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Denial, Termination and Reduction (DTR) Facts

Products Affected:

- Medica AccessAbility Solution® - Special Needs Basic Care (SNBC)
- Medica Choice Care℠ - Minnesota Senior Care Plus (MSC+)
- Medica DUAL Solution® - Minnesota Senior Health Options (MSHO)

Purpose: To address Care Coordinator (CC) frequently asked questions regarding the DTR process and forms and ensure an overall understanding of the Department of Human Services (DHS) requirements and regulations of the Minnesota Department of Health (MDH).

Timelines/Dates

1. The 10-day timeline to complete the DTR process is a MDH set regulation that has potential to result in financial penalties due to lack of compliance.

2. Because of the 10-day notice of action authorization Medica is required to complete as part of the DTR process, it is likely that the effective dates will not coincide with the waiver span start or end dates; this is acceptable.

3. All services being terminated or reduced, including Personal Care Assistance (PCA), have a 10-day notice of action authorization entered. Medica enters these authorizations and CC's will receive email notification from Medica informing of the authorization dates. The only reason a notice of action authorization would be shortened, would be due to member's disenrollment during the notice of action date span.

4. DHS has advised that CC's should initiate the DTR process for services that have been suspended (i.e. member is out of county, member is looking for new provider) for more than 30 days unless the CC is certain the service will be resuming in the near future. EXCEPTION: PCA services. DHS has advised that a DTR cannot be completed for PCA services when a member is out of area (i.e. another state or county) and not utilizing services. Once member returns to usual setting, PCA services will resume even if member has been absent for over 30 days.

    a. Member provider elects to terminate services – no DTR as provider is denying the services, not Medica. DTR to be completed if a new provider is not found within 30 days. Vendor Concern Report can be completed for provider concerns.
        i. CC will assist member in locating a new provider. CC basic job responsibilities can be reviewed in the Training Manuals.

5. CC's cannot specify the date for which the reduction/termination should occur. Medica decides this date and the decision is based on MDH regulations that Medica is required to comply. A member may choose to end services prior to the authorization end date; this is acceptable. However, Medica must follow the DTR process to meet regulatory requirements.

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Personal Care Assistance (PCA)/Extended PCA – MSC+/MSHO Only

6. When a member has both State Plan PCA and Extended PCA and the new PCA Assessment recommends less State Plan PCA than previously authorized, the CC must complete a DTR for the reduced amount of State Plan PCA. CC's must specify on the DTR form which type of PCA the DTR is for (i.e. state plan or extended) and what the reduction in the state plan amount is – regardless of Extended PCA that is in place. REMINDER: Utilize the appropriate DTR form, either state plan services or Elderly Waiver DTR depending on which type of PCA.

7. When a CC decides to authorize Extended PCA following a State Plan PCA DTR, the CC must wait for the email notification of the DTR outcome from Medica prior to authorizing Extended PCA. CC's should line up the Extended PCA authorization dates with the State Plan PCA authorization that Medica completes as part of the DTR process.

General DTR Facts

8. A DTR must be submitted if a member notifies a CC after the termination or reduction of a service in which the member has elected to terminate/reduce. The date of request will be the date of notification – not the actual date member elected to terminate/reduce services.

9. If a member has terminated or reduced a service on their own, such as Home Delivered Meals, PCA, Adult Day Center, etc., Medica must still complete the DTR process regardless of the fact that the member chose to terminate/reduce services. When there are overlapping service authorizations for a service ending and a new service starting because of the notice of action authorization Medica is required to complete, the CC must work with the member to ensure member is only accessing one of the services to avoid duplication.

10. There is a difference between providing education to a member's inquiry about what services are/eligibility for services versus a formal denial of request. The discussion between a CC and a member about why a service may not be appropriate and further discussion about alternate services that would be appropriate is not a formal denial, this is collaborative service planning. If a member continues to request a service after the CC has provided education about why the service is not appropriate/the member is not eligible, than a formal denial needs to be pursued by submitting a DTR.

11. The DTR process is the only process that initiates member appeal rights. If a CC does not complete the DTR process, the member will not receive information on how to appeal a denial, termination or reduction decision made (this includes the closing of elderly waiver spans).

12. DTR's are processed by two different departments at Medica. State Plan DTR's are processed by Medica Health Management Prior Authorization team and Elderly Waiver (EW) and other non-medical service DTR's are processed through Care Coordination Products (CCP) Operations Team involving Clinical Supervisor, Clinical Manager and CCP Director review. If a CC needs to complete both DTR forms, please fax separately.

13. Member's moving to a higher level of care (i.e. moving from Customized Living to Nursing Home) require a DTR due to the services/waiver ending as a result of transition.

14. If a CC is closing member elderly waiver, then a DTR must be completed. The DTR for closing a waiver span can include a detailed listing of all EW services ending on the same form. An additional DTR is needed for any State Plan services ending with the closing of the waiver span.

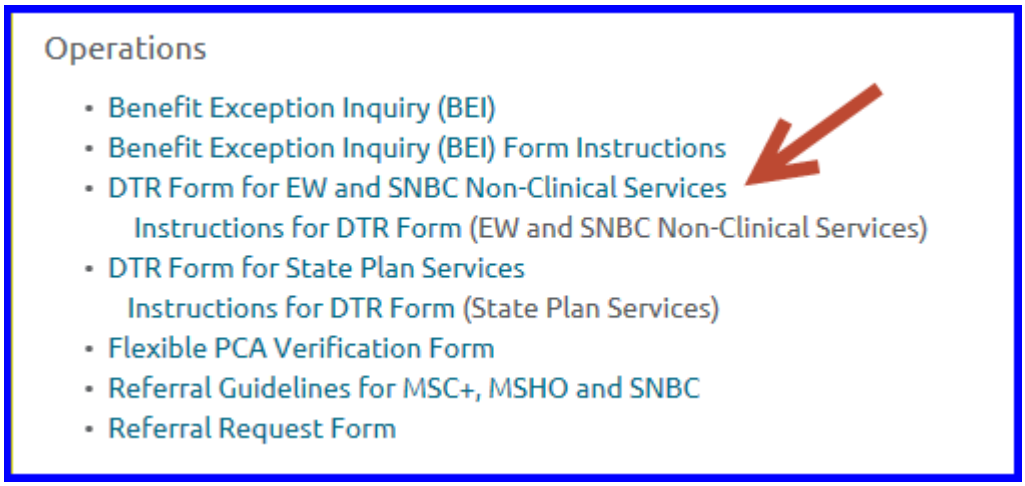
15. If a member resides in a Residential Setting (i.e. Customizing Living, Adult Foster Care) and has had a reduction in services resulting in the daily rate to decrease, a DTR must be submitted. CC's may not reduce services until the email notification from Medica is received.

16. DTR's for services not managed by Medica (i.e. SNBC members – PCA, other waiver services) cannot be processed by Medica as those DTR requests must be processed through the entity responsible for approving or denying those services. CC's should note the service changes in member care plan.

    a. For Prior Authorization requests completed by a provider for a service item (i.e. wheelchair), Health Management will review and complete a DTR if the request was denied.

DTR Resources:

Care Coordination - Tools and Forms



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