

MED – Children’s Health Care Prevention and Well Child Care Promotion Prior Authorizations

Purpose: Private duty nursing and personal care services are available for member’s age 20 years and under. The need for services must exceed the services available under the intermittent guidelines. The total number of services may not exceed 16 hours per day. A prior authorization (PA) is required and usually is no longer than six months in duration except in rare and unusual circumstances.

Identification of Roles:

Review Coordinator (RC) – verifies eligibility, responds to prior authorization requests and completes authorizations based on criteria.

Review Assistant (RA) – logs PA requests in OnBase, assigns PA number and keywords, forwards PA request to appropriate RC, requests additional information and mails and/or faxes PA forms to providers and send alerts to case managers.

Physician Reviewer (PR) – provides determination for authorizations regarding questioned medical necessity.

Medicaid Medical Director (MMD) – completes physician review or determines that a specialist consultant is necessary.

Case Manager (CM) – communicates with family and provider regarding PA determination.

Performance Standards: In accordance with URAC standards, prospective reviews are completed within 15 calendar days of receipt of the request.

- Complete 95 percent of prior authorization (PA) requests not requiring physician review, and entering them into the system and sending appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.
- Complete 95 percent of PA requests requiring physician review, and entering them into the system and sending appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.
- For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

- Provide an alert to case manager 95 percent of the time 12 months prior to the member turning 21 years of age. Complete 100 percent six months prior to the member turning 21 years of age.

Path of Business Procedure: The Children’s Health Care Prevention and Well-Child-Care Promotion PAs will be received through the PA workflow.

Urgent requests for prior authorization of services will be reviewed and a decision rendered and communicated in no more than 72 hours from receipt of the request. A request is urgent if the situation poses an immediate threat to the health and safety of the Medicaid member or if the attending physician, member or family member indicates that the need is urgent.

This time frame includes holidays and weekends. When an urgent request is received, RC will confer with manager and log the request on the spreadsheet located at MedSrv/Urgent Requests/Urgent Request Tracking.

Step 1: Upon receipt of prior authorization (PA) in review queue, the RC will verify member eligibility.

Step 2: The RC will review previous authorizations in Medicaid Management Information System (MMIS).

Step 3: The RC may review the Children’s Health Care Prevention and Well-Child-Care Promotion request and supporting documentation electronically or elect to review it on hard copy, as home health supporting documentation is extensive.

Step 4: The RC will review the request for completeness to ensure all information necessary to make a decision is present.

Step 5: The RC will review the request for compliance with Medicaid Policy and medical necessity utilizing the Medical Needs Acuity Scoring Tool (MNASt) and Functional Needs Acuity Tool (FNASt) and/or Social Needs Acuity Tool (SNASt), if applicable.

Step 6: The scoring tools will then be used to assist in determining the level of care (LOC) to be authorized.

Step 7: The RC will also reviewed to ensure compliance with the Children’s Health Care Prevention and Well-Child-Care Promotion program guidelines:

- a. Services provided in the home or a combination of home and other settings to the level that care would normally be required in the home.

- b. Services are not provided in a facility.
- c. Services for private duty nursing or personal care do not include homemaker, respite, nurse supervision (including chart review, case discussion, report time or scheduling), services provided to other household members, unauthorized services, transportation and homework assistance.
- d. Services are provided according to a written plan of care authorized by a licensed physician.
- e. Treatment plan must include the total home health agency services including waiver services.
- f. The continuous medical monitoring and assessment order is supported and addressed hourly in the documentation.
- g. Services are authorized for a six-month time frame except in rare and unusual circumstances.
- h. A member who is in a Health Maintenance Organization (HMO) receives services through the HMO.

Step 8: The RC will identify if services requested meet the criteria for special circumstances.

Step 9: If additional information is needed, the RC will complete a request for the information. Only information that is necessary to approve the service will be requested.

Step 10: When the provider returns the additional information, the RA will find the document(s) in the Med Prior Auth queue. RAs do not make clinical decisions or complete clinical interpretation of information.

Step 11: If there is a LOC issue, the RC will refer the request to the Medicaid Medical Director (MMD) for approval of a decrease in the number of approved hours or other medical issues.

Step 12: Upon determination made by the RC or return of the consultant's recommendation, the RC will inform the CM by e-mail or by phone of the determination with instruction for the worker to notify the provider and family. Decreased hours letter is sent to agency with a copy of the MNAST.

Step 13: The RC will identify the CM for the member through Individual Services Information System (ISIS).

Step 14: If the PA cannot be approved as requested, the RC will ask the CM by phone or email to make a determination regarding the following options:

- a. a possible alternative plan;
- b. if the provider will modify the request to match what has been approved; and/or
- c. if any team member requests a conference call in writing to discuss the issue

Step 15: If the CM responds in writing that a team member requests a conference call, the RC will schedule and convene a telephonic conference.

Step 16: When the RC questions medical necessity, amount of hours or the LOC, the RC will refer the PA request to the MMD for determination.

Step 17: The RC will enter the PA in MMIS when decision is complete.

Step 18: For denied authorizations, the RC will generate a denial letter in MMIS to the member selecting the reason for the denial. Appeal Rights will be printed on the back of the Notice of Decision (NOD).

Step 19: The RC will enter comments in free-form text area in MMIS for modified or denied authorizations as needed for clarification.

Step 20: The RA will return the completed forms to the provider.

Step 21: The RA will fax and mail a copy of the PA and related forms to the provider and case manager.

Forms/Reports:

Modification Letter

<Date>

Regarding Prior Authorization #:

Dear Family/Guardian:

Medical Services recently received a Prior Authorization request for [MEMBER NAME].

The requested services were:

Rev. 6/14

- hours/day, days/week and hours per month RN supervision.

Upon review, the services requested have been modified. Documentation and Plan of Treatment submitted by for continued private duty-nursing supports the following authorized services that have been approved:

- hours/day, days/week and hours per month RN supervision.
- Alternate planning for non covered hours as decided by the Case Manager

This modification was discussed with on .

This decision is made in accordance with 441 Iowa Administrative Code 78.9(249A).

You have the right to appeal. See the back of this letter to find out how to file an appeal.

Sincerely,

Iowa Medicaid Enterprise
Medical Services

470-4173 (Rev 8/07)

Denial Letter from MMIS

IOWA DEPARTMENT OF HUMAN SERVICES

NOTICE OF DECISION

Name

Date

Address

City, State, Zip

RE: Requested Medical Services

The request for prior authorization for medical services or drugs for you has been DENIED. This action has been taken according to:

DENIAL REASON

Denial Code-IOWA ADMINISTRATIVE CODE IAC

Your county Department of Human Services will assist you in filing an appeal if you ask them, or you may contact Iowa Legal Aid at 1-800-532-1275, or if you live in Polk County 243-1193, if you need help with an appeal.

If a request for prior authorization was submitted in writing, a copy of the request is attached. Column 15 lists the services that were requested. In code in column 21 indicates the decision on that service (i.e. those marked "D" were denied; those marked "A" were approved).

If you have questions regarding this notice, discuss this notice with your doctor or provider. If you still have questions or believe this action to be in error, you may:

- 1) Ask your doctor or other provider to request a review of this decision by resubmitting the request for prior authorization form with complete and /or additional information to Medical Services.
And/or
- 2) Request an appeal hearing.

470-0390 (Rev. 7/05)

You Have the Right to Appeal

What is an appeal?

An **appeal** is asking for a hearing because you do not like a decision the Department of Human Services (DHS) makes. You have the right to file an appeal if you disagree with a decision. You do not have to pay to file an appeal. [441 Iowa Administrative Code Chapter 7].

How do I appeal?

Filing an appeal is easy. You can appeal in person, by telephone or in writing for Food Assistance or Medicaid. You must appeal in writing for all other programs. To appeal in writing, do **one** of the following:

- Complete an appeal electronically at <https://dhssecure.dhs.state.ia.us/forms/>, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

How long do I have to appeal?

For Food Assistance or Medicaid, you have 90 calendar days to file an appeal from the date of a decision. For all other programs, you must file an appeal:

- Within 30 calendar days of the date of a decision or
- Before the date a decision goes into effect

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing.

If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending?

You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal:

- Within 10 calendar days of the date the notice is received. A notice is considered to be received 5 calendar days after the date on the notice or
- Before the date a decision goes into effect

Any benefits you get while your appeal is being decided may have to be paid back if the Department's action is correct.

How will I know if I get a hearing?

You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. This letter will tell you why you did not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Can I have someone else help me in the hearing?

You or someone else, such as a friend or relative can tell why you disagree with the Department's decision. You may also have a lawyer help you, but the Department will not pay for one. Your county DHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

**Policy Regarding Discrimination, Harassment,
Affirmative Action and Equal Employment Opportunity**

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, please send a letter detailing your complaint to:

Iowa Department of Human Services, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email contactdhs@dhs.state.ia.us

(Food Assistance only) USDA – Director, Office of Adjudication, 1400 Independence Ave SW, Washington, DC 20250-9410, or call 1-866-632-9992 voice. Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at 800-877-8339; or 800-845-6136 (Spanish).

Decreased Hours Letter

Date

PA#:

Member Name and SID:

Dear _____ :

The prior authorization request and supporting documentation for _____, dates of service _____, has been reviewed. It has been determined that _____ can be approved. In order to allow the family and member time to adjust to the decreased hours, a plan is needed to allow a gradual decrease in the amount of time the nurse/home health aide is providing service until the supported level of service is met. This can be done over a _____ week time period. Please submit a plan using the space provided on this form of how you would like to decrease the hours from _____ to _____. Your plan will be reviewed after received and approved if deemed reasonable. Also, indicate if you or the child's parents/guardians would like a care conference to discuss the plan. If you disagree with the reduction, please provide rationale below.

Plan for decreasing hours from _____ to _____ :

Would you like a care conference scheduled to discuss this plan? Yes No

If yes, please list names and phone numbers of people to be involved in the conference call and dates and times when they will be available:

Please complete and return Iowa Department of Human Services, PO Box 36478, Des Moines, IA 50315, or fax to 515-725-1356 within 10 calendar days. Thank you for your prompt response.

Sincerely,

Iowa Medicaid Enterprise

RFP Reference:

6.2.4

6.2.4.1

6.2.4.2

6.2.4.

Interfaces:

DHS
ISIS
MMIS
OnBase

Attachments:

Attachment A: Children's Health Care Prevention and Well Child Care Promotion Prior Authorizations

MED - Early Periodic Screening, Diagnosis, and Treatment Special Circumstances

Purpose: If the request is for an initial prior authorization (PA), there may not be adequate documentation available to secure an approved authorization for home health services or a current authorization may need to be modified. The member may also be returning home from a hospitalization or other facility or determined to be terminally ill and services are immediately necessary. Eligibility changes may have occurred or there may be a change of circumstances or a change in the member's condition. The CM is able to secure a short-term authorization allowing nursing services to become involved until the necessary documentation can be provided.

Identification of Roles:

Review Coordinator (RC) – responds to prior authorization requests, completes authorizations based on criteria and coordinates care.

Review Assistant (RA) – verifies eligibility, mails and/or faxes PA forms to providers and closes Workflow Process Management (WPM) tool when necessary.

Physician Reviewer (PR) – provides determination for authorizations regarding questioned medical necessity.

Medicaid Medical Director (MMD) – completes physician review or determines that a specialist consultant is necessary.

Case Manager (CM) – communicates with family and provider regarding PA determination.

Performance Standard: In accordance with URAC standards, prospective reviews are completed within 15 calendar days of receipt of the request

- Process 95 percent of requests from providers or the public for services under the Children’s Health Care Prevention and Well Child Care Promotion program that are outside the coverage for the regular Medicaid program within 10 business days of receipt of complete information. Process 100 percent within 25 business days.
- Notify case managers that a PA is due within 60 business days of the due date. Complete 95 percent of PA requests not requiring physician review within 10 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 20 business days.
- Complete 95 percent of requests for private duty nurse and personal care services, when notified that the member is being discharged from the hospital within one business day of receipt of PA request. Complete 100 percent within three business days.
- Complete 95 percent of PA requests requiring a physician review within 15 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 30 business days.
- Provide an alert to case manager 95 percent of the time 12 months prior to the member turning 21 years of age. Complete 100 percent six months prior to the member turning 21 years of age.

Path of Business Procedure:

Step 1: The RA or RC will receive notice from the CM or provider by email or by phone of request for an authorization of services under special circumstances.

Step 2: The RA or RC will verify eligibility.

Step 3: The RA will alert RC to special circumstance PA in queue.

Step 4: A special circumstance is a member who is currently inpatient in a hospital or other facility for which services will be provided immediately upon discharge from the hospital or other facility And is considered to be an urgent request.

Step 5: The RC will confirm that a service worker, the CM or Child Health Specialty Clinics (CHSC) staff person is assigned to the member.

- Step 6:** If no worker or case manager is assigned, the RC will contact CHSC who will assign a staff person in lieu of a CM.
- Step 7:** The RC will review the request, the Plan of Care, and the proposed breakout of cares and identify the covered services using the Medical Needs Acuity Scoring Tool (MNASt) and Functional Needs Acuity Tool (FNASt) and/or Social Needs Acuity Tool (SNASt).
- Step 8:** A telephonic care planning conference will be held when needed.
- Step 9:** The provider will submit a written request as discussed via telephone or email.
- Step 10:** The RC will also determine if the level of care is supported. If the level of care is not supported, the RC will refer the request to the MMD.
- Step 11:** The RC will complete the approved PA following Home Health Authorizations procedure.
- Step 12:** The RC will indicate this in box 29 or 25 (depending on the form) on the PA Request.
- Step 13:** The RC will indicate in box 25/29 of the PA if the MMD determines the documentation does not support the LOC.
- Step 14:** The RC will also notify the CM.
- Step 15:** The RC will update MMIS with the appropriate units, LOC and update narrative.
- Step 16:** The RC will route the PA Request to the RA.
- Step 17:** All PA requests will be imaged into OnBase and stored for 18 months.
- Step 18:** The RA will enter the PA request in workflow, assign additional key words per procedures, and forward to appropriate RC to keep.

Forms/Reports: Social Needs Acuity Tool (SNAAT)

Measure	Range	Points		Comments:
Number of persons in household <u>over</u> the age of 18. Exclude member	4 or more	0.00	<input type="checkbox"/>	
	3	0.50	<input type="checkbox"/>	
	2	1.00	<input type="checkbox"/>	
	1	1.50	<input type="checkbox"/>	
Number of persons in household <u>under</u> the age of 18 Exclude member If other child(ren) under the age of 18 require assistance with activities of daily living (ADLs), do not allot points for this section. See below.	More than 4	4.00	<input type="checkbox"/>	
	3 - 4	3.00	<input type="checkbox"/>	
	2	2.00	<input type="checkbox"/>	
	1	1.00	<input type="checkbox"/>	
Number of persons in household under the age of 21 requiring assistance with activities of daily living (ADLs) outside the normal developmental parameters i.e., a 5 year-old would typically need some assistance, therefore this is considered “normal development”. Exclude member	More than 4	6.00	<input type="checkbox"/>	
	4	5.00	<input type="checkbox"/>	
	3	4.00	<input type="checkbox"/>	
	2	3.00	<input type="checkbox"/>	
	1	2.00	<input type="checkbox"/>	
<p>Family dynamics total points this section: _____</p>				
Measure	Range	Points		Comments:
Does caregiver(s) work outside the home?	Yes	1.00	<input type="checkbox"/>	
	No	0.00	<input type="checkbox"/>	

Hours per day worked	4	1.00	<input type="checkbox"/>
	6	2.00	<input type="checkbox"/>
	8	3.00	<input type="checkbox"/>
	10	4.00	<input type="checkbox"/>
	12	5.00	<input type="checkbox"/>
Does the caregiver(s) attend school outside the home?	Yes	1.00	<input type="checkbox"/>
	No	0.00	<input type="checkbox"/>
Hours per day at school	Less than 4	1.00	<input type="checkbox"/>
	4	1.50	<input type="checkbox"/>
	6	2.00	<input type="checkbox"/>
Days per week at school/work	Less than 5	1.00	<input type="checkbox"/>
	5 or more	2.00	<input type="checkbox"/>
Travel time required to work or school	Less than one hour	1.00	<input type="checkbox"/>
	More than one hour	2.00	<input type="checkbox"/>

Caregiver availability total points from this section: _____

Member Name:

Medicaid SID:

PA Number:

Measure	Range	Points	Comments:
Documented back-up plan on file with agency?	Yes	0.00	<input type="checkbox"/>
	No	1.00	<input type="checkbox"/>
Are back-up caregiver(s) trained on all cares?	Yes	0.00	<input type="checkbox"/>
	No	1.00	<input type="checkbox"/>
Are back-up caregiver(s) capable of	Yes	0.00	<input type="checkbox"/>

providing all cares?	No	2.00	<input type="checkbox"/>	
Expected time frame for training of back-up caregiver(s)?	More than 12 hours	5.00	<input type="checkbox"/>	
	10 – 12 hours	4.00	<input type="checkbox"/>	
	8 – 9 hours	3.00	<input type="checkbox"/>	
	6 – 7 hours	2.00	<input type="checkbox"/>	
	4 – 5 hours	1.00	<input type="checkbox"/>	
	Less than 4 hours	0.50	<input type="checkbox"/>	
Family training needs total points from this section: _____				

Points will not be allotted for children under the age of three who do not attend school.

Order	Frequency	Points		Comments:
Does member attend school?	Yes	1.00	<input type="checkbox"/>	
	No	2.00	<input type="checkbox"/>	
Hours per day at school:	Less than 4	1.00	<input type="checkbox"/>	
	4	1.00	<input type="checkbox"/>	
	6	0.50	<input type="checkbox"/>	
	8	0.50	<input type="checkbox"/>	
Days per week at school:	Less than 5	1.00	<input type="checkbox"/>	
	5	0.50	<input type="checkbox"/>	
Member specific educational needs total points from this section: _____				

Total cumulative points total is: _____

Medical Needs Acuity Scoring Tool (MNASt)

Member Name:

Medicaid SID:

PA Number:

Order	Frequency	Points	Comments:
Behavior that interferes with cares	Mild	1.00 <input type="checkbox"/>	
	Moderate	2.00 <input type="checkbox"/>	
	Severe	3.00 <input type="checkbox"/>	
Requires isolation	1.00 <input type="checkbox"/>		
Miscellaneous total points from this section:			

Order	Frequency	Points	Comments:
Skilled assessment of <u>one</u> system:	Every 2 hours or more often	2.00 <input type="checkbox"/>	
<input type="checkbox"/> Respiratory	Every 4 hours	1.50 <input type="checkbox"/>	
<input type="checkbox"/> Neurological	Every 8 hours	1.00 <input type="checkbox"/>	
<input type="checkbox"/> Cardiovascular	Daily	0.50 <input type="checkbox"/>	
<input type="checkbox"/> Gastrointestinal			
<input type="checkbox"/> Genitourinary			
<input type="checkbox"/> Integumentary			
Skilled assessment of <u>two or more</u> systems check all that apply:			
<input type="checkbox"/> Respiratory	Every 2 hours or more often	4.00 <input type="checkbox"/>	
<input type="checkbox"/> Neurological	Every 4 hours	3.00 <input type="checkbox"/>	
<input type="checkbox"/> Cardiovascular	Every 8 hours	2.00 <input type="checkbox"/>	
<input type="checkbox"/> Gastrointestinal	Daily	1.00 <input type="checkbox"/>	
<input type="checkbox"/> Genitourinary			

<input type="checkbox"/> Integumentary			
Assessment needs total points this section:			
Order	Frequency	Points	Comments:
Scheduled medications excludes topical medications.	Simple: 1 or 2	3.00	<input type="checkbox"/>
	Moderate: 3 to 5	4.00	<input type="checkbox"/>
	Complex: 6 to 9	5.00	<input type="checkbox"/>
	Extensive: 10 or more	7.00	<input type="checkbox"/>
PRN Medications one point given if PRN medication(s) are ordered. Additional points may be given if documentation is submitted showing the frequency of specific PRN medication administration.	PRN Medication Order	1.00	<input type="checkbox"/>
	Simple: 1 to 2	2.00	<input type="checkbox"/>
	Moderate: 3 to 5	3.00	<input type="checkbox"/>
	Complex: 6 to 9	4.00	<input type="checkbox"/>
	Extensive: 10 or more	5.00	<input type="checkbox"/>
Nebulizer treatment one point given if PRN nebulizer treatment is ordered. See above for additional points for PRN medications	PRN Nebulizer treatments	1.00	<input type="checkbox"/>
	Scheduled at least daily, less often than every 8 hours	2.00	<input type="checkbox"/>
	Scheduled every 6 to 8 hours	3.00	<input type="checkbox"/>
	Scheduled every 4 to 5 hours	3.50	<input type="checkbox"/>
	Scheduled every 2 to 3 hours	4.00	<input type="checkbox"/>
IV Medications choose method of administration. <input type="checkbox"/> Peripheral IV <input type="checkbox"/> Central Line <input type="checkbox"/> PICC line Hickman <input type="checkbox"/> Other includes TPN, excludes heparin or saline flush	Weekly	1.00	<input type="checkbox"/>
	Daily	1.50	<input type="checkbox"/>
	Less than every 8 hours	2.00	<input type="checkbox"/>
	Every 8 hours	2.50	<input type="checkbox"/>
	Every 6-7 hours	3.00	<input type="checkbox"/>
	Every 4-5 hours	3.50	<input type="checkbox"/>
	More than every 4 hours	4.00	<input type="checkbox"/>
Medication needs total points from this section:			

Member Name:

Medicaid SID:

PA Number:

Order			Points	Comments:
Order	Frequency	Points		
Tracheostomy check one: <input type="checkbox"/> No trach, patent airway <input type="checkbox"/> No trach, unstable airway <input type="checkbox"/> Trach, established and stable <input type="checkbox"/> Trach, new or unstable				
Trach Cares	Scheduled and/or PRN	6.00	<input type="checkbox"/>	
Suctioning	Scheduled and/or PRN (Trach or NT)	5.00	<input type="checkbox"/>	
	Scheduled and/or PRN (oral)	1.00	<input type="checkbox"/>	
Oxygen	Continuous and/or daily use	1.00	<input type="checkbox"/>	
	PRN	1.00	<input type="checkbox"/>	
Pulse Oximetry	Continuous pulse oximetry with PRN oxygen parameters	1.00	<input type="checkbox"/>	
	PRN or spot check pulse oximetry with PRN oxygen parameters	1.00	<input type="checkbox"/>	
Ventilator	Ventilator, dependent, 24 hours per day	20.00	<input type="checkbox"/>	
	Ventilator, intermittent 12 or more hours per day	18.00	<input type="checkbox"/>	
	Ventilator, intermittent, 8 to 11 hours per day	16.00	<input type="checkbox"/>	
	Ventilator, intermittent, 4 to 7 hours per day	14.00	<input type="checkbox"/>	
	Ventilator, intermittent, less than 4 hours per day	12.00	<input type="checkbox"/>	
BiPap or CPAP	BiPAP or CPAP more than 8 hours per day	5.00	<input type="checkbox"/>	

	BiPAP or CPAP less than 8 hours per day	4.50	<input type="checkbox"/>		
	BiPAP or CPAP used only at night	4.00	<input type="checkbox"/>		
Chest Physiotherapy (CPT) manual or with use of airway clearance vest:	PRN CPT	1.00	<input type="checkbox"/>		
	Daily	1.00	<input type="checkbox"/>		
	Every 8 hours or more	2.00	<input type="checkbox"/>		
	Every 4 to 7 hours	3.00	<input type="checkbox"/>		
	More often than every 4 hours	4.00	<input type="checkbox"/>		
Respiratory needs total points from this section:					

Order	Frequency	Points		Comments:
			<input type="checkbox"/>	
Nutrition choose all that apply: <input type="checkbox"/> Routine oral feeding <input type="checkbox"/> Difficult, prolonged oral feeding <input type="checkbox"/> Reflux and/or aspiration precautions <input type="checkbox"/> G-tube <input type="checkbox"/> J-tube <input type="checkbox"/> Other	Physician ordered oral feeding attempts i.e., treatment of oral aversion	1.00	<input type="checkbox"/>	
	Tube feeding routine bolus or continuous	2.00	<input type="checkbox"/>	
	Tube feeding combination bolus and continuous	2.50	<input type="checkbox"/>	
	Complicated tube feeding residual checks, aspiration precautions, slow feed, etc.	3.00	<input type="checkbox"/>	
	Feeding needs total points from this section:			

Member Name:

Medicaid SID:

PA Number:

Order	Frequency	Points		Comments:
			<input type="checkbox"/>	
Seizures: ■ If Continuous Medical Monitoring and Assessment (CMMA) order present for neurological system, do	Seizure diagnosis, not activity documented	0.00	<input type="checkbox"/>	
	Mild: daily, no intervention	0.00	<input type="checkbox"/>	

not allow additional points for minimal interventions <i>unless</i> the specific intervention is documented. ■ If CMMA order is not present, but documentation indicates daily seizure activity, allow points for minimal intervention if the plan of care has a seizure treatment plan included.	Moderate: minimal intervention daily	2.00	<input type="checkbox"/>	
	Moderate: minimal intervention 2 to 4 times daily.	4.00	<input type="checkbox"/>	
	Moderate: minimal intervention 5 or more times daily	4.50	<input type="checkbox"/>	
	Severe: requires IM/IV/Rectal medications daily	5.00	<input type="checkbox"/>	
	Severe: requires IM/IV/Rectal medications 2 to 4 times daily	5.50	<input type="checkbox"/>	
	Severe: requires IM/IV/Rectal medications 5 or more times daily	6.00	<input type="checkbox"/>	
Seizure needs total points from this section:				

Order	Frequency	Points	Comments:
Intermittent Catheter	Every 4 hours	5.00	<input type="checkbox"/>
	Every 8 hours	4.00	<input type="checkbox"/>
	Every 12 hours	3.00	<input type="checkbox"/>
	Daily or PRN	2.00	<input type="checkbox"/>
Strict I & O	Every 4 hours	4.00	<input type="checkbox"/>
	Every 8 hours	3.00	<input type="checkbox"/>
	Daily	2.00	<input type="checkbox"/>
Elimination needs total points from this section:			

Order	Frequency	Points		Comments:	
			<input type="checkbox"/>		
Fractured or casted limb		1.00	<input type="checkbox"/>		
Splinting schedule	On/Off daily	1.00	<input type="checkbox"/>		
Basic range of motion (ROM)	At least every 8 hours	1.00	<input type="checkbox"/>		
Body Cast		1.00	<input type="checkbox"/>		
Miscellaneous skilled therapies one point each miscellaneous therapy ordered: <ul style="list-style-type: none"> ▪ If diagnosis of skin disease, i.e. psoriasis, and PRN topical medications ordered, may allow 1 point for misc. therapies. ▪ If restraints are routinely used and documented, may allow one point for misc. therapies. 	Daily or PRN	1.00	<input type="checkbox"/>		
	Less often than every 8 hours	1.00	<input type="checkbox"/>		
	Every 4 to 7 hours	2.00	<input type="checkbox"/>		
	More often than every 4 hours	3.00	<input type="checkbox"/>		
Therapies/Orthotics/Casting total points from this section:					

Member Name:

Medicaid SID:

PA Number:

Order	Frequency	Points		Comments:
			<input type="checkbox"/>	
<input type="checkbox"/> PEG or G-tube dressing change	At least daily	1.00	<input type="checkbox"/>	
Choose all that apply <input type="checkbox"/> Stage 1 – 2 pressure ulcer, <input type="checkbox"/> IV change new site	At least daily	2.00	<input type="checkbox"/>	
Choose all that apply <input type="checkbox"/> Stage 3 – 4 pressure ulcer <input type="checkbox"/> Multiple wound sites	At least daily	3.00	<input type="checkbox"/>	
Dressing changes total points from this section:				

Cumulative point total is:

Private duty nursing is authorized as follows:

Functional Needs Acuity Tool (FNAST)

Member Name:

Medicaid SID:

PA Number:

Points will not be allotted for ADL assistance for children under the age of five.

Need	Assistance Needed:	Points		Comments:	
Bathing	Independent	0.00	<input type="checkbox"/>		
	Assistance needed	2.00	<input type="checkbox"/>		
	Dependent	3.00	<input type="checkbox"/>		
Dressing	Independent	0.00	<input type="checkbox"/>		
	Assistance needed	2.00	<input type="checkbox"/>		
	Dependent	3.00	<input type="checkbox"/>		
Toileting	Independent	0.00	<input type="checkbox"/>		
	Assistance needed	2.00	<input type="checkbox"/>		
	Dependent	3.00	<input type="checkbox"/>		
Continence - bowel	Incontinent	2.00	<input type="checkbox"/>		
	Continent	0.00	<input type="checkbox"/>		
Continence - bladder	Incontinent	2.00	<input type="checkbox"/>		
	Continent	0.00	<input type="checkbox"/>		
Eating	Independent	0.00	<input type="checkbox"/>		
	Assistance needed	2.00	<input type="checkbox"/>		
	Dependent	3.00	<input type="checkbox"/>		
Activities of Daily Living (ADLs) needs total points this section:					

Points will not be allotted for transfer/ambulation assistance for children under the age of two.

Need	Assistance Needed:	Frequency	Points		Comments:
Orthotics	Upper Extremities	q 2hr	2.50	<input type="checkbox"/>	
		q 4hr	2.00	<input type="checkbox"/>	
		On/Off daily	1.00	<input type="checkbox"/>	
	Lower Extremities	q 2hr	2.50	<input type="checkbox"/>	
		q 4hr	2.00	<input type="checkbox"/>	
		On/Off daily	1.00	<input type="checkbox"/>	
Transfer assist	Minimum assist		1.00	<input type="checkbox"/>	
	Maximum assist		2.00	<input type="checkbox"/>	
Ambulation:	Independent		0.00	<input type="checkbox"/>	
	Assistance needed		2.00	<input type="checkbox"/>	
	Dependent		3.00	<input type="checkbox"/>	
Medical Equipment (Describe misc. medical equipment)	Wheelchair		2.00	<input type="checkbox"/>	
	Hospital bed		2.00	<input type="checkbox"/>	
	Hoyer lift		2.00	<input type="checkbox"/>	
	Miscellaneous		2.00	<input type="checkbox"/>	
ROM	> q 2hr		4.00	<input type="checkbox"/>	
	q 2hr		3.00	<input type="checkbox"/>	
	q 4hr		2.00	<input type="checkbox"/>	
	< q 4hr		1.00	<input type="checkbox"/>	
Therapies and mobility needs total points this section:					

Member Name:

Medicaid SID:

PA Number:

Need		Points		Comments:
Restraints	Soft restraints	2.00	<input type="checkbox"/>	
	Other (specify)	2.00	<input type="checkbox"/>	
Aggressive		3.00	<input type="checkbox"/>	
Harm to self or others		3.00	<input type="checkbox"/>	
Behavioral need total points this section:				

Points will only be allotted for diagnosed sensory impairments noted on the POC that are outside “normal” developmental milestones for child’s age.

Need	Assistance Needed:	Points		Comments:
Vision	Impaired	2.00	<input type="checkbox"/>	
	Functional	0.00	<input type="checkbox"/>	
Hearing	Impaired	2.00	<input type="checkbox"/>	
	Functional	0.00	<input type="checkbox"/>	
Communication	Impaired	2.00	<input type="checkbox"/>	
	Functional	0.00	<input type="checkbox"/>	
Sensory Impairment Needs total points this section:				

Cumulative points total is

Interfaces:

Child Health Specialty Clinics
 MMIS
 OnBase

RFP Reference:

6.2.4

6.2.4.1

6.2.4.2

6.2.4.

Attachments:

N/A

MED - Children's Health Care Prevention and Well Child Care Promotion Care Coordination

Purpose: If there is a change to the service request, the member's case manager, providing agency or family may request a telephonic conference to review the PA) decision with the applicable team CM, CHSC, family, other involved agencies and provider.

Identification of Roles:

Review Coordinator (RC) – responds to prior authorization requests, completes authorizations based on criteria and coordinates care.

Review Assistant (RA) – responsible for mailing and/or faxing PA forms to providers and closing OnBase when necessary and verifies eligibility.

Physician Reviewer (PR) – provides determination for authorizations regarding questioned medical necessity.

Case Manager (CM) – communicates with family and providers.

Area Education Agency (AEA) - participate in the care conference if requested by the case manager.

Child Health Specialty Clinics (CHSC) – communicates with the family and providers.

Performance Standard: In accordance with URAC standards, prospective reviews are completed within 15 calendar days of receipt of the request

- Process 95 percent of requests from providers or the public for services under the Children's Health Care Prevention and Well Child Care Promotion program that are outside the coverage for the regular Medicaid program within 10 business days of receipt of complete information. Process 100 percent within 25 business days.
- Notify case managers that a PA is due within 60 business days of the due date. Complete 95 percent of PA requests not requiring physician review within 10 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 20 business days.
- Complete 95 percent of requests for private duty nurse and personal care services, when notified that the member is being discharged from the hospital within one business day of receipt of PA request. Complete 100 percent within three business days.
- Complete 95 percent of PA requests requiring a physician review within 15 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 30 business days.
- Provide an alert to case manager 95 percent of the time 12 months prior to the member turning 21 years of age. Complete 100 percent six months prior to the member turning 21 years of age.

Path of Business Procedure:

Step 1: The review coordinator (RC) will notify the CM by email that a PA request will not be approved as requested. Activity will be logged in OnBase.

Step 2: The RC will receive notification from CM by phone or email of the team decision.

Step 3: If the provider and other team members agree with the modification or denial, the RC will complete the authorization.

Step 4: If a team member requests a telephonic conference, the RA will schedule the conference and notify all participants.

Step 5: The CM will supply the names and phone numbers of conference participants.

Step 6: The conference activity will be logged in OnBase.

Step 7: Prior to the conference call RA and RC will complete a care conference agenda which outlines areas of concern noted in the review.

Step 8: The RA will mail, e-mail or fax a copy of the completed care conference agenda to all participants prior to the scheduled date and time of the care conference.

Step 9: An educational conference call will also be held with the provider when the documentation submitted by the provider does not support the requested hours. The provider will have time to submit new documentation to support the order.

Step 10: At the appointed time, the RC will convene and facilitate the conference call.

Step 11: The CM may elect to facilitate the conference call.

Step 12: At the end of the conference, the RC will provide a verbal summary of the outcome of the discussion.

Step 13: The RA will provide a written summary of the conference.

Step 14: A copy will be sent to the CM, provider, family, and a copy will be retained in the member's electronic file in OnBase.

Step 15: The RC will receive amended PA request from provider, if applicable.

Step 16: The RC will complete the PA.

Care Coordinator Conference Report

Member Name: _____ Prior Auth No: _____

SID: _____ Date of telephonic conference: _____

Review Coordinator Name: _____

Case Manager: _____ Phone: _____

Other Participants: _____ Phone: _____

_____ Phone: _____

_____ Phone: _____

What was requested: _____

Discussion:

Conclusion:

Forms/Reports:

Children's Health Care Prevention and Well-Child-Care Promotion Care Conference Agenda

Participants

IME RC

IME Manager

CHSC

Case Manager

Parent/Guardian

Agency Representatives RA

Conference Details

Date: _____ Time: _____

Member Name: _____ SID: _____ PA Number:

Instructions for calling in:

Agenda

- Introductions
- Brief explanation of the Children's Health Care Prevention and Well Child Care Promotion program and review process

Children's Health Care Prevention and Well Child Care Promotion is Early and Periodic Screening, Diagnosis and Treatment for Medicaid members through 20 years of age, until the end of the month of their 21st birthday. This umbrella of the Medicaid program encompasses all services provided to this age group of the Medicaid population. Home health services and private-duty nursing are large components of the Children's Health Care Prevention and Well Child Care Promotion program. Through the Children's Health Care Prevention and Well Child Care Promotion program families are afforded the opportunity to utilize home health aides or private duty nursing when the alternatives would be hospitalization or institutionalization. The private-duty nursing component of Children's Health Care Prevention and Well Child Care Promotion allows for member to have the benefit of skilled nursing care while continuing with their normal activities. Additional information on the Children's Health Care Prevention and Well Child Care Promotion program can be obtained from <http://www.ime.state.ia.us/Members/AdditionalServices/EPSDT>

- Parent(s) or Guardians(s) speak about their expectations of the Children's Health Care Prevention and Well Child Care Promotion program and how the services in question impact their child.
- Reason for care conference:

-
- Suggested items for discussion

Is there additional information regarding child and his/her cares that was not included in the original submission?

How will this reduction, if implemented, affect child's health and welfare?

Are any other programs being used in conjunction with Children's Health Care Prevention and Well Child Care Promotion?

- Resolution discussion
- Dismissal

Please notify Iowa Medicaid at (515) 256-4624 or 1-888-424-2070 if further information needed prior to conference call.

RFP Reference:

6.2.4

6.2.4.1

6.2.4.2

6.2.4.

Interfaces:

Area Education Agency

School

Child Health Specialty Clinics

Attachments:

N/A

**MED - Children’s Health Care Prevention and Well Child Care
Promotion Quality Review**

Purpose: Provide a retrospective quality of care review of nursing documentation to ensure compliance with plan of care.

Identification of Roles:

Quality Improvement Facilitator (QIF) – Selects and assigns authorizations for quality review.

Review Coordinator (RC) – verifies eligibility, responds to prior authorization requests, completes authorizations based on criteria, completes request for quality review documentation, and completes review of documentation for compliance with plan of care and the Iowa Administrative Code.

Review Assistant (RA) – logs PA requests in OnBase, assigns PA number and keywords, forwards PA request to appropriate RC, requests documentation for quality review, and mails and/or faxes PA forms to providers.

Case Manager (CM) – communicates with family and provider regarding PA determination.

Performance Standard: In accordance with URAC standards, prospective reviews are completed within 15 calendar days of receipt of the request

- Process 95 percent of requests from providers or the public for services under the Children’s Health Care Prevention and Well Child Care Promotion program that are outside the coverage for the regular Medicaid program within 10 business days of receipt of complete information. Process 100 percent within 25 business days.
- Notify case managers that a PA is due within 60 business days of the due date. Complete 95 percent of PA requests not requiring physician review within 10 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 20 business days.
- Complete 95 percent of requests for private duty nurse and personal care services, when notified that the member is being discharged from the hospital within one business day of receipt of PA request. Complete 100 percent within three business days.
- Complete 95 percent of PA requests requiring a physician review within 15 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 30 business days.
- Provide an alert to case manager 95 percent of the time 12 months prior to the member turning 21 years of age. Complete 100 percent six months prior to the member turning 21 years of age.

Path of Business Procedure:

Step 1: The Children’s Health Care Prevention and Well-Child-Care Promotion PAs will be received through the PA workflow.

Step 2: Following Work Distribution procedure PA type number 02 is utilized for Children’s Health Care Prevention and Well-Child-Care Promotion Home Health reviews.

Step 3: The QIF will select and assign to review coordinator (RC) prior authorizations for quality review.

Step 4: A minimum of 10 percent of prior authorizations will be selected for quality review.

- a. This number will be determined based on the prior authorizations completed the previous fiscal year for unique members e.g., 225 unique member prior authorizations completed the previous FY would require a minimum of 23 quality reviews.

Step 5: The number of quality reviews will be dispersed over the 12 month fiscal year.

Step 6: The number of Children’s Health Care Prevention and Well Child Care Promotion prior authorizations submitted by each provider will determine the minimum number of quality reviews requested from each provider.

- a. A home health provider agency with five or less Children’s Health Care Prevention and Well Child Care Promotion prior authorizations will receive a minimum of one quality review each year.
- b. A home health provider with six or more Children’s Health Care Prevention and Well-Child Care Promotion Home Health PAs will receive a minimum number of quality reviews equal to 10 percent of the number of authorizations submitted by the provider.

Step 7: Providers assigned for quality review for the month will be determined by stratified random sampling based on the minimum number of quality reviews to be conducted during the state fiscal year.

Step 8: The QIF will monitor which agencies have had quality reviews completed to ensure that each provider receives at least one review during the fiscal year. Providers where quality concerns are noted during the review, may have additional reviews performed.

Step 9: The first PA received by Medical Services for the month by the selected providers will be assigned for quality review.

Step 10: Upon receipt of PA in review queue, the RC will verify member eligibility.

Step 11: The RC will complete request for additional information letter indicating the case has been selected for a quality review, therefore four complete weeks of nursing documentation is requested for review.

Step 12: When provider returns the additional information, the RA will find the document(s) in med PA queue. The documents will be returned to RC for review.

- a. The RC will review the documentation using the home health PA quality review tool.
- b. The RC will review documentation and complete the tool for the following:
 1. Plan of care includes place of service, type of service to be rendered, the treatment modalities being used and frequency of services.
 2. Plan of care includes date home health services were initiated, progress of member in response to treatment and description of member’s medical condition.
 3. Plan of care certification period is no more than 62 days.
 4. Orders on the plan of care are being followed.
 5. Services are not provided that are not ordered.

6. Services are not respite, supervision, provided to other household members, transportation or homework assistance.

Step 13: The RC will complete review of prior authorization request.

Step14: The RC will complete quality review of documentation, entering met or not met on each item of form 470-4853 Home Health PA Quality Review Tool.

Step15: The RC will enter feedback comments to assist the home health agency in increasing compliance with the plan of care and Iowa Administrative Code.

Step16: All PA requests and documentation will be imaged into OnBase.

Step17: The RA will return the completed forms to the provider.

Step18: The RA will fax and mail a copy of the PA and related forms to the provider and case manager.

Forms/Reports:

Home Health Prior Authorization Quality Review Tool

Provider:
 SID:

Review Date:

Member Name:

SCORING

Reviewers assign a score to each applicable component using the following scale:

1 = Met

0 = Not met

N/A = Not applicable – component is not applicable and is removed from the denominator

References: Iowa Administrative Code, Chapter 78: Amount, Duration and Scope of Medical and Remedial Services (Medicaid) and Chapter 79: Other Policies Relating to Providers of Medical and Remedial Care (Medicaid)

PLAN OF CARE			
DESIRED OUTCOME: Member's plan of care developed and implemented toward a positive outcome			
Measure	Score	Comments	
Plan of Care includes place of service, type of service to be rendered, the treatment modalities being used and frequency of services [IAC 78.9 (1)a, b and c]			
Plan of Care includes date home health services were initiated, progress of member in response to treatment and description of member's medical condition [IAC 78.9(1)e, f and h]			
Plan of Care certification period is no more than 62 days. [IAC 78.9(1)j]			
	Score Subtotal:		

RFP Reference:

6.2.4

6.2.4.1

6.2.4.2

6.2.4.

Interfaces:

MMIS
OnBase

Attachments:

Attachment B: Children's Health Care Prevention and Well Child Care Promotion
Quality Review

MED - Children's Health Care Prevention and Well Child Care Promotion Alerts

Purpose: To provide alerts to case manager (CM) and Child Health Specialty Clinics (CHSC) about prior authorizations (PAs) coming due and member reaching the age of 20. This avoids disruption of services to member and prompts transition planning for member requiring adult services.

Identification of Roles:

Review Assistant (RA) - provides program support for medical services.

Case Manager - communicates with family and provider.

Child Health Specialty Clinic (CHSC) - receive alerts about upcoming PA's that are due.

Manager- receives the reports and forwards them to appropriate people.

Performance Standard: In accordance with URAC standards, prospective reviews are completed within 15 calendar days of receipt of the request

- Process 95 percent of requests from providers or the public for services under the Children's Health Care Prevention and Well Child Care Promotion program

that are outside the coverage for the regular Medicaid program within 10 business days of receipt of complete information. Process 100 percent within 25 business days.

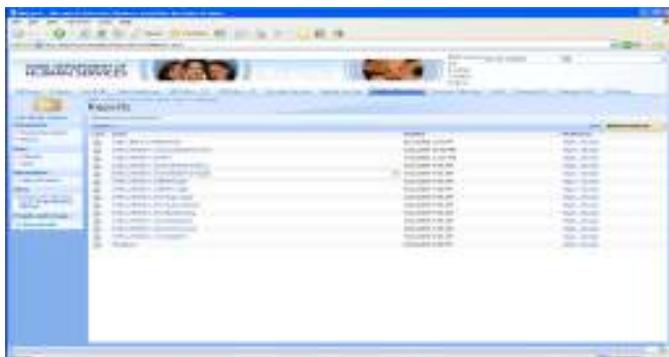
- Notify case managers that a PA is due within 60 business days of the due date. Complete 95 percent of PA requests not requiring physician review within 10 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 20 business days.
- Complete 95 percent of requests for private duty nurse and personal care services, when notified that the member is being discharged from the hospital within one business day of receipt of PA request. Complete 100 percent within three business days.
- Complete 95 percent of PA requests requiring a physician review within 15 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 30 business days.
- Provide an alert to case manager 95 percent of the time 12 months prior to the member turning 21 years of age. Complete 100 percent six months prior to the member turning 21 years of age.

Path of Business Procedure:

Step 1: The manager and/or RA will retrieve monthly reports from data warehouse for members turning 20 and PAs due for CM. The data warehouse reports can be accessed at: <http://dhs moss1/ime/bltc/Reports/Forms/AllItems.aspx> by personnel who have been granted access to these reports by DataWarehouse.

Step 2: The review assistant (RA) and/or manager will access the reports via the internet website.

Step 3: On Reports screen double click on report to be accessed.



Step 4: On the Specify Parameter Values screen choose the correct month and year to be accessed from the dropdown boxes.



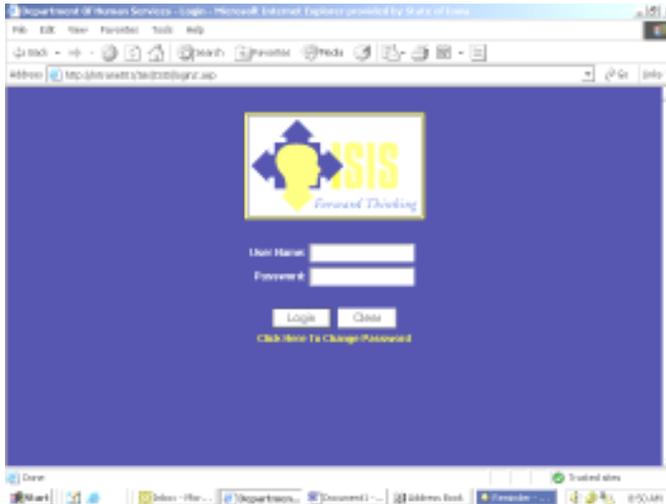
Step 5: The following reports pertinent to the Children's Health Care Prevention and Well-Child-Care Promotion Home Health program are available:

- a. DSRS_MedServ_CaseLoadDueForCHSC
- b. DSRS_MedServ_EPSDT
- c. DSRS_MedServ_HomeHealthCareExp
- d. DSRS_MedServ_HomeHealthTurning20
- e. DSRS_MedServ_PrivateDutyNursing
- f. DSRS_MedServ_ScreeningsDue
- g. DSRS_MedServ_ScrnCtrSrvCost
- h. DSRS_MedServ_TreatmentHx

Step 6: The RA will identify the CMs for each member through Individualized Services Information System (ISIS).

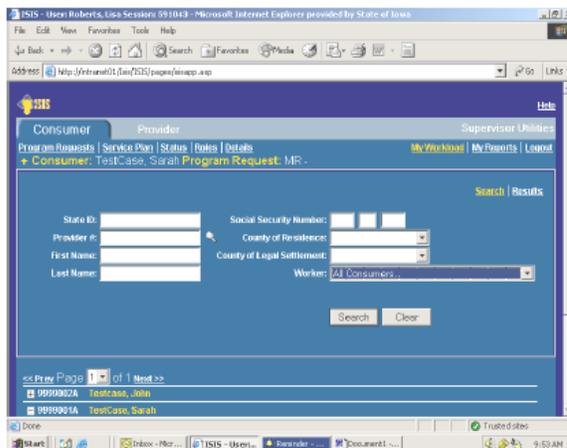
Step 7: The RA will logon to the ISIS system via Internet explorer.

ISIS Log on Screen



Access the CONSUMER SEARCH screen by clicking on the small yellow arrow icon (just to the left of the word "Consumer" or phrase "No Consumer Selected") on the WORKLOAD screen. You also may access this screen by clicking on the SEARCH button.

If you don't see the SEARCH link, you can find it by clicking on the arrow next to the words, "NO CONSUMER SELECTED" or "CONSUMER" in the upper left corner of the screen. Now the search screen or the link to the SEARCH screen will be displayed.



The CONSUMER SEARCH screen displays fields into which you may enter data relevant to a consumer you want the system to find. You may enter search criteria one or more of

Step 8: The RA will notify CM by email, the RC will click on worker name in ISIS that PA is due within 60 days. Appropriate CHSC nurse is copied on these e-mails.

Step 9: If the PA request is not received, the RA will send a second reminder to the CM that a past due within four weeks.

Step 10: The RA will notify the DHS CM by email that a member in the Children's Health Care Prevention and Well-Child-Care Promotion Home Health program will turn 20 in the next month. Appropriate service area manager is copied on these e-mails.

Forms/Reports:

Email Alert to Case Manager

This is notify you that _____ SID _____

Has a Home Health Prior Authorization with name of agency that is due _____

Your facilitation of receipt of the prior authorization request in the Children's Health Care Prevention and Well Child Care Promotion unit of Medical Services is appreciated.

Email Alert to Case Manager

This is notify you that _____ SID _____

Will be turning age 20 on _____ and may need continuous care planning.

RFP Reference:

6.2.4

6.2.4.1

6.2.4.2

6.2.4.

Interfaces:

Child Health Specialty Clinic

Data Warehouse
ISIS

MMIS
OnBase

Attachments:

N/A

**MED-Children's Health Care Prevention and Well Child Care
Promotion Internal Quality Control**

Purpose: To provide continuous quality improvement to the Children's Health Care Prevention and Well Child Care Promotion functions, meet all performance standards and complete all required reports.

Identification of Roles:

Manager - tracks and reports all performance standards.

Review Assistant (RA) - receives the error reports and forwards them to the manager.

Performance Standard: In accordance with URAC standards, prospective reviews are completed within 15 calendar days of receipt of the request.

- Process 95 percent of requests from providers or the public for services under the Children's Health Care Prevention and Well Child Care Promotion program that are outside the coverage for the regular Medicaid program within 10 business days of receipt of complete information. Process 100 percent within 25 business days.
- Notify case managers that a PA is due within 60 business days of the due date. Complete 95 percent of PA requests not requiring physician review within 10 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 20 business days.
- Complete 95 percent of requests for private duty nurse and personal care services, when notified that the member is being discharged from the hospital within one business day of receipt of PA request. Complete 100 percent within three business days.
- Complete 95 percent of PA requests requiring a physician review within 15 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 30 business days.
- Provide an alert to case manager 95 percent of the time 12 months prior to the member turning 21 years of age. Complete 100 percent six months prior to the member turning 21 years of age.

Path of Business Procedure:

Monthly Reports

Step 1: The manager will track and report all performance standards in a format approved by the Department of Human Services (DHS).

Step 2: The manager will implement monthly tracking measures. Any problem trends will be addressed through process and/or workflow changes designed to reverse the trend and avoid a problem before it impacts a performance standard. Monthly tracking measures will confirm the following performance standards:

- a. Processing of 95 percent of receiving complete PA requests and supporting documentation within five business days.
- b. Processing new requests for private duty nursing and personal care services within one day. The manager will confirm with home health review staff number of new requests and response time.
- c. Processing exception to policy requests within 8 business days by compiling recommendation for DHS.

Step 3: Completing all required alerts in a timely fashion. Manager will review documentation of alerts in MedSrv/PA-EPSTD-TCM/Reports/EPSTD Reports/yyyyEPSTD Alert Report.

Step 4: Completing monthly reports by the tenth business day of the month.

Step 5: The manager will complete hard copy of monthly Children's Health Care Prevention and Well Child Care Promotion Scorecard located in IME Universal/MED SRV SUBMITTED REPORTS/Administrative/Monthly Performance Measures/YYYY based on review of the above performance measures. The manager will forward to designated project assistant to complete scorecard.

Step 6: The manager will access reports through by accessing <http://dhsboss1/ime/bltc/Reports/Forms/AllItems.aspx>

- a. Follow directions found in section 8200.5 on how to access report information.

Step 7: Each month by the third business day, the manager will confirm the reports are available by selecting each report in the menu and clicking build report.

- a. Private duty nursing procedures by member
- b. Screenings due for foster care and medically needy with spend down
- c. Foster care and medically needy with spend down treatment history (non HMO)
- d. Children's Health Care Prevention and Well Child Care Promotion service summary claim and encounter data
- e. Screening center service costs by provider

Forms/Reports:

Monthly, Quarterly and Annual as directed by the Department of Human Services

RFP Reference:

6.2.4

6.2.4.1

6.2.4.2

6.2.4.

Interfaces:

Data Warehouse
Iowa Department of Education
Iowa Department of Public Health
MMIS
OnBase

Attachments:

N/A

MED - Children's Health Care Prevention and Well Child Care Promotion Disruption of Business Plan

Purpose: To provide procedures for the continuation of business in the event of inability to utilize electronic programming.

Identification of Roles:

Review Coordinator (RC) – responds to PA requests, verifies eligibility and enters data elements on PA spreadsheet. All activities will be noted on the manual-tracking log

Review Assistant (RA) - receives PA request, enters on spreadsheet, routes to the appropriate RC and sends notices to providers as needed. All activities will be noted on the manual-tracking log

Manager – provides direction, training and oversight in PAs

Performance Standard: In accordance with URAC standards, prospective reviews are completed within 15 calendar days of receipt of the request

- Process 95 percent of requests from providers or the public for services under the Children's Health Care Prevention and Well Child Care Promotion program

that are outside the coverage for the regular Medicaid program within 10 business days of receipt of complete information. Process 100 percent within 25 business days.

- Notify case managers that a PA is due within 60 business days of the due date. Complete 95 percent of PA requests not requiring physician review within 10 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 20 business days.
- Complete 95 percent of requests for private duty nurse and personal care services, when notified that the member is being discharged from the hospital within one business day of receipt of PA request. Complete 100 percent within three business days.
- Complete 95 percent of PA requests requiring a physician review within 15 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 30 business days.
- Provide an alert to case manager 95 percent of the time 12 months prior to the member turning 21 years of age. Complete 100 percent six months prior to the member turning 21 years of age.

Path of Business Procedure:

Step 1: The review assistant (RA) will receive prior authorization (PA) request via fax or mail.

Step 2: Upon receipt of the PA request on form 470-0829, the RA and/or RC will assign a PA number in Box 12 on the form composed of a unique ten-digit number composed of the last digit of the year, three-digit Julian date, a two-digit PA type number and a four-digit document number (YJJJPA####).

Step 3: The RA and/or RC will enter the following data in PA spreadsheet:

- a. Date Received
- b. RC
- c. PA Number
- d. PA Type
- e. Date Span
- f. Provider Number
- g. Provider Name
- h. Member ID #
- i. Member Name
- j. Date out for Additional Information
- k. Dates of Nudge Requests
- l. Date Additional Information Returned
- m. Date Sent To Consultant
- n. Date of Nudge for Consultant
- o. Date Returned from Consultant

- p. Time spent by the consultant
- q. Disposition
- r. Comments

Step 4: The RA and/or RC will forward PA request to the appropriate RC.

Step 5: The RA and/or RC will complete eligibility and medical review as outlined in PA procedures.

Step 6: The RA and/or RC will complete additional information requests and physician/consultant reviews utilizing form templates in Microsoft Word.

Step 7: The RA and/or RC will complete modification or denial notice of decisions (NODs) utilizing form templates in Microsoft Word.

Step 8: The RC will enter data elements 10-18 on the PA spreadsheet.

Step 9: The RC will return adjudicated PA request form to RA.

Step 10: The RA will fax or mail completed PA request form and NODs (if applicable).

Step 11: The RA will file paper copies of PA Request form by provider name.

Step 12: The RA will enter data in on-base when system returns to function.

Forms/Reports:

N/A

RFP Reference:

6.2.4

6.2.4.1

6.2.4.2

6.2.4.

Interfaces:

Data Warehouse

MMIS

OnBase

Attachments:

N/A

MED- Children’s Health Care Prevention and Well Child Care Promotion Urgent Request

Purpose: The RC will discuss with their manager and log the request.

Identification of Roles:

Review Coordinator (RC) –enter urgent care request in Individualized Services Information System and urgent request tracking log.

Manager- Report the number of urgent care requests and timeliness quarterly to corporate Utilization Review Accreditation Committee (URAC) compliance staff.

Director- Ensure the percent of timely urgent request are reported on the URAC compliance dashboard quarterly.

Path of Business Procedure:

Step 1: Urgent requests for prior authorization of services will be reviewed and a decision rendered and communicated in no less than 72 hours from receipt of the request.

Step 2: A request is urgent if the situation poses an immediate threat to the health and safety of the Medicaid member or if the attending physician, member or family member indicates that the need is urgent. This time frame includes holidays and weekends.

Step 3: When an urgent request is received, the staff member will confer with manager and log the request on the spreadsheet located at MedSrv/Urgent Requests/Urgent Request Tracking.

Form/Reports:

Urgent Request Tracking

Program	Review Coordinator	Member L. Name	Member F. Name	SID	Requestor	Initial Date of Service	Date & Time of Request	Decision	Date & Time of Decision	No. of Hrs.	Notes

RFP Reference:

N/A

Interfaces:

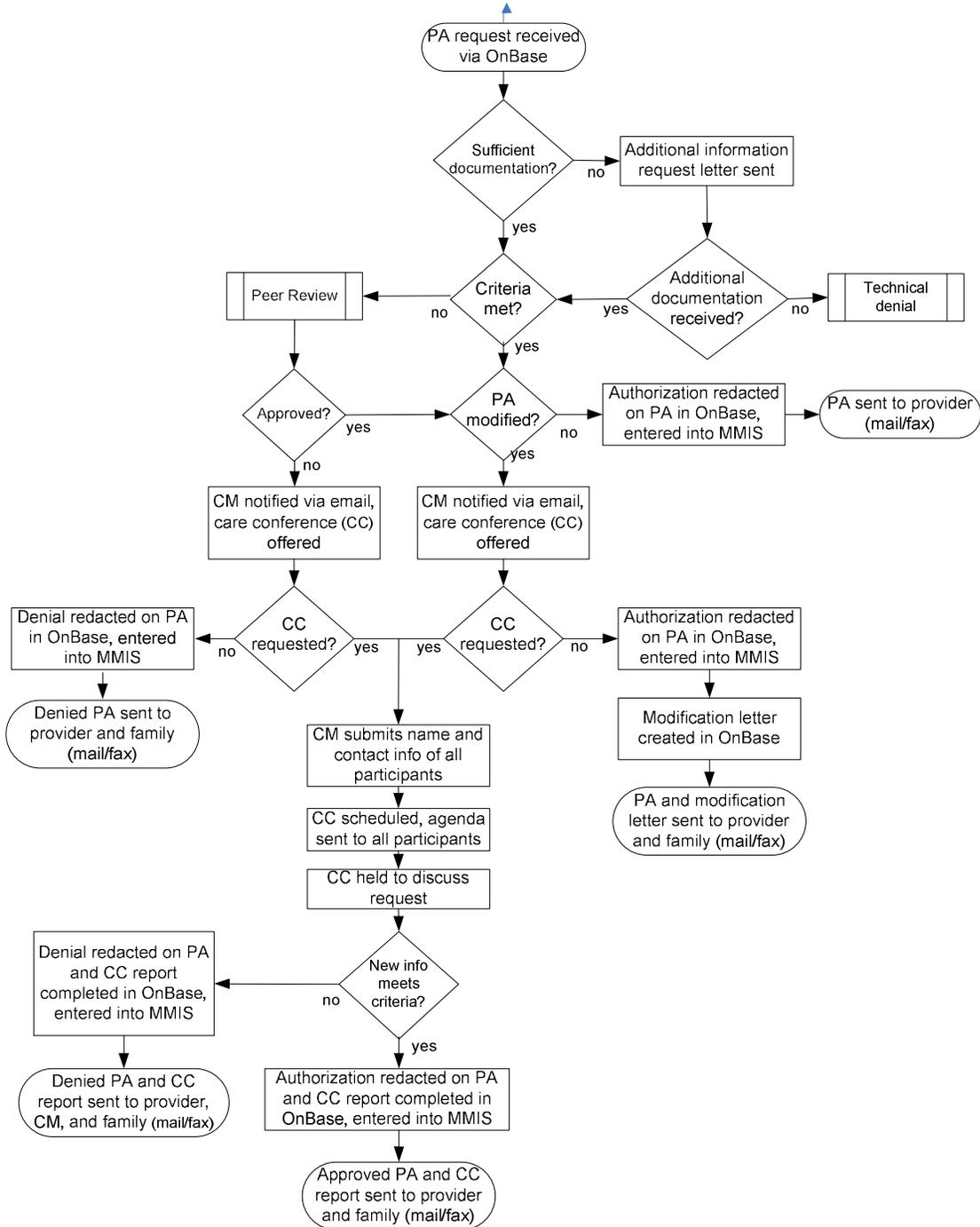
N/A

Attachments:

N/A

Attachment A:

Children's Health Care Prevention and Well-Child-Care Promotion Home Health PA



Attachment B:

Children's Health Care Prevention and Well Child Care Promotion Quality Review

