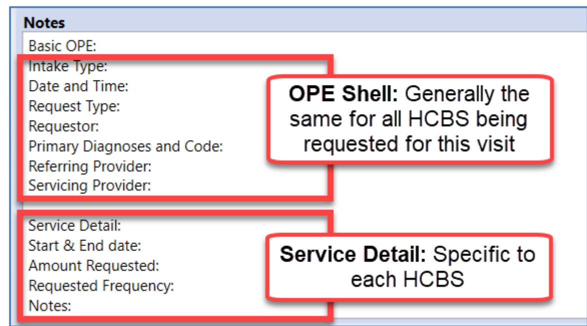
Outpatient Event Service Detail Templates

SCO Care Management

TUFTS Health Plan



The first section of every OPE Template contains the same information, and many lines can be copied and pasted if you are requesting a number of HCBS for your member.

You will need to confirm that each service requested has the appropriate **Servicing Provider** and **Primary Diagnosis/Code** (i.e. Nursing Services may be ordered appropriately for Diabetes, but the member may need Transportation due to their Unsteady Gait.)

Instructions for completing the **OPE Shell** are in a different Job Aid. These instructions are specific to the **Service Detail** sections of each OPE.

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TUFTS Health Plan

Adult Day Health – Shell covers both Adult Day Health and Transportation; **Blue text to be populated by RNCM**

Annual Referral Form required – SCO Admin Team will send the first year, RNCM responsible for preparing annual forms and placing in "Ready to Send" status.

Select ADH OPE:

[OPE Shell]
Servicing Provider: **ASAP (if contracted with them) or ADH Facility**

Service Detail ADH (HPP/basic/complex): **Select one (see ADH Levels):**

- **Basic**
- **Complex**

Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **# of days**
Requested Frequency: per week
Notes: **RN to note ADL Assistance, Skilled Services and/or Skilled Nursing needs (see ADH Levels)**

Service Detail: Transportation Day Care-one way
Start & End date: **Populate dates (up to 1 year)**
Amount Requested (2 one way units per day): **Populate with # of one-way trips per day (1 unit = 1 one-way trip; If member attends 5 days/week then transportation should be 10 units/week)**
Requested Frequency: per week
Notes: **Populate as needed with any special transportation needs**

ADH Referral:
ADH Name: **Populate with ADH Provider**
Caregiver name and phone: **Populate with primary caregiver's name & phone number**
ADH Provided via ASAP (y/n): **Select Yes/No**
ADH Level (HPP, Basic, Complex): **Select one (see ADH Levels):**

- **Basic**
- **Complex**

Days per week: **# of days**
Transportation (y/n): **Select Yes/No**

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Adult Foster Care; Blue text to be populated by RNCM

Annual Referral Form required – SCO Admin Team will send the first year, RNCM responsible for preparing annual forms and placing in "Ready to Send" status.

Select AFC OPE:

[OPE Shell]
Servicing Provider: **AFC Agency**

Service Detail AFC (level): **Select either Level 1 or Level 2**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: 1 PMPD
Requested Frequency: per month
Notes: **RN to note ADL Assistance and/or Behavior Management needs (see AFC Levels)**

AFC Referral:

AFC Name: **AFC Agency**
Caregiver name and phone: **Populate with primary caregiver's name & phone number**
Surrogate name and phone: **Populate with surrogate's name & phone number (delete if no Surrogate)**

Group Adult Foster Care; Blue text to be populated by RNCM

Annual Referral Form required – SCO Admin Team will send the first year, RNCM responsible for preparing annual forms and placing in "Ready to Send" status.

Select GAFC OPE:

[OPE Shell]
Servicing Provider: **GAFC Provider**

Service Detail: Group Adult Foster Care
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: 1 PMPD
Requested Frequency: per month
Notes: **Include primary caregiver's name & phone number (if applicable)**

TUFTS Health Plan

Basic OPE: General Outpatient Event Notification Template – to be used for most services through the ASAP – Homemaking and PC (these two must be separate), Home Health Aide (HHA), Companion, Heavy Chore, Home Delivered Meals (HDM), Laundry; **Blue text to be populated by CM**

For all services below, select Basic OPE:

[OPE Shell]
Servicing Provider: **ASAP (change if service will be provided by another agency)**

Chores/Heavy Chores

Service Detail: **Chores/Heavy Chores**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **# of units** *(Remember: 1 unit = 15 minutes; 4 units = 1 hour)*
Requested Frequency: **once**
Notes: **Populate with details of services requiring Chores/Heavy Chores assistance**

Companion

Service Detail: **Companion**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **# of units** *(Remember: 1 unit = 15 minutes; 4 units = 1 hour)*
Requested Frequency: **per week**
Notes: **Populate with details of services requiring Companion**

Grocery Shopping

Service Detail: **Other: Grocery Shopping and Delivery**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **# of units** *(Remember: 1 unit = 1 shopping trip)*
Requested Frequency: **per week**
Notes: **Populate with any special instructions**

Home Delivered Meals

If Servicing Provider is **Mom's Meals**, ensure Referral Form is attached to Clinical Note.

Service Detail: **Home Delivered Meals**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **# of units** *(Remember: 1 unit = 1 meal)*
Requested Frequency: **per week**
Notes: **Populate with details of any special needs (ex. lunches, low salt, vegetarian, etc.)**

Home Health Aide

Ensure *PC Care Plan for ASAP* is renamed *HHA Care Plan for ASAP* and attached to Clinical Note

Will need to copy the Service Detail section for HHA Agency's Nursing Services to complete their annual POC visit

Service Detail: **Home Health Aide**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **# of units** *(Remember: 1 unit = 15 minutes; 4 units = 1 hour)*
Requested Frequency: **per week**
Notes: **Populate with details of services requiring HHA**

Service Detail: **Nursing Services**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **1 visit**
Requested Frequency: **annually**
Notes: **Annual Skilled Nursing Visit for HHA**

Homemaker

Service Detail: **Homemaker**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **# of units** *(Remember: 1 unit = 15 minutes; 4 units = 1 hour)*
Requested Frequency: **per week**
Notes: **Populate with details of services requiring Homemaker**

Laundry

Service Detail: **Other: Laundry**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **# of units** *(Remember: 1 unit = 10 pound bag)*
Requested Frequency: **per week**
Notes: **Populate with any special instructions**

Medication Dispenser

Will need to copy the Service Detail section for both Medication Dispensing System and Skilled Nurse to fill system

Service Detail: **Medication Dispensing System**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **1 unit**
Requested Frequency: **per month**
Notes: **Populate with any special information**

Service Detail: **Nursing Services**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **1 unit**
Requested Frequency: **per month**
Notes: **To prefill medication dispensing system** *(Note: Make sure Nursing Services are also provided by ASAP. If not, there will need to be a separate OPE for Nursing Services.)*

Personal Care

Ensure *PC Care Plan for ASAP* is attached to Clinical Note

Service Detail: **Personal Care**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **# of units** *(Remember: 1 unit = 15 minutes; 4 units = 1 hour)*
Requested Frequency: **per week**
Notes: **Populate with details of services requiring PC**

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Personal Care Attendant; Blue text to be populated by RNCM

Annual Referral Form required – SCO Admin Team will send the first year, RNCM responsible for preparing annual forms and placing in "Ready to Send" status.

First Select FI OPE:

[OPE Shell]
Servicing Provider: **FI Agency**

Service Detail: **Personal Care Attendant**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested/Day Time Hours: **Populate # of day time hours**
Requested Frequency: **per week**
Procedure Code: **T1019**
Notes: **Populate with brief details of services requiring PCA**

***** Delete this section if member will not have night hours *****

Service Detail: **Personal Care Attendant**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested/Night Time Hours: **Populate # of night time hours**
Requested Frequency: **per week**
Procedure Code: **T1019**
Notes: **Populate with brief details of services requiring PCA**

Service Detail: **PCA Holiday**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **Populate # of holiday hours** *(see chart or calculate by dividing the total number of weekly hours by 7, then rounding up to the nearest quarter hour)*
Requested Frequency: **Other: per holiday**
Procedure Code: **T1019**
Notes:

Hours per Week	Holiday Hours	Hours per Week	Holiday Hours
1	0.25	22	3.25
2-3	0.5	23-24	3.5
4-5	0.75	25-26	3.75
6-7	1	27-28	4
8	1.25	29	4.25
9-10	1.5	31-31	4.5
11-12	1.75	32-33	4.75
13-14	2	34-35	5
15	2.25	36	5.25
16-17	2.5	37-38	5.5
18-19	2.75	39-40	5.75
20-21	3	41-42	6

Also Select PCM OPE:

[OPE Shell]
Servicing Provider: **PCM Agency**

Service Detail: **PCA Skills Training**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **1 unit**
Requested Frequency: **per month**
Procedure Code: **T2022**
Other Notes:

Service Detail: **PCA Admin Fee**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **31 units**
Requested Frequency: **per month**
Procedure Code: **T1020**
Other Notes: **PCA Daily Admin Fee 31 units/month**

***** Include this section only for members new to PCA *****

Service Detail: **PCA Intake and Orientation**
Start & End date (3 months): **Populate dates (3 months only)**
Amount Requested: **1 unit**
Requested Frequency: **per month**
Procedure Code: **T1023**
Other Notes: **Approved PCA intake and orientation, 1 unit/month for 3 months**

PCM Referral Form:
PCM Name: **Populate with PCM Agency Name**
FI Name: **Populate with FI Agency Name**
Can the member manage the PCA program independently?: **Select Yes/No**
If no:
Surrogate name and phone: **Populate with surrogate's name & phone number (delete if no surrogate)**
Caregiver name and phone: **Populate with primary caregiver's name & phone number**
Day Time hours: **# of day time hours/week**
Night Time hours: **# of night time hours/week**
Holiday hours: **# of holiday hours** *(see FI OPE template for calculation)*

TUFTS Health Plan

Personal Emergency Response; **Blue text to be populated by CM**

Select PERS OPE:

[OPE Shell]
Servicing Provider: **ASAP or other PERS provider**

Service Detail: **Personal Emergency Response System-Monthly**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **1 PMPM**
Requested Frequency: **Monthly**
Notes: **Document if Cellular, Wifi, Fall Detection, Wandering, etc.**

***** Include this section only for members new to PERS *****

Service Detail: **Personal Emergency Response System-Install**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **1 unit**
Requested Frequency: **once**
Notes: **Populate with any special instructions**

Transportation; **Blue text to be populated by CM**

SCO members are also eligible for one non-medical round-trip per month through Logisticare. *(Must be within 20 miles; cannot drive to airport or casinos.)*

Select Transportation OPE:

[OPE Shell]
Servicing Provider: **Logisticare** *(change if provider is not Logisticare)*

Service Detail: **Other Non-emergency transportation**
Start & End date: **Populate dates (up to 1 year)**
Amount Requested: **4 units** *(Note that 1 unit = 1 one-way trip; 2 units = 1 round trip)*
Requested Frequency: **per week**
Notes: **Approved two stops per each round trip as needed (during medical appts) to the lab and the pharmacy.**