Colorado Utilization Review / Utilization Management

Provider User Guide

Updated August 2023

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.

Included are important tips and general information. Specific information for each review type will be outlined in their own sections further into the guide. See the tables for Children's and Adult reviews for documentation requirements. Lastly, additional resources and Department contacts to help users are provided at the end of this guide.

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), Complementary and Integrative Health (FCIH), 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)
- SLS Exception Reviews (added 1/2/2022)

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 July 2023

As of the most recent update, the following items in the review process are new:

* Starting May 2023, new review types are available. These are:

1. IHSS + OCC Rapid Review
2. CDASS + OCC Rapid Review
3. IHSS + OCC Express Review

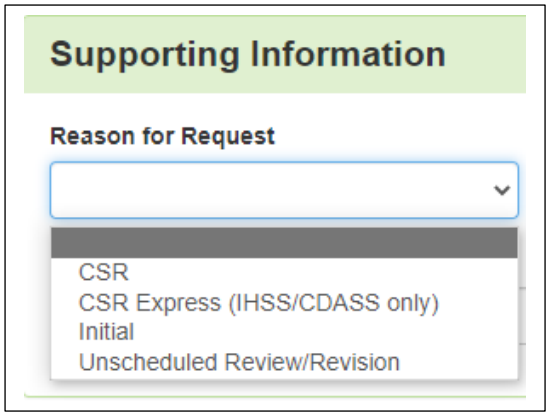
4. CDASS + OCC Express Review

* *Updates to required documentation for OCC and Overlapping OCC reviews

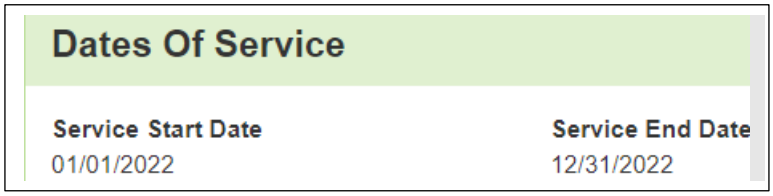
Qualitrac Features

Reason for Request

The CSR Express Option in the Reason for Request box will be removed. Continue to submit Express Reviews as described below and select CSR as the Reason for the request.



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 below)



Please be sure to submit all documentation outlined in the Review Submission Requirements tables below.

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.
- Rapid reviews are not currently available for CES and CHCBS reviews.

Outcomes

Potential Outcomes

Outcomes include Approved, Partial Denial and Denied. Each procedure code entered will have its own outcome. For the Procedure Code 99509 which is requested on all HMA reviews, the outcome will always be Outcome Not Rendered as there are no HMA items to review in this code. Other procedure codes submitted may also result in Outcome Not Rendered when Telligen uses the information submitted in the review but is not charged with issuing an outcome on that item.

Case Managers can request a reconsideration for any partial denial or denial. Reconsiderations are not needed, or allowed, for Outcome Not Rendered determinations.

Reconsiderations/First Level Appeal in Qualitrac

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 automatically when the First Level Appeal is created. 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 a denial for missing documents only since no RFI will be issued for these requests. If the denial is for any other reason a reconsideration may not be used and a standard request should be submitted.

A reconsideration 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.

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 within 90 days of the original submission date. 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.

Requests for Information

Requests for Information (RFIs) are issued when more information is needed for a request. The submitter will receive an automated notification from Qualitrac when the case is an RFI is requested by the reviewer. Information needed is included in the RFI letter attached to the case. Please read the RFI carefully and be sure to address all items.

The most common reasons for RFIs are missing documentation, missing justification for services being requested (may require an update to the BUS documentation or additional documentation to be submitted in a separate document, requests for hours in an IHSS calculator that don't match the agency care plan, etc. Please review the documentation and include information that supports the minutes being requested, including what services are being requested, the individual's need for the services, what the caregiver is

doing (hands-on assistance) how long it takes each time and how often the service is performed.

Telligen's reviewers will access the BUS to review the documentation there – the CM does not need to submit a digital copy.

When responding to an RFI, submit all relevant information and ensure that each item in the RFI is addressed.

RFIs must receive a response within five (10) business days. If there is no response the case will be moved into a Technical Denial. CMs may reopen a case in Technical Denial status when all information in the RFI is available. Cases may be reopened one time within 90 days of the original submission.

Reviews for Children

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.

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, any time there is a significant change in the member's condition (Unscheduled Review), and at annual redetermination (Continued Stay Review, or CSR).

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.

Telligen has access to the Department's system to review the Long Term Care Screen (LTC). Case Managers can also provide additional supporting documentation as they see fit

All CHCBS waiver members will need to submit a review to Telligen at CSR and Unscheduled 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.

More Information about IHSS reviews for children on the CHCBS waiver can be found in the Health Maintenance Activities (HMA) Reviews: In-Home Support Services (IHSS)& Consumer Directed Attendant Support Services (CDASS) section of the guide.

Children's Reviews				
	Children's Extensive Waiver	**Children's Home and Community Based Services (CHCBS)**	**In-Home Support Services (IHSS)**	**IHSS + CHCBS Overlapping Scope Review**
Place of Service	Community	Community	Community	Community
Type of Service	Home and Community Based Services	Home and Community Based Services	Home and Community Based Services	Home and Community Based Services
Timing	Prospective, Concurrent	Prospective, Concurrent	Prospective, Concurrent	Prospective, Concurrent
Selecting Providers	Select the case management agency (CMA) for both *Treating Provider* and *Ordering Provider*. The CMA should also be selected in the *Visibility Panel*. **The NPI or Other ID that was used by the case management agency to register for Qualitrac must be selected.**			
Suggested Procedure Code	H2014: Community HCBS Habilitation	H2014: Community HCBS Habilitation	See Procedure Codes/Modifiers reference information and a link to the Procedure Codes-Modifiers List.	H2014: Community HCBS Habilitation See Procedure Codes/Modifiers reference information and a link to the Procedure Codes-Modifiers List.

Examples of Clinical Documentation	**Required:** Long Term Care Screen CES Application **Optional:** Clinical Notes Other Documents demonstrating need PMIP Therapy Notes Medical Records Provider/physician orders/clinical notes/letters and any other supporting documentation Medication List	**Required:** Long Term Care Screen PMIP (initial only) **Optional:** Therapy Notes Medical Records Medication List	**Required:** Long Term Care Screen IHSS Care Plan Calculator IHSS Agency Plan of Care Signed and completed LTHH PAR (if applicable) LTHH Agency 485 / Plan of Care (if applicable) **Optional:** PDN Plan of Care and schedule Verification of exercise plan Therapy Notes Medical Records Previous service plans including previous provider agency care plan Provider/physician orders/clinical notes/letters and any other supporting documentation	**Required:** Long Term Care Screen PMIP (initial only) IHSS Care Plan Calculator IHSS Agency Plan of Care Signed and completed LTHH PAR (if applicable) LTHH Agency 485 / Plan of Care (if applicable) **Optional:** Therapy Notes Medical Records Medication List PDN Plan of Care and schedule Verification of exercise plan Previous service plans including previous provider agency care plan Provider/physician orders/clinical notes/letters and any other supporting documentation

Turn-Around Times for Reviews				
	Children's Extensive Waiver	**Children's Home and Community Based Services (CHCBS)**	**In-Home Support Services (IHSS)**	**IHSS + CHCBS Overlapping Scope Review**
Standard	10 Business Days		4 Business Days	7 Business Days
Rapid	Not Available		2 Business Days	Not Available
Request For Information Case Manager Response	10 Business Days *If no additional information received by Telligen, a Technical Denial will be issued			
Post-RFI Response Review	5 Business Days	5 Business Days	5 Business Days	5 Business Days
Reconsideration Window	5 Business Days from Outcome Rendered Date *If desired outcome is not rendered after reconsideration, a new review must be submitted			

Reviews for Adults

Health Maintenance Activities (HMA) Reviews: In-Home Support Services (IHSS)& Consumer Directed Attendant Support Services (CDASS)

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.

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 outcome 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 outcome letter for the PAR being revised to decrease HMA units.

See the Adult Review Table below for additional review submission information.

Over-Cost Containment (OCC) Review

The OCC review is required when the average daily cost of HCBS and LTHH services exceeds $315/day for the EBD, BI, CMHS, and CIH 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 Long Term Care Screen (LTC) 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 $315 or higher, an OCC review shall be submitted prior to revised services being authorized.

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.

Overlapping Reviews

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, CMs 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.

The following Overlapping Reviews are available:

CDASS / OCC
CDASS / OCC Rapid
IHSS / OCC
IHSS / OCC Rapid
IHSS / CHCBS

Express 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 and submit the form with each Express Review. The form can be found here: Express Review Qualification Attestation Form

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

NOTE: Express reviews may only be utilized every-other review. An express review cannot be submitted as an extension of another express review.

The following Express Reviews are available:

IHSS
IHSS + OCC (as of May 2023)
CDASS
CDASS + OCC
OCC

Instructions for submitting Express reviews can be found in Tip Sheet 4

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 the case management agency making the submission for both Treating Provider and Ordering Provider. Also select the same CMA in the Visibility Panel. **Be sure to select the listing of the case management 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 Procedure Codes/Modifiers reference information and a link to the Procedure Codes-Modifiers List. 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 HMA/OCC Express 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.

SLS Exceptions Reviews

SLS Exceptions reviews are 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.

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.

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.

Adult Reviews						
	Consumer Directed Attendant Support Services (CDASS)	**In-Home Support Services (IHSS)**	**Over Cost Containment (OCC)**	**Consumer Directed Attendant Support Services + Over Cost Containment (CDASS + OCC)**	**In-Home Support Services + Over Cost Containment (IHSS = OCC)**	**Supported Living Services (SLS)**
Place of Service	Community	Community	Community	Community	Community	Community
Type of Service	Home and Community Based Services	Home and Community Based Services	Home and Community Based Services	Home and Community Based Services	Home and Community Based Services	Home and Community Based Services
Timing	Prospective, Concurrent	Prospective, Concurrent	Prospective, Concurrent	Prospective, Concurrent	Prospective, Concurrent	Prospective, Concurrent
Selecting Providers	Select the case management agency (CMA) for both *Treating Provider* and *Ordering Provider*. The CMA should also be selected in the *Visibility Panel*. **The NPI or Other ID that was used by the case management agency to register for Qualitrac must be selected.**					
Suggested Procedure Code	See Procedure Codes/Modifier reference information	See Procedure Codes/Modifier reference information	See Procedure Codes/Modifier reference information	See Procedure Codes/Modifier reference information	See Procedure Codes/Modifier reference information	H2014: Community HCBS Habilitation & See Procedure Codes/Modifiers reference information and a link to the Procedure Codes-Modifiers List

Examples of Clinical Documentation	**Required:** Long Term Care Screen CDASS Task Worksheet Exercise Orders if applicable **Optional:** Medical Records Provider/ physician orders / clinical notes/ letters and any other supporting documentation Medication List	**Required:** Long Term Care Screen IHSS Care Plan Calculator IHSS Agency Plan of Care Signed and completed LTHH PAR (if applicable) LTHH Agency 485 / Plan of Care (if applicable) **Optional:** PDN Plan of Care and schedule Verification of exercise plan Therapy Notes Medical Records Previous service plans including previous provider agency care	**Required:** Long Term Care Screen **CDASS Specific Requirements** CDASS Task Worksheet CDASS Review Case ID **IHSS Specific Requirements** IHSS Care Plan Calculator IHSS Agency Plan of Care IHSS Review Case ID **LTHH Specific Requirements** LTHH Signed and Completed LTHH PAR LTHH Agency 485/Plan of Care **Optional:** PDN Plan of Care and schedule	**Required:** Long Term Care Screen CDASS Task Worksheet Exercise Orders if applicable **Optional:** Medical Records Provider/ physician orders/clinical notes/letters and any other supporting documentation Medication List	**Required:** Long Term Care Screen IHSS Care Plan Calculator IHSS Agency Plan of Care Signed and completed LTHH PAR (if applicable) LTHH Agency 485 / Plan of Care (if applicable) **Optional:** PDN Plan of Care and schedule Verification of exercise plan Therapy Notes Medical Records Previous service plans including previous provider agency care	**Required:** Long Term Care Screen SLS Exceptions Review Request Form Screen shot of authorized PAR CDASS Approval Case ID when applicable **CDASS Specific Requirements** CDASS Task Worksheet CDASS Review Case ID CDASS Exercise Orders, if applicable **Optional:** Medical Records Provider/ physician orders/clinical notes/letters and any other supporting

		plan Provider /physician orders/clinical notes/letters and any other supporting documentation Medication List	Verification of exercise plan Therapy Notes Medical Records Previous service plans including previous provider agency care plan Provider/ physician orders/clinical notes/letters and any other supporting documentation Medication List		plan Provider/ physician orders/clinical notes/letters and any other supporting documentation Medication List	documentation Medication List

Turn-Around Times for Reviews						
	CDASS	**IHSS**	**OCC**	**CDASS + OCC**	**IHSS + OCC**	**SLS Exceptions**
Standard	4 Business Days	4 Business Days	4 Business Days	4 Business Days	4 Business Days	5 Business Days
Rapid	2 Business Days	2 Business Days	2 Business Days	2 Business Days	2 Business Days	Not Available
Request For Information Case Manager Response	10 Business Days * If no additional information received by Telligen, a Technical Denial will be issued					
Post-RFI Response Review	5 Business Days	5 Business Days	5 Business Days	5 Business Days	5 Business Days	5 Business Days
Reconsideration Window	5 Business Days from Outcome Rendered date	5 Business Days from Outcome Rendered date	5 Business Days from Outcome Rendered date	5 Business Days from Outcome Rendered date	5 Business Days from Outcome Rendered date	5 Business Days from Outcome Rendered date
Reconsideration Review	5 Business Days *If desired outcome is not rendered after reconsideration, a new review must be submitted					

PASRR

Submit all requests for PASRR reviews in Qualitrac (www.myqualitrac.com). Previously used PASRR Level 1 screening forms (PAL/PAS) will not be accepted.

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 (no additional procedure codes are needed)
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 (Required when Level 2 is indicated) 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

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 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 is no longer required for these reviews.

For details on selecting procedure codes and modifiers, and entering costs, in Qualitrac please see Tip Sheet 5.

Additional Resources

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

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: hcpf_hcbs_casemanagement@state.co.us

For PASRR, contact:

- PASRR: Margaret Anderson, Margaret.anderson@state.co.us