Care Coordination ICR Manual

The intent of the ICR Manual is to provide a data entry tool for Care Coordinators and support staff to enter Service Agreements/Authorizations and DTRs for Blue Plus MSHO and MSC+ members.

March 28, 2019
*updates documented in Red
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LOGGING OUT OF ICR

APPENDIX A: SERVICE AGREEMENTS REQUIRING ADDITIONAL INFORMATION

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Interactive Care Reviewer (ICR)

ICR is an online authorization tool Care Coordinators can access through the Availity Portal. Care Coordinators will use ICR to create and submit Service Agreements/Authorizations. Care Coordinators can also check the status of authorizations in ICR. There are resources related to ICR posted on the Blue Plus Care Coordination website including:

✓ Recorded webinar (parts 1-3)

Definitions

Interactive Care Reviewer (ICR): The portal used by Care Coordinators to enter authorizations for members in MSC+ or MSHO that receive Elderly Waiver, MA paid state plan benefits, PCA, or Moving Home MN benefits.

Elderly Waiver Services: A set of services available to members who have been determined eligible for Elderly Waiver in the State of Minnesota through the LTCC Assessment. This benefit set is listed in DHS-3945.

Moving Home Minnesota (MHM) Services: A set of services available to members who are eligible to receive Elderly Waiver benefits and who are transitioning out of an inpatient setting, such as a nursing facility. Elderly Waiver benefits must be used prior to MHM services. This benefit set is listed in DHS-3945.

MSHO Supplemental Benefits: An additional set of benefits for MSHO members only.

State Plan Benefits: A set of services offered through the standard Medicaid benefit that offer services within a member’s home, which Care Coordinators are allowed to authorize according to BCBS. The set includes: Home Health Aide, Skilled Nursing Visit, Personal Care Assistance, Home Care Nursing (formerly PDN) and Physical, Occupational, Respiratory and Speech Therapy.
Approve: will move the authorization to a complete status and generates the accompanying authorization and service agreement required.

Deny: will allow the Care Coordinator to report if the authorization is being denied. Note: DTRs are not being completed in ICR at this time. See Care Coordination Guidelines.

Request for Review: allows the Care Coordinator to send the authorization for UM review. This is used when the authorization requires further review by Utilization Management (UM) or a Medical Director, or UM staff need to take additional action (i.e. entry of a negotiated rate).

Requesting Provider: the Care Coordinator’s delegate agency

Servicing Provider: the provider that will be billing for the service

Ordering Provider: ordering provider is not applicable for care coordination purposes. You can check either same as Requesting or Service Provider.

Subscriber ID: Member’s Blue Plus ID number

Services Authorized by the Care Coordinator in ICR

All services approved by a Care Coordinator require an authorization completed in ICR including:

- Elderly Waiver Services within benefit limits and up to the monetary limit of the member’s assigned Case Mix Cap

- Moving Home Minnesota benefits: Use the appropriate DHS MHM codes to authorize MHM services.

- MA State Plan Benefits: Person Care Assistance, Home Health Aide Services, Skilled Nursing visits, Home Care Nursing (formerly PDN) and Physical, Occupational, Respiratory and Speech Therapy within the limits of the benefit and update the monetary limit of the assigned Case Mix Cap for an Elderly Waiver Member, if applicable.

- MSHO Supplemental Benefits: NOTE: Supplemental benefits will not be authorized in ICR until a later date. See the Care Coordination website for details on how to authorize supplemental benefits.

NOTE: Care Coordination and Case Aide services do NOT require an authorization in ICR.

Rates for Service

Fee schedule service rates are automatically applied during the authorization and claims payment process unless the service has a negotiated rate. You will not need to enter a rate of service for services that have a DHS set rate.
**COLAs, Rate Adjustments additional information coming soon**

DHS COLAs and/or Rate Adjustments will be automatically applied to existing service agreements/authorizations in ICR.

**Waiver Obligations**

Waiver Obligations, if applicable, will be displayed in Member360 under Active Alerts.

**Contacting Availity**

Availity Support Team: **1-800-282-4548**

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**Accessing Availity/ICR** (see ICR Module 1: Getting Started on the Care Coordination website)

Care Coordination staff will access the ICR tool through the Availity Portal at [www.availity.com](http://www.availity.com). Availity is a multi-payer portal. It is recommended to use Chrome, Internet Explorer 11, Safari or Firefox.

If your organization is not registered on the Availity portal, one of your staff members will need to take responsibility for being your organization’s Availity account administrator and go to [www.availity.com](http://www.availity.com) and select “Register” to begin the registration process. See ICR Module 1: Getting Started on the Care Coordination website.

Once your organization is registered, the your Availity Administrator will add Users and assign Roles. To add users, select Maintain User or Add User. See ICR Module 1: Getting Started on the Care Coordination website.

You will then assign each user a User Role. Select both “Authorization and Referral Inquiry” and “Authorization and Referral Request”.

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![My Account Dashboard](https://via.placeholder.com/150)
Logging in to Availity/ICR

1) Log into ICR via Availity using www.availity.com

2) To access Authorizations, select Patient Registration

3) Choose Authorizations and Referrals (click on the heart to save to your favorites)
To enter an authorization, select **Authorizations**

Add to your favorites by click on the heart.
• Select Payer **BCBSMN BLUE PLUS MEDICAID WAIVER**

Always pick BCBSMN BLUE PLUS MEDICAID WAIVER regardless of the service or member’s rate cell.
The care coordination agency should default; if the user has multiple organizations added to their ID, then they need to select appropriate organization.

- Select Submit
- Select Accept on the next screen

ICR will launch in a new window. ICR will default to an ICR dashboard. Only submitted requests from the last 90 days from your agency will appear on the dashboard.

Creating a Service Authorization  See ICR Module 2: Authorization Requests on the Care Coordination website for complete details.
Care Coordinators will use the same process (described below) to create service agreements/authorizations for:
✓ EW services
✓ MA Home Care services
✓ PCA and
✓ Moving Home Minnesota

Complete the steps above to log in to Availity. From the ICR Dashboard you will select Create New Request.

Select **Create New Request**

See below for instructions on how to complete each required section of the request.

You will see the following icons (save case, delete case, case transaction history, print case).

1. **Patient Details Tab**

This is where you will enter information about the Member.

   a. Enter the Request type of **Outpatient**
   b. Enter the Case type of **Medical**
   c. And Enter **From** and **To** dates. This is the date the service begins and ends. The “From” Date is limited:
- up to 120 days in the past
- up to 1 year in the future
- “From” and “To” dates cannot span past a member’s eligibility span.

ICR will allow for authorizations to be created for a future date. Exp. If a Care Coordinator completed a reassessment on 02/15/2019 with an effective date of 04/1/2019, ICR will allow the Care Coordinator to create authorizations starting on the date of 04/1/2019.

ICR DOES NOT calculate the number of days within the date span.

d. Enter the **Subscriber ID** (Blue Plus ID number) and enter *at least one* of the following patient identifiers: First Name, Last Name or Birth Date.

e. Select **Find Patient**

f. ICR returns a patient confirmation page. Review the confirmation screen and click **Confirm Patient**

NOTE: If member is not associated to Delegated Agency then no member information will display, and a message will appear indicating that the Care Coordinator cannot enter an authorization.
g. After selecting “Confirm Patient”, the Services Detail Page will Display.

2. Service Details Tab

This is where you will enter information about which SERVICE you are authorizing.

Care Coordinators will create service agreements/authorizations for:
- ✓ EW services
- ✓ MA Home Care services
- ✓ PCA and
- ✓ Moving Home Minnesota

a. You will first complete the Diagnosis fields (place of service, type of service and level of service):

b. Under Diagnosis, the Care Coordinator must:
   1) Enter the Place of Services as Home
   2) Enter the Type of Service as Transitional Care
   3) And enter the Level of Services as Elective

   4) Enter Diagnosis code for the member and click the + icon. You must select the plus icon to move on.
If the diagnosis is unknown, user can click on the magnifying glass to search for the Diagnosis code and then add. More than one diagnosis code can be provided.

5) Click **Next**

c. Next you will enter information under Services.

Under **Services**, the Care Coordinator must:

6) Enter **Procedure code** (Ex. S5120 chore) and the corresponding **modifier** (if applicable). If procedure code is not known, then use the magnifying glass to search for the procedure code and add.

7) Enter the total number of units for the entire span in the **Quantity** field.

**NOTE**: this is the **TOTAL** number of units for the span (with the exception of CDCS, See CDCS authorizations below).
8) Click the **Plus + sign** to add the code to the authorization. Only one code can be entered for each authorization.

9) Click **Next**

### 3. Provider Details Tab

This is where you will enter information about which PROVIDER you are authorizing and your agency. You will enter the Requesting Provider, Servicing Provider and Ordering Provider. Note: for Ordering Provider, you can select Same as Requesting or Same as Service Provider as this is not applicable for Care Coordinators.

a. First select **Requesting Provider** (Requesting Provider is the Care Coordinator’s organization) by selecting the Magnifying glass.
1) Click on the magnifying glass to search for the name of the Care Coordination agency by Name and State or by NPI. OR click on the Star button if your agency has already been added to your favorites.

2) Make sure the Provider Group radio button is selected

3) A results area will appear. Select the Plus + sign next to the provider to select the provider. If there are no results that match your search or the provider you are selecting does not appear in the drop-down menu, select the “click here” link to manually enter provider data in text fields.

TIP: Care Coordinators can add their agency to favorites for easy selection in the future.

   To add to favorites, click the Star Icon by the desired provider in search results. ✪

   To access favorites, click on the Star Icon at the top of the screen and then the Plus + icon next to the provider you would like to select.

   You can save up to 25 of each type of provider (Requesting and Servicing Providers) in your favorites.

4) In the Contact Last Name, Contact First Name, Contact Telephone and Email Address enter the Care Coordinator name and contact information. If you would like to receive communication from Amerigroup Utilization Management via email, make sure to include your email address as the Care Coordinator.
b. Select **Servicing Provider** (the Provider that will be billing for the service)

1) Click on the magnifying glass to search for the name of the **Service Provider** by Name and State or by NPI. OR click on the Star button if the agency has already been added to your favorites.

2) Make sure the **Provider Group** radio button is selected
3) A results area will appear. Select the Plus + sign next to the provider to select the provider. If there are no results that match your search or the provider you are selecting does not appear in the drop-down menu, select the “click here” link to manually enter provider data in text fields.

TIP: Care Coordinators can add agencies to favorites for easy selection in the future.
To add to favorites, click the Star Icon by the desired provider in search results.
To access favorites, click on the Star Icon at the top of the screen.
You can save up to 25 of each type of provider (Requesting and Servicing Providers) in your favorites.

Out of Network Providers/Continuity of Care
For new members with existing services, if servicing provider is out of network, and the Care Coordinator would like to request an exception due to Continuity of Care, the Care Coordinator will complete the following:
- Enter the Provider in the Servicing Provider field
- ICR will give a popup screen after the selection of “next” and identify that the provider is out of network.
- Select “edit or proceed”
- ICR will ask if you are requesting an out of network provider request. The Care Coordinator should select “yes” and supply reasons and rationale for use of the out of network provider (exp. Continuity of Care).

c. Select Ordering Provider (ordering provider is not applicable for care coordination purposes). You can check either same as Requesting or Service Provider.
Click **Next**. ICR will advance to the **Request Summary Page**.

### 4. Request Summary Tab

This is where you complete a review of your authorization.

- a. Review the request to assure correctness
- b. If correct, click **Next**. ICR will advance to the **Decision Page**.
- c. If incorrect, return to the applicable tab (Patient Details, Service Details or Provider Details) to make adjustments

### 5. Decision Details Tab

This is where you enter the “Decision” of your authorization and additional information for Utilization Management as applicable.
a. **Date Decisioned**: The date that the decision was made by the Care Coordinator to Approve, Deny or Request for Review. See the Care Coordination Guidelines for complete instructions re: DTRs.

Enter or use the calendar options to select the Date of the Decision or “Date Decisioned”

b. **Decision Status**: The decision made by the Care Coordinator. Select **Approve, Deny, or Request for Review** of an authorization.

   ![Decision Status](image)

   **Approve**: moves the authorization to a complete status and generates the accompanying authorization and service agreement required.

   **Deny**: allows the Care Coordinator to report if the authorization is being denied. DTRs are not currently being completed in ICR. See Care Coordination Guidelines for details.

   **Request for Review**: used when the authorization requires further review or additional entry by UM staff or a Medical Director. See Appendices A-C for more information about Requesting a Review.

c. **Description of Service**: The Care Coordinator must add information about what is being provided. *(refer to Appendix A)*

   This is required for the following services:

   - Specialized Medical Equipment
   - Lift chair
   - Consumer Directed Community Supports (CDCS)
   - Environmental Accessibility Adaptations
   - Customized Living/24 hr CL
   - Out of Home Respite
   - Transportation – Bus Pass/tickets
   - Transportation – One Way Trip
   - Transportation – Per Mile (Commercial and Non-Commercial)
   - Transitional Support Services
   - Foster Care, Family/Corporate
   - PERS
d. **Additional Comments/Notes:**

1. **Frequency of the service**

Enter the Frequency of the service in the Additional Comments/Notes area. (For example, 3 hours per week, 2 cans/day, once per day, 1 time per month, 12 units per day, etc.)

2. **Authorization Template**

The services listed above require additional information. A template has been created to assure necessary information is communicated to UM to complete the authorization. This template can be cut and pasted into the authorization request in ICR. (refer to Appendix A)

![Additional Comments/Notes](image)

e. **Approval Option Provider Information** – check Approval Option Provider Information if the Care Coordination delegate is acting as a pass-through biller for the approval option service. Enter the actual provider of the service in the text field.

![Approval Option Provider Information](image)

f. Read and check the disclaimer

![Disclaimer](image)

g. Click Next. ICR will advance to the Clinical Details page.

6. **Clinical Details Tab**

Regardless if the Care Coordinator has Clinical Documentation to upload, the CC must complete all asterisked fields. If there are no clinical notes to submit, you can indicate Not Applicable, N/A or none.
If the Care Coordinator is requesting a review and has clinical information regarding the request, the Care Coordinator should attach the documentation using the Upload button and/or provide details in the Clinical Notes section. If the Care Coordinator indicates there is no clinical documentation, UM will reach out to the provider to request clinical details, if required.

a. **Attach** any documents, assessments, and clinical information required to complete the authorization, if applicable
b. Complete the clinical notes field. If there are no clinical notes, enter N/A, Not Applicable or None.
c. Click **Add Note**.

d. Click **Next**. ICR will advance to the **Case Overview** tab.

7. **Case Overview Tab**

Case Overview allows a final review of the authorization prior to submission.

b) Review each section to ensure accurate information. Tip: Sections can be collapsed or expanded for viewing.
c) If needed, return to any section that needs revision.

d) If all sections are correct, click **Submit**.

ICR will return to dashboard where submitted authorizations can be seen.

If you have sent your authorization through as approved, you will see Approved in the Status column and “System” in the Updated By column.

If you have sent your authorization through as Deny or Request for Review, you will see Review in Progress in the Status column and the UM staff in the Updated By column.

Once the review has been completed you will see “System” in the Updated By column.
You can also select the Request Tracking ID to view additional details about the request including viewing and printing service agreement letters.

Note: The Care Coordinator will be notified of the authorizations through CareCompass notifications in the New Message Section. All authorizations can be viewed in Member360.

**Searching for Authorizations in ICR** (see ICR Module 3: Authorization Inquiries on the Care Coordination website)

Care Coordinators can search for authorizations in ICR, using the search function. Care Coordinators can search by ICR Tracking #, auth number located in Member360, subscriber ID, or date.

To check the status of an authorization, on the Authorization & Referrals page, select **Authorization Inquiry**
If you have been transferred a case and are unable to find an authorization in ICR, you can find the authorization status in Member360. See CareCompass-Member360 manual for instructions.

Modifying an Authorization

Modifications to existing service agreements/authorizations cannot be made in the current authorization. A NEW auth must be created with the modified information. Amerigroup UM will adjust the service agreement/authorization for the provider.

Approving Additional Units for an Existing Authorization

1. Create a **NEW** authorization for the **NEW** units and span. Complete all the steps listed in the *Creating a Service Authorization* section above.

   a. In the **Patients Detail** screen, the Care Coordinator should enter the **new** auth span applicable to the increase in units.
   b. On the **Services Detail** page, the Care Coordinator will enter the **new** quantity of total units for the auth span.

   Exp. An existing auth for homemaker services from 1/1/19 to 12/31/19 for a total of 416 units (2 hrs/week). On 3/1/19, the member is approved for an increase to 3 hours per week. Enter the NEW authorization for 3/1/19-12/31/19 for a total of 528 units (3 hours per week for 44 weeks).

   c. On the **Decision Detail** page, the Care Coordinator will enter that the authorization is an increase in units and the reason for the increase in the Additional Comments/Notes Section.
   d. In the **Decision Detail** page, the Care Coordinator will select **Request for Review**. The authorization will be routed to the UM team for completion.
   e. UM will adjust the previous span and complete the new Service Agreement letter for the provider.
Changing a Provider for an Existing Authorization

1. Create a NEW authorization for the new Provider with the new units and new span. Complete all the steps listed in the *Creating a Service Authorization* section above.

   a. In the **Patients Detail** screen, the Care Coordinator should enter the **new** auth span for the new provider.
   
   b. In the **Provider Detail** screen, the Care Coordinator should enter the **new** provider information.
   
   c. On the **Decision Details** page, in the Additional Comments/Notes section, the Care Coordinator will complete the Change in Provider Template (below) and paste into the comments section.
   
   d. In the **Decision Detail** screen, the Care Coordinator will select **Request for Review**. The authorization will be routed to the UM team for completion.
   
   e. UM will complete the new Service Agreement letter for the new provider.

<table>
<thead>
<tr>
<th>Auth # needing closure:</th>
<th>Click here to enter text.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closure date</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Updated authorized units (amount to be left on previous auth)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>

Increase in Rate for an Existing Authorization

1. Create a NEW authorization for the new rate with the new units and new span. Complete all the steps listed in the *Creating a Service Authorization* section above.

   a. In the **Patients Detail** screen, the Care Coordinator should enter the **new** auth span for the new rate.
   
   b. In the **Provider Detail** screen, the Care Coordinator should enter the provider information.
   
   c. On the **Decision Details** page, in the Additional Comments/Notes section, the Care Coordinator will complete the Increase in Rate Template (below) and paste into the comments section.
   
   d. In the **Decision Detail** screen, the Care Coordinator will select **Request for Review**. The authorization will be routed to the UM team for completion.
   
   e. UM will complete the new Service Agreement letter for the new rate and close the previous auth.

<table>
<thead>
<tr>
<th>Auth # needing closure (auth that has the old rate):</th>
<th>Click here to enter text.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closure date</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Updated authorized units (amount to be left on previous auth)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>

Service Agreement Errors

If a Care Coordinator identifies that an error was made while creating the Service Agreement, Care Coordinators can complete the *Service Agreement Error* form to make the adjustment. Use this form for the following reasons:

- member information entered incorrectly
- service description or HCPC codes entered incorrectly
- the wrong number of units entered
- incorrect auth span entered
- incorrect provider
- incorrect negotiated rate

**The Care Coordinator will:**

1. Locate the existing service agreement in ICR.
2. Using the Care Coordinator *Request for Service Error* form, the Care Coordinator should identify the:
   a) Member information: Member ID, Name, Date of Birth
   b) Care Coordinator/Delega
de agency information
   c) Service agreement/authorization number
   d) Describe the error
   e) Enter the correct information
   f) Indicate if a new authorization letter needs to be sent to the member and provider
3. The Care Coordinator will fax the template to the UM Operations team by faxing to 844-429-7763 within 24 hours of the identified error.

**Entering Retro Authorizations**

Care Coordinators can enter retro authorizations for new enrollees per the Care Coordination Guidelines.

If the provider has already billed and received a denial for no authorization and the Care Coordinator approves the service, there are two options:

1. The provider could appeal the denial requesting Continuity of Care
   OR
2. The Care Coordinator can approve an authorization in ICR following the steps under *Creating a Service Authorization*. The provider would work with Amerigroup Provider Dispute Team for payment. The Care Coordinator should advise the service provider to contact Provider Services and request the Provider Dispute Team.

**Denying, Terminating and Reducing Services**

See the Care Coordination Guidelines for details on submitting DTRs. DTRs are no longer completed in ICR.

Service agreements will be closed by UM staff upon receipt of the Notification of DTR form from the Care Coordinator. For service closures when a DTR is not required (i.e. death or term from Blue Plus, service auths will be automatically closed upon termination from Blue Plus).

**Authorizing PCA Services**
### PCA Service codes

<table>
<thead>
<tr>
<th>PCA Service</th>
<th>HCPCS Code</th>
<th>Modifier</th>
<th>Service Unit</th>
<th>Benefit Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:1 PCA Services</td>
<td>T1019</td>
<td></td>
<td>15 Minutes</td>
<td>Based on Assessment</td>
</tr>
<tr>
<td>1:2 PCA Services</td>
<td>T1019</td>
<td>TT</td>
<td>15 Minutes</td>
<td>Based on Assessment</td>
</tr>
<tr>
<td>1:3 PCA Services</td>
<td>T1019</td>
<td>HQ</td>
<td>15 Minutes</td>
<td>Based on Assessment</td>
</tr>
<tr>
<td>Supervision of PCA Services</td>
<td>T1019</td>
<td>UA</td>
<td>15 Minutes</td>
<td>Based on Assessment</td>
</tr>
<tr>
<td>1:1 PCA Services – Complex</td>
<td>T1019</td>
<td>TG</td>
<td>15 Minutes</td>
<td>Based on Assessment</td>
</tr>
<tr>
<td>1:2 PCA Services – Complex</td>
<td>T1019</td>
<td>TG TT</td>
<td>15 Minutes</td>
<td>Based on Assessment</td>
</tr>
<tr>
<td>1:3 PCA Services - Complex</td>
<td>T1019</td>
<td>HQ TG</td>
<td>15 Minutes</td>
<td>Based on Assessment</td>
</tr>
<tr>
<td>Transitional Decrease in Units</td>
<td>T1019</td>
<td>U5</td>
<td>15 Minutes</td>
<td>Based on Assessment</td>
</tr>
<tr>
<td>Temporary Increase in Units</td>
<td>T1019</td>
<td>U6</td>
<td>15 Minutes</td>
<td>Based on Assessment</td>
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<td>Extended PCA Services: 1:1</td>
<td>T1019</td>
<td>UC</td>
<td>15 Minutes</td>
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<td>Extended PCA Services: 1:2</td>
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<td>Extended PCA Services: 1:3</td>
<td>T1019</td>
<td>UC HQ</td>
<td>15 Minutes</td>
<td>Based on Assessment</td>
</tr>
</tbody>
</table>

### PCA Authorization Processes

**New enrollees with existing PCA authorizations**

1. Complete all the steps listed in the *Creating a Service Authorization* section above for each PCA span. PCA must be divided into 2 authorization spans.
2. If the provider is in the Blue Plus network, the Care Coordinator must enter the existing authorizations and select Approve on the Decisions Details page.

**Out of Network Providers/Continuity of Care- PCA**

For new members with existing PCA, if servicing provider is out of network, and the Care Coordinator would like to request an exception due to Continuity of Care, the Care Coordinator will complete the following:

1. Enter the Provider in the Servicing Provider field
2. ICR will give a popup screen after the selection of “next” and identify that the provider is out of network.
3. Select “edit or proceed”
4. ICR will ask if you are requesting an out of network provider request. The Care Coordinator should select “yes” and supply reasons and rationale for use of the out of network provider (exp. Continuity of Care).
5. Select Approve on the Decisions Details page.
New PCA authorization requests for current enrollees

Prior to starting services, the Care Coordinator must enter an authorization into ICR.

1. Complete all the steps listed in the *Creating a Service Authorization* section above for each PCA span.
2. PCA must be divided into 2 authorization spans. The Care Coordinator may align the PCA date spans with the EW date span by indicating so in the start and end dates on the ICR authorization.
3. If the request for PCA is not a Standard request, in the Service Description (on the Detailed Decision tab of ICR) the Care Coordinator should enter “Flexible Use” or “PCA Choice Option” to identify the type of authorization being approved.
4. Select **Approve** on the Decisions Details page.

PCA Supervision (T1019 UA)

Supervision by a qualified professional is required for all PCA services types. Members are required to have 2 hours per month, up to 96 units per year.

1. Complete all the steps listed in the *Creating a Service Authorization* section above for the PCA supervision authorization.
2. Select **Approve** on the Decisions Details page

Re-assessment PCA authorization requests

1. Complete the PCA Assessment and Service Plan prior to the end of the authorization period
2. Complete all the steps listed in the *Creating a Service Authorization* section above for each PCA span.
3. PCA must be divided into 2 authorization spans. The Care Coordinator may align the PCA date spans with the EW date span by indicating so in the start and end dates on the ICR authorization.
4. If the request for PCA is not a Standard request, in the Service Description (on the Detailed Decision tab of ICR) the Care Coordinator should enter “Flexible Use” or “PCA Choice Option” to identify the type of authorization being approved.
5. Select **Approve** on the Decisions Details page.

Change in PCA Provider

If member has a current PCA but wishes to change PCA providers, the Care Coordinator must confirm the new PCA provider is in network by verifying with the PCA provider directly or calling Member Services.

If the new provider is in network, the Care Coordinator must enter an authorization for the new provider into ICR. See *Changing a Provider for an Existing Authorization* above.

PCA Temporary Start/Temporary Increase

If member has immediate or acute PCA needs prior to being assessed or re-assessed, Care Coordinators can authorize up to 45 days of PCA within ICR.

If a member has an immediate need for PCA services, the Care Coordinator will:

1. Enter the request for authorization in the Interactive Care Reviewer (ICR).
2. Starting dates of the service should be entered as listed on the Personal Care Assistant (PCA) Authorization Request form under section: PCA Temporary Start/Temporary Increase.
3. Enter End Date of the service as listed on the Personal Care Assistant (PCA) Authorization Request form, or up to 45 days from start date of the auth.
4. Select **Approve** on the Decision Details page.

**PCA Denial, Termination, Reduction (DTR)**

Reductions or terminations in services require a **10-day** notice prior to the date of the proposed action.

Refer to the Care Coordination Guidelines for complete details.

**Extended PCA Requests for members on EW**

For Blue Plus members open to EW, extended PCA hours may be authorized by the Care Coordinator in ICR, as applicable. Extended PCA services cannot be a “stand-alone” PCA service. To be eligible for extended PCA, the member must first be accessing PCA services under their medical benefits.

1. Complete all the steps listed in the *Creating a Service Authorization* section above to enter the extended PCA authorization.
2. Select **Approve** on the Decisions Details page.

**MSHO Supplemental Benefits* (Coming Soon)**

Follow the alternate process described on the Care Coordination website to authorize MSHO Supplemental Benefits until further notice.

**Logging out of ICR**

Select Logout to logout of ICR

---

**Appendix A: Service Agreements Requiring Additional Information**

Some services require additional information to be entered into the authorization in the **Description of Service** and **Additional Comments/Notes** sections of the request. They are:

- Specialized Supplies and Equipment
- Lift chair
- Consumer Directed Community Supports (CDCS)
- Environmental Accessibility Adaptations
- Customized Living/24 hr CL
- Out of Home Respite
- Transportation – Bus Pass/tickets
- Transportation – One Way Trip
- Transportation – Per Mile (Commercial and Non-Commercial)
- Transitional Support Services
- Foster Care, Family/Corporate
A template has been created to assure necessary information is communicated to UM to complete the authorization. This template can be cut and pasted into the Additional Comments/Notes section in ICR. See below for instruction on how to complete an auth for these services.

Specialized Supplies and Equipment: T2029

**Single Item less than $500**

1. Complete all the steps listed in the *Creating a Service Authorization* section above.
2. In the Service Detail page, **enter the max unit allowed of 1 per month** into the Quantity Area of the service section.
4. On the Decision Details page, **enter the description of the services to be delivered**, such as “Ensure supplement”
5. On the Decision Details page, in the **Additional Comments/Notes** section, **copy and paste this template or type in the information**.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>
| Equipment new/rental/repair or used: | ☐ NU (New)  
☐ RR (Rental)  
☐ RB (Repair)  
☐ UE (Used) |

**Example:**

![Example Image](image-url)

*Single Items over $500* *(except lift chairs and air conditioners- follow separate process)*
1. Complete all the steps listed in the *Creating a Service Authorization* section above.
2. In the Service Detail page, **enter the max unit allowed of 1 per month** into the Quantity Area of the service section.
4. On the Decision Details page, **enter the description of the services to be delivered**
5. On the Decision Details page, in the **Additional Comments/Notes** section, **copy and paste this template or type in the information**.
6. Include the necessary clinical information/rationale for review for requesting an item over $500
7. Documents for clinical review can be uploaded to the last tab of the ICR page, if applicable.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>
| Equipment new/rental/repair or used: | ☐ NU (New)  
☐ RR (Rental)  
☐ RB (Repair)  
☐ UE (Used) |

**Lift Chairs (Mechanism and Chair Portion)**

- If the lift mechanism is *denied* under MA/Medicare, the Care Coordinator will enter 1 authorization into ICR portal for the total cost of the chair portion and lift mechanism.

- If the lift mechanism is *approved* under MA/Medicare, the Care Coordinator will enter 1 authorization into ICR portal for the cost of the chair portion only.

1. Complete all the steps listed in the *Creating a Service Authorization* section above.
2. In the Service Detail page, the Care Coordinator will **enter the max unit allowed of 1** into the Quantity Area of the service section.
3. The Care Coordinator will select **Request for Review** in the Decision Status on the Decision Detail page.
4. On the Decision Details page, the Care Coordinator will **enter the description of the services** to be delivered (Exp: lift and chair portion OR chair portion only)
5. On the Decision Details page, **on the Decision Details page, in the Additional Comments/Notes section**, **copy and paste the template below or type in the information**.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>
| Equipment new/rental/repair or used: | ☐ NU (New)  
☐ RR (Rental)  
☐ RB (Repair)  
☐ UE (Used) |

**Air Conditioners**

---

*pg. 31*
• If the member has 1 of the following diagnosis: Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Asthma, Chronic Kidney Disease receiving dialysis, limited mobility secondary to muscular abnormality/obesity and the cost of the unit is $800 or less complete all the steps listed in the Creating a Service Authorization section above.

1. In the Service Detail page, the Care Coordinator will enter the max unit allowed of 1 into the Quantity Area of the service section.
2. The Care Coordinator will select Request for Review in the Decision Status on the Decision Detail page.
3. On the Decision Details page, the Care Coordinator will enter the description of the services to be delivered (Exp: air conditioner)
4. Include the necessary clinical information/rationale for review for requesting an item over $500
5. Documents for clinical review can be uploaded to the last tab of the ICR page, if applicable
6. On the Decision Details page, in the Additional Comments/Notes section, copy and paste the template below or type in the information.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable)</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Equipment new/rental/repair or used:</td>
<td>☐ NU (New)</td>
</tr>
<tr>
<td></td>
<td>☐ RR (Rental)</td>
</tr>
<tr>
<td></td>
<td>☐ RB (Repair)</td>
</tr>
<tr>
<td></td>
<td>☐ UE (Used)</td>
</tr>
</tbody>
</table>

• If the member does not have one of the diagnoses above OR the unit is over $800: complete all the steps listed in the Creating a Service Authorization section above.

1. In the Service Detail page, the Care Coordinator will enter the max unit allowed of 1 into the Quantity Area of the service section.
2. The Care Coordinator will select Request for Review in the Decision Status on the Decision Detail page.
3. On the Decision Details page, the Care Coordinator will enter the description of the services to be delivered (Exp: air conditioner over $800)
4. On the Decision Details page, in the Additional Comments/Notes section, copy and paste the template below or type in the information.
5. Include the necessary clinical information/rationale for review for requesting the air conditioner over $800 or without one of the qualifying diagnoses.
6. Documents for clinical review can be uploaded to the last tab of the ICR page, if applicable.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable)</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Equipment new/rental/repair or used:</td>
<td>☐ NU (New)</td>
</tr>
<tr>
<td></td>
<td>☐ RR (Rental)</td>
</tr>
<tr>
<td></td>
<td>☐ RB (Repair)</td>
</tr>
<tr>
<td></td>
<td>☐ UE (Used)</td>
</tr>
</tbody>
</table>
Consumer Directed Community Supports (CDCS) T2028

NOTE: In ICR, CareCompass and Member360 T2028 will show as “Specialized Supply, not otherwise specified, waiver”. This is the default HCPC code entered in AGP systems.

1. Complete all the steps listed in the Creating a Service Authorization section above.

2. On the Service Detail page, you must enter **30 units per month** (30 X the number of months in the span) or **360 units per year**, in the Quantity area of the service page.

3. On the Decision Details page, the Care Coordinator must enter the **yearly or total budget amount** for CDCS services into the Additional Comments/Notes section.

4. On the Decision Details page, select Approve.

5. On the Decisions Details page, complete the CDCS template and paste into the Additional Comments/Notes section or type the information in.

<table>
<thead>
<tr>
<th>CDCS Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDCS Budget Total Amount</td>
</tr>
<tr>
<td>Reason for Change in Budget (if applicable):</td>
</tr>
<tr>
<td>Additional Notes:</td>
</tr>
</tbody>
</table>

Example:

![Decision Details](image)

**Changes to CDCS budget**

If the authorize budget dollar amount changes, a new authorization must be created in ICR by the Care Coordinator. Follow the process under Modifying an Authorization.

1. The Care Coordinator must enter in the Service Description that the budget as changed: Ex: “Changed in CDCS Budget”
2. The authorization must include the new amount available per the auth span and the reason for the change in the authorization in the Additional Comments/Note section.
3. The Care Coordinator will select **Request for Review** in the Decision Status on the Decision Detail page.

4. On the Decisions Details page, **complete the CDCS template and paste into the Additional Comments/Notes section or type the information in.**

<table>
<thead>
<tr>
<th>CDCS Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CDCS Budget Total Amount</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for Change in Budget (if applicable):</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Additional Notes:</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>

Example:

![Decision Details]

**Environmental Accessibility Adaptations T1028, S5165, T2039 & T2039 (UD)**

*Benefit set has a combined limit of $20,000 per waiver span.*

1. Complete all the steps listed in the *Creating a Service Authorization* section above.
2. In the Service Detail page, **enter the units associated with the service, one unit = 1 service,** into the Quantity Area of the service section.
3. Select **Approve** in the Decision Status on the Decision Detail page.
4. On the Decision Details page, **enter the description of the service or the assessment to be delivered** in the Description of Service field.
5. On the Decision Details page, enter the negotiated rate into the Additional Comments/Notes section using the template below. You can cut and paste the template into the Additional Comments/Notes field or type the information into the field.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable):</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Equipment new/rental/repair or used:</td>
<td>☐ NU (New) ☐ RR (Rental) ☐ RB (Repair) ☐ UE (Used)</td>
</tr>
</tbody>
</table>

Example:
Customized Living and 24 hr Customized Living T2030 and T2031

1. Complete all the steps listed in the Creating a Service Authorization section above.
2. In the Service Detail page, enter the units associated with the service, one unit = 1 day or 365 days in a year, into the Quantity Area of the service section. ICR does not calculate the number of days for the total span authorized.
3. Select Approve in the Decision Status on the Decision Detail page.
4. On the Decision Details page, enter the negotiated daily rate into the Additional Comments/Notes section based on the county of residence. The county of residence must also be provided. Complete the template below and paste into the Additional Comments/Notes section or type the information into the field.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>County of Service (If applicable)</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>

Example:

Decision Details

Please provide the decision for this request and enter the detailed rationale and comments to support this decision.

<table>
<thead>
<tr>
<th>Date Decisioned</th>
<th>Decision Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/31/2018</td>
<td>Approve</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of Service</th>
<th>Additional Comments/Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheel Chair ramp installation</td>
<td>Rate of Service (if other than fee schedule): $125.00, County of Service (If applicable) Des Moines</td>
</tr>
</tbody>
</table>
Respite Services – Out of Home Respite (Per Diem) H0045 (exp. for respite provided in a nursing home or hospital setting)
*Benefit limit: Services are limited to 30 consecutive days.

1. Complete all the steps listed in the Creating a Service Authorization section above.
2. Select Approve in the Decision Status on the Decision Details page.
4. On the Decision Details page, enter the rate associated with the description into the Additional Comments/Notes section using the template below or typing the information into the Additional Comments/Notes field.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>County of Service (If applicable)</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>

Example:

Transportation – T2003 (UC) Bus Pass/Tickets
1. Complete all the steps listed in the Creating a Service Authorization section above.
2. On the Provider Details page, enter the authorization for Bus Pass or ticket Provider as the Servicing Provider.
3. In the Service Detail page, enter the units associated with the service, one unit = 1 service, into the Quantity Area of the service section.
   - For a monthly bus pass = 1 pass/month.
   - For tickets, 1 unit = 1 book of tickets.
   If the authorization is for 12 months, then the units listed for a monthly (or 31-day pass) is 12 units total. If the authorization is for 2 books of tickets per month, for the same 12-month period, the total number of units is 24.
4. Select Approve in the Decision Status on the Decision Details page.
5. On the Decision Details page, enter the description of the service
   - “New” OR “Existing” pass AND
   - type of pass or the number of books of tickets
6. On the Decision Details page, for Bus Passes, the Care Coordinator must enter Additional Comments/Notes including:
   a. the amount of the Bus Pass per month,
   b. the frequency of the bus pass,
   c. the request date, and
   d. the current mailing address of the member.

Use the appropriate template below to copy and paste into the Additional Comments/Notes section.

<table>
<thead>
<tr>
<th>Transportation Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bus Pass Amount</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Frequency of the Bus Pass</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Request Date of Pass to Begin</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Mailing Address of the member</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>

**OR**

<table>
<thead>
<tr>
<th>Transportation Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ticket Amount Per Book</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Frequency the Book of Tickets should be provided</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Request Date to receive the book of tickets</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Mailing Address of the member</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>

Example:

<table>
<thead>
<tr>
<th>Date Decisioned</th>
<th>Decision Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/21/2018</td>
<td>Approve</td>
</tr>
</tbody>
</table>

Description of Service:

- **New 31 Day Metro Transit Bus Pass**

**Additional Comments/Notes**

- Transportation Information:
  - Bus Pass Amount: $25.00
  - Frequency of the Bus Pass: 1 per month
  - Request Date of Pass to Begin: 12/1/18
  - Mailing Address of the member: 1307 Linn Ave Boone

**Transportation – T2003 (UC) Per One Way Trip**

1. Complete all the steps listed in the *Creating a Service Authorization* section above.
2. On the Provider Details page, enter the name of the transportation provider as the **Servicing Provider**.
3. In the Service Detail page, enter the units associated with the service, 1 unit = 1 one-way trip or 2 units = a round trip, into the Quantity Area of the service section.
4. Select **Approve** in the Decision Status on the Decision Detail page.
5. On the Decision Details page, enter the description of the service: “One Way Trip”

**Decision Details**

![Image of Decision Details form]

Transportation – S0215 per Mile (Commercial and non-commercial)

1. Complete all the steps listed in the *Creating a Service Authorization* section above.
2. On the Provider Details page, will enter the name of the transportation provider as the **Servicing Provider**.
3. In the Service Detail page, **enter the units associated with the service**, 1 unit = 1 mile up to 9999 units/miles, into the Quantity Area of the service section.
4. Select **Approve** in the Decision Status on the Decision Detail page.
5. On the Decision Details page, enter the description of the service, Example: “Commercial” or “Non-commercial Mileage”.
6. On the Decision Details page, enter the amount rate for the provider into the Additional Comments/Notes section. “Rate: 1.54” or “Rate: .54”

Example:

![Image of Example decision details]

Or:

![Image of Example decision details]

Transitional Support Services – T2038

1. Complete all the steps listed in the *Creating a Service Authorization* section above.
2. In the Service Detail page, **enter the max unit allowed of 1 per month** into the Quantity Area of the service section.
3. Select **Approve** in the Decision Status on the Decision Detail page.
4. On the Decision Details page, enter the description of the services to be delivered, such as “Rental Deposit”.
5. On the Decision Details page, include the negotiated rate into the Additional Comments/Notes section using the template below or typing the information into the field.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>

Example:

Foster Care, Adult Family and Adult Corporate- S5140 and S5140 U9

1. Complete all the steps listed in the *Creating a Service Authorization* section above
2. In the Service Detail page, **enter the units associated with the service**, one unit = 1 day or 365 days in a year, into the Quantity Area of the service section. ICR does not calculate the number of days for the total span authorized.
3. Select Approve in the Decision Status on the Decision Detail page.

4. On the Decision Details page, the Care Coordinator must enter the negotiated daily rate based on the Residential Services Tool into the Additional Comments/Notes section. Copy and paste the template below or type the information into the Additional Comments/Notes section.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>

Example:

![Decision Details](image)

**PERS- S5160, S5161, S5162**

1. Complete all the steps listed in the *Creating a Service Authorization* section above
2. In the Service Detail page, **enter the units associated with the service.**
3. Select Approve in the Decision Status on the Decision Detail page.

On the Decision Details page, the Care Coordinator must enter the negotiated rate into the Additional Comments/Notes section. Copy and paste the template below or type the information into the Additional Comments/Notes section.

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>

**Change in Provider**

1. Complete all the steps listed in Creating a Service Authorization section above
2. Select Approve in the Decision Status on the Decision Detail page.

On the Decision Details page, the Care Coordinator must enter the information to close the previous SA line for the old provider in the Additional Comments/Notes section. Copy and paste the template below or type the information into the Additional Comments/Notes section.

<table>
<thead>
<tr>
<th>Auth # needing closure:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Closure date</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Updated authorized units (amount to be left on previous auth)</td>
<td>Click here to enter text.</td>
</tr>
</tbody>
</table>
Appendix B: Authorizations Requiring Utilization Management Review/Request for Review

When authorizing one of the services or items below, the Care Coordinator must create the authorization in ICR and select “Request for Review.”

If Utilization Management (UM) requires additional information, UM will contact the Care Coordinator via email or phone.

- More than 52 Skilled Nurse Visits per year (or more than 2 visits per week)
- More than 156 Home Health Aide visits per year (or more than 3 visits per week) (not including Extended HHA)
- More than 20 visits per discipline per year of MA home therapy:
  - Physical (S9131)
  - Occupational (S9129)
  - Speech (S9128) or
  - Respiratory therapy (S5181)
- Any Home Health Aide visits for members in Customized Living or Adult Foster Care.
  - Care Coordinator must attach a copy of the RS tool to the Clinical Note in ICR.
- Any Home Health Aide visits in conjunction with PCA Services
- All Home Care Nursing (formerly Private Duty Nursing)
- All EW Specialized Supplies and Equipment (T2029)
  - Single items over $500 require a UM review
  - Air conditioners without a qualifying diagnosis or over $800 require UM review
- Any change in CDCS budget
- New service agreement requests to modify existing auths (i.e. adding units or changing providers)
Appendix C: Authorization Templates

ICR Authorization Templates

When creating authorizations in ICR, some services require additional information to be entered into the authorization.

A template for applicable services has been created to assure necessary information is communicated to UM to complete the authorization. Templates can be cut and pasted into the Additional Comments/Notes section of the authorization in ICR.

Specialized Supplies and Equipment (T2029)
- Submit all T2029 requests as Request for Review

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th>Click here to enter text.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of Service:</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Reason for the Rate Change (if applicable):</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Equipment new/rental/repair or used:</td>
<td>☐ NU (New)</td>
</tr>
<tr>
<td></td>
<td>☐ RR (Rental)</td>
</tr>
<tr>
<td></td>
<td>☐ RB (Repair)</td>
</tr>
<tr>
<td></td>
<td>☐ UE (Used)</td>
</tr>
</tbody>
</table>

Environmental Accessibility Adaptations T1028, S5165, T2039 & T2039 (UD)
- Submit as Approve

<table>
<thead>
<tr>
<th>Rate Information:</th>
<th>Click here to enter text.</th>
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<tbody>
<tr>
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<tr>
<td>Equipment new/rental/repair or used:</td>
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</tr>
<tr>
<td></td>
<td>☐ RR (Rental)</td>
</tr>
<tr>
<td></td>
<td>☐ RB (Repair)</td>
</tr>
<tr>
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<td>☐ UE (Used)</td>
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CDCS or changes to CDCS budget T2028
- Submit as Approve for new authorizations
- Submit as Request for Review for changes to CDCS budget

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<tr>
<th>CDCS Information:</th>
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<tr>
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<tr>
<td>Reason for Change in Budget (if applicable):</td>
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<td>Additional Notes:</td>
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Customized Living T2030 or 24 hr Customized Living T2031
- Submit as Approve

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<tr>
<td>County of Service (If applicable)</td>
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<tr>
<td>Reason for the Rate Change (if applicable)</td>
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Respite Services – out of Home respite. Per Diem H0045
- Submit as **Approve**

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Transitional Support Services T2038
- Submit as **Approve**

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Foster Care, Adult Family and Adult Corporate- S5140 and S5140 U9
- Submit as **Approve**

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Transportation – T2003 (UC) Bus Pass/Tickets
- Submit as **Approve**

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<td>Frequency of the Bus Pass</td>
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<tr>
<td>Request Date of Pass to Begin</td>
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<tr>
<td>Mailing Address of the member</td>
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<tr>
<td>Frequency the Book of Tickets should be provided</td>
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<tr>
<td>Request Date to receive the book of tickets</td>
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<tr>
<td>Mailing Address of the member</td>
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PERS- S5160, S5161, S5162
- Submit as **Approve**

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<tr>
<td>Reason for the Rate Change (if applicable)</td>
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Change in Provider
- Submit as Request for Review

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<tbody>
<tr>
<td>Closure date</td>
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</tr>
<tr>
<td>Updated authorized units (amount to be left on previous auth)</td>
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Increase in Rate (increasing rate mid waiver span)
- Submit as Request for Review

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Closure date</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Updated authorized units (amount to be left on previous auth)</td>
<td>Click here to enter text.</td>
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Appendix D: Frequently Asked Questions/Troubleshooting

Purpose of the FAQ: This FAQ is to help Care Coordinators working with MSC+/MSHO members in Minnesota troubleshoot common errors in the Interactive Care Reviewer (ICR).

1) Q: My member is eligible according to MN-ITS and in CareCompass/Member360 but is not found in ICR. I get the error, “Member not found in our systems - Please Correct and Resubmit”. Why?

A: The Patient Details tab has three required fields to be entered by the user, Request Type, Case Type and Subscriber ID. For ICR to return the valid member information the subscriber ID must be entered exactly as it appears on the members ID card. The ID card will have an LMN prefix for MSC+ members and a JTM prefix for MSHO members followed by the subscriber ID located in CareCompass or Member360.

*NOTE: Members who have recently switch between the MSC+/MSHO products may have two subscriber ID’s. Check Member360 to assure the correct subscriber ID is being selected.

Member eligibility can be found under the Eligibility tab under enrollment history in Member360.
The Care Coordinator may add more information to help aid in the search for a member in the form of a Date of Birth, First and Last Name. The information must be entered exactly as the Date of Birth, First and Last Name are shown in Member360 or CareCompass. If information is entered incorrectly or different from what is shown in Member360 or CareCompass, the member will not be found.

If the patient information is found, details will display for the user to confirm before starting the ICR request. If the patient information isn’t valid, users will select “Back to Find Patient” button, to clear the page and start over with a fresh page.

2) **Q:** My member is eligible according to MN-ITS, is not found in ICR or in CareCompass or Member360. I get the error, “Member not found in our systems - Please Correct and Resubmit”. Why?

A: If the member is eligible in MN-ITS, but is not eligible in ICR, CareCompass or Member360, the care coordinator may contact enrollment_mn@anthem.com for MSC+ members and mmmmp@anthem.com for MSHO members to confirm the enrollment and ask them to update the enrollment if necessary. Once enrollment has updated the member eligibility, the member will appear in CareCompass, Member360 and ICR within 48 hours. After 48 hours, the Care Coordinator should attempt to enter the authorization again.

*NOTE: State updates to enrollment typically will be seen in the AGP systems within 48 hours of AGP receiving the State file.*

3) **Q:** My member is eligible according to MN-ITS and in CareCompass/Member360 but is not found in ICR. I get the error, “Member cannot be processed through ICR. Please contact the number on the Member’s ID care...” Why?

A: If the Care Coordinator is encountering this error, the Care Coordinator should fax in the requested authorization. AGP is currently working on a more permanent solution for this error.

4) **Q:** When I attempt to enter a member, I get an error that states “It appears you are not authorized for the member entered. Please contact the delegated agency”. What do I do?

A: To protect member information, ICR has two built in system checks that makes sure the care coordinator entering Service Agreements has permission to do so. The first check is to assure the care coordinator is employed or connected to the care coordination agency the member is assigned to for care.

The care coordinator should assure they are using the correct Tax ID for the agency. A list of Tax ID’s being used by ICR is available or have been provided to the care coordination agency.

If the care coordinator is using the correct tax ID, the Care Coordinator should check to make sure that they were provided the correct permission by the care coordination agency as identified in Care Coordinator ICR Manual under “Accessing Availity/ICR” section.

If the care coordinator continues to get this error, please contact your partner relations consultant. Please provide the following information to your partner relations team: Tax ID, Care Coordinator Name, Delegate Agency Name, any screen shots of error received etc.

5) **Q:** The drop-down boxes in ICR are not working. What do I do?
A: Is the care coordinator using a touch screen? ICR does not function using a touch screen. Please contact your IT department to learn how to disable your touch screen.

ICR is supported on the internet platforms Chrome or Internet Explorer. ICR also recommends the care coordinator clear their cache, to assure that all cookies and other items are cleared before attempting to continue in ICR.

If the care coordinator is not using a touch screen and is using Chrome or Internet Explorer, please call the support desk at 1-888-268-4368. Addition issues that should be reported to the help desk are:

- Slowness in the system, loading pages taking more than 15 seconds.
- Errors indicating that the system is unavailable
- Paging not loading correctly
- Being “kicked out” of the system more than one time in a session.

6) **Q:** I have filled in all the boxes, but ICR is not letting me proceed to the next tab when I click “NEXT”.

A: If the care coordinator has filled in all the appropriate boxes, the care coordinator should assure they have clicked all the appropriate boxes within the screen, such as the [+] sign seen on many screens. Other buttons to watch out for include, disclaimer notices and “Add note” buttons.

NOTE: On the clinical information tab, ICR requires the entry of clinical information. If the Service Agreement is being approved by the care coordinator and requires no clinical information, please enter “NA” or “No clinical information available”. Select “ADD NOTE” and then “NEXT”.

7) **Q:** I received a pop-up message, indicating that the servicing provider is out of network when they are actually in network. What do I do?

A: This is informational only and not a hard stop. The care coordinators can continue with the request. If the care coordinator has a concern related to the network status, a note can be added within the clinical notes.

8) **Q:** When I search for a members Service Agreement, the system asks for a Tax ID, which Tax ID should I use?

A: The tax ID for either the servicing, requesting provider, or care coordination agency can be used to pull up a Service Agreement for a member.

9) **Q:** ICR is not letting me back date a service agreement.

A: ICR will allow a Service Agreement to be backdated up to 120 days, but ICR will not allow a service to be backdated prior to 1/1/2019 in the ICR system.

*Note: The member must be eligible during the time of service in order to enter the authorization into ICR. The Care Coordinator may contact enrollment_mn@anthem.com for MSC+ members and mmmmp@anthem.com for MSHO members to confirm the enrollment and ask them to update the enrollment if necessary. Once enrollment has updated the member eligibility, the member will appear in CareCompass, Member360 and ICR within 48 hours. After 48 hours, the Care Coordinator should attempt to enter the authorization again.

10) **Q:** My service agreements are not displaying in ICR.

A: Any request prior to 1/1/19 in ICR will not display the service agreement. Service agreement letters for authorizations generated in Bridgeview and converted to AGP systems will not be present in AGP systems. If a
service is authorized after 1/1/19 in ICR, a service agreement letter should be generated and available in the system.

Note: If providers are trying to get information to support their existing services, they should keep their current service agreement from Bridgeview which termed 12/31/18 and print the existing ICR authorization. They should use the two documents together to have all the information needed for authorizations and claims purposes.

11) **Q:** Can providers see the status of a pending authorizations in ICR, when the care coordinator has a pending auth for review?

A: Yes, providers can see the status of authorizations care coordinators have entered in ICR.

12) **Q:** I made an error on one of the pages, how do I go back to fix them?

A: When at all possible the care coordinator should not use the back or forward button on the internet platform being used if possible.
   a. Use should use “previous” buttons, that will take them back to the previous tab,
   b. Before the authorization is submitted the CoCare Coordinator can click on any previous tab to go back to that tab and make edits.
   c. If a CoCare Coordinator decides they should start the case over, they can select “delete case”

13) **Q:** I have a member who has a future term date or end date in the system. Can I enter the authorization into ICR?

A: Yes, an authorization for the dates the member is eligible for services can be entered. If the member has a term date or end date in the system, the authorization cannot run past the term or end date for the member. ICR will give a warning to the Care Coordinator that the member is not eligible for the dates of service entered into ICR.

14) **Q:** How do I know which provider to pick when multiple providers are available under servicing provider tab?

A: If the care coordinator locates numerous providers in ICR when completing a search, the care coordinator can select the appropriate provider by Specialty type, address, phone number or provider ID.
If the care coordinator does not know any of these demographics, move to instructions in #15…

15) Q: What do I do when I need to request an auth for a servicing provider that does NOT have an NPI number?

A: When a provider and/or delegate (requesting provider) does not have an NPI, the care coordinator should search for the provider by clicking on the magnifying glass.

- Select “Provider Group”
- Enter a fake organization name and select “search”
- To manually add information about the provider, select “click here”

Care Coordinators should complete all required fields with a red *.
- Provider Type: Select “Provider Group” -After selected either last/first name fields or org field will be added for entry.
- Specialty Type: Select “Other”
- NOTE: NPI is required field for requesting provider. Enter the dummy NPI of 1234567899.
- Once all red * have been manually added, click “next” on provider details page.
Sample of filled out information below:

Since the delegate information has been entered manually, the system may not know if delegate information is in or out of network. This may result in a Pop-up message of ‘could not be verified’ to display. Click “Yes” to move past the Pop-up. If the Pop-up is not received, the care coordinator should not be concerned and proceed forward.
• After clicking “Yes” on ‘could not be verified’ Pop-up, the Request Summary page will display. Click next.
• If the care coordinator received a “could not be verified” message, an out of network Pop-up will display.
• Choose “no”. The selection of “no” will allow the care coordinator to continue with entering the service agreement request.

Authorizations with no NPI’s and manually entered information in ICR can be identified by the UM Operations team. The UM Operations team will assure that the correct provider or delegate is added to the authorization.

Tip: User can add UMPI to comments/notes on decision details page or clinical details page. This will help the UM team match the right delegate when they update service agreements.

16) **Further Assistance with ICR:** If a Care Coordinator is not able to enter an authorization into ICR after attempting the suggestions within this FAQ, the Care Coordinator should send a full screenshot of an errors securely to their Partner Relations Consultant.

FINAL PAGE