

## June 2014 - Monthly Provider Support Call Summary

*\*\*Please share with your case managers and administrative staff or other employees.\*\**

Each month the WDH-Behavioral Health Division holds a monthly provider support call to let providers know what is going on and give additional clarification on items that have been released. **The next call is Monday, July 28<sup>th</sup> at 2pm.**

### CALL TOPICS & SUMMARY

## CASE MANAGERS- IMPORTANT REMINDERS FROM PSS UNIT

- Plans of care cannot be transitioned in the middle of the month. All closures for any waiver type must be effective on the LAST DAY of the month. The new waiver will need to start on the first day of the month.
- Case Managers should not be starting closures for the Child DD waiver more than 90 days in advance. Completing closures before then will cause issues for them when they try to complete modifications on the Child DD waiver.

### Documentation Standards reminder

**Due to some concerns being found with provider documentation, we are asking providers to go back and read the documentation standards in Chapter 45. Here are some of the key reminders from errors we have found:**

- The person providing the service is required to sign the documentation, so if it is a provider staff that is providing the service, that staff is required to sign the documentation, not the provider.
- In addition, providers must ensure all persons signing documentation for services must meet the same qualifications as the provider in order to provide services and sign the schedules. For example CPR/First Aid, Background checks, participant specific training, Medication assistance, the divisions training modules.
- All signatures should be legible and if not, the provider, or provider staff should also print their name below their signature. Initials are not allowed to replace signatures.
- Also, all providers are required to submit service documentation and billing information for each month to the case manager by the 10th business day of the following month. This includes all schedules, and copies of XEROX billing summaries for each individual participant. Case managers are required to review all documentation of services that providers submit. Without the documentation, case managers are unable to complete this requirement. If a provider fails to submit the required documentation, the case manager shall give written notification of noncompliance to the provider with a copy submitted to the Behavioral Health Division. Chronic failure to submit documentation may result in provider sanctions.
- Please remember that following documentation standards is the responsibility of the provider, not the Division, not the case manager, not the guardians. If providers are confused on how to follow the documentation standards, they must contact their Provider Support Specialist for assistance. Provider Support specialists are always available to provide assistance, training, and additional education to any area of waiver service provision in which a provider may be confused which includes following documentation standards.
- Please remember to review the documentations standards on a regular basis, and have it posted next to where you complete your paperwork as a good reminder for what must be included in documentation.

### Conflict Free Case Management Agency Application

- All case managers, including sole proprietors and agencies who want to continue to perform services beyond July 1, 2015 will need to complete the Conflict Free Case Management Agency Application.
- If you have not already submitted official transcripts to the Division, please have them sent directly from the accredited University or College you attended to your area Provider Support Specialist. A copy of a diploma will not be accepted as proof of a Degree. When filling out the application ensure you have

included detailed work experience for case management services or other related experience you have completed. You will also need to include contact information for each previous employer. The Division will be verifying all information included in the application.

- It is very important that all conflict of interest be resolved, before you submit your case management application. For example, if you provide case management and services to the same participant or if you are a case manager working for an agency, you must resolve the conflicts prior to submitting your application. This will help us to ensure all new case managers are conflict free going forward.
- Case managers should include the new code, rate and units when submitting plans of care with the effective start date of January 1st, 2015 and beyond.
- We are encouraging all case managers to start this application process early, to ensure they have sufficient time to have their questions answered and their completed paperwork submitted to their area Provider Support Specialist.

**Note:** It has been brought to the Division's attention that our current EMWS system is not set up to allow a case manager to work for two different providers and in order to set this type of system up, it would take considerable enhancements, not to mention ensuring HIPAA compliance at many different levels. For this reason, it has been determined that case managers will not be able to work for two different agencies at the same time. The current model will be updated in the near future to reflect this change.

### Case management questions

- **Can home visits be done monthly and billable for non-residential participants?**

For non-residential participants, monthly home visits or more than quarterly home visits may be completed if this is requested by the team. Otherwise, non-residential participants only require a quarterly home visit.

A billable unit of case management is any task or function defined by the behavioral health division as a case management activity that only the case manager or case management agency can provide to or on behalf of the participant and guardian. The Division will be drafting a document which will detail what types of activities will be allowed for billing case management. This should be completed by the end of July and will be posted with the model and sent to case managers.

- **Case Management Back up – An individual is required to have a back-up case manager. However, other language suggests there is no subcontracting. Do you have any ideas/suggestions about how to pay a back-up case manager if they need to step in? IDEAS: Maybe an exception for subcontracting or maybe have the case manager enrolled as an employee?**

When the case manager is meeting with a backup case manager, that due to the PA# assigned to the case manager, only the case manager can actually bill for that time. It will be up to the case manager to provide payment to the backup if that is the arrangement that is made. The Division is not involved in that process. Many of our case managers partner with a specific case manager as back up for their entire caseload and usually it works out equally

- **You are asking for 8 hours a year of training, is this billable and how can case managers get reimbursed for this?**

The 8 clock hours of required annual training will not be billable. Training is already included in the 15 minute rate.

- **Based on the rate methodology what is the division recommending that case managers be paid by the company they work for?**

The Division cannot dictate to case management agencies what they will pay to case managers they employ. This is up to the case management agency to determine. The model located on our website has the rate methodology posted with detailed explanations on how the rate was determined.

### Third party liability forms

**As a reminder, federal law (42 CFR §433 Subpart D, §433.138, and 433.139) requires third parties who are liable for payment of services must be identified. The Medicaid waiver is considered a payer of last resort.** If another insurer or program has the responsibility to pay for costs incurred by a Medicaid eligible individual, that entity is generally required to pay all or part of the cost prior to the Medicaid Waiver making any payment. Service are available through the Rehabilitation Act of 1973 (Department of Workforce Services or Division of Vocational Rehabilitation (DVR), Public Law 94-142 (Department of Education), Medicaid, Medicare, state and federal grants, private insurers, or other available programs. If the service is available to the participant, it must be accessed prior to requesting and using waiver funding.

### Third Party Liability Form / Payer of Last Resort –questions from case managers

**We are having issues with the payor of last resort form. DVR is refusing to sign this form. Could you please tell us what we should do about this? Will you not sign off on plans if this form is not included?**

The participant has to apply for services with DVR for them to consider “yes” or “no” that they will cover the service. If you need more time for the DVR appointments and decision, talk to your PSS about getting some services approved now while you are waiting on DVR to evaluate the case. If they still refuse to sign it and decide not to open a case, please let us know where that is occurring so we can work with DVR on resolving those issues.

**When home health services have been contacted for the payor of last resort form and to see if they would provide nursing to our participants some are saying that they would need to do an assessment first. The quoted assessment has been around \$450. Who is going to pay for this? Our participants don't have extra money on their plans for this.**

They should not be charging an assessment fee. If skilled nursing is ordered from a physician then a home health should be considered to cover the service. We have heard that a couple are trying to charge an assessment fee to the participant. If this is occurring, please email your PSS the situation, the name of the provider, the type of assessment and we will get involved with that provider. We are planning a call with home health providers in order to figure out what the issues are.

Talk with your PSS if you need a smaller amount approved until the third party payor situations can get worked through.

### Self Direction Update

As of July 1<sup>st</sup> there will be an additional 20 slots available to participants who wish to utilize self-direction. Public Partnerships, LLC (PPL), who is the contracted entity for financial management services will provide notice to anyone who will receive an invitation for one of the open slots. There are currently 34 participants on the waiting list.

There are two services that are new services for the comprehensive and support waiver which will not be available until September 1, 2014. Those are the homemaker service and residential habilitation shared living. The delay is due to updating both the PPL web portal system and database, as well as, Xerox in order for billing to go through correctly.

Starting on July 1, there will be a new policy put in place for participants utilizing self-directed services. For anyone that has not utilized services for 90 consecutive days, the participant will be automatically disenrolled from self-direction. PPL will notify the case manager 30 days in advance of being disenrolled. If there is extenuating circumstances, case managers can report these to PPL and these will be considered on a case by case basis. In review of utilization, the Division found that some participants were not utilizing self-direction for the full plan year and many that went for six months or longer with no utilization of services. This impacts participants that are on the waiting list.

### Division's new HIPAA secure email system

There is a new secure email system that HIPAA office implemented to all Division from Participant Support and Provider Support Units. It requires users to log on to a portal in order to access the message. We are required to have this feature now and apologize for the inconvenience it causes you.

### **CRT Case Reviews**

Based on questions we have received on CRT, we want to give you more information. Once a formal request for a Clinical Review is submitted through the Electronic Medicaid Waiver System, the Participant Support Specialist assigned to the Participant's case works with the case manager to assemble the information and data needed to support the request. The request must be accompanied by additional information that the participant's Plan of Care Team does not think is adequately captured in the present ICAP, such as significant medical or behavior needs or extraordinary support or service needs.

During the CRT review meeting, the CRT members review all of the case information and request. The plan of care, assessments, and evidence/verification of need submitted are part of this review and discussion. The CRT members then use the Level of Service (LOS) Need rubric and the Residential Habilitation Tiers to determine if the requested increase matches the descriptions in the rubric or tier levels.

To date, the CRT has reviewed twenty-two cases, but the Division is not reporting exact numbers at this time due to confidentiality. Of those cases reviewed, some cases have been sent back to the case manager for documentation to help in supporting the request for a level of service change, some cases have been approved for an increase in Level of Service, and some cases have had no change in the Level of Service. The CRT has also made recommendations for follow up on cases, including a six month re-evaluation, evaluation for nursing facility level of care and a third party referral for assistance with evaluating how to better support the behavioral needs of participants.

There are more cases in the queue for review, however there have been delays in providing the required documentation for a review of these cases. The Division is finding that there is not supporting documentation contained in the case files for behavior and medical indicators that would support an increase in the level of service.

For instance, when a request is presented to the CRT about concerns with behavior - there needs to be current documentation of that behavior for the team, including data on the frequency and severity of the behavior, a written positive support plan and any data that would support the evidence of that behavior, such as graphs and incident reports for the last 6 months.

Requests for a change in Level of Service based on Medical indicators are revealing a similar lack of documentation. The medical condition must be documented by a doctor with written protocol and supporting documentation of the diagnosis.

### **Next Call**

***Next call is July 28<sup>th</sup> at 2pm. Calls will be held on the last Monday of each month when there is no holiday interruption.***

***Thank you for reading and for making time to call in each month!***