

Denials, Termination, and Reduction (DTR)



What are DTRs?

DTR = Denial/Termination/Reduction.

- Required in specific situations- when services are:
 - Requested by enrollee.
 - Ordered by network provider.
 - Ordered by approved non-network provider.
 - Ordered by care manager.
 - Ordered by a court.
- DTR letters serves as “official notification” to members and providers when a service (requested or ordered as above) is denied, terminated, or reduced.



DTR Requirements

- DHS contracts are very specific when it comes to DTRs.
 - mandates timeframes for decision making and notification.
 - mandates what has to be on the notice.



Notice Requirements

- A DTR notice must provide information regarding:
 - Service requested.
 - Determination.
 - Reason for determination.
 - Supporting citation (policy) for determination.
 - Member appeal rights.
- Form must be approved by DHS, contain language block.



DTR Notice

- The official DTR letter is issued by UCare
 - Notice is issued when a service is denied, terminated or reduced.
- Notice is sent to:
 - Member.
 - Provider.
 - Care Coordinator (fax).
- “Notice of Action” is DHS’s terminology, although the actual notice is a UCare form.



General Info About DTRs

- Care Coordinators only deal with DTRs for EW services and PCA services.
- DTRs of waiver services require a DTR notice to be sent to the member and provider, but do not require “utilization review”.
- Care coordinators (nurses or social workers) may make waiver and PCA DTR determinations.
 - However, DTR of waiver and PCA services still require a formal DTR notice.
- When in doubt, issue a DTR.



DTR Notice Timeframe

- Decision to *Deny, Terminate, or Reduce* a service
 - Must be made and communicated to member and provider within 14 calendar days of their request for the service.
 - Request usually is made to the CC, or by the CC, but could also be made to others (provider)
 - Day 1" = date request is first received to the CC.
- In order to meet this timeframe, the CC must send the DTR Notification form to UCare no later than 1-3 business days of request.



Advance Notice

For Terminations and Reductions, an **advance notice** is required before services are terminated or reduced.

- Must give *14 calendar days after* notice is mailed to member.
- Services must continue through the notice period.
- UCare enters effective date of termination/reduction on letter.



DTR Process

- Member, provider, CC requests a waiver service.
- CC determines the service is denied, terminated, or reduced
 - Decision must be made and communicated to member and provider within 14 calendar days of request.
- CC sends Waiver DTR Notification Form to UCare
 - This form tells UCare to issue a formal DTR notice to member and provider.
 - Must be sent timely so we can notify member within 14 days of request.
- UCare sends the formal notice (DTR form) to the mbr and provider.
 - Contains DHS-required info, including appeal rights and language block.
 - For Terminations and reductions, the 14 calendar day advance notice is figured out by UCare and entered on DTR form by UCare.



DTR Forms on UCare Website

DTR forms on UCare website under the Denial Forms section of Care Managers tab.

There are 3 Forms on UCare website that may be used for waiver DTRs- CCs should select one based on the type of service being DTR'd:

- Waiver DTR Notification Form
 - Instructions posted separately on website.
- Home Health Communication Form
- PCA Communication Form



Waiver DTR Form

- Used to DTR any waiver service except extended PCA, extended HHA
 - Up to 4 separate DTRs per form
 - New check box for Terming EW Eligibility
 - Drop down boxes for selecting service descriptions
 - Requires CC to note the EW waiver span, particularly for reductions
- Accompanying Forms to Waiver DTR:
 - Instructions – guides CC in filling out waiver DTR notification form
 - Waiver Reason Codes
 - DTR Waiver Situations - What Do I Do If? – scenarios for additional help

EW DTR Form Examples



[Reset Form](#)



Elderly Waiver DTR Notification Care Coordinator Use Only

FYI *Incomplete, illegible or inaccurate forms will be returned to sender.* Please complete the entire form. Allow 14 calendar days for processing of this request.



Fax form and any relevant documentation to:
612-884-2185 or **1-866-402-5018**



For questions, **call: 612-676-6705**
Email: CLSintake@ucare.org

MEMBER INFORMATION	Member Name	<u>Joe Member</u>	Member ID	<u>000-00000000</u>
	Member Address	<u>1 Apple Ave</u>	PMI	<u>XXXXXXX</u>
	Member City, State, Zip	<u>Mpls, MN</u>	Date of Birth	<u>01/01/0000</u>
	Member Phone	<u>XXX-XXX-XXXX</u>	Gender:	<input type="checkbox"/> Female <input checked="" type="checkbox"/> Male
CC INFO	Care Coordinator Name	<u>Sally J</u>	Phone Number	<u>XXX-XXXX</u>
	Care Coordinator Email	<u>SallyJ@xxxx.org</u>	Fax	<u>XXX-XXXX</u>
ATTENDING HEALTH CARE PROFESSIONAL INFO	Clinician Name	<u>Dr. F</u>		
	Clinic Name	<u>Dr. F Clinic</u>	NPI	<u>XXXXXXX</u>
	Clinic Address	<u>100 Clinic Ave</u>		
	Clinic City, State, Zip	<u>Mpls, MN 55443</u>		
	Clinic Phone	<u>XXX-XXXX</u>	Fax	<u>XXX-XXXX</u>

Form must be completed by a UCare Delegated Care Coordinator.

NEW OR CURRENT EW DATE SPAN		<u>11/1/18</u>	TO	<u>10/31/19</u>
SERVICES/PROCEDURES/ ITEMS REQUESTED	ELDERLY WAIVER SERVICES			
	<input type="checkbox"/> Denial	Reason Code:	DTR Comments (<i>e.g. inpatient admission/out of country date/services reduced via CL Tool</i>)	
	<input checked="" type="checkbox"/> Termination	<u>1602</u>	<u>Member requests to stop meals</u>	
	<input type="checkbox"/> Reduction			
	Service Description	<u>Home Delivered Meals – S5170</u> <i>select an option</i>		
	Frequency (<i>e.g. hrs per week/daily/monthly</i>)	<u>1 meal per day</u>	Rate Per Unit if negotiated	
Provider Name	<u>XYZ Meals</u>	NPI	<u>123456</u>	
Provider Phone	<u>612-XXX-XXXX</u>	Fax	<u>612-XXX-XXXX</u>	

EW DTR Form Examples



Elderly Waiver DTR Notification (continued)

NEW OR CURRENT EW DATE SPAN <u>11/1/18</u> TO <u>10/31/19</u>	
SERVICES/PROCEDURES/ ITEMS REQUESTED	ELDERLY WAIVER SERVICES <input type="checkbox"/> Denial Reason Code: <u>1615</u> DTR Comments (e.g. inpatient admission/out of country date/services reduced via CL Tool) <input type="checkbox"/> Termination <input checked="" type="checkbox"/> Reduction <u>1615</u> <u>Mbr requests to reduce ACD from 4 days/week to 2 days/week</u>
	Service Description <u>Adult Day Services – S5100</u> <i>select an option</i>
	Frequency (e.g. hrs per week/daily/monthly) <u>2 days/week</u> Rate Per Unit <u>if negotiated</u>
	Provider Name <u>ABC ADC</u> NPI <u>123456</u> Provider Phone <u>612-123-XXXX</u> Fax <u>612-123-XXXX</u>
SERVICES/PROCEDURES/ ITEMS REQUESTED	ELDERLY WAIVER SERVICES <input checked="" type="checkbox"/> Denial Reason Code: <u>1611</u> DTR Comments (e.g. inpatient admission/out of country date/services reduced via CL Tool) <input type="checkbox"/> Termination <input type="checkbox"/> Reduction <u>1611</u> <u>Member wants chore services but lives with family, not part of care plan</u>
	Service Description <u>Chore Services – S5120</u> <i>select an option</i>
	Frequency (e.g. hrs per week/daily/monthly) <u>0</u> Rate Per Unit <u>if negotiated</u>
	Provider Name <u>ABC Chores</u> NPI <u>123455</u> Provider Phone <u>612-XXX-XXXX</u> Fax <u>612-XXX-XXXX</u>
SERVICES/PROCEDURES/ ITEMS REQUESTED	ELDERLY WAIVER SERVICES <input type="checkbox"/> Denial Reason Code: <u>1615</u> DTR Comments (e.g. inpatient admission/out of country date/services reduced via CL Tool) <input type="checkbox"/> Termination <input checked="" type="checkbox"/> Reduction <u>1615</u> <u>mbr requests reduction of transport rides to 2 days/wk</u>
	Service Description <u>Transportation – T2003 UC</u> <i>select an option</i>
	Frequency (e.g. hrs per week/daily/monthly) <u>2 days per week</u> Rate Per Unit <u>1.25 per mile</u> <i>if negotiated</i>
	Provider Name <u>ABC Transport</u> NPI <u>123456</u> Provider Phone <u>612-XXX-XXXX</u> Fax <u>612-XXX-XXXX</u>



Home Health Communication Form

- Used instead of EW DTR Notification Form to request and deny/ terminate/reduce home health services.
- CCs can ONLY request DTR of waiver home health services
 - HHA, Extended HHA

HH Communication Form, Example



HOME HEALTH COMMUNICATION FORM

Form must be completed by UCare Care Coordinator.

FYI **Incomplete, illegible or inaccurate forms will be returned to sender.** All information is required in order for UCare to process the request. Please allow up to 14 calendar days for processing of this request.



Fax form to 612-884-2499 or
Email to hcm_fax@ucare.org.



For questions, call 612-676-6705 or
toll free 866-610-7215.

MEMBER INFO	Member Name <u>Mr. X</u>	Member ID <u>000-0000000</u>
	PMI <u>XXXXX</u>	DOB <u>1/1/10</u>
	ICD-10 <u>J-010x</u>	
CC INFO	Care Coordinator Name <u>Sally J</u>	Phone Number <u>612-000-0000</u>
	Email <u>SallyJ@XXXX.org</u>	Fax _____
ATTENDING HEALTH CARE PROFESSIONAL INFO	Clinician Name <u>Dr. X</u>	
	Clinic Name <u>X clinic</u>	
	Address <u>1 Apple Ave.</u>	City, State, Zip <u>Mpls, MN</u>
	Phone <u>612-xxx-xxxx</u>	Fax <u>612-xxx-xxxx</u>

HH (Home Health) Services -

- Use this form to **reduce/terminate** home health services such as Home Health Aide (HHA), Home Health Aide Extended (HHA Ext), or Skilled Nurse Visits (SNV). CM should ensure coordination to reduce or terminate services is communicated with Home Care Agency.
- Use this form to **request** Elderly Waiver Extended HHA (T1004).
Extended HHA: Extended home care services follow state plan home care policies, but allow the services to exceed the limits on amount, duration and frequency. HHA provides medically oriented task(s) to maintain health or to facilitate treatment of an illness or injury provided in a person's place of residence. Only one visit per day per person is permitted for HHA.

SERVICES REQUESTED	HH SERVICES	
	Service Description <u>Terminate Extended HHA</u>	
	Frequency <u>2x/week</u>	
	Start Date <u>12/1/18</u>	End Date _____
	PCA Provider Name <u>PCA XXX</u>	PCA Provider UCare ID <u>XXXXXX</u>
	Phone <u>612-XXX-XXXX</u>	Fax <u>612-XXX-XXXX</u>
	<i>Detailed description of reason for request:</i>	
	<u>Terminate extended HHA due to member getting other services</u>	

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PCA Communication Form

- Used INSTEAD of EW DTR Notification Form
 - to request and deny/terminate/reduce PCA services such as 45 day temp start, increase/reduce/deny, terminate PCA or extended PCA

PCA Communication Form, Example



PERSONAL CARE ASSISTANCE (PCA) COMMUNICATION FORM

Form must be completed by UCare Care Coordinator.

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** All information is required in order for UCare to process the request. Please allow up to 14 calendar days for processing of this request.



Fax form to 612-884-2094 or
Email to ucarepca@ucare.org.



For questions, call 612-676-6705
(option 2, option 4).

MEMBER INFO	Member Name <u>Member XYZ</u>	Member ID <u>000-xxxxxxx00</u>
	PMI <u>XXXX</u>	DOB <u>01/01/18</u>
	ICD-10 <u>J010</u>	
CC INFO	Care Coordinator Name <u>SallyJ</u>	Phone Number <u>612-000-0000</u>
	Email <u>SallyJ@XXXX.com</u>	Fax <u>612-000-0000</u>
ATTENDING HEALTH CARE PROFESSIONAL INFO	Clinician Name <u>Dr. Y</u>	
	Clinic Name <u>Dr Y Clinic</u>	
	Address <u>210 Apple Street</u>	City, State, Zip <u>Mpls, MN</u>
	Phone <u>612-000-0000</u>	Fax <u>612-000-0000</u>

PCA Services - This section is used to request and/or deny/terminate/reduce PCA services (E.g. 45 Day Temp Start/Increase, Reduce/Term PCA services, PCA Extended services). Please also use this section to report inability to complete PCA assessment due to member refusal/unable to reach or denial of an early PCA reassessment.

- Provide LTC/EW date span.
- Service description – select from most commonly used.
*45 day temp authorizations cannot exceed 45 days and cannot be used to cover gap in services.
- Service frequency – should indicate the amount TOTAL of PCA services (E.g. Current XX hours daily, increase by XX hours to TOTAL XX hours daily x 45 day).
- List provider's name and UCare legacy number.
- To better understand your request, provide a detailed description.

As the Care Coordinator and entity responsible to conduct the PCA Assessment, Page 9 of the Supplemental PCA Assessment should be completed at the time of the face to face PCA Assessment to request/recommend less PCA hours (than assessed) in lieu of other waiver services.

In the event a reduction or termination in PCA is being requested after the PCA Assessment has already taken place (days or months later); use this section to reduce/terminate PCA services as requested by the member.

Change of PCA Provider - The member has the right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, and medical assistance, or other health program (Mn Home Care Bill of Rights/Mn Statute 144A.44).

- We recommend an allowance of an advance 14 day transfer date to change to new PCA provider.
- PCA Providers are required to communicate these changes with one another to prevent duplicate and overlapping services.
- UCare's PCA Team will provide an official end date notice to the current (old) provider.
- If an advance transfer date cannot be provided, a detailed explanation and description must be included.
- To ensure member's right to choose, member/RP and Care Coordinator acknowledgement and signature should be affixed in this section.

Notification of Chosen Provider - If member did not identify a PCA provider at the time of the assessment and now has chosen one, use this section to report the chosen provider. To ensure member's right to choose, member/RP and Care Coordinator acknowledgement and signature should be affixed in this section.

PCA Communication Form, pg. 2



Form must be completed by UCare Care Coordinator.

Request copy of most recent PCA assessment <i>Select preference of fax or secure email.</i>	<input checked="" type="checkbox"/> Fax to CC	<input type="checkbox"/> Secure email to CC
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NEW OR CURRENT LTC/EW DATE SPAN <u>11/1/18</u> TO <u>10/31/18</u>	
SERVICES REQUESTED	PCA SERVICES
	Service Description <u>Reduce PCA Services</u>
	Frequency <u>4 hours daily, 3x/week from 4 hours daily 5x /week</u>
	Start Date <u>12/1/18</u> End Date <u>11/30/18</u>
	PCA Provider Name <u>PCA Z</u> PCA Provider UCare ID <u>0000000</u>
	Phone <u>612-000-0000</u> Fax <u>612-000-0000</u>
	<i>Detailed description of reason for request (E.g. current XX hours daily, increase by XX hours to TOTAL XX hours daily x 45 days):</i> <u>Reduce PCA from current 4 hours daily 5 x/week to 4 hours daily 3x/ week, per new assessment results.</u>

SERVICES REQUESTED	CHANGE OF PCA PROVIDER/NEW PROVIDER NOTIFICATION <i>Please allow an advance transfer date of at least 14 days to new provider.</i>
	Current PCA Provider Name _____ PCA Provider ID _____
	New PCA Provider Name _____ PCA Provider ID _____
	Start/Transfer/Change Date _____
	<i>Additional description for request:</i>
	Member acknowledgement - <i>By affixing my signature below, I have made a decision to switch to the new provider on effective date shown in above. I was informed of the transfer process and all of the information above is accurate to the best of my knowledge. I agree that UCare may use and release information regarding my PCA Services to the new PCA provider above.</i>
	Member or Responsible Party's Signature _____ Date _____
CC's Signature _____ Date _____	

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Reminders

- Verify mbr. ID number and name.
- Verify provider ID number.
- Remember to check the box for “Terminating EW Eligibility” when a member is losing eligibility for some reason
 - Out of area.
 - Exit from waiver.
 - Loses NF eligibility.
 - Goes into a NF, etc.
- Submit a separate DTR line item for each waiver service mbr is receiving.
- Include your email address when faxing request to UCare, so we can notify you that we received the request.



Summary

- Complete the DTR forms in their entirety.
- Use instructions as a guide.
- Use correct service and reason codes- refer to DHS Rate guide and UCare website.
- Use separate forms for Extended PCA and HHA
 - PCA Communication Form
 - HHA Communication Form
- Submit via email at CLSintake@ucare.org (for waiver svcs), or Ucarepca@ucare.org. (for PCA svcs), or fax to number on bottom of Notification Form.
- UCare sends the CC a faxed copy of the actual DTR letter that is mailed to the member.



Additional Resources

- Contact CLSintake@ucare.org with questions about whether or not the DTR notification form was received by UCare.
- Contact Clinicalliaison@ucare.org with general operational questions related to DTRs- when to send, how to send, etc.



Thank You!

- Thank You for Viewing this Webex!

