Developmental Disabilities Medicaid Waiver

Developmental Disabilities Supports Division

NEW MEXICO
DEPARTMENT OF
HEALTH

Developmental Disabilities Waiver Budget Worksheet Instructions

July 1, 2017

Developmental Disabilities Waiver
Budget Worksheet Instructions
Developmental Disabilities Supports Division

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Introduction

DDSD has issued a new Budget Worksheet for services using clinical criteria effective July 1, 2017.

These worksheets are required for the Annual Budget and Revisions, and are to be submitted to the Outside Reviewer (OR) along with an OR Coversheet and documents demonstrating clinical justification.

Case Managers should ensure that they use a valid budget worksheet (BWS), by downloading these BWS directly from the DDSD website regularly. Case Managers are responsible for verifying that the version date in the far upper left- hand corner is the most current.

It is the responsibility of all members of the inter-disciplinary team (IDT) to ensure that services requested can be clinically justified.

The budget worksheet auto-fills the suggested Base Budget and Professional Services Budget for the individual for whom the worksheet is being completed based on their Living Care Arrangements (LCA, Customized In-Home Supports-Living Independently; Customized In-Home Support-Living with Family; Family Living; Supported Living; and Intense Medical Living Support) and the proposed budget level (numbered 1 through 7).

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Section 1: Identifying Information

As shown on page 6, the first section of the budget worksheet includes identifying information for the individual for whom the worksheet is being completed, that individual's living care arrangement and proposed budget level, the time period covered by the Individual Service Plan (ISP) year and the type of ISP, the prior authorization period, and the total dollar amount listed in the worksheet. The row and column labels have been added to the picture in order to easily reference the cells. In the list below, each field is referenced by the column label (one or two letters) and the row label (a number). For example, 'M3' refers to column M, row 3 (in which the individual's name is input).

M3: Name

Input the name of the individual for whom the worksheet is being completed in the following order: last name, first name, middle initial (if applicable).

AN3: SSN

Input the Social Security Number of the individual for whom the worksheet is being completed. Input numbers only; the worksheet is formatted to added hyphens.

AW3: DOB

Input the date of birth of the individual for whom the worksheet is being completed.

BC3: County

Input the county of residence of the individual for whom the budget worksheet is being completed. The case manager is responsible for checking whether the individual's county qualifies for the Standard or Incentive rate for services whose rates vary by county.

BK3: LCA

- Use the drop-down list to input the Living Care Arrangement (LCA) of the individual for whom the worksheet 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.**

Note that if an individual's LCA changes during their ISP year, a new budget worksheet must be completed.

CA3: Proposed Budget Level

Use the drop-down list to input the Proposed Budget Level (numbered 1 through 7) of the individual for whom the worksheet is being competed.

Note that if an individual's Proposed Budget Level changes during their ISP year, a new budget worksheet must be completed.

BR5: Omnicaid Code

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.

These codes, in turn, correspond to the suggested base budget and suggested professional services budget.

This field is automatically populated by the worksheet based on the selections in cells BK3 and CA3 and cannot be accessed by the user.

C8: ISP Start Date

Input the beginning date of the ISP for the individual for whom the worksheet is being completed.

G8: ISP End Date

This field is automatically calculated by the worksheet by adding 365 days to the start date input in C8. This field cannot be accessed by the user.

C12: ISP Type

Use the drop-down list to indicate the 'type' of ISP that is applied to the budget worksheet being completed. There are three options:

- Initial ISP or transfer from the Mi Via Waiver (See section six for additional submission instructions)
- Annual ISP
- Transfer from child ARA (See section six for additional submission instructions)

N8: Prior Auth. Effective Date

Input the Prior Authorization effective date for the budget worksheet being completed.

This date is not necessarily the same as the ISP start date. The case manager should not change this field for revisions unless either the individual's Living Care Arrangement or Proposed Budget Level has changed partway through the ISP year. However, individual service line dates may change when starting or closing a provider/service.

AI8: Age at Effective Date

This field is automatically calculated to report the age of the individual for whom the worksheet is being completed at the Prior Authorization effective date. This field cannot be accessed by the user.

AN8: Prior Auth. End Date

Input the Prior Authorization end date for the budget worksheet 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 either the individual's Living Care Arrangement or Proposed Budget Level has changed partway through the ISP year. However, individual service line dates may change when starting or closing a provider/service.

AW8: Duration of Budget

This field measures the number of days between the Prior Authorization effective and end dates and is automatically calculated. This field cannot be accessed by the user.

BB8: First Submittal Date

Input the date that the initial Prior Authorization is being or was submitted.

M11: PA Effective Date Basis

Use the drop-down list to indicate the basis for the Prior Authorization effective date. There are four options:

- Start of client's ISP year
- Transfer from the Mi Via Waiver during the ISP year
- Change in the individual's Living Care Arrangement during the ISP year
- Transfer from child ARA

AM11: PA End Date Basis

Use the drop-down list to indicate the basis for the Prior Authorization end date. There are three options:

- End of client's ISP year
- Transfer to the Mi Via Waiver during the ISP year
- Change in the individual's Living Care Arrangement during the ISP year

BA12: Revision Date

If applicable, input the date of the budget worksheet revision.

BE12: Revision Number

If applicable, input the number of the budget worksheet revision.

BM8: Suggested Base Budget

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 worksheet 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.

This field cannot be accessed by the user.

BQ8: Cost of Base Budget Services in the Prior Auth. Period

This field is automatically calculated by summing the value of the services listed in the worksheet for Case Management, in-home or residential services, Customized Community Supports, and employment services.

This field cannot be accessed by the user.

BM9: Suggested Professional Services Budget

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 worksheet 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.

This field cannot be accessed by the user.

BQ9: Cost of Prof. Services in the Prior Auth. Period	This field is automatically calculated by summing the value of the services listed in the worksheet for ongoing Behavioral Supports Consultation and Occupational/ Physical/ Speech Therapies. This field cannot be accessed by the user.
BQ10: Cost of Other Services in the Prior Auth. Period	This field is automatically calculated by summing the value of the services listed in the worksheet that are not captured in the base and professional services budgets. This field cannot be accessed by the user.
BQ11: Total Cost of Services in the Prior Auth. Period	This field is automatically calculated by summing the value of all of the services listed in the worksheet. This field cannot be accessed by the user.
CA7: Exception Request	This field is reserved for potential exception requests and is used by DOH.
CA7: Reserved for OR	This field is reserved for potential exception requests.

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v. OR Test1 — Developmental Disabilities Waiver Budget

Name (Last, First, MI)	SSN	Date of Birth	County
			(select county)

Living and Care Arrangement (LCA): (select Living and Care Arrangement)

Proposed Budget Lvl: (select)

TPA enters this code [ ] into Omnicaid

Exception Request: Not requested

Requires DOH approval

reserved for OR:

Client's Full ISP Year

Start date	End date

12 mos. (as tied to ISD review)

Type of ISP: (select one)

This Prior Authorization (PA) Budget Period (full or part of ISP Year)

PA Effective Date	Age at eff. dt	PA End Date	Duration of budget	First submittal date of this PA

PA Effective Date based on: | PA End Date based on:

Revisions after first submittal date

Revision date | Rev#

Prorated Suggested Budgets		This PA $
Base		$0.00
Prof svc		$0.00
	Other	$0.00
	Total:	**$0.00**

Section 2: Base Budget

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

The Base Budget Section is included on page 10. Column and row labels have been added to the picture for reference in the table below.

Column A: Service Grouping	This column includes groups of services. Fields in this column cannot be accessed by the user.
Column G: Services	Using the drop-down lists, input the service(s) proposed to be authorized for the individual for whom the worksheet is being completed.
Column AD: Service Code	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. Fields in this column cannot be accessed by the user.
Column AG: Service Modifier	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.
Column AK: Provider	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 with a service is selected.
Column AR: Provider ID	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 with which a service is selected.
Columns AX and BB: Service Dates	Input the start and end date for the proposed service/ provider authorization *only* if these dates differ from the Prior Authorization start and end dates listed in cells N8 and AN8.
Column BF: Service Unit	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. Fields in this column cannot be accessed by the user.
Column BJ: Number of Units	Input the number of units proposed to be authorized for the service/ provider listed in the same row.
Column BM: First Unit Rate for PA Term	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. Fields in this column cannot be accessed by the user.

Column BP: Rate Change	Fields in this column are automatically populated with the unit rate for the service selected from the drop-down list on the same row *only* 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.
Column BQ: Budget Value	Fields in this column are automatically calculated by multiplying the number of units reported in column BJ by the unit rate from column BM for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. Fields in this column cannot be accessed by the user.
Column BT: Date Revised if After Original	Input the date of the proposed authorization *only* if submitting a revised worksheet after the original submittal for the individual's ISP.
Column BW: Date Revised if After Original	Input the date of the proposed authorization *only* if submitting a revised worksheet after the original submittal for the individual's ISP. There are five options: • Add units • Decrease units • Close service • Open service • Provider correction

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:

Rows 21-24:	Case Management
Rows 26-30:	In-home or residential services. The listing of services will change according to the individual's Living Care Arrangement as reported in cell BK3.
Rows 32-38:	Customized Community Supports
Rows 40-45:	Community Integrated Employment

The final two rows of this section (rows 47-48) provide summary information regarding the suggested budget as well as the cost of the services proposed for authorization:

BM47: Total Base Budget	This field is automatically calculated by summing the value of the services proposed for authorization in the Base Budget Section. This field cannot be accessed by the user.
AE48: Annualized Suggested Base Budget	This field is automatically populated to reflect the suggested budget for the individual for whom the worksheet is being completed based on their Living Care Arrangement and Proposed Budget Level. This field cannot be accessed by the user.

AK48: Daily Suggested Base Budget	This field is automatically calculated by dividing the Annualized budget listed in cell AE48 by 365 days. This field cannot be accessed by the user.
AX48: Prorated Suggested Base Budget	This field is automatically calculated by multiplying the Daily budget listed in cell AK48 by the number of days covered by the Prior Authorization period based on the start and end dates listed in cells N8 and AN 8. This field cannot be accessed by the user.
BM48: Comparison to Suggested Base Budget	This field is automatically calculated by comparing the cost of the services proposed for authorization from cell BM47 to the prorated suggested budget from cell AX48.

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BASE BUDGET

This form calculates a budget value using the first available per-unit-rates as of this PA's start date 1/0/00. The budget value is for comparison to the maximum limit. Unit-rates are subject to change.

		Service (use drop down button)	Service Code	Modifiers	Provider	Prov ID	Svc-provider dates if other than 1/0/00 - 1/0/00 From	To	unit	# Of Units	First unit-rate for PA term	Paid rate depends on date service rendered. rate chg	Budget value	Date revised if after orig	Purpose of Revision
21	Case Mgmt	x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
26	*Choose LCA*	x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
32	Customized Community Supports (CCS)	x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
40	Community Integrated Employment	x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			
		x_add a service row									$0.00	$0.00			

47	Suggested Base Budget	Annualized	per day	*Sugg Base Budget prorated*	*Total This Base Budget*	$0.00
48		need PA dates		*(days)*	*Exceeds sugg by +*	

Section 3: Professional Services Budget

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

The Professional Services Budget Section is included on page 14. Column and row labels have been added to the picture for reference in the table below.

Column A: Service Grouping	This column includes groups of services. Fields in this column cannot be accessed by the user.
Column G: Services	Using the drop-down lists, input the service(s) proposed to be authorized for the individual for whom the worksheet is being completed.
Column AD: Service Code	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. Fields in this column cannot be accessed by the user.
Column AG: Service Modifier	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.
Column AK: Provider	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 with a service is selected.
Column AR: Provider ID	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.
Columns AX and BB: Service Dates	Input the start and end date for the proposed service/ provider authorization *only* if these dates differ from the Prior Authorization start and end dates listed in cells N8 and AN8.
Column BF: Service Unit	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. Fields in this column cannot be accessed by the user.
Column BJ: Number of Units	Input the number of units proposed to be authorized for the service/ provider listed in the same row.
Column BM: First Unit Rate for PA Term	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. Fields in this column cannot be accessed by the user.

Column BP: Rate Change

Fields in this column are automatically populated with the unit rate for the service selected from the drop-down list on the same row *only* 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.

Column BQ: Budget Value

Fields in this column are automatically calculated by multiplying the number of units reported in column BJ by the unit rate from column BM for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. Fields in this column cannot be accessed by the user.

Column BT: Date Revised if After Original

Input the date of the proposed authorization *only* if submitting a revised worksheet after the original submittal for the individual's ISP.

Column BW: Date Revised if After Original

Input the date of the proposed authorization *only* if submitting a revised worksheet after the original submittal for the individual's ISP. There are five options:

- Add units
- Decrease units
- Close service
- Open service
- Provider correction

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:

Rows 58-60:

Behavioral Supports Consultation; check the rate table for a listing of Standard and Incentive counties.

Rows 63-66:

Occupational Therapy; check the current rate table for a listing of Standard and Incentive counties.

Rows 69-72:

Physical Therapy; check the current rate table for a listing of Standard and Incentive counties.

Rows 75-77:

Speech Therapy; check current rate table for a listing of Standard and Incentive counties.

Rows 80-87

Rows for additional services. These rows provide more space if any of the four service categories above exceed the number of available rows.

Case Managers must receive the corresponding prior authorization packets from the therapist(s) and BSCs, at least 14 days prior to the ISP meeting for ongoing therapies, in order to complete the budget worksheet for the Professional Services Budget section for submission to the Outside Reviewer (OR). This is not necessary for initial evaluations.

The final two rows of this section (rows 90-91) provide summary information regarding the suggested budget as well as the cost of the services proposed for authorization:

BM90: Total Prof. Svcs. Budget	This field is automatically calculated by summing the value of the services proposed for authorization in the Base Budget Section. This field cannot be accessed by the user.
AE91: Annualized Suggested Prof. Svcs. Budget	This field is automatically populated to reflect the suggested budget for the individual for whom the worksheet is being completed based on their Proposed Budget Level. This field cannot be accessed by the user.
AK91: Daily Suggested Prof. Svcs. Budget	This field is automatically calculated by dividing the Annualized budget listed in cell AE91 by 365 days. This field cannot be accessed by the user.
AX91: Prorated Suggested Prof. Svcs. Budget	This field is automatically calculated by multiplying the Daily budget listed in cell AK91 by the number of days covered by the Prior Authorization period based on the start and end dates listed in cells N8 and AN 8. This field cannot be accessed by the user.
BM91: Comparison to Suggested Prof. Svcs. Budget	This field is automatically calculated by comparing the cost of the services proposed for authorization from cell BM90 to the prorated suggested budget from cell AX91.

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PROFESSIONAL SERVICES BUDGET

This form calculates a budget value using the first available per-unit-rates as of this PA's start date 1/0/00. The budget value is for comparison to the maximum limit. Unit-rates are subject to change.

		Service (use drop down button)	Service Code	Modifier	Provider	Prov ID	Svc-provider dates if other than 1/0/00 - 1/0/00 From	To	unit	# Of Units	First unit rate for PA term	Paid rate depends on date service rendered. rate chg	Budget value	Date revised if after orig	Purpose of Revision
58	Beh. Support Consult	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
	check standard/ incentive county	x_add a service row							-		$0.00	$0.00			
63	Occupational Therapy	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
	check standard/ incentive county	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
69	Physical Therapy	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
	check standard/ incentive county	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
75	Speech Therapy	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
	check standard/ incentive county	x_add a service row							-		$0.00	$0.00			
80	Additional rows for any above	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
	check standard/ incentive county	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			

	Maximum Professional Service Budget	Annualized	per day	*Max Prof. Svc Budg. prorated*	*This Prof Serv Budget*	$0.00
90						
91		**Need PA dates**		*(days)*	*Exceeds max by +*	

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-Medical Transportation, Nutritional Counseling, Therapy Initial Evaluations, Personal Support Technology, Preliminary Risk Screening, Adult Nursing, Socialization and Sexuality, and Supplemental Dental.

The Other Services Budget Section is included on page 18 Column and row labels have been added to the picture for reference in the table below.

Column A: Service Grouping	This column includes groups of services. Fields in this column cannot be accessed by the user.
Column G: Services	Using the drop-down lists, input the service(s) proposed to be authorized for the individual for whom the worksheet is being completed.
Column AD: Service Code	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. Fields in this column cannot be accessed by the user.
Column AG: Service Modifier	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.
Column AK: Provider	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 with a service is selected.
Column AR: Provider ID	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.
Columns AX and BB: Service Dates	Input the start and end date for the proposed service/ provider authorization *only* if these dates differ from the Prior Authorization start and end dates listed in cells N8 and AN8.
Column BF: Service Unit	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. Fields in this column cannot be accessed by the user.
Column BJ: Number of Units	Input the number of units proposed to be authorized for the service/ provider listed in the same row.
Column BM: First Unit Rate for PA Term	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. Fields in this column cannot be accessed by the user.

Column BP: Rate Change

Fields in this column are automatically populated with the unit rate for the service selected from the drop-down list on the same row *only* 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.

Column BQ: Budget Value

Fields in this column are automatically calculated by multiplying the number of units reported in column BJ by the unit rate from column BM for the service selected from the drop-down list on the same row. If no service is selected, the field remains blank. Fields in this column cannot be accessed by the user.

Column BT: Date Revised if After Original

Input the date of the proposed authorization *only* if submitting a revised worksheet after the original submittal for the individual's ISP.

Column BW: Date Revised if After Original

Input the date of the proposed authorization *only* if submitting a revised worksheet after the original submittal for the individual's ISP. There are five options:

- Add units
- Decrease units
- Close service
- Open service
- Provider correction

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:

Rows 100-101: Assistive Technology; check current Service Standards for the annual maximum that may be authorized before submitting the worksheet.

Rows 103-105: Crisis Support.

Requires Prior Authorization or Approval from Bureau of Behavior Support

Rows 107-108: Environmental Modifications; check current Service Standards for the five-year maximum benefit that may be authorized before submitting the worksheet.

Rows 110-111: Independent Living Transition; check current Service Standards for the maximum lifetime benefit that may be authorized before submitting the worksheet.

Rows 113-114 Non-Ambulatory Stipend; this service is only available to individuals in a Supported Living placement.

Rows 116-118 Non-Medical Transportation

Rows 120-121 Nutritional Counseling; this service is not available to individuals in a Supported Living, Family Living, or Intense Medical Living Support placement.

Rows 123-130 Behavioral Supports Consultation and Therapy Evaluations

Rows 132-134 Personal Support Technology; check current Service Standards for the annual maximum that may be authorized before submitting the worksheet.

Rows 136-138 Preliminary Risk Screen and Consult for Inappropriate Sexual Behavior; check current Service Standards for listing of Standard and Incentive counties.

Rows 140-143 Adult Nursing Services Prior Authorization Request (ANSPAR) must be used for Adult Nursing Services.

Rows 145-147 Socialization and Sexuality Education classes; check current rate table for a current listing of Standard and Incentive counties and the maximum lifetime benefit that may be authorized before submitting the BWS.

Rows 149-150 Supplemental Dental Care; check current Service Standards for the annual maximum that may be authorized before submitting the BWS.

Rows 152-155 Rows for additional services. These rows provide more space if any of the service categories above exceed the number of available rows.

The final row of this section (row 158) provides the cost of the services proposed for authorization.

DEVELOPMENTAL DISABILITIES WAIVER

Budget Worksheet Instructions

Developmental Disabilities Supports Division

	A	G	AD	AG	AK	AR	AX	BB	BF	BJ	BM	BP	BQ	BT	BW
		OTHER SERVICES									This form calculates a budget value using the first available per-unit-rates as of this PA's start date 1/0/00. The budget value is for comparison to the maximum limit.		Unit-rates are subject to change.		
		Service (use drop down button)	**Service Code**	**Modifier**	**Provider**	**Prov ID**	**Svc-provider dates if other than 1/0/00 - 1/0/00** *From*	*To*	**unit**	**# Of Units**	**First unit rate for PA term**	Paid rate depends on date service rendered. rate chg	**Budget value**	Date revised if after orig	Purpose of Revision
100	Assistive Tech	x_add a service row							-		$0.00	$0.00			
	(check yrly. max)	x_add a service row							-		$0.00	$0.00			
103	Crisis Support	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
107	Environ. Mod	x_add a service row							-		$0.00	$0.00			
	(check 5-yr. max)	x_add a service row							-		$0.00	$0.00			
110	Ind. Living Trans.	x_add a service row							-		$0.00	$0.00			
	(check life. max)	x_add a service row							-		$0.00	$0.00			
113	Non-Ambulatory Stipend	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
116	Non Medical Transportation	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
120	Nutrition Counseling	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
123	BSC and Therapy Initial Evals.	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
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132	Personal Support Tech	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
	(check yrly. max)	x_add a service row							-		$0.00	$0.00			
136	Inapprop. Sex. Beh.*	x_add a service row							-		$0.00	$0.00			
	check standard/	x_add a service row							-		$0.00	$0.00			
	incentive county	x_add a service row							-		$0.00	$0.00			
140	Adult Nursing	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
145	Social./ Sexuality	x_add a service row							-		$0.00	$0.00			
	check standard/	x_add a service row							-		$0.00	$0.00			
	incentive county	x_add a service row							-		$0.00	$0.00			
149	Supplemental dental	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
152	Additional rows for any above	x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		x_add a service row							-		$0.00	$0.00			
		*Preliminary Risk Screen and Consult for Inappropriate Sexual Behavior									***Other Services Total:***		**$0.00**		

Section Five: Signature, Total Cost and Prior Authorization Section

The final section of the Budget Worksheet (illustrated on page 21) 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 Third Party Assessor to complete, including Prior Authorization ID, date of submission, completion, OR reviewer initials, and Prior Authorization Waiver type code (from page one of the budget sheet).

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Developmental Disabilities Waiver
Budget Worksheet Instructions
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Signature indicates agreement to the provision of the services, service units, and effective dates	Total Cost $0.00
Individual:	Date:
Case Manager / Agency:	Date:
Guardian / Representative	Date:

Third Party Assessor Assigns Prior Authorization ID for Omnicaid Tracking

TPA Reviews		For Submittal Date	Review Completion Date	Reviewer (initials)
First submittal				
Revisions submitted	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
	9			
	10			
	11			

Once approved, re-enter the PA waiver type code in the TPA-locked cell below

(A1, B1, etc.)

This PA is part of the audit trail documentation to validate services and expenditures.

#REF!

Changes to the NM Grp (A-G) or LCA will require a new PA, since some services already authorized and used may become invalid or exceed budget limits.

However, an approved H after the PA started can be a revision without changing the Grp A-G.

If an approved H status ends before this PA expires (1/0/00): A new PA is needed since some services already authorized and used may become invalid or exceed budget limits when the H status is removed.

Section Six: Case Manager Instructions for submissions of budgets to the Outside Review (OR) Continual Outside Review and Evaluation (CORE) team.

1. Case Managers develops the budget worksheet with the individual receiving services, their 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 via secure communications to the IDT and providers for review.
3. If a member of the IDT proposes a data entry change, case managers should make any agreed upon corrections prior to submission to the TPA and/or OR.
4. 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 individual 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.
5. If the individual changes to another Case Manager and/or agency, Case Managers and Case Management Agency Directors can make necessary contact information changes to the CORE data managers by submitting the new Case Manager contact information to the CORE on their Case Management Agency letterhead.
6. Case Managers MUST email the submission and all supporting documentation to the CORE at HSC-CORE@salud.unm.edu for review. Each Waiver budget Worksheet (BWS) that is emailed to the CORE must use the same naming convention.
    a. The SUBJECT Line of the email should say XX DDW ISP. XX represents the initials of the individual's first name and last name.
    b. Each document must be named using:

    XX DDW ISP ANNUAL 2015-2016
    XX DDW ANNUAL BUDGET
    XX DDW ISP REV. NUMBER: _____
    XX DDW REV. (number) RFI RESPONSE
    XX DDW BEHAVIORAL
    XX DDW MEDICAL
    XX DDW ISP ANNUAL 2015 2016 RFI RESPONSE
    XX DDW EMPLOYMENT XX DDW RESIDENTIAL
    Note: XX refers to the DD Waiver recipient's initials
7. For transitions for children to adult age categories on the DD Waiver,
    The Case manager will submit one of two ways:
        i. The CM will submit directly to Qualis Health, 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.
        ii. The CM 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 CM 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 worksheets to Qualis Health via JIVA.
8. The CORE has 10 business days to complete the submission review. For annual ISP budgets, Case Managers are required to submit budget worksheets and supporting clinical documentations at least 60 days prior to the expiration date of the ISP year.

9. If a case manager identifies an error on a submission shortly after it was submitted, the OR may be able to correct the error depending on where the review is in the process. 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.

Revisions

1. **Timing of revision submissions:** For revisions to an approved budget during the ISP year, Case Managers are required to submit the approved budget worksheet with Prior Approval number and all supporting documents at least 30 days prior to the start of the new or changed service.
2. **Living Care Arrangement (LCA) Changes**: When the LCA changes, two budget worksheets are required. The first one closes out all service lines on the existing budget, pro-rating each service with units used through the end of the close-out budget span. The second BWS revision opens the new budget (under the new LCA) utilizing the remaining pro-rated units left. The second budget span should begin with the new budget start date and carry through the remainder of the ISP term. These two submissions should be numbered in consecutive order and will be processed at the same time by the OR and Qualis Health.
3. **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." All services lines on the budget must be closed out and the close out units should reflect all the units billed through the end of the date span of the DD Waiver budget.
4. **Required Fields**: All required fields related to the budget revision must be completed on the budget worksheet including the:
   - "Revisions after first submittal date", which means the DATE of the REVISION SUBMISSION,
   - "Date revised if after original", which means the DATE of the REVISION SUBMISSION and
   - "Svc-provider dates if other than… from and to", which means the DATE SPAN of the REVISION(S).

   For revisions that are increasing units for a service that already was approved, use the ISP date span and not a new revision date span.
5. **Prior Authorization number, CORE clinical review signature and Order of Submission**: Budget revisions must be completed on budget worksheets that have been approved by the OR and submitted in the next chronological order as indicated in the signature block at the bottom of the worksheet. All revisions must be submitted on the last approved budget worksheet that has the prior authorization number (PA#) on it, except with submissions for changes in LCA or transfers to/from Mi Via.
6. **Special circumstances:** In extenuating circumstances, Case Managers may work with their Regional Office Case Management Coordinators to submit budget worksheets to the CORE outside of the normal submission windows outlined above. Case Managers can submit revisions for health and safety reasons with a 3 or 5-day turnaround for review at the CORE under the Imminent Review Process. Case Managers can also submit revisions for retroactive date approval of a service, or ask for a waiver of the 30-day submission window required by following the guidance of Regional Case Management Coordinators, which requires specific letters of justification.

Requests for Information (RFIs)

1. When the CORE requires additional information to process a request, the CORE will suspend the review and send a Request for Information (RFI) letter to the CM, DD Waiver recipient, and guardian if applicable.
2. The CM must respond to the RFI within 10 business days.

3. If the OR sends an RFI, 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 include the OR Cover Sheet with the RFI response, ensuring that they include the CORE reference number for the submission on the OR Cover Sheet.
5. Once the CORE receives the RFI response, the CORE has 10 business days to resume and complete the final review.
6. If the CORE does not get a response from the Case Manager within 10 business days, The CORE may issue a Technical Denial to the CM, individual and guardian, if applicable.

Prior Authorization Approvals

1. The CORE will enter the approved services into the Jiva portal, where Qualis Health will review and enter the services into the Medicaid Management Information System (MMIS), Omnicaid, and issue a prior authorization to the CM within 10 business days.
2. Case Managers are responsible for distributing approved prior authorizations to all providers.

Partial Approvals

1. When only some of the requested services have been clinically justified, and approved, a Partial Approval will be granted.
2. The CORE will email a Partial Approval letter and Notice of Right to Appeal to the CM, and mail a copy to the DD Waiver recipient and guardian (if applicable.).

Denial Letter

1. When all services have not been clinically justified after a case manager responds to an RFI, the CORE may issue a Denial letter.
2. The CORE will email a copy of the denial letter and a Notice of Right to Appeal to the case manager and mail a copy 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.

Partial Approval/Technical Denial Letter

1. 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 and no services were clinically approved, the CORE will send a Partial Approval/Technical Denial Letter.
2. The CORE will email a copy of the Partial Approval/Technical Denial Letter and a Notice of Right to Appeal to the case manager and mail a copy to the DD Waiver recipient and guardian (if applicable).
3. The Partial Approval/Technical Denial letter will list services (if any) that could be approved, and will list the services that were not approved.
4. Case managers are required to notify the IDT and appropriate providers of a Technical Denial.

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 DDSD. The agency conference is an opportunity to resolve the adverse decision by the OR. Agency conferences are usually attended by the case manager, the individual and guardian, if applicable, and the reviewer who made the adverse decision.
3. If the issue is resolved at the agency conference, DDSD 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 will then have the opportunity to submit any agreed upon documentation that came from the resolution of the AC, if appropriate. The OR will then proceed with the clinical review on the submission and follow current process to include Fair Hearing rights when a decision is made.
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.