PROVIDER SIGNATURE REQUIREMENTS FREQUENTLY ASKED QUESTIONS

*****Generally, the Care Coordinator should stress, with the member, the importance of or relevance of sharing certain information contained in the care plan with the providers. This will help the member in their determination when evaluating these types of services.

Reminder: Refer to the Instructions for the Collaborative Care Plan (or other health plan specific instructional resources) for details on the process and documentation requirements for sharing care plan information with providers

1. **Q: When a member has a MnCHOICES assessment, starts EW then joins a Health Plan is the Health Plan Care Coordinator required to obtain signatures for EW services that start prior to Health Plan enrollment?**
   A: No. Any services that started prior to Health Plan enrollment does not require the Care Coordinator to obtain the provider signature.

2. **Q: What is the timeline for the second attempt to obtain the signature?**
   A: The second attempt to obtain the signature must be within 60 days from the completed date of the care plan.

3. **Q: What is the process if at the annual assessment the member chooses to start homemaking, but has not yet selected a provider?**

   A: Write in "potential provider" on the signature page of the care plan at the time of assessment. Update the Care Plan with the name of the provider and the start date once a provider has been selected following the process outlined in section titled *Updates to the Support Plan* of Instructions for the Collaborative Care Plan. You have 30 days from the date when the provider is selected to send the 1st signature attempt to the selected provider.

4. **Q: When we receive a new member from Fee for Service who had a MnCHOICES assessment within the past 365 days, can we use the CSSP signature page that came with the transfer paperwork?**
   A: Yes. However, if the member increases or starts new services, you must follow the process outlined in sections titled *Updates to the Support Plan* of the Instructions for the Collaborative Care Plan to discuss members decision to share care plan information with the new provider and follow up on obtaining new signatures, if applicable.

5. **Q: If a member has a change in provider, an addition of a provider, or a change in units of any service but had their care plan developed in 2017, should a new care plan be filled out?**

   A: The requirements are effective 1/1/18 and a new care plan isn't required until reassessment. Follow the process outlined in section titled *Updates to the Support Plan* of the Instructions for the Collaborative Care Plan.

6. **Q: What do I need to document in my case notes regarding the provider signature?**

A: A copy of the letter and/or documentation in your case notes is sufficient. Discuss with your health plan specific requirements. See Instructions for the Collaborative Care Plan for case note examples.

7. **Q: Can I use the RS tool or ICLS Planning form in place of the copy of the care plan or the care plan summary letters?**

   A: The member can choose to send the RS tool or ICLS Planning form, for applicable providers. A cover letter is not required; however, you should document the decision in your case notes.

8. **Q: If the member chooses to send the RS tool, where does the provider sign?**

   A: The provider can sign anywhere on the RS tool.

9. **Q: If the member chooses to send only the RS Tool or ICLS Planning form to the provider (instead of a copy of the full care plan), which box do we check on the care plan Signature Page?**

   A: Check "None" unless you are sending the care plan or summary letter.

10. **Q: Do we need to do a member change letter for changes in state plan services?**

    A: No. This requirement if for EW services only or PCA services if the member is on EW.

11. **Q: Do we need to send more than one letter if the service provider is proving more than one service**

    A: You only need to send one letter to the provider even if they are providing more than one service.

12. **Q: What EW transportation requires notification to the member and provider signature?**

    A: Complete the applicable requirements for members who utilize transportation in these situations:
    - Through EW for community connections. (Going to church, health fairs, shopping and other community events)
    - Through a **DHS enrollment-required service (formerly a tier 1 service)** such as:
      - Mode 4 (door through door, ambulatory)
      - Mode 5 (wheelchair, ramp) or
    - Through **Approval-option: direct-delivery service (formerly tier 2 service) including**
      - Mode 2 (volunteer drivers)
      - Mode 3 (curb-to-curb drivers)
    - When accessing EW services that does not include transportation (i.e. Adult Day services)

13. **Q: What type of EW transportation is <u>not</u> included in this notification?**

    A: Purchased-item service (formerly tier 3) transportation provided by a commercial or common carrier vendor. Commercial common-carriers include buses, taxicabs and light rails.