

**Developmental Disabilities Medicaid Waiver**  
**Developmental Disabilities Supports Division**



**Developmental Disabilities Waiver Budget  
Worksheet (BWS) Instructions**

**March 1, 2018**

**DEVELOPMENTAL DISABILITIES WAIVER**  
**Budget Worksheet Instructions**  
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**Introduction**

DDSD has issued a revised Budget Worksheet (BWS) for services using clinical criteria effective March 1, 2018, and a separate BWS for Jackson Class Members (JCMs). These worksheets are required for all submissions: annual and revisions.

Case Managers should ensure that they use a current BWS by requesting clean versions regularly from DDSD via the [dd.waiver@state.nm.us](mailto:dd.waiver@state.nm.us) mailbox. Case Managers are responsible for verifying that the version date in the far upper left-hand corner is the correct version based on date and JCM status. Versions are titled by: V-OR 2018 03-01 and V-JCM 2018 03-01.

**Section 1: Identifying Information**

The first section of the BWS includes identifying information for the individual for whom the worksheet is being completed, that individual’s living care arrangement (LCA) and proposed budget level, the time period covered by the Individual Service Plan (ISP) year, the type of ISP, the prior authorization period, and the total dollar amount listed in the BWS. In the list below, each field is referenced by the field title in the BWS.

- Name**                    Input the name of the individual for whom the BWS is being completed in the following order: last name, first name, middle initial (if applicable).
  
- SSN**                    Input the Social Security Number of the individual for whom the BWS is being completed. Input numbers only; the BWS is formatted to added hyphens.
  
- DOB**                    Input the date of birth of the individual for whom the BWS is being completed.
  
- County**                Input the county of residence of the individual for whom the BWS is being completed. The case manager is responsible for checking whether the individual qualifies for the Standard or Incentive rate for services whose rates vary by county or JCM status.
  
- LCA**                    Use the drop-down list to input the Living Care Arrangement (LCA) of the individual for whom the BWS is being completed. There are five LCAs:
  - Customized In-Home Supports-Living Independently ('1' in Omnicaid)
  - Customized In-Home Support-Living with Family ('2' in Omnicaid)
  - Family Living ('3' in Omnicaid)
  - Supported Living ('5' in Omnicaid)
  - Intense Medical Living Support ('6' in Omnicaid)**\*For individuals who do not receive residential services and have respite only, the Case Manager should choose the LCA: CIHS-Family.**
  
- Proposed Budget Level**    Use the drop-down list to input the Proposed Budget Level (numbered 1 through 7) of the individual for whom the BWS is being completed. For JCMs, this field will automatically reflect "JCM."

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<b>Omnicaid Code</b>	This field is the two-character code used by Omnicaid based on the individual’s LCA and Proposed Budget Level. The first character refers to the budget level, which will now be designated ‘H’ for all individuals. The second character is a digit that corresponds to the five LCAs as indicated in the list in the LCA section above. For JCMs, “JCM” will be fixed in this field. These codes, in turn, correspond to the suggested base budget and suggested professional services budget. This field is automatically populated by the BWS and cannot be accessed by the user.
<b>ISP Start Date</b>	Input the beginning date of the ISP for the individual for whom the BWS is being completed.
<b>ISP End Date</b>	This field is automatically calculated by the BWS by adding 365 days to the start date. The user cannot access this field.
<b>ISP Type</b>	Use the drop-down list to indicate the ‘type’ of ISP that is applied to the BWS being completed. There are three options: <ul style="list-style-type: none"><li>• Initial ISP or transfer from the Mi Via Waiver (See section six for additional submission instructions.)</li><li>• Annual ISP</li><li>• Transfers from child ARA (See section six for additional submission instructions.)</li></ul>
<b>Prior Auth. Effective Date</b>	Input the Prior Authorization effective date for the BWS being completed.  This date is not necessarily the same as the ISP start date. The case manager should not change this field for revisions. However, individual service line dates may change when starting or closing a provider/service.
<b>Age at Effective Date</b>	This field is automatically calculated to report the age of the individual for whom the BWS is being completed at the Prior Authorization effective date. The user cannot access this field.
<b>Prior Auth. End Date</b>	Input the Prior Authorization end date for the BWS being completed.  This date is not necessarily the same as the ISP end date. The case manager should not change this field for revisions, unless the revision is closing out the PA due to the individual moving to the Mi Via Waiver. However, individual service line dates may change when starting or closing a provider/service.
<b>Duration of Budget</b>	This field measures the number of days between the Prior Authorization effective and end dates and is automatically calculated. The user cannot access this field.
<b>First Submittal Date</b>	Input the date that the initial Prior Authorization is beginning or was submitted.
<b>PA Effective Date Basis</b>	Use the drop-down list to indicate the basis for the Prior Authorization effective date. There are four options: <ul style="list-style-type: none"><li>• Start of client’s ISP year.</li><li>• Transfer from the Mi Via Waiver during the ISP year.</li><li>• Transfer from child ARA.</li></ul>

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<b>PA End Date Basis</b>	Use the drop-down list to indicate the basis for the Prior Authorization end date. There are two options: <ul style="list-style-type: none"> <li>• End of client’s ISP year.</li> <li>• Transfer to the Mi Via Waiver during the ISP year.</li> </ul>
<b>Revision Date</b>	If applicable, input the date of the BWS revision.
<b>Revision Number</b>	If applicable, input the number of the BWS revision.
<b>Suggested Base Budget</b>	This field is automatically populated with the suggested base budget (covering Case Management, In-home or Residential services, Customized Community Supports, and Employment services) for the individual for whom the BWS is being completed based on the individual’s Living Care Arrangement and Proposed Budget Level. If the prior authorization period does not cover 365 days, the suggested amount is prorated based on the number of days that are covered. The user cannot access this field.
<b>Cost of Base Budget Services in the Prior Auth. Period</b>	This field is automatically calculated by summing the value of the services listed in the BWS for Case Management, In-home or Residential services, Customized Community Supports, and Employment services. The user cannot access this field.
<b>Suggested Professional Services Budget</b>	This field is automatically populated with the suggested professional services budget (covering ongoing Behavioral Supports Consultation and Occupational/ Physical/ Speech Therapies) for the individual for whom the BWS is being completed. The user cannot access this field.
<b>Cost of Prof. Services in the Prior Auth. Period</b>	This field is automatically calculated by summing the value of the services listed in the BWS for ongoing Behavioral Supports Consultation and Occupational/ Physical/ Speech Therapies. The user cannot access this field.
<b>Cost of Other Services in the Prior Auth. Period</b>	This field is automatically calculated by summing the value of the services listed in the BWS that are not captured in the base and professional services budgets. The user cannot access this field.
<b>Total Cost of Services in the Prior Auth. Period</b>	This field is automatically calculated by summing the value of all services listed in the BWS. The user cannot access this field.
<b>Exception Request</b>	This field is reserved for potential exception requests and is used by DOH.
<b>Reserved for OR</b>	This field is reserved for potential exception requests. The user cannot access this field.

### Section 2: Base Budget

The first budget section of the BWS is the Base Budget Section, which includes Case Management, Living Care Arrangements, Customized Community Supports and Community Integrated Employment.

**Service Grouping** This column includes groups of services. The user cannot access fields in this column.

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<b>Services</b>	Using the drop-down lists, input the service(s) proposed to be authorized for the individual for whom the BWS is being completed.
<b>Service Code</b>	Fields in this column are automatically populated with the service code for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Service Modifier</b>	Fields in this column are automatically populated with the modifier(s) for the service selected from the drop-down list on the same row, if applicable. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Provider</b>	Input the full name of the provider agency authorized to provide the service listed in the same row. A separate row must be completed for each provider and this field must be completed for any row in which a service is selected.
<b>Provider ID</b>	Input the Provider ID number (billing number) for the provider authorized to provide the service listed in the same row. A separate row must be completed for each provider and this field must be completed for any row in which a service is selected.
<b>Service Dates</b>	Input the start and end date for the proposed service <u>only</u> if these dates differ from the Prior Authorization start and end dates.
<b>Service Unit</b>	Fields in this column are automatically populated with the unit of service for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Number of Units</b>	Input the number of units proposed to be authorized for the service/provider listed in the same row.
<b>First Unit Rate for PA Term</b>	Fields in this column are automatically populated with the unit rate for the service selected from the drop-down list on the same row as of the start date of the Prior Authorization period. This is the rate used to calculate the cost of services. The user cannot access fields in this column.
<b>Rate Change</b>	Fields in this column are automatically populated with the unit rate for the service selected from the drop-down list on the same row <u>only</u> if the rate will change during the Prior Authorization period. If the rate will not change, the field will be blank. Fields in this column cannot be accessed by the user.
<b>Budget Value</b>	Fields in this column are automatically calculated by multiplying the number of units reported by the unit rate for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Date Revised if After Original</b>	Input the revision date <u>only</u> if submitting a revised BWS after the original submittal for the individual's ISP.

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**Purpose of Revision** Input the purpose of revision only if submitting a revised BWS after the original submittal for the individual’s ISP. There are six options:

- End Close Service
- Decrease Units
- Increasing Units
- Adding new service
- Provider/ID Correction
- Transfer Change Provider

Each row in the main part of the Base Budget Section includes the ability to propose a service for authorization, authorized by service category, as follows:

<b>Rows</b>	Case Management
<b>In Home and Residential Services</b>	<p>In-home or Residential services. The listing of services will change according to the individual’s Living Care Arrangement chosen in Section 1.</p> <p>When the LCA changes during the ISP term,</p> <ul style="list-style-type: none"> <li>• Change the option in the LCA drop-down box in Section 1 to reflect the new LCA.</li> <li>• On the existing LCA service line, enter an end date and pro rate the number of units needed until the end date.</li> <li>• On a separate LCA service line enter the new LCA service code with the start date after the end date of the existing LCA.</li> </ul>
<b>Customized Community Supports:</b>	Drop down menus list all service models under Customized Community Supports.
<b>Community Integrated Employment:</b>	Drop down menus list all service models under Community Integrated Employment.
<b>Rows</b>	Rows for additional services. These rows provide more space if any of the four service categories above exceed the number of available rows.
<b>Rows</b>	The final two rows of this section provide summary information regarding the suggested budget as well as the cost of the services proposed for authorization, and is not applicable to JCMs.
<b>Total Base Budget</b>	This field is automatically calculated by summing the value of the services proposed for authorization in the Base Budget Section. The user cannot access this field.
<b>Annualized Suggested Base Budget</b>	This field is automatically populated to reflect the suggested budget for the individual for whom the BWS is being completed based on their Living Care Arrangement and Proposed Budget Level. This field cannot be accessed by the user and is not applicable to JCMs.

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<b>Daily Suggested Base Budget</b>	This field is automatically calculated by dividing the Annualized budget by 365 days. This field cannot be accessed by the user and is not applicable to JCMs.
<b>Prorated Suggested Base Budget</b>	This field is automatically calculated by multiplying the Daily budget by the number of days covered by the Prior Authorization period based on the start and end dates. This field cannot be accessed by the user and is not applicable to JCMs.
<b>Comparison to Suggested Base Budget</b>	This field is automatically calculated by comparing the cost of the services proposed for authorization to the prorated suggested budget and is not applicable to JCMs.

**Section 3: Professional Services Budget**

The next section of the BWS is the Professional Services Budget, which includes Physical Therapy, Speech Therapy, Occupational Therapy, and Behavioral Support Consultation.

<b>Service Grouping</b>	This column includes groups of services. The user cannot access fields in this column.
<b>Services</b>	Using the drop-down lists, input the service(s) proposed to be authorized for the individual for whom the BWS is being completed.
<b>Service Code</b>	Fields in this column are automatically populated with the service code for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Service Modifier</b>	Fields in this column are automatically populated with the modifier(s) for the service selected from the drop-down list on the same row, if applicable. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Provider</b>	Input the name of the provider agency authorized to provide the service listed in the same row. A separate row must be completed for each provider and this field must be completed for any row in which a service is selected.
<b>Provider ID</b>	Input the Provider ID number (Provider billing number) for the provider authorized to provide the service listed in the same row. A separate row must be completed for each provider and this field must be completed for any row in which a service is selected.
<b>Service Dates</b>	Input the start and end date for the proposed service <i>only</i> if these dates differ from the Prior Authorization start and end dates.
<b>Service Unit</b>	Fields in this column are automatically populated with the unit of service for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Number of Units</b>	Input the number of units proposed to be authorized for the service/provider listed in the same row.

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<b>First Unit Rate for PA Term</b>	Fields in this column are automatically populated with the unit rate for the service selected from the drop-down list on the same row as of the start date of the Prior Authorization period. This is the rate used to calculate the cost of services. The user cannot access fields in this column.
<b>Rate Change</b>	Fields in this column are automatically populated with the unit rate for the service selected from the drop-down list on the same row <i>only</i> if the rate will change during the Prior Authorization period. If the rate will not change, the field will be blank. The user cannot access fields in this column.
<b>Budget Value</b>	Fields in this column are automatically calculated by multiplying the number of units reported the unit rate for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Date Revised if After Original</b>	Input the revision date <i>only</i> if submitting a revised BWS after the original submittal for the individual’s ISP.
<b>Date Revised if After Original</b>	Input the purpose of revision <i>only</i> if submitting a revised BWS after the original submittal for the individual’s ISP. There are six options abbreviated as follows: <ul style="list-style-type: none"> <li>• End Close Service</li> <li>• Decrease Units</li> <li>• Increasing Units</li> <li>• Adding new Service</li> <li>• Provider/ID Correction</li> <li>• Transfer Change Providers</li> </ul>

Each row in the main part of the Professional Services Budget Section includes the ability to propose a service for authorization, authorized by service category, as follows:

<b>Rows</b>	Behavioral Support Consultation; check the rate table for a listing of Standard and Incentive counties. JCM’s receive the Incentive county rate.
<b>Rows</b>	Occupational Therapy; check the current rate table for a listing of Standard and Incentive counties. JCM’s receive the Incentive county rate.
<b>Rows</b>	Physical Therapy; check the current rate table for a listing of Standard and Incentive counties. JCM’s receive the Incentive county rate.
<b>Rows</b>	Speech Therapy; check current rate table for a listing of Standard and Incentive counties. JCM’s receive the Incentive county rate.
<b>Rows</b>	Rows for additional services. These rows provide more space if any of the four service categories above exceed the number of available rows.

The final two rows of this section provide summary information regarding the suggested budget as well as the cost of the services proposed for authorization and is not applicable to JCMs.

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<b>Total Prof. Svcs. Budget</b>	This field is automatically calculated by summing the value of the services proposed for authorization in the Base Budget Section. The user cannot access this field.
<b>Annualized Suggested Prof. Svcs. Budget</b>	This field is automatically populated to reflect the suggested budget for the individual for whom the BWS is being completed based on their Proposed Budget Level. This field cannot be accessed by the user and is not applicable to JCMs.
<b>Daily Suggested Prof. Svcs. Budget</b>	This field is automatically calculated by dividing the Annualized budget by 365 days. This field cannot be accessed by the user and is not applicable to JCMs.
<b>Prorated Suggested Prof. Svcs. Budget</b>	This field is automatically calculated by multiplying the Daily budget by the number of days covered by the Prior Authorization period based on the start and end dates. This field cannot be accessed by the user and is not applicable to JCMs.
<b>Comparison to Suggested Prof. Svcs. Budget</b>	This field is automatically calculated by comparing the cost of the services proposed for authorization to the prorated suggested budget and is not applicable to JCMs.

**Section Four: Other Services Budget**

The Other Services Budget incorporates all services that are not part of the Base Budget or Professional Services Budget, including Assistive Technology, Crisis Supports, Environmental Modification, Independent Living Transition Service, Non-Ambulatory Stipend, Non-Medical Transportation, Nutritional Counseling, Personal Support Technology, Preliminary Risk Screening, Adult Nursing, Socialization and Sexuality, and Supplemental Dental. The Other Services Budget Section includes:

<b>Service Grouping</b>	This column includes groups of services. Fields in this column cannot be accessed by the user.
<b>Services</b>	Using the drop-down lists, input the service(s) proposed to be authorized for the individual for whom the BWS is being completed.
<b>Service Code</b>	Fields in this column are automatically populated with the service code for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Service Modifier</b>	Fields in this column are automatically populated with the modifier(s) for the service selected from the drop-down list on the same row, if applicable. If no service is selected, the field remains blank. Fields in this column cannot be accessed by the user.
<b>Provider</b>	Input the full name of the provider agency authorized to provide the service listed in the same row. A separate row must be completed for each provider and this field must be completed for any row in a service is selected.
<b>Provider ID</b>	Input the Provider ID number (Billing number) for the provider authorized to provide the service listed in the same row. A separate row must be completed for each provider and this field must be completed for any row in which a service is selected.

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<b>Service Dates</b>	Input the start and end date for the proposed service <u>only</u> if these dates differ from the Prior Authorization start and end dates.
<b>Service Unit</b>	Fields in this column are automatically populated with the unit of service for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Number of Units</b>	Input the number of units proposed to be authorized for the service/provider listed in the same row.
<b>First Unit Rate for PA Term</b>	Fields in this column are automatically populated with the unit rate for the service selected from the drop-down list on the same row as of the start date of the Prior Authorization period. This is the rate used to calculate the cost of services. The user cannot access fields in this column.
<b>Rate Change</b>	Fields in this column are automatically populated with the unit rate for the service selected from the drop-down list on the same row <u>only</u> if the rate will change during the Prior Authorization period. If the rate will not change, the field will be blank. The user cannot access fields in this column.
<b>Budget Value</b>	Fields in this column are automatically calculated by multiplying the number of units entered by the unit rate for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. The user cannot access fields in this column.
<b>Date Revised if After Original</b>	Input the revision date <u>only</u> if submitting a revised BWS after the original submittal for the individual's ISP.
<b>Date Revised if After Original</b>	Input the purpose of revision <u>only</u> if submitting a revised BWS after the original submittal for the individual's ISP. There are six options abbreviated as follows: <ul style="list-style-type: none"> <li>• End Close Service</li> <li>• Decrease Units</li> <li>• Increasing Units</li> <li>• Adding new Service</li> <li>• Provider/ID Correction</li> <li>• Transfer Change Provider</li> </ul>

Each row in the main part of the Other Services Section includes the ability to propose a service for authorization, by service category, as follows:

<b>Rows</b>	Assistive Technology.
<b>Rows</b>	Crisis Support.
<b>Rows</b>	Environmental Modifications.
<b>Rows</b>	Independent Living Transition.

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<b>Rows</b>	Non-Ambulatory Stipend.
<b>Rows</b>	Non-Medical Transportation.
<b>Rows</b>	Nutritional Counseling.
<b>Rows</b>	Personal Support Technology.
<b>Rows</b>	Preliminary Risk Screen and Consult for Inappropriate Sexual Behavior.
<b>Rows</b>	Adult Nursing Services.
<b>Rows</b>	Socialization and Sexuality Education classes.
<b>Rows</b>	Additional Rows. These rows provide more space if any of the service categories above exceed the number of available rows.

The final row of this section provides the cost of the services proposed for authorization.

#### **Section Five: Signature, Total Cost, and Prior Authorization Section**

The final section of the BWS includes the following:

- The total cost of all three budget sections is automatically calculated.
- Space for the signatures of the Case Manager, Individual, and/or Guardian.
- A section for the Medicaid TPA to complete, including Prior Authorization ID, date of submission, completion, OR reviewer initials, and Prior Authorization Waiver type code (from page one of the worksheet). In the case of JCM, the Medicaid TPA provides reviewer initials.
- Prior Authorization Number.
- Qualis Health enters the services into Omnicaid, and will issue a prior authorization to the CM within 10 business days.

#### **Section Six: Case Manager Instructions for Submissions of Budgets to the Outside Review (OR) Continual Outside Review and Evaluation (CORE) team and Medicaid Third Party Assessor (TPA), Qualis Health.**

- 1) Case Managers develop the BWS with the person receiving services, his/her guardian, if applicable, and with the interdisciplinary team.
- 2) At least 48 hours or two (2) business days prior to the submission of a packet to the TPA and/or OR, Case Managers are required to send relevant information including the BWS via secure communications to the IDT and providers for review.
- 3) If a member of the IDT notices an error on the BWS (e.g. provider code, service effective dates, number of units), case managers should make any agreed upon corrections prior to submission to the TPA and/or OR.
- 4) For adult DD Waiver participants who are not JCMs, the BWS is submitted by secure email using CISCO to the OR along with an OR Coversheet and documents demonstrating clinical justification.
  - a) Case Managers must correctly complete and submit the OR Cover Sheet along with all documents required for each submission. Case Managers need to complete all sections of the OR Cover Sheet, ensuring that the section with the person and guardian's information is accurate. Case Managers should also be clear as to the nature of the submission and provide an explanation if needed.

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- b) The SUBJECT Line of the email should say XX DDW ISP. “XX” represents the initials of the individual’s first name and last name.
- c) If a Case Manager identifies an error on a submission to the CORE shortly after it was submitted, the OR may be able to correct the error before the review is complete. The subject line of the CISCO email should say “Error with Submission” and the body of the email must include the person’s name, date of birth, date of original submission, a brief description of the error and the request for change.
- d) Each BWS and associated documents that are emailed to the CORE must use the same naming convention. Each document must be named using:
  - (1) XX DDW ISP ANNUAL 2015-2016
  - (2) XX DDW ANNUAL BUDGET
  - (3) XX DDW ISP REV. NUMBER: \_\_\_\_\_
  - (4) XX DDW REV. (number) RFI RESPONSE
  - (5) XX DDW BEHAVIORAL
  - (6) XX DDW MEDICAL
  - (7) XX DDW ISP ANNUAL 2015 2016 RFI RESPONSE
  - (8) XX DDW EMPLOYMENT XX DDW RESIDENTIAL
- 5) When turning 18 years old, an individual may choose to remain on the ARA through the expiration of the current ISP or choose to transition to the Adult waiver. Depending on the individual’s choice, the Case Manager will submit the budget one of two ways:
  - a) The Case Manager will submit directly to Qualis Health using the Qualis Health Portal, the close out child MAD 046 ending the same month that the child turns 18. Open MAD 046 with the adult code if the individual would like to stay in the same services until the end of the ISP term, beginning the first day of the next month that the child turns 18, or
  - b) The Case Manager will submit directly to the outside reviewer (OR) the close out Child MAD 046 ending the month that the child turns 18. If the individual chooses to transition to the adult budget, the Case Manager will submit the adult budget using the BWS, beginning the first day of the next month that the child turns 18. These should be submitted together to the CORE. The CORE will submit these two BWS to Qualis Health via JIVA.
- 6) For annual budgets, Case Managers are required to submit the BWS and supporting clinical documentation at least 60 days prior to the expiration date of the ISP year, 30 days for JCMs. The relevant TPA has 10 business days to complete the review of submission or issue a Request for Information (RFI).
- 7) BWS for JCMs do not go through the OR; they are submitted directly to the TPA using the Qualis Health Portal: <http://www.qualishealth.org/healthcare-professionals/new-mexico-medicaid/provider-resources>. JCMs must transition from 2007 to 2018 service codes by ISP expiration date using a crosswalk provided by DDSD.
- 8) If the person changes to another Case Manager and/or agency, Case Managers and Case Management Agency Directors can make necessary contact information changes with the OR and Medicaid TPA, as appropriate, by submitting the new Case Manager contact information on their Case Management Agency letterhead.

### Revisions

- 1) **Timing of Revision Submissions:** For revisions to an approved BWS during the ISP year, Case Managers are required to submit the approved BWS with Prior Authorization number and all supporting documents at least 30 days prior to the start of the new or changed service.
- 2) **Closure Budgets for Individuals Transferring from the DDW to Mi Via:** When an individual is transferring to the Mi Via Waiver from the DD Waiver, Case Managers must close out the DD Waiver budget. The “PA End Date Based On” drop down menu must have the choice that indicates “Transfer to Mi Via during ISP year.”

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All service lines on the budget must be closed out by entering the end date and total number of units reflecting all the units billed through the end of the date span of the DD Waiver budget.

- 3) **Open and Close Budgets:** It is not necessary to open and close an entire BWS based changes to any service providers or service types. This includes changes to a LCA or any services with tiered rate categories. Services can be opened and closed on the same BWS by including the appropriate start and end dates with accurate proration of units or two separate service lines in the same BWS. There cannot be an overlap of dates for two LCA's or for any service provider changes.  
**Note:** Changes to LCAs and tiered rates cannot be completed on a single BWS if using OR -V 2015. Supported Living Category 4 cannot be accessed using a BWS version prior to V-OR 2018 03-01. To make revisions in these instances, the approved budget must be transcribed to the most current version of the BWS and revision completed on the newer version. Both BWS must be submitted to the OR and the OR will transfer the PA.
- 4) **Required Fields on the BWS:** All required fields related to the budget revision must be completed on the BWS including the:
  - a) "Revisions after first submittal date", which means the DATE of the REVISION SUBMISSION,
  - b) "Date revised if after original", which means the DATE of the REVISION SUBMISSION, and
  - c) "Svc-provider dates if other than... from and to", which means the DATE SPAN of the REVISION(S).
- 5) **Date Spans:** For revisions that are increasing units for a service that was already approved, the ISP date span, or the date of the originally approved revision adding the service, *not* a new revision date span, is used.
- 6) **Order of Submission:** Budget revisions must be added to a BWS that has been approved. Revisions must be submitted in chronological order demonstrated in the signature block at the bottom of the BWS.

#### Special Instructions:

In extenuating circumstances, Case Managers must contact and work with their Regional Office Case Management Coordinators to submit BWS outside of the normal submission windows outlined above. These submissions are made through DDS after Regional Office Case Management Coordinators review and approve the special circumstances. Special circumstances are:

- Imminent Review
- Waiver of 30- day timeline for OR Review
- Retroactive Start Dates

#### Requests for Information (RFIs)

- 1) When additional information is needed to process a submission, a Request for Information (RFI) letter is sent to the CM.
- 2) The CM must respond to the RFI according to timelines provided in the RFI (e.g., within ten business days to CORE; seven business days to Qualis Health).
- 3) If an RFI is sent, Case Managers are required to notify appropriate providers within one business day of receipt of the RFI. This notification will be sent in writing via secure communications.
- 4) The CM should respond by following all instructions from the entity that sent the RFI:
  - a) Use CISCO, an OR Cover Sheet and the OR Reference Number for RFI's from the CORE; and
  - b) For JCMs, use JIVA Portal and applicable episode number for Qualis Health at:  
<http://www.qualishealth.org/healthcare-professionals/new-mexico-medicaid/provider-resources>
- 5) Once a response to a RFI response is received, the applicable entity has 10 business days to resume, review and finalize.

## **DEVELOPMENTAL DISABILITIES WAIVER**

### **Budget Worksheet Instructions**

### **Developmental Disabilities Supports Division**

#### **Issue of Prior Authorization Numbers**

- 1) The CORE will enter the approved services into the Qualis Health Portal.
- 2) JCM budgets go straight to Qualis Health for data entry.
- 3) Qualis Health will review and enter the services into the Medicaid Management Information System (MMIS), Omnicaid, and issues a prior authorization to the CM within 10 business days.
- 4) Case Managers are responsible for distributing approved prior authorizations to all providers.

#### **Partial Approvals (Clinical) and Partial Approvals (Technical Denials) (N/A for JCMs)**

- 1) When only some of the requested services have been clinically justified, and approved, a Partial Approval is granted, and the CORE will send a Partial Approval Letter.
- 2) If some services were clinically approved but the Case Manager did not respond to an RFI within 10 business days, or if the Case Manager did not respond to an RFI within 10 business days the CORE will send a Partial Approval/Technical Denial Letter.
- 3) The CORE emails letters and Notice of Right to Appeal to the CM, and mails a copy to the DD Waiver recipient and guardian (if applicable.)
- 4) Case Managers are required to notify the IDT and appropriate providers of a Technical Denial.

#### **Denial Letter (N/A for JCMs)**

- 1) When all services have not been clinically justified after a Case Manager responds to an RFI, a Denial letter may be issued.
- 2) A copy of the denial letter and a Notice of Right to Appeal will be emailed to the Case Manager and a copy will be mailed to the DD Waiver recipient and guardian (if applicable).
- 3) The Case Manager is responsible for distributing the denial letter to the provider(s) whose services were denied.

#### **Fair Hearings and Agency Conferences**

- 1) The Fair Hearing Process may be initiated by the waiver recipient or guardian, if applicable, within 90 days of the date of a Partial Approval or a Denial Letter.
- 2) If a Fair Hearing is requested, an agency conference (AC), will be offered by DDS. The agency conference is an opportunity to resolve the adverse decision. The case manager usually attends Agency conferences, the individual and guardian, if applicable, and the reviewer who made the adverse decision, or the designated OR representative.
- 3) DDS will issue written notification within seven (7) business days of the AC to the individual, guardian, if applicable, and the CM. This notification will reflect any agreements made and next steps during the AC. The CM then can submit any agreed upon documentation to the OR that came from the resolution of the AC, if appropriate.
- 4) If the AC is not successful in resolving the issue, the Fair Hearing will proceed. While the CM is not mandated to attend the Fair hearing, they may be asked to participate by the individual or included by the administrative law judge as necessary witnesses.