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Service Utilization Guidelines Information Session FAQ

REVISED 9.23.2020

1. For SED services 18-21, what assessment should be completed since they are still receiving SED services? The locus is not on the list of assessments to input for children services. ***The Child and Adolescent Functional Assessment Scale (CAFAS) should be used.***

2. Can the SUGs available on the DWIHN website be updated to include levels divided by SNI scores for authorizing IDD services? ***YES. It will be updated.***

3. How long can you request general fund, 3 month 6 months? ***The initial General Fund authorization is 90 days. During that time, it is expected that the provider assists the consumer to apply or reinstate Medicaid. Additionally, supporting documentation is expected to be available. Any additional requests beyond the initial 90 authorization will be reviewed by the UM department.*** Or can it be the full year of the IPOS? ***No (See above).***

4. What are the UM guideline limits for Respite? dduckett@psygenics.org ***Respite services are up to 312 units or up to 624 units per quarter based on ages and/or CAFAS scores.***

5. Can you clarify which service request scenarios would call for a CRSP to send a Due Process notice to the person served, versus which scenarios call for the DWIHN to issue the required Due Process notice? ***If a CRSP is terminating, reducing or suspending services, the CRSP will send out the Adverse Benefit Determination (ABD) form. All other scenarios (i.e., medical necessity or admirative denials) DWIHN will send out the ABD. Please also refer to the Policy; ID: 6939438*** https://dwmha.policystat.com/print_server/7f537217115d-48eb-87de-7fcd981c6944/wait/

6. In the new UM guidelines, wraparound is listed as an encounter for the reporting units but it should be listed as a 15-minute unit. Seeing if it was an error to list it as an encounter. ***Yes. That is an error and will be corrected to 15-minute units.***

7. Can you send answers to all questions to all attendees so we all can learn from each other's questions and the answers? ***Yes.***

8. Where are the UM guidelines for youth DD clients? The UM guidelines are still only listed for adults. ***That is correct. At this time, all services requested for youth DD will process to our UM queue for prior review and approval based on medical necessity.***

9. I am also inquiring about case management being authorized for IMH services. It is listed in the new UM guidelines, but it is my understanding that IMH is a bundled service. Can you clarify this? ***Yes, Case Management is bundled within Home Based Service, H0036. Per DWIHN Bulletin #19-004, we add the "IF" modifier to H0036 to identify Infant Mental Health services.***

10. When reviewing the SUGs for services that can be billed in a bundle like Individual Therapy (90832, 90834, 90837), the Excel grid indicates at the minimum, 20 units per year for each of these. If we are billing the bundle code, 9083x, does this mean 20 total units can be authorized per year or 20 per specific code? ***Yes. The number(s) are reflective of one year.***

11. If the total units are 20 per year for a specific code and they have been used up prior to the end of a year, will a future authorization be denied? ***No. It will come to our queue for clinical review prior to approval***. If so, can another SIS be completed to ensure that the consumer is at the correct SIS level? ***Yes, as needed***.

12. For SMI consumers and the LOCUS, what is the difference between the sublevels (1A and 1B, 2A and 2B, etc.) and how would I know if a consumer was at which of these sublevels? The SMI guidelines indicate that there are sublevels but not the LOCUS score associated with each. ***The lower score(s) is Level A and the higher score(s) is Level B.***

13. For SMI, the sublevels referenced above do not appear to mesh with the MI Health Link grid for authorizations. For example, the MHL grid has sublevels for Level 3 (A and B). Is something missing from the SMI document or the MHL grid? The number of units by CPT codes also does not match between the MHL grid and the SMI SUGs (e.g., therapy codes 9083x). Should they match? ***We will double check to ensure accuracy as they may not match at this time.***

14. If members are pre-authorized for 1 Biopsychosocial (BPS) (H0031) and 1 IPOS (H0032) annually how far in advance can we complete the next annual BPS and IPOS without the claim being denied? (e.g. within 30 or 60 days prior to expiration date). ***Within 30 days of the expiration of the current authorization.***

15. Per the SUG grid, there are no annual pre-authorized H0031 or H0032 services for MI Health Link Locus Level 1 and 2 members. Do we have to request authorizations to complete the annuals (e.g. H0031 and H0032) for these members? ***Yes. Those services require a pre-authorization.***

16. If a member is being considered to be stepped down to the outpatient program from ACT, stepped up to ACT or assessed for AFC residential, could an authorization request for a full biopsychosocial (H0031-BI) be approved or would the Locus assessment (H0031-LO) only be approved in these cases? ***Based on medically necessity and the individual need(s) of the consumer, you may request one or both.***

17. I am a new manager of Supports Coordination and I'm not sure who our "return to requester" things are going to right now. Can I request that I be the individual that JVS's are sent to? How do we change the email receiver of the authorization request? ***Return to requestor goes back to the staff profile record and associated email that the individual requested the authorization. You may contact Director, June White in MCO at jwhite1@dwihn.org for any changes to the "return to requestor" designator.***

18. If a SIS has been deferred or declined would they be defaulted to a level one? ***If no SIS has been conducted (i.e., hasn't been scheduled, has been refused or deferred, etc.) you will request services based on your supporting clinical documentation/assessments, etc. The UM department will review your clinical documents (i.e. Individual's Person-Centered Plan, other supporting assessments, etc.) for medical necessity and determination.***

19. Is the BIO supposed to be listed as one of the Goals? ***Services and assessments should never be a goal. The strengths, needs, supports identified in the assessment would be incorporated into the IPOS and support an authorization.***

20. So, Intervention is the same as Objective? ***No. In the DWIHN's Standardized IPOS, they are separate sections. Objectives are the specific, measurable, attainable, relevant, and time-bound part of the goal parts which tells you how you know the goal is accomplished. Interventions are the part of the goal which details steps which list the specific steps, services, and actions to accomplish the goal.***
    a. ***See below reference:*** ***https://omh.ny.gov/omhweb/pros/person_centered_workbook/quick_guide_to_developing_goals.pdf***

    b. **Tips for Developing Interventions: Using the 5 W's**
        i. ***Who is providing the intervention?***
            - **Include the name of the person providing the intervention and his or her relationship to the person**
        ii. ***What is the modality that will be used?***
            - **Group therapy? Individual therapy?**
        iii. ***Where will the intervention be provided?***
            - **Include the name of the PROS Service and the location where it will be provided**
        iv. ***When will the intervention be provided?***
            - **Include both the frequency and the duration of the intervention, i.e. weekly for three months**
        v. ***Why is the intervention being provided?***
            - **What is the purpose for providing the intervention? What mental health barrier is being addressed?**

    c. **Guidelines for Objectives:**
        i. ***Objectives are SMART: Simple or straightforward,***
        ii. ***Measurable***
        iii. ***Achievable***
        iv. ***Realistic***
        v. ***Time framed***

d. **Objectives can be also be remembered via *RUMBA:***
   i. ***Realistic***
   ii. ***Understandable***
   iii. ***Measurable***
   iv. ***Behavioral***
   v. ***Attainable***

21. Should the yearly physical requirement be listed as a Goal? ***Goals are based on what the member wants as a goal. Goals are not services, functions, or tasks; Goals are the intended outcome or what the member wants to achieve. A hypothetical example could be perhaps the member's goal is: I want to have good health. The objective could be; I will obtain an annual physical by December 31, 2020. The intervention may hypothetically be something like; Sarah has identified having good health is important to her but needs assistance ensuring she obtains her annual physical. Sarah and the Support Coordinator (SC) called the health plan to see if they have any automatic call features/assistance to help schedule appointments. Although there is not an automatic feature, the health plan will schedule drop off and pick up for the appointment (this demonstrates exhausting community resource). Sarah does not have any natural supports to assist her further (natural supports exhausted). The SC will write down the name and telephone number of Sarah's physician for her. Sarah will call and make an appointment and call her health plan to schedule transportation. Sarah will put the time and date of the appointment in her telephone. The SC will check with Sarah at least one time per month to ensure progress has been made. After the appointment, Sarah has agreed to provide the SC with a copy of her annual physical to assist with ongoing coordination of care. (This is a hypothetical example and is not inclusive of all steps a member may want to include)***

22. Should the goals include any information from the assessments that have been completed? ***Goals are based on what the member wants as a goal and the intended outcome, this may be information from the assessment.***

23. Does that mean we can no longer refer people to service providers who were not one of the agencies suggested by DWIHN for service for CLS and Respite? ***No, staffing agencies are impaneled through DWIHN to provide staff.***

24. I just want to clarify that CLS and Respite staff who currently work for staffing agencies can continue to work for them if they want to. ***Yes. That is correct.***

25. Does this mean that the agencies outside of the recommended agencies will no longer be able to provide the services? ***As long as a provider is currently impaneled through DWIHN, they are an option to provide services.***

26. Am I understanding correctly, that families can no longer choose the agency they want to work with as far as CLS services are concerned. ***If Community Living Supports are authorized and the family needs assistance finding staff, DWIHN has a list of impaneled staffing agencies to assist with locating staff.***

27. If a client's IPOS authorization is submitted and approved and 5 months later the client loses Medicaid, will the GF authorization request overlap with the regular IPOS authorization? ***A specific GF request would need to be made at the point the Medicaid lapses.***

28. Just wanted to confirm that family hires do not have to switch providers if family is happy with their provider such as ProCare? ***Correct.***

29. But future families will not be able to choose a provider like ProCare? ***Yes, if a family needs assistance finding staff. DWIHN has a list of impaneled staffing agencies to help members locate staff for the authorized services.***