



NC Department of Health and Human Services

LME-MCO Communication Bulletin J297

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Purpose

LME-MCO, *LS v Wos* Instruction

- In November 2017, DHHS received a notice of noncompliance from plaintiffs' counsel with respect to the *LS v. Wos* Settlement Agreement. The department has reviewed the information provided by plaintiffs' counsel and has agreed to take certain corrective actions as outlined below.

Residential Supports and Supported Living

- The level of Residential Supports or Supportive Living requested in the plan of care or approved by Utilization Management (UM) must be based on medical necessity in each participant's individual case.
- The SIS Level is only one piece of evidence that may be considered.
- The SIS score may be considered as a guideline only and should not be the sole piece of evidence in determining the level of these services.

Residential Supports Example

- LEVELS
- Residential Supports levels are determined by the Individual Budget Tool and other evidence of support need. The SIS Level is only one piece of evidence that may be considered.
  - Level 1: SIS Level A
  - Level 2: SIS Level B
  - Level 3: SIS Level C and D
  - Level 4: SIS Level E, F, and G
- The results of a SIS and the IBT Base Budget are guidelines that do not constitute a binding limit that may not be exceeded on the amount of services (including the level of this service) that may be requested or authorized in a Plan of Care.

Supported Living Example

- LEVELS
- Supported Living levels are determined by the Individual Budget Tool and other evidence of support need. The SIS Level is only one piece of evidence that may be considered.
  - Level 1: SIS Level A and B
  - Level 2: SIS Level C and D
  - Level 3: SIS Level E, F, and G
- The results of a SIS and the IBT Base Budget are guidelines that do not constitute a binding limit that may not be exceeded on the amount of services (including the level of this service) that may be requested or authorized in a Plan of Care.

Supported Living - Training Material Example

- Daily service for individuals who live in their own home
- Up to three individuals may live together without licensure needed
- May not be owned/rented by provider
- May include live-in caregiver
- ~~Level is based on SIS Level~~

Residential Supports- Training Material Example

- Residential Supports:
- ~~Residential Supports levels are determined by the Individual Budgeting Table Category~~
- Staff who provide Residential Supports should not provide other waiver services to the beneficiary
- Respite may be used to provide relief to individuals who reside in Licensed and Unlicensed AFLs.

Making Requests

- It is essential that individuals and families are supported to request whatever level of Innovations waiver services they believe are needed, regardless of the SIS score or assigned budget guideline.
- Any discouragement of individuals, families, or providers from requesting the level of support the believe is needed is strictly prohibited.
  - Level of Support means the service, the amount, the frequency, and/or the duration.
- Care Coordinators can and should offer education of Innovations Waiver requirements, service planning, and service definitions, but cannot refuse to submit a request even if the Care Coordinator believes that it contradicts waiver policy.

Reviewing Requests for Waiver Services

- When reviewing a request for services which exceed the assigned budget, the decision must be based solely on the needs of that individual waiver participant based on all available evidence.

- A denial must not be based upon a finding that the participant is not an outlier to his/her assigned budget category or does not have atypical needs when compared to other participants in the same budget category.

UM/UR Process

The following three components are included in the plan review process:

- Health and Safety
- Waiver Compliance
- Support Needs

Examples of Unacceptable Denial Reasons

- "Member appears to have been receiving services previously that are not in alignment with the assigned budget category level and individual base budget category."

- "The assigned budget would typically meet the needs of someone with similar support needs."

- "[Name] has requested an array of services in excess of his base budget- a higher amount of services that would typically be needed to meet the needs of someone with similar support needs."

- "Authorization should mirror use of services within budget."

Examples of Acceptable Denial Reasons

- "Based on the clinical information provided *including* the SIS © assessment, medical necessity is not met for the requested service hours."

- "*The information/assessments provided* do not justify an increase in service hours."

- "The information provided does not indicate that the individual would benefit from the combination of service hours requested."

Intensive Review

- Participants requesting services over their individual budget must not be required to request the Intensive Review process in order to obtain services over budget.
- A participant may request Intensive Review, but such a request is independent of the LME/MCO's obligation to determine the need for services based solely on medical necessity in that case.

Intensive Review, Cont'd

- The Intensive Review Committee makes recommendations about the appropriateness of Intensive Review.
- The Intensive Review Committee may request additional information or make alternative recommendations as appropriate.
- If the Committee determines that Intensive Review is not appropriate, the individual will not be assigned to the Intensive Review Group the Intensive Review Response Letter will be sent to the Care Coordinator / Legally Responsible Person noting that the person has not been recommended for the Intensive Review Group and an Individual-specific budget has not been set.
- The recommendations on the Intensive Review Letter should not be focused on the individual coming into their his/her budget category.

Service Authorizations Less that Requested

- If an LME/MCO authorizes a requested service for a duration less than as requested, the beneficiary must receive written notice with appeal rights at the time of that limited authorization.
  - The notice must include the clinical reasons for that decision
  - Note- this does not apply if the service has a maximum benefit duration contained within the Innovations Waiver and the LME/MCO authorizes the service requested up to that maximum.

- If services are approved for less than the maximum authorization period based on an expectation that the individual's needs will change during the plan year, the LME/MCO must provide written notice of the adverse benefit determination based upon this limited authorization of the service, and this notice must include the specific reason services are expected to be needed only for a limited time.

Questions