SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: ELIGIBILTY FOR SERVICES
	Subject: Annual MPQH Reviews

Reference: ARM 37.40.1005 and ARM 37.40.1114

PURPOSE

Members who are receiving Community First Choice/Personal Assistance Services (CFC/PAS) are required to participate in a functional assessment by contract licensed nurses through Mountain Pacific Quality Health (MPQH) on an annual basis. This annual review ensures the member continues to have a medical/functional need to receive CFC/PAS services. The annual MPQH review also provides a current authorization for CFC/PAS services on the Service Profile (SLTC-155).

PROCESS

1. Every month MPQH produces a list of members whose annual review is coming up in the following month.

   a. MPQH faxes the list to every provider agency for review and verification.

2. Provider agency reviews the list to verify that the member is receiving CFC/PAS services from the agency and to confirm that the member's demographic information is current.

   a. Provider agency makes appropriate corrections to the list and faxes it back to MPQH. The list must be reviewed and faxed back to MPQH within 10 working days of receiving the list. If the list is current and accurate it should be faxed back with a note stating everything is current.

   b. If the agency believes that MPQH should conduct an onsite annual with a member listed, the provider agency should note that information on the form.

   c. MPQH will contact the agency if they do not receive the report within 10 working days.

3. On the first of each month, the MPQH nurse coordinator receives a list of members that are due for their annual review.

4. MPQH nurse coordinators will contact Members/Personal Representatives (PR) by telephone. The telephone contact will be utilized to determine if there is a need for an onsite review. MPQH nurse coordinators will review the Overview and Service Profile with the member/PR to determine whether the case needs onsite work. Situations that may warrant an onsite include:

    a. Change in environment that could affect the delivery of care;

    b. Significant change in condition or functional abilities;

    c. Communication deficit that does not allow for telephone review;

    d. Increased use of equipment or specialized modifications to the home; or

    e. Agency, member/PR, or Department requests an onsite review.

5. MPQH nurse coordinator completes the onsite review in the month the annual is due. If an onsite is not warranted, the annual review will be processed by the nurse coordinator via a telephone screen.

6. MPQH central office inputs information into database and faxes member Overview and Service Profile to the member's CFC/PAS agency no later than the last working day of the month in which the annual is due.

7. MPQH faxes the member Overview and Service Profile to the provider agency and Plan Facilitator.

8. The provider agency must ensure that they have a current Service Profile from MPQH in order to continue providing CFC/PAS. If they do not receive an updated annual profile within 10 working days after the end of the month the MPQH annual was due, the provider agency should contact MPQH.

    a. If the provider agency has documentation that they contacted MPQH about a late annual, the provider agency may continue to provide services until the MPQH annual occurs. The provider agency should implement a temporary authorization until MPQH completes the annual. This should occur within the next 28 days.

9. If the annual results in a decrease in service authorization, MPQH sends a notice to the member, along with the provider agency and Plan Facilitator.

10. Provider agency determines whether it is necessary to make a follow up home visit to adjust the Service Plan based on the annual MPQH Service Profile. The provider agency may complete an amendment to the Service Plan in person or over the phone.

    a. If the member has experienced a decrease in hours, the provider agency must adjust the member's Service Plan Schedule to accommodate the reduction in hours within 10 working days of receiving the annual MPQH Service Profile.

    b. If the member experiences an increase in hours, the provider agency must adjust the member's schedule per the member's wishes and within the flexibility parameter guidelines. If the member does not want to utilize the time that was authorized, the provider agency must detail the reason on the Service Plan form and fax the amendment to MPQH.

11. If the provider agency and member believe that a medically necessary task was omitted or that there is a general inconsistency between the MPQH Service Profile and the member's need for service, the provider agency may notify MPQH via the Service Plan to request a change in authorization.

12. The MPQH annual does not have to correspond to the member's Person Centered Plan annual or the 180-day agency re-evaluation criteria.

INCOMPLETE ANNUALS

1. The MPQH nurse coordinator will contact the member/PR by telephone to schedule the annual. If the nurse coordinator is unable to reach the member on the first attempt, the nurse coordinator will attempt to contact the member at least two additional times. The nurse coordinator will leave a message on the answering machine, when available, to have the member/PR return the call so they can complete the required annual.

2. If the MPQH nurse coordinator is unable to reach the member and complete the annual authorization, the nurse coordinator will notify the provider agency via a faxed note on the first page of the MPQH Overview (SLTC-154).

    a. The note will state that the MPQH nurse coordinator was unable to complete the annual review and services will be terminated unless the member/PR contacts the MPQH nurse coordinator to coordinate the review.

3. If the member/PR fails to contact the MPQH nurse coordinator within the month the annual is due and the provider agency does not receive the MPQH annual Service Profile authorization, the provider agency may implement a temporary authorization to extend the expired Service Profile for up to 28 days.

    a. In addition to issuing the temporary service authorization, the provider agency must follow-up with the member/PR to notify them that CFC/PAS services will be terminated after 28 days unless they contact the MPQH nurse coordinator and complete the annual review. The provider agency should document this in the member's case notes.

    b. If MPQH cannot complete the annual review during the 28-day extension period the provider agency must discharge the member from CFC/PAS.