NEW MEXICO
DEPARTMENT OF
HEALTH

Outside Review Frequency of Clinical Reviews

Streamlined Process for Clinical Reviews and Revised Clinical Review Schedule

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Learning Objectives

- Overview of what services require clinical reviews
- Understand the frequency of clinical reviews for each service type
- Understand the Three-Year Clinical Review Schedule by ISP Month and learn what happens on the “off” years
- Review changes in required documentation and forms
- Roll-Out and timeframes

Why make changes?

Core Values

- Accountability
- Communication
- Teamwork
- Respect
- Leadership
- Customer Service

Guiding Principles

- Focus on results
- Improve systems simplicity, accountability, transparency
- Stay person/family-centered
- Work in partnership
- Promote choice
- Emphasize prevention and evidence-based intervention

Why make changes?

- Commitment to change: October 2016 memo
- Streamline the process
- Reduce burden
- Stakeholder feedback-we heard you!
- Learn from OR data-where are the problems?
- Improve the system-together!

Overview of Changes

- Effective March 1, 2018:
  - DD Waiver Service Standards
  - Clinical Criteria v 4
  - New Budget Worksheet V OR 2018-03-01
  - OR Streamlining Plan: Clinical Review Frequency Schedule
  - Three Year Clinical Review Schedule by ISP Month

Overview of changes: DD Waiver Service Standards

- https://nmhealth.org/publication/view/regulation/4173/
- Strengthened language around PCP, informed choice, Employment First, Human Rights, and Settings Requirements
- Policies previously incorporated by reference are now detailed in one place
- Director's Releases and other instructions are included
- Improved readability

Overview of changes: DD Waiver Service Standards

- Providers must use entire document, can no longer just go to one chapter.

- Common responsibilities among all providers are outlined in new chapters (e.g. Billing, Person Centered Planning, Individual Service Plan).

- Shared understanding of Program Requirements is intended to help with team work.

Overview of changes: DD Waiver Service Standards

- Outside Review process included

- Provider responsibilities to review BWS before submissions included

*Created a need to revise Clinical Criteria and BWS

Overview of Changes: BWS V OR 2018 03-01

- Replace IIBS-SL with Supported Living Category 4
- Remove Evaluation Units for Therapies and BSC
- Remove “Switch LCA during the ISP Year” as a drop down option for basis of PA Effective dates

Overview of Changes: Clinical Criteria v 4

- SL Category 4
- Staffing grid is no longer required for Supported Living
- IMLS short term can be requested for up to 90 days
- Therapy and Behavior Support Consultation Evaluation units do not have to be requested separately from requests for ongoing services in these disciplines
- Elimination of TSPARs, BSCPARs, and ANSPARs
- Funding from Division of Vocational Rehabilitation (DVR) must be accessed for Job Development/ Short Term Job Coaching and Self Employment.

Overview of changes: OR Streamlining Plan

- Streamlined process for clinical review
- Expansion of services which do not require a clinical review i.e. case management
- Typical review schedule of every 3 years
- Services characterized by intensive levels of support may be reviewed annually
- Elimination of SPARS (therapy, nursing and behavior consultation) and Staffing Grid for Supported Living
- Elimination of evaluation units
- Number of units requested triggers clinical reviews for specific services

Outside Review Streamlining Plan: Clinical Review Frequency Schedule

- Lists every service option by:
  - Service Name
  - Frequency of Clinical Review
  - Service Limitations, if applicable

- "Request" refers to *both* Revisions and Annual submissions

Outside Review Streamlining Plan: Clinical Review Frequency Schedule

- "*Frequency of Clinical Reviews*" that have criteria that says "If a request is for an increase in total units previously approved or from the previous ISP year, or increase in category previously approved or from previous ISP year" will be validated by the CORE by reviewing all prior authorizations (PA) from the ISP year (there may be more than one PA)

Outside Review Streamlining Plan: Clinical Review Frequency Schedule

- Use the Outside Review Streamlining Plan: Clinical Review Frequency Schedule to determine what is needed as part of every submission, regardless of year (annuals and revisions)

*See attached Outside Review Streamlining Plan: Clinical Review Frequency Schedule and Three Year Schedule of Clinical Reviews by ISP month

Outside Review Streamlining Plan: Clinical Review Frequency Schedule

- IDTs can still ask for what they can clinically justify
- Clinical services now have a specified number of hours/units that trigger a clinical review
- Clinical services requests below the specified number if hours/units will not require a clinical review

Assistive Technology

- Initial
- Every three years
- Every request
  - Validation of units only-no clinical review

*$250.00 inclusive of up to 10% administrative fees for AT Purchasing agency per ISP year

Behavior Support Consultation

- Initial
- Every three years
- Request exceeds 60 hours (240 units) per year for initial requests and new allocations
- Request exceeds 50 hours (200 units) per year for on-going supports
- Fading still required

Case Management

- No clinical review

*No more than 12 units can be authorized in an ISP year

*No more than 1 monthly unit in a 30-day span can be authorized

Community Integrated Employment Services

- Job Development
  - Initial
  - Annually
- Job Maintenance
  - Initial
  - Annually

*No more than 12 units can be authorized in an ISP year

*No more than 1 monthly unit in a 30-day span can be authorized

Community Integrated Employment Services

- Individual Self-Employment
  - Initial
  - Every three years

Community Integrated Employment Services

- Job Aide
  - No clinical review

Community Integrated Employment Services

- Intensive
  - Initial
  - Annually
  - Requests that exceed 10 hours per week

Community Integrated Employment Services

- Group Category 1
  - Initial
  - Every three years
  - If request is for an increase in total units previously approved or from the previous ISP year

Community Integrated Employment Services

- Group Category 2 (Extensive)
  - Initial
  - Annually
  - If there is a request to increase the category from the previous approval or the previous ISP year
  - If request is for an increase in total units previously approved or from the previous ISP year

Customized Community Supports (CCS)

- When the combination of all CCS services (Individual, Small Group, Group Category 1 and Group Category 2) exceeds 25 hours per wee, a clinical review would be triggered

Customized Community Supports (CCS)

- Individual
  - Initial
  - Every three years
  - If request is for an increase in total units previously approved or from the previous ISP year

- Small Group
  - Initial
  - Every three years
  - If request is for an increase in total units previously approved or from the previous ISP year

Customized Community Supports (CCS)

- Group Category 1
  - Initial
  - Every three years
  - If the request is for an increase in total units previously approved or from the previous ISP year
- Group Category 2
  - Initial
  - Annually
  - If the request is for an increase in total units previously approved or from the previous ISP year
  - If there is a request to increase the category from the previous approval or the previous ISP year

Customized Community Supports (CCS)

- Individual Intensive Behavioral
  - Initial
  - Annually
  - If request is for an increase in total units previously approved or from the previous ISP year

Customized Community Supports (CCS)

- Aide
  - No clinical review

Customized Community Supports (CCS)

- Fiscal Management for Adult Education
  - Initial
  - Every three years
  - Every request
    - Validation of units only-no clinical review

*$550 per ISP inclusive of 10% administrative fee

Customized In-Home Supports

- Initial
- Every three years
- Requests for over 30 hours per week

Crisis Supports

- No clinical review

Environmental Modifications

- Initial
- Every three years
- Every request
  - Validation of units only-no clinical review

*$5,000.00 every 5 years inclusive of 15% administrative fees

Independent Living Transition

- Initial
- Every three years
- Every request
  - Validation of units only-no clinical review

*One time only $1,500.00 inclusive of 15% administrative fees

Family Living

- Initial
- Every three years

*340 daily units to cover 365 calendar days of service

Supported Living

- Category 1: Basic Support
  - Initial
  - Every three years

*340 daily units to cover 365 calendar days of service

Supported Living

- Category 2: Moderate Support
  - Initial
  - Every three years
  - If there is a request to increase the category from the previous approval or the previous ISP year

*340 daily units to cover 365 calendar days of service

Supported Living

- Category 3: Extensive Support
  - Initial
  - Annually
  - If there is a request to increase the category from the previous approval or previous ISP year

*340 daily units to cover 365 calendar days of service

Supported Living

- Category 4: Extraordinary Support
  - Initial
  - Annually
  - If there is a request to increase the category from the previous approval or the previous ISP year

Supported Living

- There will be no more IIBS Supported Living beginning March 1, 2018.
  - No new IIBS SL service requests
  - No revisions to existing IIBS SL on current budget requesting to increase the service amount
  - Existing IIBS SL services will end when the current budget and ISP term expire
- Staffing grids will no longer be required for any Supported Living request

Supported Living

- Non-Ambulatory Stipend
  - Initial
  - Every three years

*340 daily units to cover 365 calendar days of service

*Cant be used with SL Category 4

Intensive Medical Living Service

- Initial
- Every three years

*Long Term: 340 daily units to cover 365 calendar days of service

*Short Term: Allowable for 90 calendar days

Non-Medical Transportation

- Initial
- Every three years
- Every request
  - Validation of units only-no clinical review

*$0.41 per mile not to exceed $750 per ISP year

*Pass/Ticket is $1.00 per item not to exceed $460.00 per ISP year

Adult Nursing

- Initial
- Increase in units
- Annually
- Request exceeds 12 hours (48 units) per year

Nutritional Counseling

- Initial
- Every three years

Personal Support Technology

- Initial
- Every three years
- Every request
  - Validation of units only-no clinical review

*$5000 per ISP year inclusive of 15% administrative fees

Preliminary Risk Screening and Consultation

- Initial
- Every three years
- Every request
    - Validation of units only-no clinical review

*The initial preliminary risk screening shall not exceed twenty-five (25) hours per Individual Service Plan (ISP) year. An additional screening, if needed, in a subsequent ISP shall not exceed fifteen (15) hours per ISP year. If periodic consultation is needed beyond the screening, additional units to provide technical assistance shall not exceed fifteen (15) hours per ISP year.

Respite

- Initial
- Every three years

Socialization and Sexuality Education

- Initial
- Every three years
- Every request
  - Validation of units only-no clinical review

*2 full series or 48 total classes per ISP year

Supplemental Dental Care

- Initial
- Every three years

*1 visit per ISP year

Therapy Services

- Initial
- Request exceeds 45 hours (180 units) per year, per discipline, for initial requests and new allocations
- Request exceeds 35 hours (140 units) per year, per discipline, for on-going supports
- If request is for an increase in total units previously approved or from the previous ISP year
- Every three years

Clinical Review Schedule

	Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
Batch #1			x			x			x			x
Batch #2		x			x			x			x	
Batch #3	x			x			x			x		

Three Year Clinical Review Schedule

By ISP month

- Batch #1: June 2018, September 2018, December 2018, March 2019

- Batch #2: February 2020, May 2020, August 2019, November 2019

- Batch #3: January 2021 , April 2021, July 2020, October 2020

What happens on the “off” years?

- Annually an updated person-centered plan, i.e., the ISP, must be submitted to the OR.
- Annually an updated budget (BWS) must be submitted to the OR.
- The Outside Review Streamlining Plan: Clinical Review Frequency Schedule must be used to determine what needs to be included with every submission (annual or revision)
- The OR will validate every submission on the “off” years and verify, using the prior year’s PA, that the submitted budget does not contain new or additional units that require a clinical review.
- RFIs can be issued related to submissions on the “off” years.

What happens on the “off” years?

- New Clinical Criteria v 4 will be used beginning March 1, 2018 for all revisions and annual budgets.
- During the first year of implementation of the streamlined process, all budgets will be reviewed through the new process based on the “Frequency of Clinical Reviews” as described in OR Streamlining Plan: Clinical Review Frequency Schedule, regardless of Batch #1,#2 or #3.

Revisions

- For every revision the Outside Review Streamlining Plan: Clinical Review Frequency Schedule must be used to determine what needs to be included with the submission
- The CORE will either validate or perform a clinical review on all revisions, as appropriate

Roll-Out

- Reference DDSD Numbered Memo 2018-03
- All Submissions made prior to 3/1/2018 will be reviewed using Clinical Criteria v3 and following old process
- Clinical Criteria v4 is applied to all reviews received after 3/1/2018
- Start uptake of BWS V OR 2018-03-01 by annual
- Transfer to BWS V OR 2018-03-01 when necessary

Don’t forget!

- The importance of timely and quality submissions to the OR by providers!
- Efforts are to streamline and reduce RFIs and the success of these changes are a shared responsibility!

- Changes can be made as we pilot this streamlined process!

FAQs

- If you are approved for 75 hours per year of on-going PT services on year 1, do you have to go through a clinical review for the 75 hours on years 2 and 3 (because it's more than 35 hours per year)? Yes, for that service only
- Do you still need to use the Verification of Benefits Eligibility Form? Yes
- If you stop and restart BSC services in the same ISP year, would you get the 60 hours per year because it's considered an initial request again? Yes

FAQs

- Who submits clinical documentation for a combination of CCS services that exceed 25 hours per week? All CCS service providers
- Will an RFI be issued if supporting clinical documentation is sent for services on a non-review year? No
- Can a RFI be issued on a submission during an "off" year? Yes

FAQs

- Will an RFI be issued if a BSC does not show the breakdown of add-ons requested in the total unit amount? No
- Will IIBS Supported Living be an option when the standards go into effect? No
- Are providers responsible to list the number of staff hours of support for SL services since the staffing grid has been eliminated? No

FAQs

- If a therapy initial request is put on the budget (45 hours/180 units), the evaluation is completed, and no on-going therapy is recommended, does the CM submit a revision to reduce the budgeted hours/units? Yes
- If an evaluation unit is put on an existing budget as a revision, will it be RFI'ed? Yes
- As we pilot this new process, will we make changes as necessary? Yes

Resources

- DD Waiver Service Standards Effective March 1, 2018
- BWS V OR 2018 03-01
- Clinical Criteria Version 4
- Outside Review Streamlining Plan: Clinical Review Frequency Schedule March 1, 2018
- Three Year Clinical Review Schedule by ISP Month
- DDSD- Numbered Memo 2018 02 Change of process: “Open and Close Budgets” are no longer required for changes to Living Care Arrangements and services with tiered rates
- DDSD- Numbered Memo 2018 -03 Roll Out of Clinical Criteria V4, the OR Streamlining Plan: Clinical Review Frequency Schedule, Clinical Review Schedule by ISP Month and Budget Worksheet (V OR 2018 03-01)

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