PROVIDER COUNCIL FAQ

OCTOBER, 2017

Do UM Care Managers Specialize in the service being requested on TARs? Does Cardinal need to hire more UM Care Managers?

Category: Operations

Population: All

Each UM team has an area of expertise. We have 3 Managers and 8 Supervisors. Each team has between 6 and 8 Care Managers depending on the volume of TARS received by each team.

- Child MH Non-Residential Team
- Child MH Residential Team
- Adult MH team
- Complex team (State funded MH and I/DD services and b-3 services)
- SUD/Inpatient Team
- Registry Team (Innovations and State funds list)
- Innovations Waiver Team

The need for more or less UM Care Managers is considered regularly and is driven by data. In UM we track productivity monthly and that includes measuring Turn-Around-Time, the expectation is that services get processed sooner and preliminary data is showing that this is happening. We will have more definitive information on the next UM Dashboard to be presented in the next Cardinal Provider Council meeting. UM is noticing great strides especially with PRTF reviews we are now averaging a 4-5 days to approval of the service.

This question is regarding the Reconsideration Process. Providers are concerned that services without an authorization will result in denials and waste agency resources. The time to track down reimbursement for services rendered is a burden on providers. Is there a way to receive temporary authorizations during the reconsideration process?

Category: Denial/Appeals

Population: All

- At this time Cardinal Innovations will not provide temporary authorizations during the reconsideration process.
- Providers can deliver the same amount and type of service they were delivering to the member prior to the denial. If the decision is not overturned during the reconsideration process the provider does run the risk of having a pay back. Providers cannot "bill" during this time period but they will have 90 days to submit claims in the event the decision is overturned.

Providers are concerned regarding delays in Cardinal authorizing residential services, specifically in emergencies. In the residential setting, it may be necessary to provide services in an expeditious manner. At times sites also need to be added to the contract. Are there procedures in place for these types of emergencies?

Category: Authorization

Population: All

Cardinal expedites all requests for initial services. If a "routine" member specific agreement is required in order to add an additional site to a Providers' contract the process can take up to 25 days from start to finish because of the different departments involved and the information each requires to ensure compliance. If a situation is an emergency please reach out to the Network Specialist to discuss options.

What is Review and Determination?

Category: Authorization

Population: All

R&D is the process by which a provider would submit a treatment authorization request for re-review, used when a provider has made an inadvertent error on a prior submission. R&D cannot be used if there is not a valid PCP or an auth in place. Providers need to be in our Network for R&D.

What's the timeframe for emergency slots?

Category: Innovations

Population: I/DD

When an Emergency Innovations Slot request is received it is staffed with a Psychologist or Psychiatrist as soon as possible. A letter is generated and sent to the LRP or member informing them of the next steps. There are several things that must happen before a waiver slot can be activated, especially if the member does not have Medicaid, a SIS or psychological testing to validate their diagnosis. An Emergency slot will help the member get Innovations waiver services faster however, it could take the planning team up to 90 days to complete all required steps. Crisis Services and/or other funding sources should be utilized if the member's health and safety are in jeopardy and services are needed immediately.

Service Specific Questions:

Can a member receive State Funded Residential Supports and B3 Respite in the same authorization period?

Category: (b)(3)

Population: All

No, the (b)(3) Respite service definition indicates that Respite cannot be provided or billed during the same authorization period as State Funded Residential Services.

Innovations Crisis services: providers are unclear on how and when to provide the service. Providers are requesting additional training from Cardinal. The service can be delivered prior to receiving an authorization, however, providers expressed concern that if a service is provided without an authorization, there is no guarantee of payment. What are the steps that a provider should take to ensure they will receive authorization?

Category: Innovations

Population: I/DD

- Providers could consider working with the planning team to add Innovations Crisis Services to the annual ISP. This way the service will be in the plan and an update will not have to be submitted unless something more significant changes with regard to the member's services.
- Consideration will be given to the request for additional training.

There is concern about Mobile Crisis providers not being able to call the person in crisis directly but must take the information that the Cardinal staff has gathered. In the past, being able to speak directly with the person in crisis has been a vital part of the service and safety of the staff and individual. Why did this change?

Category: Coordination of Care

Population: All

Cardinal altered the methods of dispatch to increase the measurement of appointments kept within the timeframes (2.15 hours from the call to the call center). By doing this we changed our stats from 82% in Q4 to 92% in Q1. Additional concerns/ questions can be directed to Access Clinical Manager, Scott Evans.

Questions about MSAs:

A PCP is required for State Funded Residential Services. A Client Specific Agreement is required to add an AFL site to the contract for a member that receives State Funded Residential Services. What is the process for providers to follow that does not cause an authorization gap when a member is moving from one AFL site to another within the agency?

Category: Coordination of Care

Population: All

It is best if the member is not moved until an authorization is issued. The provider can submit the request for an MSA (member specific agreement) up to 30 days prior to the move date. Additionally, it is recommended that a discharge TAR is submitted. If the situation is an emergency please reach out directly to your Network Specialist (see question and answer #3)

Questions about TARS:

After reviewing TARs, UM often requests additional information. Each time that this happens the TAR is unprocessed and the provider must enter a new TAR with the additional information which restarts the 14 day period for review. Can UM pend the TAR and give the provider time to respond rather than submitting a new TAR and restarting the 14 day process?

Category: Authorization

Population: All

- If UM requests "additional information" the TAR is not marked "Unable to Process."" The TAR is returned to the provider so that they can answer the questions and resubmit the request. The start date of the service requested does not change when it is resubmitted. It is the same date as the original submission.
- There is a difference between requesting additional information (RAI) versus unable to process (UTP). RAI-requests are regarding additional clinical information or compliance clarification. UTP actions- are incomplete standard items that are listed as requirements in the service records manual i.e. - invalid PCP.

Questions about UTP:

There is a perception that UM has added additional requirements for B3 and State funded services. Providers have been reporting to us that since we added these "new requirements" that more TARS are being marked as Unable to Process.

Category: Coordination of Care

Population: All

We want to clarify that UM has not added additional requirements. What we discovered through Utilization Reviews and other internal audits was that providers were not consistently following the service definitions and/or the service records manual expectations regarding PCPs. When UM would ask for information to be submitted sometimes it wasn't available. That was a concern for us because we want to make the best clinical decision and we can't do that if we don't have the most up to date clinical information or valid PCPs. This resulted in UM asking for this information rather than just "assuming" providers had it in their records.

There are times when UM will mark TARs Unable to Process without contacting us to resolve the problem first. Why?

Category: Authorization

Population: All

- Marking a TAR as UTP is a quick way for UM Care Managers to prioritize requests that come to us correct.

- UM has begun to only UTP 1 time per request if a TAR is submitted and is UTP'd once it cannot be UTP'd again. The UM CM has to reach out to the provider to discuss the request. However, the CM will put in a provider concern for trending which will tell us how many times a specific provider is receiving a UTP.

When unified plans are required, should all agencies affiliated with it be penalized when it is returned as "unable to process?"

Category: Plans

Population: All

Not having a unified plan is not a reason for the UM Care Manager to mark something as Unable to Process, however, the UM Care Manager will recommend that the plan be unified and a provider concern will be entered into the CI system for tracking and trending. The request for service should be returned and additional information should be requested versus UTP.

The responses to the above questions have been formulated to provide general guidance on the utilization management process. However, providers also should ensure that they are familiar with the applicable service definitions, provider manuals, State documentation manuals, person centered plan (PCP) manual, clinical guidelines, etc. Authorization guidelines are also subject to change, so providers should routinely review the provider communication bulletins and joint communications bulletins from the State to ensure they have the most current information.

PROVIDER COUNCIL FAQ

SEPTEMBER, 2016

During a series of provider meetings and feedback from the provider councils, questions regarding Cardinal Innovations Healthcare's utilization management processes have been raised. After the questions were reviewed, the Utilization Management Department recognized that many of the topics were reoccurring. As a result, Utilization Management created this document containing frequently asked questions and answers to assist providers with a better understanding of those reoccurring topics.

What if a provider requests authorization for services that a Cardinal Innovations member already has authorization for from another provider?

Category: Authorization

Population: All

UM is not able to provide authorization for a new provider of the same service until the original provider discharges (or submits a TAR indicating when the discharge is occurring. Depending on the service the plan may support a short overlap for transition purposes). There are a few exceptions where two providers may be authorized for the same services during the same authorization period; however, there must be a coordinated plan in these cases to ensure the authorization guidelines are not exceeded.

Will existing authorizations be changed if a plan is submitted by another agency?

Category: Authorization

Population: All

The existing authorization will not be changed without discussion with the authorized provider; however, if UM receives a signed request by the guardian requesting to change providers, the guardian's request will be honored.

What are the basic requirements or data items that are needed for UM to approve a plan (for example, SIS®, preference assessment, skills, assessment, etc.)?

Category: Authorization

Population: All

The documentation required to be submitted varies depending on the services being requested. For Innovations specific services, providers should be working with their care coordinator to determine what data will be required.

What criteria does Cardinal Innovations use to determine a decision to overrule a physician's/provider's recommendation for a medically necessary treatment for an individual?

Category: Authorization

Population: All

UM reviews service requests based on the Medicaid, State, and Federal guidelines including the waiver, service definitions, and clinical practice guidelines to determine a decision. A recommendation alone does not mean that UM is able to determine that all necessary criteria is met. The best way to support this is for the individual making the recommendation to fully outline why he/she is making the recommendation including supporting how the service criteria is met, why alternative services or less intensive treatment would be unable to meet the individual's needs, and how what the service/treatment being requested is consistent with best practices when applicable. There are many reasons why additional information may be required or a denial might be issued even when a recommendation has been received.

Can you clarify the requirements for (b)(3) plans when members are in other services such as Residential or enhanced services?

Category: (b)(3)

Population: All

In these cases all services should be on the members PCP using the state template. If the PCP is already in place, an update to add the additional (b)(3) services should be completed using PCP update form, which should then contain all services. It is best practice for goals to be centered around the member's need, and may be addressed by multiple providers, but interventions may differ depending on the service being received.

When a member receives multiple (b)(3) services, are these required to be on one plan?

Category: (b)(3)

Population: All

Based on the principles of person-centered planning, it is best practice for the member to have one plan that contains all services; however, a treatment plan/service plan will be accepted if the provider has a plan for coordination of services when a member is not in any enhanced or residential services and is only receiving (b)(3) services. If services are authorized and reauthorization is requested and there is no evidence of coordination, these will be addressed on a case by case basis as coordination of care should be occurring.

There is a Community Guide Needs Assessment that in Innovations the care coordinators develop with individual. Is it required with (b)(3) guide services?

Category: (b)(3)

Population: IDD

The Community Guide Needs Assessment (CGNA) is intended to be used to guide the discussion with the individual and family about what activities through Community Guide they feel they need assistance with. However, the CGNA is not a required Assessment. Care Coordinators may complete these assessments for both individuals with Innovations services and those with (b)(3) services. UM is also aware that a number of the Community Guide providers complete their own internal assessments on top of anything the Care Coordination Department complete to help guide these services.

Additional information is now being requested for (b)(3) services. Have the requirements changed?

Category: (b)(3)

Population: All

The service requirements have not changed. UM is requesting additional information as part of the review process. The documentation requested is the standard documentation that providers should have always maintained in their records this is now just submitted to UM.

How does a provider know if a member is receiving other services?

Category: Coordination of Care

Population: All

As part of the intake process, providers should ask detailed questions to determine if the member is receiving other services. UM will alert the provider if there is another MH or IDD already authorized and inform them who the provider is for coordination of care once a request is submitted.

Why was maintenance of service eliminated?

Category: Denial/Appeals

Population: All

Maintenance of service is not eliminated. It applies when a current service authorization is adjusted prior to the authorizations expiration date. If there is an authorization from January 1, 2016, to March 1, 2016, but in February UM makes an adjustment to the authorization based on new information, the member has the right to appeal and have the service maintained at the originally approved frequency while exercising their due process rights.

Can UM provide clarification and/or documentation about the authorization guidelines/benchmark documents that are utilized to make decisions on services that are requested in the plan?

Category: Guidelines

Population: All

Both the waiver "Hard Limits-Benchmarks for providers and families" and "Authorization Guidelines" can be found on the Cardinal Innovations website under the provider resources. If you have specific questions, email the designated UM mailboxes.

What documents do you need to make the ISP approval process more streamline? My last ISP took 7 days for approval?

Category: Innovations

Population: IDD

UM reviews requests as timely as possibly but as all Innovations annual plan requests are submitted on the first of the month, this can require up to the allowed time frames to complete all reviews. This is why ISPs are submitted a month in advance of the effective dates and updates should be submitted at least to 15 days in advance. For urgent situations, the Care Coordinator would work with UM to prioritize. For any concerns, the provider should discuss with the Care Coordinator.

When ISPs are reviewed are their documents that are more important?

Category: Innovations

Population: IDD

Providers should reference the waiver and the Clinical Coverage Policy 8P. The Clinical Coverage Policy in section 5.3.4 outlines the documents that are required for submission with the ISP for approval. Section 5.3.5 outlines the service specific requirements for each unique service beyond the general documents that must be submitted.

What are overall long-term and short-term outcomes UM is seeking?

Category: Innovations

Population: IDD

UM has to approve Innovations services as directed by the waiver. Generally, we have to ensure waiver compliance, health and welfare. We have to ensure all services are being delivered efficiently and effectively and align with best practices.

When do Outpatient Units Reset?

Category: Outpatient

Population: All

These reset on July 1 of each fiscal year.

Do I need to submit a discharge TAR for Outpatient, if services were under the unmanaged units?

Category: Outpatient

Population: All

Yes, a discharge TAR should be submitted for all services. This provides clinical information on reason for discharge and any recommendations for future planning.

How can I ensure the other provider completes the plan updates?

Category: Plans

Population: All

Best practice is that the plan be developed during a coordinated treatment team or child and family team so that all parties have input and receive the same document. Providers should work collaborative and discuss how information about the member will be communicated.

What signatures are required on a plan?

Category: Plans

Population: All

The PCP manual documents the required signatures on the this document. This includes the need for the member signature, even when under 18 in cases where plans contain SUD information. The service order section must also be fully completed. For service plan/treatment plans, these must be signed at a minimum by the guardian, the provider completing the plan, the member where SUD information is contain, and a service order when this is required for the individual service.

How will authorizations be in sync with one another? (The tar often expires before the plan does. For example, if an agency has been using a modified plan and another agency starts services, will the authorization end dates change to the PCP end date? What if the PCP ends in the middle of the month?

Category: Plans

Population: All

It is common for non-Innovations services that the plans are developed with goals for the full year. Authorizations are based on the established guidelines for the service and in many cases are for a shorter time period than the plan is valid for. Plans and goals should be reviewed by the team monthly to document progress, and update plans (that do not exceed the original plan end date) can be done as necessary to adjust goals/add new services, etc. Plans can be valid for up to 1 year (from date plan developed or signatures whichever is first) but can be less if providers prefer these end at the end of a month. New annual plans can be developed at any time to best coordinate goals and services for the member.

Do we use the NC PCP or the ISP for (b)(3) services?

Category: Plans

Population: All

Either is acceptable for (b)(3) services as long as all the elements required for the plans based on the services are met. For example, MH (b)(3) services require service orders by a licensed clinician.

Who is considered the Clinical Home provider that is responsible for the plan?

Category: Plans

Population: All

Typically, this would be the residential or enhanced service provider, however, as part of the person-centered process, this should be determined by the team and is not determined by Cardinal Innovations.

Can providers and families be provided more information on the documentation needed for ISPs?

Category: Plans

Population: IDD

Clinical Coverage Policy 8P offers information or providers, individuals and families concerning documentation requirements. This should be discussed within the teams and with the Care Coordinator if there are specific questions from the member/their guardian.

Are there specific tools that are used in Routine Reviews and in Focused Utilization Reviews?

Category: Utilization Review

Population: All

Yes. Each service we choose to review has a tool developed by the clinical team in conjunction with the data science team to ensure it is a fair measure. These tools contain information directly from the service definition, the state manuals, and clinical standards of care (clinical guidelines, evidenced based practice, discharge planning, coordination with other providers/primary care etc.)

The responses to the above questions have been formulated to provide general guidance on the utilization management process. However, providers also should ensure that they are familiar with the applicable service definitions, provider manuals, State documentation manuals, person centered plan (PCP) manual, clinical guidelines, etc. Authorization guidelines are also subject to change, so providers should routinely review the provider communication bulletins and joint communications bulletins from the State to ensure they have the most current information.