

## Technical Questions RE: The Benefit Utilization System (BUS) Final

### 1. Do case notes currently need to be put into the BUS?

Response

HCPF has been unable to determine whether or not the BUS can interface with the automated systems currently being used by the CCBs. Therefore, agencies that have an automated system may continue to use their system and not put case notes in the BUS. Agencies that do not have an automated system of their own are to put case notes in the BUS.

### 2. Will our TCM billings be affected if case notes are not in the BUS?

Response

Not necessarily. CCBs are required to maintain proper documentation of all TCM activity and case notes in the BUS is one way of documenting the required activity.

### 3. What needs to be put into the BUS if the ULTC 100.2 has been denied and the consumer/guardian is appealing the decision? Does the consumer continue to receive services?

Response

Under the "Case Status" option you would select "Appeal". This shows the case is no longer open but under appeal. As for the certification dates- DO NOT extend them or add a new one. The certification dates would only be addressed after the Final Agency Decision from the appeal is received. If the client wins, an "appeal overturned" copy of the assessment is made and updated with the changes. The approval date would be the date of the new assessment and the certification start date would be the date of the assessment that was overturned.

If a client wishes for services to continue through the appeal process, he/she must request an appeal hearing prior to the date of intended action. At that point services can continue (per HCPF Rule 8.057.5(A) The CCB should send a new PAR with the extended dates (normally these dates are the dates the certification would have been if the client had remained eligible) and a copy of the appeals notice to DDD. The CCB can complete a PAR for the entire span because if the client wins then they won't need to do another one. Also, it is better to do the PAR with more days then less because if the decision in the case is delayed then the CCB will need to keep revising the PAR.

Essentially, if the client loses the appeal then the CCB should send in a revised PAR so that the end date corresponds with the appeal decision. HCPF then has the right to recoup the cost of any services rendered during the appeal from the applicant and/or recipient.

- 4. When trying to complete the Mini Mental, what do we do if we start and are unable to finish because the consumer becomes flustered after two questions and is unable to finish?**

Response

It would be acceptable in a situation where the client is unable to complete the Mini Mental to indicate "No." when asked if the test was administered and then explain in the comments that it was attempted, but the client was unable to answer the questions. As long as there is an attempt and it is well documented there will not be a problem with finalizing the assessment.

- 5. It is understood that when a consumer gets a 2 or higher in at least one of the Supervision areas, a Mini Mental must be completed. Is this also applicable when the consumer meets LTC criteria based on their ADL scores, but also have a score of 2 or higher in one or both of the Supervision areas?**

Response

The mini-mental only needs to be administered if a two or higher is given under the Supervision cognitive/memory category. It does not need to be given if a score of two or more is given under supervision behavior. This is regardless if the consumer meets LTC criteria based on their ADL scores.

- 6. If an individual requests to transfer from one HCBS Waiver to another (i.e.: SLS to Comp) do they need to send the 803 or an advisement letter?**

Response

An Advisement letter would be sent for the program from which they are terminating, and an 803 would be completed for the program in which they are enrolling.

**7. What is the minimum age that the mini-mental has to be administered?**

Response

The Mini-Mental Exam should be administered for clients sixteen and older so it is not required for the HCBS Children's Waivers including CES. If the clients age sixteen and older are not capable of answering the questions then you should indicate under the comments why it was not attempted

**8. What are the ramifications if an individual (parent) in SLS refuses to provide the current benefits information to fill out on the BUS?**

Response

As it stands now there is no ramification for not having this information. The BUS will not require the CMA to enter it in order to create a referral or create a client record. However, in order to be in a Medicaid waiver the consumer/guardian signs the client choice statement stating they are accepting targeted case management services. One of the targeted case management responsibilities is to verify and document financial eligibility for the Medicaid Waiver Program per HCPF Rule 8.500.92(F). DDD does not mandate that this be maintained in the BUS, but it would be a logical place to have this information because it must be made available for our IP/TCM audits. The CCB should contact the family and/or county to obtain this information. If the county does not have current information and the family refuses to provide it, the CCB is required to send the LTC 803 terminating services based upon the aforementioned rule. If the family fails to provide accurate income information to the county, the county also has the obligation to terminate.

**9. In Chapter 8.393.2.27(B) how is the term "significant change" interpreted? For example, if the person lives at home with their family, and a primary caregiver dies, this is a significant change for the person. Would this be a correct interpretation of this regulation?**

Response

HCPF defines significant change as when there appears to be a change in the client's condition that could result in them no longer being eligible for the waiver or a change in service needs.

**10. If the person appeals the loss of Waiver services, is the provider agency obligated to continue to provide services for the person?**

Response

According to HCPF Rules 8.057.5, under “Maintaining Services”, if the client wishes to maintain services through the appeal process, he/she must request a hearing prior to the date of action. Services will continue until a final agency decision has been issued after the hearing. The exception to this is if at the hearing it is determined that the sole issue of the appeal is one of federal or state law or policy and the client is immediately informed that their services will be reduced or terminated pending the hearing decision.

During the appeal process, the provider would continue to get paid because the CM would submit a PAR with the appeal letter. However it is important to note that if the client loses the appeal, HCPF or its designee may institute recovery procedures against the applicant or recipient to recoup the cost of any services provided during the appeal process.

**11. We need to be sure how a “start date” works. For example, when completing a CSR up to 90 days in advance, does the old 100.2 stay in effect for the full year, or do we end up with a new cycle based on when the assessment was done?**

Response

The initial start date is the date of the assessment. On a CSR (which can be done up to 90 days in advance) the start date is the first day following the end date of the previous certification period.

**12. Please define medical and functional necessity.**

Response:

Medical necessity as defined in Volume 8 section 8.076.d means that the service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living.

Functional Eligibility means an individual meets the criteria for Medicaid long term care services as determined by the Assessment and necessary for enrollment into a HCBS waiver, Nursing Facility and ICF/MR program.

Assessment means a comprehensive evaluation conducted by the Case Manager with the client and appropriate collaterals, with supporting diagnostic

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information from the client's medical provider, to determine the client's level of functioning, service needs, available resources, and potential funding resources. The evaluation process includes the Functional Needs Assessment.

Functional Needs Assessment means a comprehensive face-to-face assessment (utilizing the ULTC 100.2 form) conducted at the client's place of residence by the Case Manager with the client and appropriate collaterals, to determine if the client meets the nursing facility, ICF/MR, or hospital level of care.