

Date: January 26, 2010

Hello to all UCare Case Managers, Care Coordinators, and Case Coordinators!

This Clinical Services Alert contains important information about changes in UCare's care coordination requirements. *We recommend that you review this and the attached documents in their entirety.*

Care Coordination Role and Responsibility Grids:

We have updated our Care Coordination Requirements Grids (referred to role and responsibility grids) for MSHO, MSC+, *UCare Connect* and *UCare for Seniors*. The newly revised grids will be posted on our website within the week. Changes in our care coordination requirements related to assessments are highlighted below:

Important Change regarding Interim Assessments for MSHO and MSC+:

UCare has changed our requirement for interim health risk assessments. Effective immediately (January 2010), Care Coordinators (CCs) will be required to conduct health risk assessments using the LTCC form (DHS #3428) or LTC (DHS # 3427) rather than using UCare's Interim Assessment Form.

UCare's Interim Assessment form will only be used for *UCare Connect* members.

Here is an overview of UCare's requirements for health risk assessments:

1. A health risk assessment is NOT required when:

- The member has a change in CC, **but there is not change in health plan or product**. This includes transfers from one delegate to another in the same health plan, e.g., Aspen to UCare, UCare to county; or, a transfer between CCs in the same entity; **and,**
- The case manager receives **all of** the following from the previous case management entity:
 - The previous LTCC (or verification of an LTCC entered into MMIS within the past 12 months, using activity type 02 or 06); and,
 - The most recent plan of care (POC).

Note: If the previous LTCC is not received or verified in MMIS or if a plan of care is not received, a new, full LTCC assessment must be done, face-to-face. (See #3.)

Upon receipt or verification of the LTCC and receipt of the POC, the CC would be required to:

- Ensure that the member has a face-to-face reassessment every 12 months. The CC may keep the current annual assessment schedule as long as a yearly LTCC is done.
- Inform the member of a change in CC within 10 days new CC assignment.
- Document in case notes the review of the POC, LTCC assessment or MMIS screen.
- Update the CC information in MMIS.
- No health risk assessment is due at this time.
- No new POC is required at this time, but the existing POC may be updated to include documentation of the review of transfer information. The CC must still ensure that services are appropriate and adequate for the member.

2. A health risk assessment via phone or in person IS REQUIRED when:

- The member changes CC due to a change in health plan (**member becomes a new enrollee**).
- The member changes products, even if member stays within the same health plan, and/or keeps the same CC (**member becomes a new enrollee**).

The health risk assessment:

- Must be conducted within 30 days of enrollment.
- May be conducted via phone, or in person.
- Must include a review of pertinent areas of the LTCC #3428 or LTC #3427 assessment form (**at a minimum**, those elements of the LTCC #3428 marked with a “SD”, that refer to the questions on the DHS form #3427 – LTC screening document, or all elements of the LTC #3427, plus a review of ADLs, and current medications). This should also include any questions that are pertinent to completion of an effective care plan. (The #3427T – Telephone Screening Document is NOT appropriate because it does not include review of ADLs).

In order to do a telephonic assessment, the CC **must** receive the following from the previous case management entity:

- The previous LTCC (or verification of an LTCC entered into MMIS within the past 12 months, using activity type 02 or 06).
- The most recent plan of care (POC).
 - If the previous LTCC or POC is not received (or verified in MMIS), a new full LTCC assessment must be done face-to-face.
 - The POC must meet UCare’s care plan requirements. If appropriate information is not received on the transferred POC, the CC must improve the received POC, or complete a new POC using the “Collaborative Care Plan” form. If the received POC is not sufficient to determine services needs, the CC should conduct a full LTCC, face-to-face, and complete a new POC. (See #3.)

Upon completion of the telephonic health risk assessment, the CC would be required to:

- Ensure that the member has a face-to-face reassessment every 12 months. The CC may keep the current annual reassessment schedule as long as a yearly LTCC is done.
- Inform the member of a change in case manager within 10 days of new assignment or change in CC assignment.
- Document the review of the POC and existing LTCC assessment or MMIS screen.
- Update the care coordinator information in MMIS.

MMIS Entry:

- For members who are NOT on a waiver, the CC is required to enter this assessment into MMIS using the LTC Screening document (DHS form #3427), using an activity type code 01 (telephone screen). The CC would keep the current reassessment schedule, and conduct a full LTCC, face-to-face, within 12 months of the previous full LTCC.
- For members who ARE on a waiver, the health risk assessment is NOT entered into MMIS, (because there is not an appropriate way to code this), but is kept in the member's chart. (These will be logged for Part C reporting of assessments- more information to come.)

3. The CC is required to conduct a full LTCC, using DHS form #3428, face-to-face when:

- The CC does not receive a previous LTCC and/or cannot verify that an LTCC has been conducted within the past 12 months. (The CC does not have verification of an LTCC entered into MMIS within the past 12 months; activity type **02 or 06** not in MMIS within the past 12 months); and/or,
- The CC does not receive a copy of the POC.

Any time a comprehensive LTCC (face-to-face initial or reassessment) is completed, the screening MUST be entered into MMIS, using an activity type code 02 or 06, for:

- MSHO.
- MSC+.
- MnDHO.

Extended Transportation for Elderly Waiver (EW) vs. Medical Services:

Extended transportation as an EW service:

- Is only available to members on the Elderly Waiver who have a need for non-medical transportation documented in their care plan.
- Should be billed as extended transportation, not medical.
- **Should NOT be accessed through HealthRide.** UCare can provide a list of Special Transportation Services (STS) providers for CCs to use, but these providers must bill the service as a waiver service with appropriate waiver code:
 - T2001 (UC modifier for waiver transport)-transportation-extra attendant.
 - T2003 (UC modifier for waiver transport)-transportation-one way trip.
 - S0215 (UC modifier for waiver transport)-mileage.

Care Coordinator's role in setting up extended transportation:

- Extended Transportation (for waiver services) may be set up by Care Coordinator, adult day care, assisted living providers, interpreters. (The provider must receive a copy of the "Waiver Service Approval Form" from the care coordinator.)

The CC must approve the transportation, which includes:

- There must be a documented need in the care plan.
- The service must be provided within the monthly case mix cap.
- The CC must call the transportation provider directly, and should NOT call Health ride for these rides.
- The CC sends in a "Waiver Service Approval Form" (see UCare's website) to Claims, and gives a copy to the transportation provider and any provider or entity that will be setting up rides on behalf of the member.
- CC identifies type of transportation, amount, frequency, duration.
- Rides can be approved for up to one year. The CC calls the transportation provider to set up ride, or calls day care provider to let them know what has been approved. The day care provider can call to set up the ride.

Day care or assisted living provider, or interpreter:

- May call transportation provider to set up waiver ride.
- Must have "Waiver Service Approval Form" from CC with amount, frequency, duration, type of ride.

Claims for EW transportation:

- Will pend (not be paid) in UCare Claims unless a waiver service approval form is received, containing the following:
 - Type of transportation.
 - Amount, frequency, duration of rides (# of rides, per person, per week, month, etc, and for how long).

Transportation Provider:

- ◆ Responsible to check eligibility and benefits via MINITS every month. STS providers have access to MINITS.
- ◆ Billing and Coding:
 - T2003 UC modifier, Mileage code S0215.
 - Use common carrier STS#.

HealthRide Medical Transportation:

- ◆ Can be used any time a member needs a medical ride to and from a medical appointment.
- ◆ Can be arranged by a care coordinator, or other party acting on behalf of the member.

PCA Assessment Changes:

UCare has implemented changes to our PCA program in response to recent legislative changes. Beginning December 1, 2009, everyone receiving PCA services will be assessed or reassessed under the new program guidelines. UCare noted these changes in our December 2009 Clinical Services Update Newsletter. Here are some reminders:

- ◆ All PCA assessors must have attended the DHS PCA assessment training to perform assessments.
- ◆ If previously authorized PCA services are reduced or terminated, DHS requires a notification to members 30 days prior to the termination or reduction. This is a change from the previous notification requirement of 10 days. The 30 day notification also applies to extended PCA services.
- ◆ PCA assessors will use the new PCA assessment tool for all assessments. The Medical Assistance Health Status Assessment (MAHSA) will no longer be used for PCA services.
- ◆ At the end of the PCA assessment visit, the assessor will provide the recipient the following:
 - Information about the assessment findings.
 - Referral and resource information about other resources and services available.
 - Copy of the PCA Assessment and Service Plan (DHS-3244) within 10 working days to the recipient and the PCA agency.

Collaborative Care Plan:

UCare has posted the Collaborative Care Plan document on our website, under Providers/Forms. Care Coordinators are required to use this care plan form for all new enrollees (those who have not previously had a MSHO or MSC+ care plan developed). For members who have a previous care plan, the new collaborative care plan document should be used at the next annual reassessment.