**DTR Decision Guide**

**(See DTR Reference Guide for Hospital and Nursing Home Stays below)**

| **Situation** | **Care Coordination Notification of DTR** |
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| Member’s Medical Assistance eligibility ends for any reason. | Not required |
| Member moves out of the Blue Plus service area. | Not required |
| Member switches to another health plan or fee-for-service. | Not required |
| Member dies. | Not required |
| Temporary change in payor source with no change or reduction in type, service or frequency for MA state plan home care services authorized by Care Coordinator to skilled Medicare episodic home care services. | Not required |
| Denial/termination/reduction to services covered by the Medical benefit not authorized by Care Coordinator (i.e. services or supplies/equipment covered by medical benefit and Medicare services). | Not required |
| Assessment is completed for a CW member and it is determined that she/he is not eligible for EW and she/he is **not** requesting services. | Not required |
| Change in service provider that requires ending one service provider’s authorization early and adding a new service provider. | Required |
| Correction is made by the Care Coordinator to an existing authorization.  Example: CC entered 22 units in error, authorization was processed and sent to provider/member, but it should have been 20 units and was later corrected/updated. | Required |
| An early reassessment is completed, and previous service authorizations are closed early. | Required |
| Assessment is completed for a CW member and it is determined that she/he is not eligible for EW and she/he **is** requesting services. | Required |
| Member/CC is making decision to terminate **all** EW services and **close to EW.** | Required |
| Reassessment is completed for a CW or EW member and a decision is made by member/CC to reduce services and service(s) will be less in the new assessment/waiver span. | Required |
| Reassessment is completed for a CW or EW member and a decision is made by the member/CC to terminate service(s) and service(s) will not continue in the new assessment/wavier span. | Required |
| Member with existing service(s) (previously authorized by the CC) is due for reassessment and is unable to contact/ declines reassessment and service(s) end at the end of the current assessment/wavier span (does not apply to members with another HCBS wavier case manager). | Required |
| Member/CC is making decision to reduce a currently authorized EW or state plan service. | Required |
| Member on another HCBS waiver (i.e., CADI, DD, etc.) that has a reduction and/or termination in MA state plan services previously requested and authorized by the HCBS waiver on the DHS 5841 Recommendation for State Plan Home Care Services. | Required |
| Member/CC is making decision to terminate currently authorized EW or state plan service. | Required |
| Member/CC is making decision to reduce a currently authorized MSHO Supplemental Benefit | Required |
| Member/CC is making decision to terminate currently authorized MSHO Supplemental Benefit | Required |
| Member elects to use less PCA than was assessed. | Required |
| CC is making decision to reduce or terminate services (EW or state plan) or closing EW. | Required |
| Customized Living/24 Hour Customized Living/Adult Foster Care rate is reduced due to a reduction or termination of a CL/AFC service component(s). This includes reduction or termination in any authorized service component during the current waiver span and/or at reassessment. i.e., reduction/termination in time for ADL, IADL, mileage, medication related tasks, etc. Indicate the current time, future time and frequency being authorized on the Request for DTR form. | Required |
| Member no longer qualifies for EW due to no longer meeting NF Level of Care | Required |
| Home care agency provides services without Prior Auth from Care Coordinator. Provider later approach the CC requesting authorization for services rendered and the CC does not agree that the services were necessary. | Required |
| Member is requesting and Care Coordinator is denying any service or support including MSHO supplemental benefits, Elderly Waiver requests, and items or services not covered by Medicare or Medicaid. | Required |

**DTR Reference Guide for Hospital or Nursing Home Stays or vacation/temporarily out of service area**

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| **Situation** | **Action Needed** | **Care Coordination Notification of DTR** |
| Member admits to a hospital for >30 days. | EW: Close the waiver in MMIS and service agreements in BV back to the date of hospital admission.  State plan home care: AGP will auto close authorizations, if applicable, based on DTR. | Fax DTR form on day 31 **OR** within 24-hours of the determination that the hospital stay will exceed 30 consecutive days. |
| Member admits to a nursing facility for >30 days. | EW: Close the waiver in MMIS and service agreements in BV back to the date of the nursing facility admission.  State plan home care: AGP will auto close authorizations, if applicable, based on DTR. | Fax DTR form on day 31 **OR** within 24-hours of the determination that the nursing facility stay will exceed 30 consecutive days. |
| Member is admitted to the hospital and transitions to a nursing facility. Member is in the nursing facility for >30 days. | EW: Close the waiver in MMIS and service agreements in BV back to the nursing facility admission date.  State plan home care: AGP will auto close authorizations, if applicable, based on DTR. | Fax DTR form on day 31 **OR** within 24 hours of the determination that the nursing facility stay will exceed 30 consecutive dates. |
| Member’s EW/State Plan services authorized by the Care Coordinator are on hold for **more** than 30 consecutive days due to member vacation/temporarily out of the service area | Notify providers of absence.  EW: modify service agreements in BV as appropriate.  State plan home care: Nothing required. | Not required |