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

ucare

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: Joe Member
Member ID: 000-00000000
Member Address: 1 Apple Ave
PMI: xxxxxxx
Member City, State, Zip: Mpls, MN
Date of Birth: 01/01/0000
Member Phone: xxx-xxx-xxxx
Gender: ☐ Female ■ Male

CC INFO

Care Coordinator Name: Sally J
Phone Number: xxx-xxxx
Care Coordinator Email: SallyJ@xxxx.org
Fax: xxx-xxxx

ATTENDING HEALTH CARE PROFESSIONAL INFO

Clinician Name: Dr. F
Clinic Name: Dr. F Clinic
NPI: xxxxxxx
Clinic Address: 100 Clinic Ave
Clinic City, State, Zip: Mpls, MN 55443
Clinic Phone: xxx-xxxx
Fax: xxx-xxxx

Form must be completed by a UCare Delegated Care Coordinator.

NEW OR CURRENT EW DATE SPAN 11/1/18 **TO** 10/31/19

SERVICES/PROCEDURES/ITEMS REQUESTED

ELDERLY WAIVER SERVICES

☐ Denial
■ Termination
☐ Reduction

Reason Code: 1602

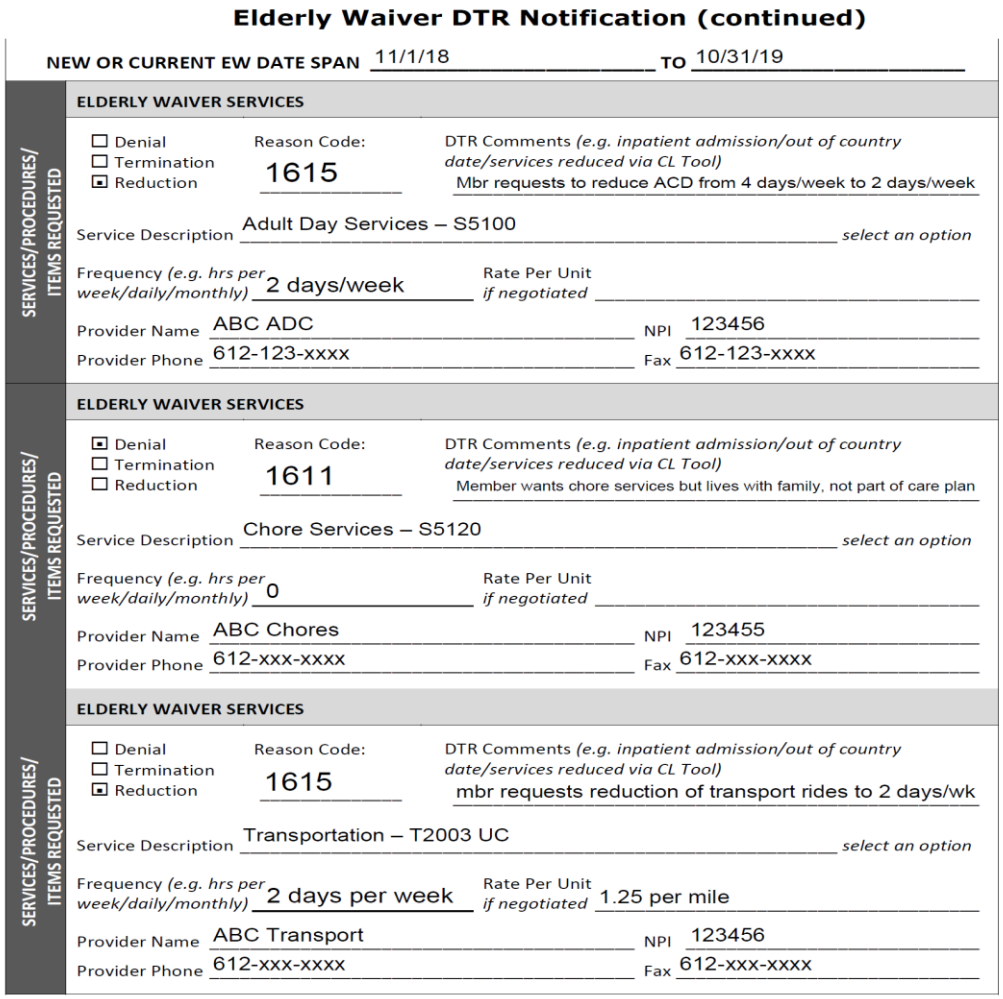
DTR Comments *(e.g. inpatient admission/out of country date/services reduced via CL Tool)*: Member requests to stop meals

Service Description: Home Delivered Meals – S5170 *select an option*

Frequency *(e.g. hrs per week/daily/monthly)*: 1 meal per day
Rate Per Unit *if negotiated*:

Provider Name: XYZ Meals
NPI: 123456
Provider Phone: 612-xxx-xxxx
Fax: 612-xxx-xxxx

EW DTR Form Examples



Elderly Waiver DTR Notification (continued)

NEW OR CURRENT EW DATE SPAN 11/1/18 TO 10/31/19

SERVICES/PROCEDURES/ ITEMS REQUESTED

ELDERLY WAIVER SERVICES

☐ Denial
☐ Termination
☒ Reduction

Reason Code: 1615

DTR Comments *(e.g. inpatient admission/out of country date/services reduced via CL Tool)*: Mbr requests to reduce ACD from 4 days/week to 2 days/week

Service Description: Adult Day Services – S5100 *select an option*

Frequency *(e.g. hrs per week/daily/monthly)*: 2 days/week

Rate Per Unit *if negotiated*:

Provider Name: ABC ADC NPI: 123456

Provider Phone: 612-123-xxxx Fax: 612-123-xxxx

SERVICES/PROCEDURES/ ITEMS REQUESTED

ELDERLY WAIVER SERVICES

☒ Denial
☐ Termination
☐ Reduction

Reason Code: 1611

DTR Comments *(e.g. inpatient admission/out of country date/services reduced via CL Tool)*: Member wants chore services but lives with family, not part of care plan

Service Description: Chore Services – S5120 *select an option*

Frequency *(e.g. hrs per week/daily/monthly)*: 0

Rate Per Unit *if negotiated*:

Provider Name: ABC Chores NPI: 123455

Provider Phone: 612-xxx-xxxx Fax: 612-xxx-xxxx

SERVICES/PROCEDURES/ ITEMS REQUESTED

ELDERLY WAIVER SERVICES

☐ Denial
☐ Termination
☒ Reduction

Reason Code: 1615

DTR Comments *(e.g. inpatient admission/out of country date/services reduced via CL Tool)*: mbr requests reduction of transport rides to 2 days/wk

Service Description: Transportation – T2003 UC *select an option*

Frequency *(e.g. hrs per week/daily/monthly)*: 2 days per week

Rate Per Unit *if negotiated*: 1.25 per mile

Provider Name: ABC Transport NPI: 123456

Provider Phone: 612-xxx-xxxx Fax: 612-xxx-xxxx

Elderly Waiver DTR Notification
Care Coordinator Use Only

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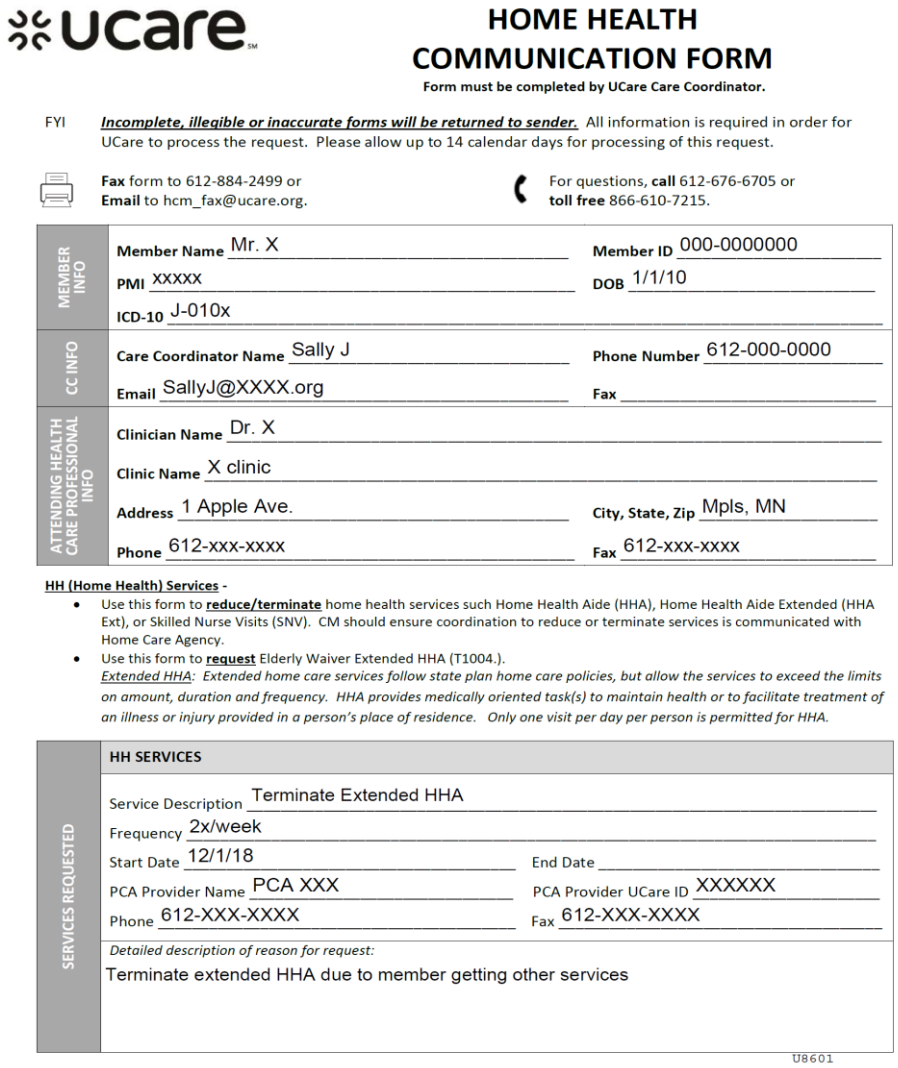
Page 2 of 2

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



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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 Mr. X **Member ID** 000-0000000

PMI xxxxx **DOB** 1/1/10

ICD-10 J-010x

CC INFO

Care Coordinator Name Sally J **Phone Number** 612-000-0000

Email SallyJ@XXXX.org **Fax**

ATTENDING HEALTH CARE PROFESSIONAL INFO

Clinician Name Dr. X

Clinic Name X clinic

Address 1 Apple Ave. **City, State, Zip** Mpls, MN

Phone 612-xxx-xxxx **Fax** 612-xxx-xxxx

HH (Home Health) Services -

- Use this form to **reduce/terminate** home health services such 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 Terminate Extended HHA

Frequency 2x/week

Start Date 12/1/18 End Date

PCA Provider Name PCA XXX PCA Provider UCare ID XXXXXX

Phone 612-XXX-XXXX Fax 612-XXX-XXXX

Detailed description of reason for request:

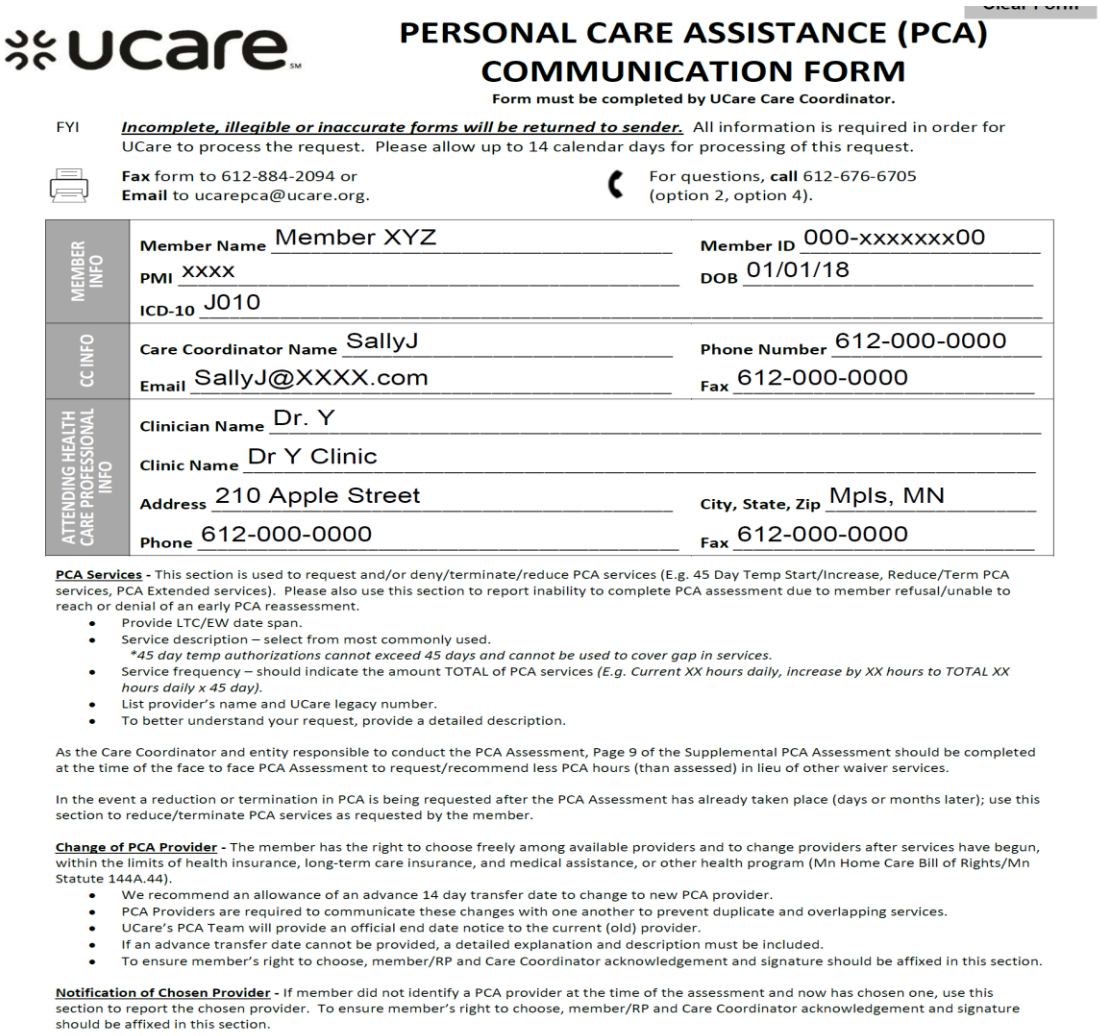
Terminate extended HHA due to member getting other services

U8601

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



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

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 *Select preference of fax or secure email.*	☑ Fax to CC	☐ Secure email to CC

NEW OR CURRENT LTC/EW DATE SPAN 11/1/18 **TO** 10/31/18

SERVICES REQUESTED

PCA SERVICES

Service Description: Reduce PCA Services

Frequency: 4 hours daily, 3x/week from 4 hours daily 5x /week

Start Date: 12/1/18 End Date: 11/30/18

PCA Provider Name: PCA Z PCA Provider UCare ID: 0000000

Phone: 612-000-0000 Fax: 612-000-0000

Detailed description of reason for request (E.g. current XX hours daily, increase by XX hours to TOTAL XX hours daily x 45 days):

Reduce PCA from current 4 hours daily 5 x/week to 4 hours daily 3x/ week, per new assessment results.

SERVICES REQUESTED

CHANGE OF PCA PROVIDER/NEW PROVIDER NOTIFICATION

Please allow an advance transfer date of at least 14 days to new provider.

Current PCA Provider Name _____ PCA Provider ID _____

New PCA Provider Name _____ PCA Provider ID _____

Start/Transfer/Change Date _____

Additional description for request:

Member acknowledgement *- 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.*

Member or Responsible Party's Signature _____ **Date** _____

CC's Signature _____ **Date** _____

U8599

Reminders

- Verify mbr. ID number and name.
- Verify provider ID number.
- Remember to check the box for “Terming 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 Clinicalliaision@ucare.org with general operational questions related to DTRs- when to send, how to send, etc.

Thank You!

- Thank You for Viewing this Webex!