Health Maintenance Level of Care or Special Considerations. If any item is checked ensure you have the documentation needed to support this request.

Please note, all information must be properly documented within the assessment narrative. Scoring requirements for the ULTC 100.2 assessment shall not be affected by the recommendations for documentation in this guide.

Basic documentation needed for reviews:

☐ ULTC 100.2 - any changes made should be dated
☐ CDASS Task Worksheet or IHSS Care Plan Calculator
☐ IHSS Agency Plan of Care (IHSS only)
☐ LTHH/PDN Plan of Care and Schedule (IHSS only)

Task, Criteria for HMA Level of Care, Special Considerations	Documentation Needed to Support
SKIN CARE Rule Criteria *8.552.3.D.3.a & 8.510.3.B.3.a* ☐ Skin is broken ☐ A chronic skin condition is active and could potentially cause infection ☐ Unable to apply prescription creams, lotions, or sprays independently ☐ Wound care or dressing changes ☐ Foot care for diabetics when directed by Licensed Medical Professional *Special Considerations* ☐ Diagnosis (Dx) of Paralysis ☐ Inability to reposition independently	➤ Criteria met needs to be documented within the **Bathing and/or IADLS Hygiene** Section of assessment and should include as needed to substantiate the level of care need: • Pertinent Dx's • Detail of wounds, areas affected, treatment required, level of intervention needed by caregiver • Description of skin condition regarding if it is chronic or ongoing and any History of (Hx) of chronic wounds/skin conditions. • *FOR CHILDREN* - Explanation of how interventions are beyond what is age-appropriate ➤ Verification of Medical Prescription (Rx) for creams, lotions, or sprays/Medication List
TRANSFERS Rule Criteria *8.552.3.D.3.i & 8.510.3.B.3.g* ☐ Unable to perform transfers due to lack of strength and ability to stand, maintain balance or bear weight reliably ☐ Has not been deemed independent with adaptive equipment or assistive devices by a licensed medical professional ☐ Use of a mechanical lift is needed	➤ Criteria met needs to be documented within the **Transfer** Section of assessment and should include as needed to substantiate level of care need: • Pertinent Dx's • Specific equipment used or observed, level of assistance needed with equipment • Details of physical, cognitive, communication, and/or behavioral limitations (this may be documented with the **Supervision**

Submitting a Review

Resources

- Using Qualitrac Training
- Tip Sheets
- Procedure Codes – Modifiers List
- Video – How to Submit a Review in Qualitrac Using Procedure Codes
- Supported Living Services Waiver Exception Review Process Webpage
- Tip Sheet #3 For SLS Waiver Assistance

Submitting a Review

Ensure the following is met for each UR/UM review:

- Basic documentation needed is included in the submission
  - ULTC 100.2/Level of Care assessment
  - IHSS Agency Care Plan (IHSS Only)
  - CDASS Task Worksheet or IHSS Care Plan Calculator
  - LTHH / PDN Plan of Care and schedule (if applicable)
  - SLS Exception Review Request Form (SLS Exception Review requests only)
- The services needed are clearly and thoroughly documented and justified in the ULTC 100.2/Level of Care assessment. There is ample documentation to ensure no duplication of services.
- Procedure code entries are correctly entered into Qualitrac (Telligen's Provider Portal).
- The frequency on the CDASS Task Worksheet / IHSS Care Plan Calculator matches all documentation submitted and tasks are clearly justified.

Questions?

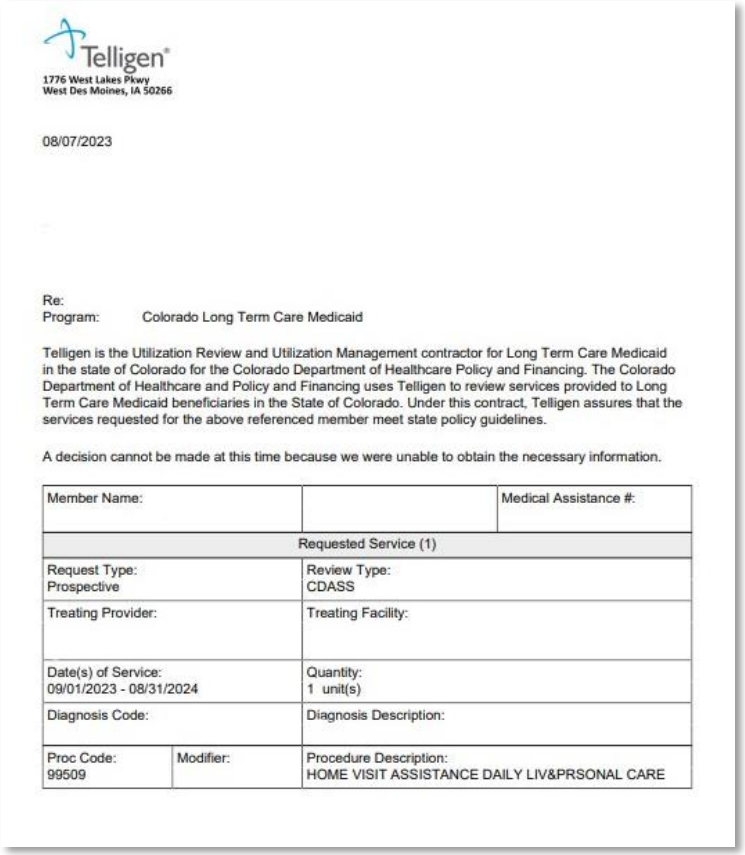
Post-Review Next Steps

Resources

- UR/UM Provider User Guide
- Telligen Office Hours Write Up
  - This document provides information on common RFIs and how to avoid them

Requests for Information (RFI)

- Requests for Information (RFI) are issued when more information is needed for a review to be completed.
- An email notification will be sent to the case manager to notify of an RFI. The RFI letter will automatically be attached to the case in Qualitrac.
- Case Managers should read through the RFI carefully and add any missing documents and information to the case
- Case Managers should respond to the RFI within 10 business days and Telligen will respond within 5 business days
- Failure to respond to an RFI within 10 days will result in a Technical Denial



Telligen
1776 West Lakes Pkwy
West Des Moines, IA 50266

08/07/2023

Re:
Program: Colorado Long Term Care Medicaid

Telligen is the Utilization Review and Utilization Management contractor for Long Term Care Medicaid in the state of Colorado for the Colorado Department of Healthcare Policy and Financing. The Colorado Department of Healthcare and Policy and Financing uses Telligen to review services provided to Long Term Care Medicaid beneficiaries in the State of Colorado. Under this contract, Telligen assures that the services requested for the above referenced member meet state policy guidelines.

A decision cannot be made at this time because we were unable to obtain the necessary information.

Member Name:		Medical Assistance #:
Requested Service (1)		
Request Type: Prospective		Review Type: CDASS
Treating Provider:		Treating Facility:
Date(s) of Service: 09/01/2023 - 08/31/2024		Quantity: 1 unit(s)
Diagnosis Code:		Diagnosis Description:
Proc Code: 99509	Modifier:	Procedure Description: HOME VISIT ASSISTANCE DAILY LIV&PRSONAL CARE

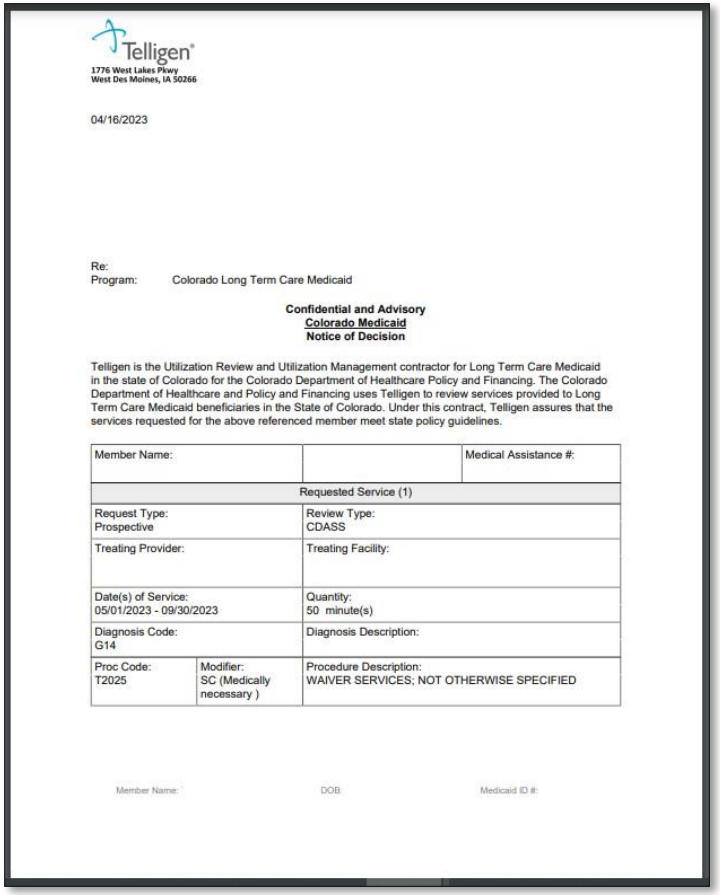
Common Reasons for RFI

Reason for RFI	RFI was received because…	Try instead…
Missing Documentation	Documents that were submitted with prior year request are not submitted with new request	Submit all documents that were submitted with previous reviews to ensure Telligen has all information relevant to the current request.
	Request for a new plan year is submitted without concurrent documentation (100.2, IHSS Care Plan Calculator, CDASS Task Worksheet, etc.)	Submit the documentation that coincides with the service date range submitted in the review. For example: services that span 1/1/2023 – 12/31/2023 should have supporting documentation (100.2, IHSS Care Plan, etc.) that cover the same date range.
	A review is submitted to Telligen, but the services requested in Bridge don't match the services requested in Qualitrac	Double check the services requested in Bridge before submitting a review to Telligen to ensure they match
Missing Justification	Request doesn't have enough information to justify the services requested	Submit justification that includes: • Number of hours for services being requested, any specific information about what the specific task looks like, and for how long etc. • Norms for services and tasks should be explained • Justification should show the details about why there is not any duplication

Outcome Letter Received

Outcome Types:

- Approval Received
- Partial Denial Received
- Denial



Telligen
1776 West Lakes Pkwy
West Des Moines, IA 50266

04/16/2023

Re:
Program: Colorado Long Term Care Medicaid

Confidential and Advisory
Colorado Medicaid
Notice of Decision

Telligen is the Utilization Review and Utilization Management contractor for Long Term Care Medicaid in the state of Colorado for the Colorado Department of Healthcare Policy and Financing. The Colorado Department of Healthcare and Policy and Financing uses Telligen to review services provided to Long Term Care Medicaid beneficiaries in the State of Colorado. Under this contract, Telligen assures that the services requested for the above referenced member meet state policy guidelines.

Member Name:		Medical Assistance #:
Requested Service (1)		
Request Type: Prospective		Review Type: CDASS
Treating Provider:		Treating Facility:
Date(s) of Service: 05/01/2023 - 09/30/2023		Quantity: 50 minute(s)
Diagnosis Code: G14		Diagnosis Description:
Proc Code: T2025	Modifier: SC (Medically necessary)	Procedure Description: WAIVER SERVICES; NOT OTHERWISE SPECIFIED

Member Name: DOB: Medicaid ID #:

Approval Received

- 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 reach out to the LTSSOCC@state.co.us

Partial Denial Received

- 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 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 reach out to the LTSSOCC@state.co.us if the case is Over Cost
- A Long-Term Care Notice of Action must be sent to the member

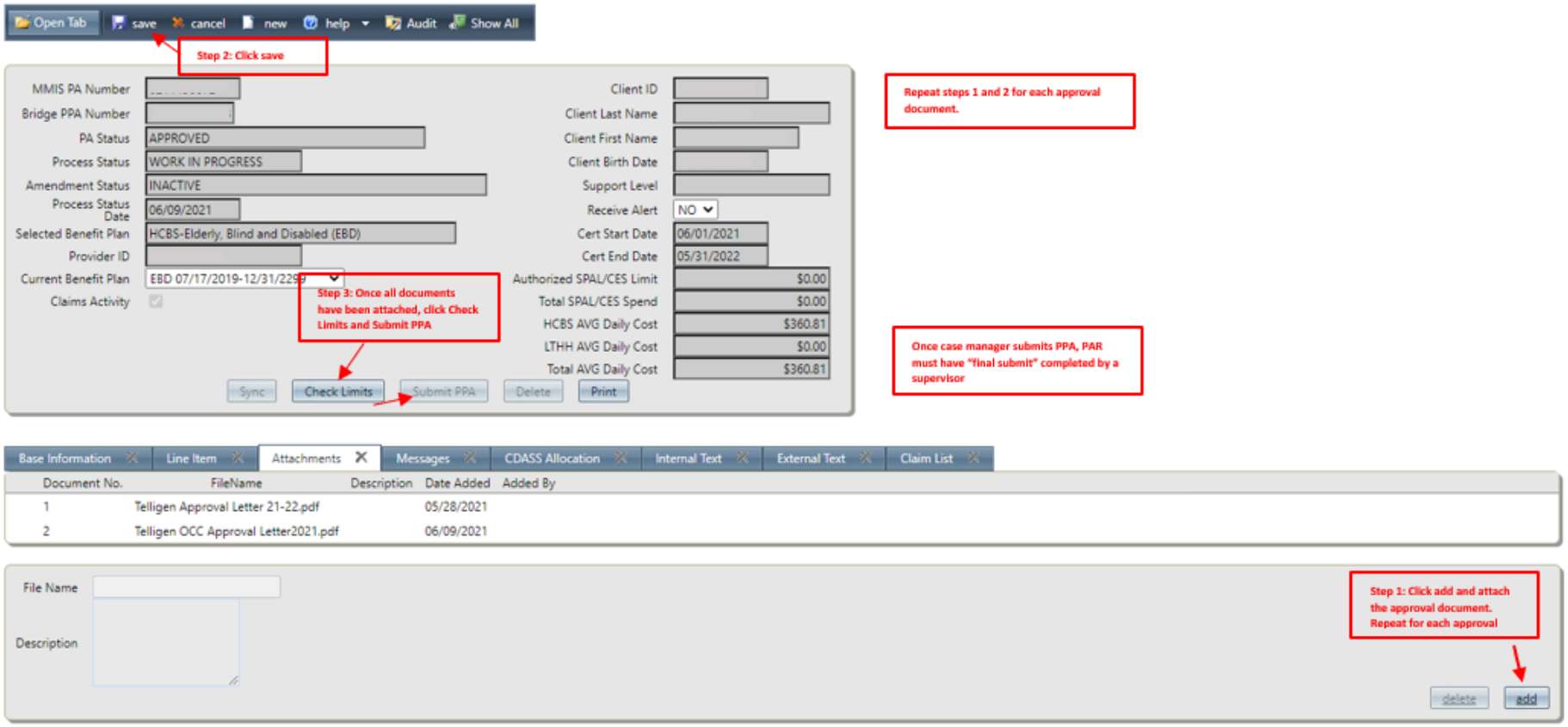
Denial Received

- 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

Steps to Upload Outcome Letter to PAR in Bridge

1. Open the PAR and go to Attachments
2. Click Add and attach the PDF Outcome letter
3. Click Save
4. Once all documents have been attached, click Check limits and then Submit PPA

Adding Outcome Letter to Bridge



Reconsiderations / First Level Appeals

- Case Managers can request a reconsideration / First Level Appeal by Telligen within 5 business days of a denial or partial approval
- A new request will be generated in Qualitrac within the same Case ID
- Case Managers will need to attach any additional documentation to support the reconsideration
- If new information is not able to be obtained, the CM can resubmit a new request at a future date when that information is obtained
- The Telligen “first level appeal” or reconsideration is **not** considered an official appeal through the Notice of Action

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.

Questions?

Long-Term Care Notice of Action (LTC NOA)

10 CCR 2505-10 8.519.22.A The Case Management Agency shall provide the long-term notice of action form to Clients within ten (10) business days regarding their appeal rights in accordance with Section 8.507 et seq when: 1. An adverse action occurs that affects the provision of the Client's Waiver services.

Example Scenario 1:

There are no approved services prior to the end of a current certification approval. (For example, late review submission to Telligen and there will not be an approval in time for the anticipated start date of the next certification period).

↓

Member does not have access to continue previously approved services; resulting in a denial of services on the anticipated start date of the next certification period.

↓

Case Manager Action: LTC NOA* must be sent as a denial of services.

Long Term Care Notice of Action (LTC NOA)

10 CCR 2505-10 8.519.22.D The Client shall be notified, pursuant to Section 8.057.2.A., when the following results in an adverse action that does not relate to waiver Client eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the needs assessment.

Example Scenario 2:

An IHSS/CDASS or OCC Review results in a partial denial or denial.

↓

Member **is not able to access all** requested services.

↓

Case Manager Action: LTC NOA* must be sent as a denial of services.

* Even if the case manager intends to submit a reconsideration, the NOA should still be sent while the case manager works through the process of updating the documentation and submitting for review to ensure services can remain at the current level through the appeal process.

Rule Citation Example for LTC NOA

Example: A CDASS Review results in partial denial of HMA for duplication of mobility time and accompaniment time.
Action: The case manager must enter an LTC NOA and notify member of adverse action using the most appropriate rule citation.

1. Identify denial "reason" → 2. Find the correct Waiver rule → 3. Find the correct service definition

For this example, both the following rule citations apply:*

10 CCR 2505-10 8.519.14.A.3. The Case Manager shall submit a PAR in compliance with all applicable regulation and ensure requested services are:
3. Not duplicative of another service, including but not limited to services provided through: a. Medicaid state plan benefits, b. Third party resources, c. Natural supports, d. Charitable organizations, or e. other public assistance programs.

10 CCR 2505-10 8.510.3.B.2.m. Accompanying includes going with the Client, as indicated in the care plan, to medical appointment and errands, such as banking and household shopping. Accompanying the Client to provide one or more personal care services as needed during the trip. Attendant may assist with communication, documentation, verbal prompting, and/or hands-on assistance when tasks cannot be completed without support of the Attendant.

*** This list is not exhaustive and is only used to demonstrate how Case Managers can determine appropriate rule citation for a LTC NOA document.**

Long Term Care Notice of Action (LTC NOA)

Example Scenario 3:

An IHSS/CDASS or OCC Review results in approval of all services requested.

⬇

Member can **access all services as requested.**

⬇

Case Manager Action: No LTC NOA needed

Final Questions?

Contact Info

HCPF Contacts

Participant Directed Programs Unit

hcpf_pdp@state.co.us

Over Cost Containment

ltssocc@state.co.us

SLS Exceptions

Emily.Walsh1@state.co.us

Telligen/Qualitrac Contacts

Telligen Call Center

833-610-1052

ColoradoSupport@Telligen.com

Office Hours Topic Request

Telligen Support Request

Thank you!