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DDW Budget Submission Process Training

Provided By: Marie Velasco, DDW Program Manager

Dates: 10-25-22 and 10-27-22

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Objectives of Training

1) Overview on Process of Budget Submission
2) Timelines, Approvals, Denials and Request for Information (RFI's)
3) Helpful Hints/Tips on Submission Process
4) Common Mistakes/Errors made on submission process
5) Question/Answer Period

Who Develops the Budget Worksheet (BWS)

The CM develops the BWS with the individual, if applicable their guardian and with the Interdisciplinary Team (IDT)

Individual Main Focus

ISP Development-Directed by the Individual

Budget Development –Directed by the Individual

Outside Review (OR) Functions

Outside Review (OR): Independent Third-Party Contractor that conducts a clinical outside review of services and service amounts

- Budgets are submitted to the Outside Reviewer
- OR issues RFIs to the Case Manager when applicable to complete the review
- OR reviews and submits approved BWS to the TPA for data entry in Ominicaid

Third Party Assessor (TPA) Functions Related to Budgets

Third Party Assessor (TPA)-Comagine Health: Contracts with the Human Service Department to review former JCM (Jackson Class Member) budgets.

- TPA enters all approved budgets into Omnicaid.
- Budgets for former JCM are submitted directly to the TPA.

** TPA also approves Level of Care (LOC)

Budget Submissions

- **Submission**: At least **45 FULL CALENDAR DAYS** in advance of **ISP Expiration.**
- **Service Revision:** This is when a budget is submitted but a change in service is needed. Must be submitted with a 30-day projected start date for the change in services
- **Imminent Review:** Waives submission deadlines under certain circumstances.
    - 3 business days
    - 5 business days
    - 1 business day (CRISIS SUPPORTS ONLY)

  Refer to DDW Service Standards for criteria.
- **Retro-Active Review:** A retroactive review is a review for a service or provider with a start date that has already passed. CM submits to OR once reviewed by RO.

Budget Submission Helpful Hints

- **Helpful Hints/Tips:**
  - Ensure you have a Verification of Receipt from the OR
  - Late submissions are counted based on time stamp of email
  - The OR has 10 business days to complete a review or issue an RFI. This starts the day after submission if submitted before 5:00 pm on a business day and starts the next business day if submitted after 5:00 pm
  - For 30- or 45-day timelines, the measure is made by date of the month (e.g., June 30 is 30 days prior to July 30)

New Allocations

- Submit budgets for new allocations as soon as possible
- New allocations are not counted in DD Waiver OR Late Budget Submission Reports
- Budgets do not have to start the first of the month.(Note: The first of the month start date only refers to Mi Via and Supports Waiver.)

Three Year Cycle for OR Submission Only

- Full Clinical Review of the entire budget will be completed every three years.
- On the off years a validation ensures that the request does not exceed what was previously approved. (Only the new or revised service will be reviewed for clinical justification)
- The three-year schedule is determined by ISP renewal month (Please see resources at end of slide)

What happens to the budget when there is no Category of Eligibility (COE)?

- Category of Eligibility (096): In order to access services an individual must meet Category of Eligibility criteria for DD Waiver Services every year
- The TPA cannot enter a budget without an active COE (096)
- The CM must check the Medicaid Portal/PA for COE
- LOC (Level of Care) approval is not the same as COE.
- **Helpful Hint** : OR approval of a Budget does not indicate the person is eligible to begin services

What happens to the budget when billed units exceed the revision request?

- Prevent Unit Discrepancies-ensure that units billed do not exceed units on revision for services that are being ended or reduced
- Providers need to agree on Prorated Units of Budget prior to submission
- CM needs to review the Medicaid Portal and incorporate already billed units into the prorated amount

Unable to Work

- Issued when the OR cannot process a submission
- The TPA does not issue *Unable to Work* this is unique to the OR
- The CM is responsible for addressing any *Unable to Work* while still adhering to timelines
- Please Note: If the CM submits the budget the day before the deadline the *Unable to Work* will result in a late budget submission

Brief List of Potential Unable to Work

- Missing BWS or ISP
- Incomplete Coversheet (blank or missing required demographic information needed for data entry)
- Missing or incorrect Prior Authorization Number (PA#) or PA# is from several years prior.
- BWS- missing units for a service requested or missing a provider information
- Documents are password protected or unable to be opened because sent in a format other than word, pdf or excel
- Revision is not numbered or incorrectly numbered
- Budget is missing proposed budget level, LCA or H Category Code
- ISP dates are different from previous year

Request for Information (RFI's)

- RFI is when additional information is needed to process or justify a submission
- Request for Information (RFI) letter is sent to the CM
- The CM must respond to the RFI according to timelines provided in the RFI

OR Request for Information (RFI's)

Notification from OR: When an RFI is received for an individual the CM will be notified via secure email from the OR

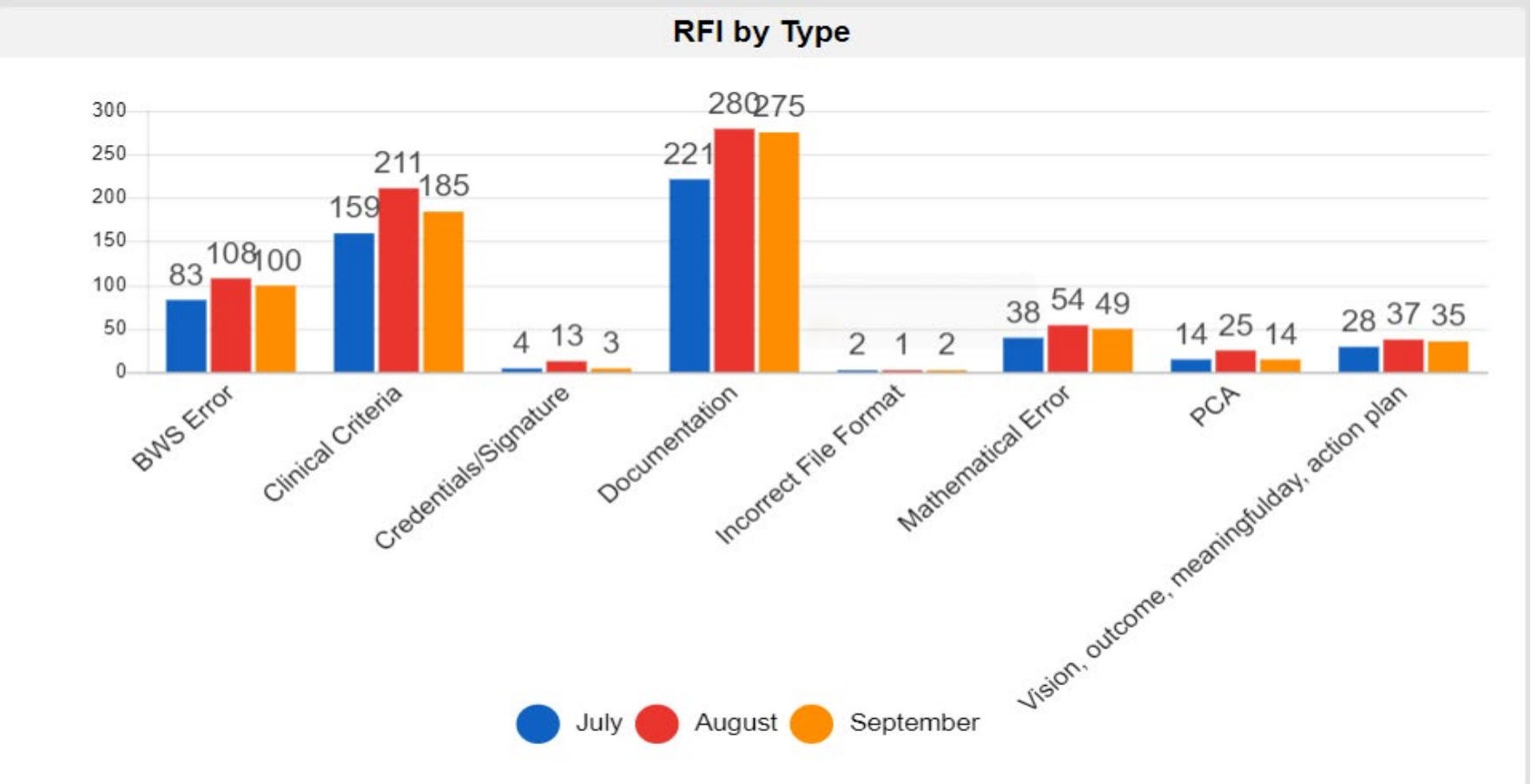
Response Time: The CM must respond to the RFI within ten business days

Notification to Providers: When an RFI is received by the CM the CM is required to notify appropriate providers within one business day of receipt of the RFI.

Follow Instructions from OR: The CM should respond by following all instructions from the OR detailed in the RFI notification

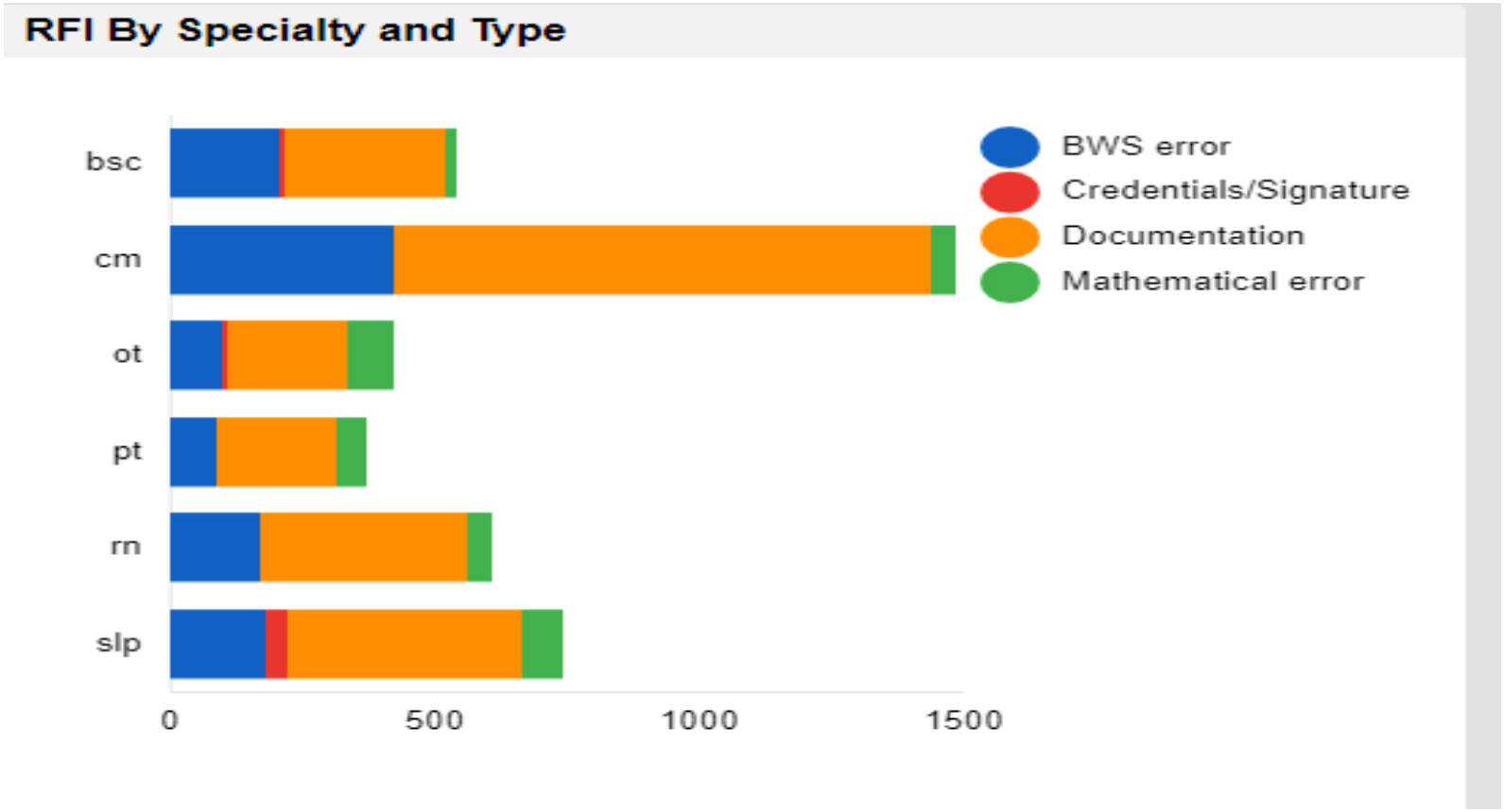
Respond to an OR RFI: Use CISCO, an OR Cover Sheet and the OR Reference Number to respond to an OR RFI

OR RFI (Continued)



Top Three RFI reasons are BWS errors, Clinical Criteria and Documentation

OR RFI (Continued)



Regional Offices are here to help Case Managers address issues with providers. Use the RORA System

TPA Request for Information (RFI's)

- For former JCM's submissions only
- Notification of RFI is in JIVA with timeline to respond
- If the TPA does not receive the required information or response, the TPA may issue a technical denial.
- Reminder: If the TPA is unable to complete the data entry into the Omnicaid system for submissions received from the OR, the TPA will issue an RFI to the OR. The OR alone responds-not the CM

Helpful/Hints Tips to Reduce RFI's

1) RFI sometimes go to junk mail so please check all of your folders.
2) Before submitting make sure all documents are complete.
3) If CM is having difficulty obtaining documents from providers, please fill out a **RORA** (Regional Office Request for Assistance)
4) Make sure OR Coversheet is filled out appropriately
5) Ensure you follow the DDW BWS Instructions when filling out the BWS
6) If submitting a close out budget the CM needs to review the Medicaid Portal and incorporate already billed units into the prorated amount
7) Use error check tab in BWS

ALWAYS DOUBLE CHECK YOUR WORK BEFORE SUBMITTING

OR COVERSHEET

Purpose of OR Coversheet: It is necessary in all email submissions to the OR. The coversheet indicates the nature of the submission and should detail any exceptions to the standard review process.

Check OR Coversheet for Potential Errors:

- Check the correct box for type of submission
- Include PA#
- Include Guardian Information
- Ensure CM Contact Information is correct
- Check ISP Begin and ISP End Dates
- Typo of names, identifying information, etc.
- Include notes

LET'S TAKE A LOOK AT A BWS

Check Budget Worksheet for these Common Errors:

- Individual's Name must match name in Omnicaid
- Incorrect SS# or DOB
- Revision Date on Header of BWS needs to match the date next to the Service Code needing revision
- Close out Budgets :When submitting a close out cm is not entering the correct PA end date in the header of the budget worksheet.
- Provider ID is incorrect or missing
- Entering 2 separate lines in the budget for the same service code, provider, and dates of service
- Verify Incentive Counties
- ISP Date of next ISP meeting is missing or not updated
- Effective dates of ISP and next term of level of care dates are not updated to current ISP term.
- CM needs to enter their contact information
- BWS needs required signatures
- Please use error check tab in BWS

Helpful Hints and Tips:

- Budgets are for the Individual to obtain services (Person Centeredness)
- Remember timelines for budget submission
- Double Check Budget Worksheet, Cover Letter prior to submission
- Respond to RFI's and Unable to Work timely
- CM should be familiar with Clinical Criteria
- Contact DD Waiver Program Manager or local Regional Office for assistance and questions.

Resources

- Where to find current BWS : DDW webpage to request a fillable form. Case Management (nmhealth.org)
- Where to find BWS Submission Instructions and OR Coversheet: Follow links for Budget Submission instructions based on if submitting through OR or TPA:
  - ✓ Instructions for OR Budget Submission: Case Management (nmhealth.org)
  - ✓ Instructions for Budget Submission to the TPA (JCM): Providers | Comagine Health
- TPA/Comagine Health contact number 1-866-962-2180

Resources Continued

- **Budget Submission Process page for Clinical Criteria:** Budget Submission Process
- **Schedule for Clinical Review:** Developmental Disabilities Waiver (nmhealth.org)
  - ✓ Under 2021 Numbered Memo 01
- **Incentive Counties:** https://www.nmhealth.org/about/ddsd/pgsv/ddw/resources/
- **DD Waiver Service Standards:** Services and Supports (nmhealth.org)
- **DDW Numbered Memos:** Developmental Disabilities Waiver (nmhealth.org)

For further questions please contact:
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Questions??

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