

# MEDICA®

<b>Policy Title:</b>	<b>Denial, Termination or Reduction (DTR)</b>
<b>Department:</b>	<b>Government Programs</b>
<b>Business Unit:</b>	<b>State public Programs</b>
<b>Approved By:</b>	<b>Director of SPP Products</b>
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## **PRODUCTS AFFECTED:**

- Minnesota Senior Health Options (MSHO) – Medica DUAL Solution®
- Minnesota Senior Care Plus (MSC+) – Medica Choice Care<sup>SM</sup> MSC+
- Special Needs BasicCare (SNBC) – Medica AccessAbility Solution®
- Special Needs BasicCare (SNBC) Integrated – Medica AccessAbility Solution® Enhanced

## **DEFINITIONS:**

**Benefit Inquiry:** means a member's discussion with their Care Coordinator about a service that the Care Coordinator may not think is appropriate, or know is not included in the member's covered services. This discussion is considered health literacy education and should precede a service authorization.

**Care Coordinator (CC):** An employee or delegate of Medica who creates a person-centered care plan with assigned members and then coordinates the provision of covered services for those members among different health and social services professionals and across settings of care.

**Denial, Termination or Reduction of Service (DTR) Action:** means: 1) the denial or limited authorization of a requested service, including decisions based on the type or level of service; requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of Medica to act within the timeframes regarding the standard resolution of grievances and appeals; 6) denial of a member's request to dispute a financial liability, including cost sharing, or 7) for a resident of a Rural Area with only Medica, the denial of a member's request to

exercise his or her right to obtain services outside the network. Action means the same as “adverse benefit determination” in 42 CFR § 438.400(b).

**DHS:** Minnesota Department of Human Services

**MDH:** Minnesota Department of Health

**Medical Necessity:** means pursuant to Minnesota Rules, Part 9505.0175, subpart 25, a health service that is: 1) consistent with the member’s diagnosis or condition; 2) recognized as the prevailing standard or current practice by the Provider’s peer group; and 3) rendered:

- (A) In response to a life threatening condition or pain;
- (B) To treat an injury, illness or infection;
- (C) To treat a condition that could result in physical or mental disability;
- (D) To care for the mother and unborn child through the maternity period;
- (E) To achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or
- (F) As a preventive health service defined under Minnesota Rules, Part 9505.0355.

**Network Provider:** means any provider, group of providers, or entity that has a network provider agreement directly with Medica or a subcontractor of Medica, and receives Medicaid funding directly or indirectly to order, refer or render covered services under contract with Medica.

**Residential Setting:** a place to live where an individual has services and supports, ranging from 24-hour supervision to on-call assistance, to live as independently as possible. These services will allow an individual to feel that they are a part of the residential community.

**Service Authorization:** means a member’s request, or a Provider’s request on behalf of a member, for the provision of services, and Medica’s determination of the medical necessity for the medical service prior to the delivery or payment of the service.

**PURPOSE:**

To ensure all Medica member DTR Actions are completed in a timely manner using the appropriate process and notification in accordance with DHS, MDH and Medica requirements.

**POLICY:**

Counties, Agencies, and Care Systems that provide services for Medica members must complete DTR Actions in accordance with the DHS, MDH and Medica requirements.

**DTR REQUIREMENTS:**

The County, Agency, and/or Care System must notify both the member and the member’s provider of all DTR Actions as follows:

1. A service is requested or initiated by a member;

2. A service is ordered by a network provider;
3. A service is ordered by an approved, non-network provider;
4. A service is ordered by a Care Coordinator (CC);
5. A service is ordered by a court;
6. A service is suspended for more than 30 days, unless the CC is certain the service will be resuming in the near future (i.e. member is out of the country, member is looking for a new provider);
7. A service is ending, such as Personal Care Assistant (PCA), that does not meet the DTR Action exceptions (see below);
8. A service authorization is ending, such as PCA or a waiver service, and the member is missing or unable to reach to complete the reassessment to continue the service;
9. A waiver span is closing;
10. A service was terminated or reduced by the member (the date of request is the date of DTR Action notification, not the date member elected to terminate or reduce the service);
11. A member moves to a higher level of care (e.g. moves from a Residential setting to a Nursing Home) since services/waiver end as a result of that transition;
12. A member resides in a Residential Setting (e.g. Customized Living, Adult Foster Care) and has a reduction in services that causes the daily rate to decrease (service may not be reduced until the email notification from Medica is reviewed).

**DTR EXCEPTIONS:**

The County, Agency, and/or Care System does not notify via a DTR Action for the following:

1. The service is not managed by Medica (e.g. for SNBC members: PCA and other waiver services), CC's should make note of the service change on the member's care plan when they become aware.
2. PCA services:
  - a. When the service being reduced or terminated is PCA for a waiver recipient and the Supplemental Waiver PCA Assessment and Service Plan (3428D) is used correctly at the time of the assessment, with the member indicating their choice to reduce or terminate the PCA by initialing their decision on the summary page number 5.
  - b. DTR Action cannot be completed for PCA services due to a member being out of the area (e.g. another state or country) and not utilizing services.
    - i. When the member returns to usual setting, PCA services will resume even if member has been absent for over 30 days.
3. When member's provider elects to terminate services.
  - a. No DTR Action is needed as provider is denying the services, not Medica.
  - b. DTR Action needs to be completed if a new provider is not found within 30 calendar days.
4. Prior Authorization requests:

- a. Are completed by a provider for service item (e.g. wheelchair).
  - i. Medica Health Services Utilization Management (UM) Operations Team will review and complete a DTR Action if the request was denied.
5. Medical Transportation DTR's are managed by customer service. The CC can refer or assist member to contact customer service to request appeal rights.

**TIMELINES:**

1. The entire DTR process must be completed within 10 business days of the service authorization request to meet MDH regulations.
2. All services being terminated or reduced, including PCA, have a 10-day DTR Notice of Action authorization entered.
3. CC's are responsible to send in the DTR Action request **as soon as possible** using the appropriate Medica DTR Action form.
  - a. Because of the 10-day DTR Notice of Action authorization, effective dates will not need to coincide with the waiver span start or end dates.
4. CC's will complete the DTR Action form appropriately.
  - a. DTR Form for State Plan Services will indicate Clinical for type of request;
  - b. DTR Form for EW and SNBC Non-Clinical Services will indicate Non-Clinical for type of request.
5. Medica will review the DTR Action request and route it to the correct department.
  - a. State Plan DTR Actions are processed by Medica Health Services UM Operations Team;
  - b. DTR for members choosing to end services, Residential Service/Customized Living reductions, and members entering a nursing home are processed by Health Services UM Operations Team
  - c. Elderly Waiver (EW) and other non-medical service DTR Actions are processed through Care Coordination Products (CCP) Team, when the member has not chosen to reduce or terminate services.
6. A member may choose to end services prior to the authorization end date; this is acceptable. Medica must still follow the DTR Action process to meet MDH requirements.
7. The DTR Action process is the only process that notifies members of their appeal rights and associated timelines.

**PROCEDURE:**

Upon receipt of a service authorization the CC will:

1. Verify eligibility and member coverage for the specific service and/or support.
2. Identify urgent/expedited requests for services and will process within the urgent/expedited review turn around time (TAT) of 72 hours.
3. Review documentation related to the request (e.g. previous service authorizations, current service plan in place, and medical necessity of requested service).
4. If the requested service meets coverage criteria or relevant benefit guideline, then authorize the service.

5. If the requested service is appropriate and fits within EW case mix caps when applicable, enter an authorization per usual processes.
6. If the requested service does not meet criteria or guidelines per the appropriate policy, and the member continues to request the service after education has been provided about purpose of requested service, covered benefits and possible alternatives, complete appropriate DTR Action form.
7. Make no change to the service until the Medica review is complete.
8. Complete the appropriate Medica DTR Action form in its entirety; ensure to list the "date of request" on the form to determine the 10-day timeline in which the DTR Action process must be completed.
  - a. When closing the waiver, the CC may submit one DTR Form indicating the "type of DTR" as non-clinical and chose "yes" to close waiver and include all the waived services that are ending, listing each service
    - i. State plan services need to be submitted on separate DTR Form indicating "type of DTR" as "clinical" and list the state plan service/s.
  - b. If a member is unable to reach or refusing a reassessment, a DTR should be completed at the end of the service authorization for all services including closing EW, if applicable.

Document in the member's case file both the date the DTR Action form was submitted to Medica and the date the service authorization was received.

9. Send in any supporting documentation regarding your recommendation for a DTR Action. Supporting documentation may include:
  - a. Brief synopsis of the request and recommendation;
  - b. Explanation of reduction that needs to occur, if applicable;
  - c. Case notes;
  - d. Completed assessments.
10. Medica will determine the appropriate date and process the decision, to include:
  - a. Enter the DTR Action authorization;
  - b. Enter the reduced authorization as applicable;
  - c. Notify the service provider, primary care provider, and CC of the DTR Action;
  - d. Notify the member via a written DTR Notice of Action that includes appeal rights information.
11. Completion of the Medica DTR process when a member is no longer going to be on the Elderly Waiver does not cross over to the State of Minnesota's Medicaid Management Information System (MMIS) system, the care coordinator will still need to follow the process to document the waiver closure.
12. A Medica DTR reviewer may contact you if there are any questions related to the submitted paperwork. The expectation is that a call is return within 1 business day.

**Note:** In special circumstances a Notice of Action authorization may be entered that exceeds 10 days. When this occurs, a member may request an appeal and be able to

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continue benefits at the higher level if the request is received before the end of the Notice of Action authorization has occurred.

**CROSS REFERENCES:**

MSHO & MSC+ Contract

SNBC Contract

Medica Benefit Guidelines

Medica DTR Form

Medica DTR Form Directions DTR Frequently Asked Questions

CC Training Manuals

Supplemental Wavier PCA Assessment and Service Plan (DHS 3428D)

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