CHAPTER VI
QUALITY MANAGEMENT REVIEW AND UTILIZATION REVIEW

CHAPTER VI
TABLE OF CONTENTS

Contents

Note: Should manual user find hyperlinks in this chapter do not work, please copy the hyperlink to clipboard and paste into browser.

INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456, and may be conducted by DMAS or its designated agent. The Department of Medical Assistance Services (DMAS) conducts periodic quality management reviews (QMRs) on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that Participation Agreement, contracts, state and federal regulations, Medicaid Memos and Provider Manual requirements for services rendered are met in order to receive payment from DMAS and its contractors. Under the Participation Agreement/contract with DMAS, Magellan of Virginia and the Medicaid Managed Care Organizations (MCOs) the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives or its designated contractor(s), the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control procedures conducted by DMAS. The MCOs conduct audits for services provided to Members enrolled in Managed Care. Providers shall contact the specific MCO for information about the utilization review and control procedures conducted by the MCO.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

COMPLIANCE REVIEWS

DMAS or its designated contractor(s) routinely conduct compliance reviews to ensure that the services provided to Medicaid individuals are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455.

Providers and individuals are identified for review by system-generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group.

To ensure a thorough and fair review, trained professionals review all cases using available resources, including appropriate consultants, and perform on-site or desk reviews.

Overpayments will be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by DMAS, the Behavioral Health Services Administrator (BHSA) or the MCOs if they are found to have billed these entities contrary to law or manual requirements, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor-quality services or of any of the above problems, DMAS, the BHSA or the MCOs may restrict or terminate the provider's participation in the program.

DMAS contracts with Health Management Systems, Inc. (HMS) to perform audits of FFS Mental Health Services in-state and out-of-state providers that participate in the Virginia Medicaid program. DMAS will also continue to audit mental health services as well. Providers that have been audited by HMS and have questions directly pertaining to their audit may contact HMS at: VABH@HMS.com

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the individual directly or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading, understanding, and adhering to applicable state and federal regulations, Medicaid Memos, their provider agreement with DMAS or its contractor, and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature or the signature of his/her authorized agent on each invoice that all information provided to DMAS and its contractors is true, accurate, and complete. If provider attests to having all required licensed as required they must be able to furnish such documentation. Although claims may be prepared and submitted by an employee or contracted business partner, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Department of Medical Assistance Services
Division of Program Integrity
Supervisor, Provider Review Unit
600 East Broad Street ,
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Office of the Attorney General
Director, Medicaid Fraud Control Unit
202 North Ninth Street
Richmond, Virginia 23219

Member Fraud

Allegations about fraud or abuse by Medicaid enrolled individuals are investigated by the Recipient Audit Unit of the DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia State Plan for Medical Assistance, DMAS must sanction

an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction. The sanction period may only be revoked or shortened by court order.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (LDSS) or to the DMAS Recipient Audit Unit via the RAU Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the RAU email address: recipientfraud@dmas.virginia.gov or forwarded to:

Department of Medical Assistance Services
Division of Program Integrity
Recipient Audit Unit
600 East Broad Street
Richmond, Virginia 23219

UTILIZATION REVIEW-GENERAL REQUIREMENTS

Utilization reviews of enrolled providers are conducted by DMAS, the designated contractor or the MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

Utilization reviews are comprised of desk audits, on-site record review, and may include observation of service delivery and review of all provider policies and procedures and human resource files. Dependent upon the setting, the utilization review may also include a tour of the program. Staff will visit on-site or contact the provider to request records. Utilization Review may also include face-to-face or telephone interviews with the individual, family, or significant other(s), or all. In order to conduct an on-site review, providers may also be asked to bring program and billing records to a central location within their organization. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

DMAS and the MCOs shall recover expenditures made for covered services when providers' documentation does not conform to standards specified in all applicable regulations. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider’s care. Such documentation shall

fully disclose the extent of services provided in order to support provider's claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered or within one business day from the time the services were rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

The review will include, but is not limited to, the examination of the following areas / items:

- If a provider lacks a full or conditional license or a provider enrollment agreement does not list each of the services provided and the locations where the provider is offering services, then during a utilization review the provider will be subject to retraction for all unlisted service and/or locations.

- Providers with provisional licenses issued by DBHDS shall not be reimbursed as Medicaid providers beginning 60 days from the issuance of the provisional license, as outlined in 12VAC30-122-230.

- An assessment of whether the provider is following The U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009).

- An assessment of whether the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.).

- The individual meets diagnostic and functional (level of care) criteria. In addition, documentation supports a need for the services delivered.

- A copy of the provider's license/certification, staff licenses, and other required staff qualifications to ensure that the services were provided by appropriately qualified individuals and licensed facilities.

- Verification that the delivered services as documented are consistent with the documentation in the individual's record, invoices submitted, and specified service limitations.

- All documentation is specific to the individual and their unique treatment needs. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient

services and may not be adequate recordkeeping mechanisms for these services.

- Determines whether all required aspects of service delivery (as set forth in the service definitions) are being provided, and also determines whether there is any inappropriate overlap or duplication of services.

- Determines whether all required activities (as set forth in the appropriate sections of this manual and related regulations) have been performed.

- No inappropriate items have been billed.

- The amount billed matches the documented amount of time provided to the individual.

Services must meet the requirements set forth in the Virginia Administrative Code (12 VAC 30) and in the Virginia State Plan for Medical Assistance Services and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

Upon completion of on-site activities for a routine utilization review, the MCO, DMAS, or its designated contractor(s) may be available to meet with provider staff for an Exit Conference. The purpose of the Exit Conference is to provide a general overview of the utilization review procedures and expected timetables.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be noted. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. The provider’s response and any additional information provided will be reviewed. At the conclusion of the review, DMAS or its designated contractor(s) will contact the provider to conduct an Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the provider.

If a billing adjustment is needed, it will be specified in the final audit findings report.

If the provider disagrees with the final audit findings report, they may appeal the findings. Refer to Chapter II for information on the provider appeal process.

MEDICAL RECORDS AND RETENTION

The provider must recognize the confidentiality of recipient medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The recipient's written consent is required for the release of information not authorized by law. Current recipient medical records and those of discharged recipients must be completed promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical/medical record.

Records of Medicaid covered services must be retained for not less than six years after the date of service or discharge. Records of minors shall be kept for a period of at least six years after such minor has reached 18 years of age. Records must be indexed at least according to the name of the recipient to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). Refer to 42 CFR 482.24 for additional requirements.

The provider must maintain medical records on all recipients in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. All medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. Documentation should be clear and legible.

GENERAL REQUIREMENTS FOR QUALITY MANAGEMENT REVIEW (QMR AND COMPLIANCE REVIEWS)

By federal law, DMAS is the single state authority responsible for the supervision of the administration of home and community-based services (HCBS) waivers in the Commonwealth of Virginia and will perform routine QMRs of waiver services and providers.

DMAS or its designated agent will conduct ongoing monitoring of compliance of a provider with DMAS participation standards and policies. A QMR includes a review of the provision of services to ensure that services are being provided in accordance with DMAS regulations, policies, and procedures. A provider's noncompliance may result in a request for a corrective action plan, provision of technical assistance, or referral to the Division of Program Integrity for determination of retractions.

DMAS or its designated agent will conduct QMRs of waiver services provided by all providers to ensure the health, safety, and welfare of the individual and the individual's

satisfaction with services. The reviews will focus on the Centers for Medicare and Medicaid's (CMS) assurances of individual service plans, including individual preferences, services being delivered in accordance with the Plan for Supports and the identification and inclusion of risks. In order to monitor the health, safety and welfare of individuals, the QMR also includes the review of documents and reports related to incident reporting (i.e., incident reports, APS reports, CPS reports, and Department of Behavioral Health and Developmental Services (DBHDS) incident reporting system). In addition to assessing the individual's ongoing need for Medicaid-funded long-term care, another purpose of the reviews is to ensure an individual's satisfaction with services and providers, and that individual's choice of services and person-centered planning are being carried out. This may involve interviews with the individual and/or the family/caregiver, as appropriate.

During QMR and compliance reviews, staff will monitor the provider's compliance with overall provider participation requirements. Particular attention is given to staffing qualifications as described in Chapter II of this manual. QMR staff will request health professionals' licenses, work references or the documentation of attempts to obtain them, documentation of any required training and/or certification, documentation of competency verification, documentation of criminal background checks, and any other staffing requirements as identified in DMAS and DBHDS regulations and policies. The provider is responsible for ensuring that all staff of the provider agency meets the minimum requirements and qualifications at the start of the employment. For consumer-directed services, the employer of record (EOR) is responsible to ensure that all stated requirements are met in the hiring and employment of attendants providing consumer-directed services.

During reviews, DMAS staff will identify any areas of concern, technical assistance needs, the plans for addressing those needs, and any recommendations that staff may have. DMAS staff may also require additional documentation to verify that the provider agency is in compliance with DMAS provider agreements and policies. For compliance reviews, this includes requirements for ownership of provider agencies. It is the responsibility of the provider to know and fulfill all applicable state and federal requirements relating to the services that the provider has a participation agreement to provide.

Providers are continually assessed to ensure they conform to Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to individuals in need of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care and who are receiving services through the Developmental Disabilities (DD) Waivers. Information used to make this assessment includes any DMAS desk or on-site reviews of the documentation submitted by the provider, the provider's files, interviews with staff and individuals, and visits to homes or program locations. DMAS bases its assessment of the provider on a comprehensive evaluation of the provider's overall performance in relation to the following:

- Individuals supported by the provider meet the program's eligibility criteria. If DMAS or its designated agent determines, during the QMR or at any other time, that the individual receiving waiver services no longer meets eligibility standards or criteria for waiver services as set forth in DMAS regulations, DMAS will review and request that the individual be removed from the waiver and that alternative services be discussed with the individual.

- Services must be rendered under the appropriate license for the service. Should a provider have a change in license type or allow a license to expire, the provider must communicate this to provider enrollment.

- Services rendered must meet the individual's identified needs, be in accordance with an active Plan for Supports, be provided under the appropriate license for the service, and be delivered in compliance with regulations and policies. The provider is responsible for continuously assessing the individual's needs through observation and communication between the provider, the individual, and other provider staff. The Plan for Supports must be revised in accordance with any substantial change in the individual's status, and the individual's record must contain documentation of any such change. This also includes the provider's responsibility to identify and inform the Support Coordinator of the needed change or to obtain any other services that the individual requires to remain in the community (e.g., durable medical equipment and supplies, etc.).

- Provider documentation must support all services billed to DMAS.

- Document and maintain written semi-annual supervision notes for each Direct Support Professional (DSP) that are signed by the supervisor. Additionally,

    - For DBHDS-licensed entities, the provider must provide ongoing supervision of staff consistent with the requirements of 12VAC35-105.

    - For providers who are licensed by VDH or have accreditation from a CMS-recognized organization to be a personal care or respite care provider, they must provide ongoing supervision of staff consistent with regulatory requirements.

- Prepare and maintain unique person-centered progress notes and written documentation in each individual's record about the individual's responses to services and rendered supports, significant events, and of specific circumstances that prevented provision of the scheduled service, should that occur. Such documentation should be written, signed, and dated on the day the described supports were provided. However, documentation that occurs after the date services were provided must be dated for the date the entry is recorded

and the date of actual supports delivery is to be noted in the body of the note. In instances when the individual does not communicate through words, the provider must note his observations about the individual's condition and observable responses, if any, at the time of service delivery.

- Examples of unacceptable person-centered progress note written documentation include:

    - Standardized or formulaic notes;
    - Notes copied from previous service dates and simply re-dated;
    - Notes that are not signed and dated by staff who deliver the service, with the date services were rendered; and
    - Notes that do not document the individual's unique opinions or observed responses to supports;

- Maintain an attendance log or similar document that indicates the date services were rendered, type of services rendered, and number of hours or units provided (including specific timeframe for services with a unit of service shorter than one day) for each service type except for one-time services such as assistive technology, environmental modifications, transition services, individual and family caregiver training, electronic home-based supports, services facilitation, and personal emergency response system support, where initial documentation to support claims will suffice.

- Services must be of a quality that meets the health and safety needs and the rights of the individual. Quality of supports is best assured through an emphasis on communication and respect between the individual and provider staff, and between the individual and the provider agency representative who is responsible for the oversight of the plan. Some of the elements included in quality of supports are:

    - Consistency of supports;
    - Continuity of supports;
    - Adherence to the plan for supports; and
    - Consideration for the health, safety, and welfare needs of the individual.

- Providers opting to use an electronic signature for documentation purposes must comply with the following:

    - The electronic signature can be clearly identified.
    - The electronic signature identifies the individual signing the document and must be accompanied by a digitally encoded time

and date stamp. This is to assist in determining non-repudiation of the signature, which means strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.
    - The electronic signature cannot be altered once it is attached to a document.
    - The date of the signature cannot be altered once attached to the signature.
    - The document cannot be altered once signed.
    - Documents cannot be signed electronically by anyone other than the individual required to sign the document.Legal signatures, including electronic signatures, must protect individual privacy and conform with all applicable federal and state laws, statutes, and regulations. Documents containing electronic signatures can be printed out upon the request of QMR Analyst.
    - More information on electronic signatures can be found in chapter II of this manual.

- The provider will maintain a record for each individual. If more than one service is provided, the record will be divided by service. Forms that may be used are available on the DMAS website at **www.dmas.virginia.gov** or the DBHDS website at **http://www.dbhds.virginia.gov**

DMAS will review the provider's performance in all the outcome areas to determine the provider's ability to achieve high quality supports and conform to DMAS regulations and policies. DMAS is responsible for providing feedback to the provider regarding those areas that may need improvement. During QMR reviews, DMAS will review individual files and conduct site visits to assess the quality of supports and continued appropriateness of services. DMAS will evaluate the individual's status, satisfaction with the service, and appropriateness of the current Plan for Supports. If the Plan for Supports is found to be inadequate, DMAS will require a revision of the plan to meet the needs of the individual.

DMAS conducts QMRs and compliance reviews to assure that the services provided are appropriate and comply with the policies and procedures for the provision of services under the DD Waivers. For the general requirements, DMAS uses the following procedures:

- DMAS or its designated agent will conduct an on-site review and/or desk review of each service delivered by the provider periodically.

- The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of individuals served, types of services rendered, etc.

- QMRs and compliance reviews may be unannounced.

- Providers may be asked to bring program records to a central location.

- During an on-site QMR or compliance review, staff will review the individual's record in the provider's place of business/offices, paying specific attention to the Plan for Supports, supervisory notes, daily records, support logs or progress notes, screening documentation, and any other documentation that is necessary to determine if services were rendered appropriately. Staff may also meet or talk with at least one individual or primary caregiver to determine individual satisfaction with waiver services and the provider. The provider may be asked to assist in setting up this visit. In all cases, the primary caregiver is encouraged to participate in the review of the individual's supports during QMR reviews.

- During the review process, staff will offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures or may refer providers to DBHDS staff for more in-depth technical assistance or training. If questions arise regarding compliance issues, staff will provide information and assistance. Any uncorrected compliance issues may result in the termination of the provider participation agreement.

- Upon completion of on-site activities for a QMR, DMAS staff will meet with designated staff to conduct an exit conference. The purpose of the exit conference is for DMAS to provide a general overview of the QMR findings, preliminary actions required, and recommendations that may help the provider correct problems in documentation or billing practices.

- If the QMR or compliance review discovers systemic concerns or health and safety concerns during the review, the QMR entity or compliance reviewer will notify the provider that referrals to the appropriate entity, such as Provider Integrity, Office of Human Rights, Department of Licensing, etc., were made in addition to continuing to provide technical assistance related to the QMR and Corrective Action Plan (CAP.).

- Following the QMR review, a written report of the findings is sent to the provider.

- If a CAP is requested, the provider will have 30 days (unless otherwise indicated) from receipt of the QMR report to submit the plan to DMAS for approval

- If there are findings that are related to licensing procedures, a letter stating these findings may be submitted to other agencies, as appropriate (e.g., Department

of Health Professions or DBHDS).

- DMAS will follow up on any CAPs that are submitted to ensure corrective procedures within the plan are implemented by the provider.

- Providers with a history of noncompliance, as evidenced by QMR, HCBS or DBHDS Office of Licensing citations, may be required to participate in mandatory provider remediation. Mandatory provider remediation consists of training and technical assistance to be provided by DMAS and/or DBHDS. DMAS and DBHDS will provide a CAP to the provider. The provider must complete all items on their CAP. DMAS shall make the final compliance determination for any provider who is in the Mandatory Provider Remediation (MPR) process.
    - Key identified areas can include but are not limited to the following:
        - Missing or inadequate progress notes
        - Inadequate Plans for Support or Individual Support Plans
        - Missing required training
        - Inadequate or unclear support instructions

- See the Compliance Review Section of this manual for additional information regarding written findings from these types of reviews.

REVIEW OF INTELLECTUAL DISABILITY (ID) AND DEVELOPMENTAL DISABILITY (DD) TARGETED CASE MANAGEMENT AND DD WAIVERS SERVICES

In addition to the general QMR and compliance review requirements, DMAS also reviews for specific requirements for the provision of ID or DD Targeted Case Management and DD Waivers Services. These requirements are:

1) eligibility for services

2) that the services are based on comprehensive and ongoing assessment and person-centered planning

3) that services are delivered, reviewed, and modified as appropriate

4) that the provider is qualified

5) that the services are consistent with billing limitations.

Specific requirements for each area follow.

ELIGIBILITY FOR ID OR DD CASE MANAGEMENT SERVICES

- There is basis for initiating DD or ID Targeted Case Management services.
    - There must be documentation of diagnostic eligibility (DD without ID) diagnosis for DD Targeted Case Management services and ID diagnosis for ID Targeted Case Management per Code of Virginia § 37.2-100) in the record of an individual receiving DD or ID Targeted Case Management services.
    - There must be documentation that the individual requires and receives active case management services.
    - ID or DD Targeted Case Management services must not duplicate any other Medicaid service provided under the Virginia State Plan for Medical Assistance or under any waiver including the DD waivers.
- There is basis for initiating 90-day ID Targeted Case Management.
    - Referral information for an individual to receive 90-day ID Targeted Case Management services must be clearly documented and provide a basis for this service. This includes evidence in the case management record that:

        a) the individual had not previously received formal case management services
        b) the individual did not have diagnostic information necessary to determine eligibility

        c) there was reason to suspect the presence of ID, and

        d) there was an indication of a need for ongoing active case management services.

    - Documentation must indicate that the 90-day Plan for Supports began no earlier than the date of the initial face-to-face contact with the individual and ended when the assessment information (diagnosis and need for active case management) was completed, but no later than 90 days from the start date. Billing can occur for a maximum of three months. If prior to the end of the 90 calendar days, an individual is determined ineligible, appropriate notification of the right to appeal must be sent to the individual.

ELIGIBILITY FOR DD WAIVERS SERVICES

- The individual meets the diagnostic criteria for DD as described in Chapter IV and Virginia Administrative Code 12VAC30-122-70.

- The individual meets functional eligibility. For individuals receiving DD Waivers services, the ICF/IID level of functioning survey, the Virginia Individual Developmental Disability Eligibility Survey (VIDES infant, child, or adult) must be in the support coordination/case management (hereafter referred to as "support coordination") record, have been completed no more than six months prior to the start of waiver services, and document that the individual meets the dependency level in 2 or more for children and infants and 3 or more for adults. This must be reviewed and completed annually and reflect the current status of the individual.

- There is basis for initiating DD Waivers services.

    - The support coordination record for an individual receiving DD waiver services must indicate that the individual meets both diagnostic and functional eligibility as described above.

    - Documentation must be evident that the individual is receiving Targeted Case Management at the time DD waiver services are initiated and during any month in which DD waiver services are provided. A support coordination Plan for Supports must be available in the record.

    - For the DD waivers, documentation must indicate that the individual meets the priority one criteria (outlined in Chapter IV) at the time of enrollment.

- The individual continues to meet eligibility for services.

    - It must be clearly documented in the support coordination record that the individual's eligibility and need for continuation of any DD Waivers services is reviewed at least annually.

    - To confirm continued diagnostic eligibility for DD Waivers services, the support coordination record must contain evidence that the individual has a developmental disability. There should be documentation that an updated psychological or other evaluation appropriate for the developmental disability is completed whenever the individual's functioning has undergone significant change and is no longer reflective of the past psychological or other evaluation. The psychological or other evaluation must be completed by a licensed professional with documented training in conducting the evaluation.

    - The support coordination record of individuals receiving DD Waivers services must contain a VIDES that was administered on an annual basis by the Support

Coordinator. The individual must meet the indicated dependency level in two or more (for infants) or three or more (for children and adults) of the categories on the VIDES. The support coordinator/case manager will indicate on the VIDES what information from the medical record was used in scoring.

COMPREHENSIVE AND ONGOING ASSESSMENT AND PLANNING

- An Individual Support Plan (ISP) is completed and reviewed.
- The support coordination/ record must include an Individual Support Plan that organizes the services and supports that are provided to the individual. The five essential components of an ISP include:
    - Personal Profile (described below under assessment information)
    - Essential Information (described below under assessment information)
    - Shared planning to include the person's desired outcomes, who will support the individual in working to achieve the outcomes, and a risk assessment.
    - Any referral decisions, as well as an evaluation of how the plan achieves the desired outcomes, from the individual's and responsible partners' perspectives, is completed prior to final agreements.
    - a documentation of agreement signed (may be a signature page) by those participating in the development and implementation of the ISP
    - A separate Plan for Supports for each waiver service requested and received by the individual (including DD and ID Targeted Case Management), which outlines the activities planned to assist in meeting the individual's needs and in attaining the individual's desired outcomes, and
    - There must be evidence that the ISP is reviewed by the Support Coordinator and updated annually (every 12 months) and whenever changes or service modifications occur.
- There is comprehensive and current assessment information.

- There must be a Personal Profile in the support coordination record, completed by the team, no earlier than one year prior to start date of services and updated annually. The Personal Profile summarizes the individual's vision of a good life, his/her talents and contributions, and what is important to the person in the following life areas:

  -
  - Employment
  - Integrated Community Involvement
  - Community Living
  - Safety & Security
  - Healthy Living
  - Social & Spirituality
  - Citizenship & Advocacy

- Additionally, the Support Coordinator maintains the Essential Information, updated at least annually and as needed, which includes:

  -
  - Representation
  - Disability Determination
  - Medications
  - Physical and Health Conditions
  - Last Exam Dates
  - Allergies
  - Accessing services
  - Social, Developmental, Behavioral and Family History
  - Education
  - Employment,
  - Integrated Community Involvement
  - Future Plans
  - Review of Most Integrated Settings.

- There should be medical information in the support coordination record for any individual receiving DD Waivers services. Individuals receiving DD Waivers services must have a medical examination completed no earlier than 12 months prior to the start of waiver services. Documentation should indicate that additional evaluations occur whenever indicated. Medical examinations of

children should follow the schedule of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) administered by DMAS.

- The support coordination record for an individual receiving DD Waiver services should contain the Virginia SIS® or other developmentally appropriate assessment completed according to the following schedule:

    - At least every four years for those individuals who are 22 years of age and older;
    - At least every three years for those individuals who are 16 years of age through 21 years of age;
    - At least every two years for individuals five years through 15 years of age when the individual is using a tiered service. Another developmentally appropriate standardized living skills assessment approved by DBHDS, such as the Brigance Inventory, Vineland, or Choosing Outcomes and Accommodations for Children must be obtained at least every two years for those in this age grouping who are not using a tiered service; or
    - For children younger than five years of age, an alternative industry assessment instrument approved by DBHDS, such as the Early Learning Assessment Profile, must be completed by the appropriate professional at least every two years for service planning purposes;or
    - When the individual's support needs have been deemed to have changed significantly for a sustained period of at least six months

- The support coordination record must also contain a risk assessment, which is integrated in the ISP. The risk assessment is an assessment used to determine areas of high risk of danger to the individual or others based on the individual's serious medical or behavioral factors. The ISP must then contain the steps and supports needed to mitigate any identified risks.

- The support coordination record must also contain the Crisis Risk Assessment Tool, completed at intake and at least quarterly thereafter to capture information that may put an individual at risk for crisis or hospitalization and to foster proactive referrals to the REACH programs if such a risk is determined.

- The above assessment information must be provided to the services providers to be available to use to develop their Plans for Supports.

- The individual and others, as appropriate, are involved in the planning process.

    - Documentation must indicate that the individual (or legal guardian, when appropriate) provided consent to exchange information with other agencies. The

support coordination record of an individual must contain a signed copy of this form, completed prior to the initiation of the DD Waiver services.

- Documentation must indicate that the individual (or legal guardian, when appropriate) was given the choice between institutional care and DD Waivers services, as appropriate. The support coordination record must contain a signed copy of the form entitled "Documentation of Individual Choice between Institutional Care or Home- and Community-Based Services" (DMAS 459-C). This form is required at the initiation of any waiver services and should be maintained in the individual's support coordination record.

- Documentation must be in the support coordination record that the individual (or legal guardian, when appropriate) has been presented with all feasible alternatives of available agency and consumer-directed services for which he or she is eligible under the DD Waivers (this is done on the Virginia Informed Choice DMAS 460).

- It must be clear that the choice of providers was offered prior to the initiation of any waiver services, annually, whenever new services are requested, when there is a request for a change in providers, when the individual requests to move to a new location and/or is dissatisfied with the current provider, and when making a Regional Support Team referral for an individual with a DD Waiver. The individual's record must contain a signed copy of the form entitled, "Virginia Informed Choice" (DMAS-460/).

- Documentation must indicate that the individual (or legal guardian or family) was involved in the development of the ISP. The team should meet within 30 calendar days of the waiver enrollment date to discuss the individual's needs, existing supports, and agency-directed and consumer-directed service options for developing the ISP. At a minimum, the individual's (and family/caregiver, as appropriate) input and satisfaction with the plan should be documented by signature(s) on the ISP in addition to the Support Coordinator's signature. The individual must sign each provider's Plans for support.Support.

- Documentation must indicate that the individual (or legal guardian) was informed of any changes in services, provided the opportunity for input, and agreed to the changes before they were implemented. Documentation of this involvement should accompany any changes to the ISP.

- For any termination or decrease of ID or DD Targeted Case Management or DD Waivers services, the support coordination record must contain written notification to the individual of the pending action and the right to appeal. See the appeal section in Chapter II for specific requirements.

- The Support Coordinator receives and reviews each Plan for Supports.

    - Each Plan for Supports must be completed prior to the initiation of services and must designate supports based on current information, reflective of the individual's desires, input, and other assessment information and agreed to by the team.

    - Each Plan for Supports must clearly describe the activities of the individual and staff and be maintained in the provider's record for the individual. This Plan for Supports must be inclusive of the support instructions that are related to the measurable support activities detailed in the Plan for Supports, as appropriate for the individual and congruent with the type and amount of service units approved through the Waiver Management System (WaMS).

    - Each Plan for Supports must include activities and supports that are meaningful and address the individual's desired outcomes. Each Plan for Supports must satisfy the specific Medicaid criteria and service limitations for each service as described in Chapter IV.

    - The general schedule of supports must be consistent with the service units authorized for that service.

    - When a 60-day assessment period is utilized for any type of residential support, personal assistance (agency-directed), any type of day service, or supported employment services, there must be evidence that the individual is new to the program/provider and a preliminary Plan for Supports and general schedule of supports are included in the record. Documentation must confirm attendance and provide specific information as described in the Plan for Supports support activities. There must be an annual Plan for Supports, based upon the assessment information, developed prior to the last day of the assessment period.

SERVICES ARE DELIVERED, REVIEWED, AND MODIFIED AS NEEDED

- Services occur as planned or are adjusted to accommodate the individual's needs and requests.

    - There must be ongoing documentation in the record of each service provider regarding the services provided to the individual and available for review by the Support Coordinator, DBHDS, DMAS, and the individual or family or both, in accordance with applicable policies and regulations. Documentation can include case notes, various modes of measurable data collection, attendance records, notes regarding significant incidents, results of medical appointments/consults

and daily progress notes/support logs. Copied or redated progress or service notes are not acceptable.

- The TCM record must document a minimum of one support coordination face-to-face contact with the individual within each 90-calendar day period with a 10-calendar day grace period. There must be evidence that the Support Coordinator assessed the individual's satisfaction with services (through observation and interviews with the individual and significant others), determined any unmet needs, evaluated the individual's status, assessed that services were appropriately implemented, reviewed Home and Community-based settings requirements, and assisted with adjustments in the services and supports as appropriate. Missed face-to-face contacts with no documented reason, particularly patterns of missed contacts, may result in the entire quarter being disallowed for reimbursement.

- Each service provider's records (including support coordination) must contain documentation that corresponds to the Plan for Supports support activities and indicates that services have been provided according to the plan. While this data may take many forms, it should be appropriate to the individual's supports and demonstrate that his or her desired outcomes are being addressed.

- TCM and DDW DD Waiver services are reviewed **at least** quarterly, whether there has been a change in status or not.

  - There must be documentation in the *TCM* record that the Support Coordinator reviewed on a quarterly basis all services provided A 30-calendar day grace period to complete the person-centered (quarterly) review of the ISP will be permitted. However, the original person-centered review due dates remain unaffected by the date the review is completed.

  - There must be documentation in the *service provider* record that the provider reviewed on a quarterly basis all services provided. There must be evidence that the service provider's person-centered reviews for the waiver services are completed and sent to the Support Coordinator no more than 10 calendar days following the end of each quarter as determined by the effective start date of ISP. However, the original person-centered review due dates remain unaffected by the date the review is completed.

  - The person-centered review for each service, including support coordination, will be reviewed to determine if it addresses:

    a) The status of outcomes and essential supports

    b) the effectiveness of the services

c) any significant events

d) the individual's and, when appropriate, the family's/caregiver's satisfaction with the services and other input, and

e) changes in the desired outcomes, support activities, or support instructions when they are ineffective or upon the individual's request.

- A comprehensive review of each service occurs annually (every 12 months).
    - The support coordination record will be reviewed to determine if the annual review includes a combination of record review, observation of service delivery, and interviews with the individual and family to determine if the services provided are effective and match the individual's needs and desired outcomes.
    - All providers must be invited to the ISP meeting and participate in the development of the new ISP annually (no longer than 365 days – 366 days in a leap year – between ISP effective dates). There is no grace period.

PROVIDER QUALIFICATIONS

There must be documentation of the needed license, certification, vendor agreement, or approval.

- It is the responsibility of the service provider to maintain documentation, readily available for review, which verifies the provider's staff qualifications.
- Provider qualifications and expectations are outlined in Chapters II and IV of this manual as well as in the DDW regulations at 12 VAC 30-122.

PAYMENT SUSPENSION FOR PROVIDER WITH PROVISIONAL

Pursuant to 12VAC30-122-230, DMAS will implement a suspension on all payments for services associated with a DBHDS provisional license until such time as the provider obtains an acceptable license. Accepted licenses include conditional, annual, and triannual licenses.

12VAC30-122-230(c)(2): Providers with provisional licenses issued by DBHDS shall not be reimbursed as Medicaid providers beginning 60 days from the issuance of the

provisional license. Providers shall not request or receive authorizations or reauthorizations for services for new or currently supported individuals upon the issuance of the provisional license.

If a provider's payment is suspended by DMAS, the provider is entitled to appeal rights. A notice letter of the provider payment suspension will be sent to the provider prior to the start of the payment suspension. The notice letter will include appeal right information. Refer to Chapter II for information on the provider appeal process.

SERVICES DELIVERED ARE CONSISTENT WITH SERVICE LIMITS

- Services must be authorized or preauthorized as appropriate.
    - All DD waivers providers must have a current DMAS Participation Agreement that lists all services for which the provider is eligible to provide and bill.
    - DD waivers services require authorization by DBHDS for the provider to be eligible for reimbursement. Consumer-directed (CD) services facilitation does not require service authorization. The number of hours of CD services does require authorization.
    - Terminations of single waiver services are processed via WaMS.
    - Terminations of all waiver services must be reflected on a completed DMAS-225.

- There must be documentation that services were provided in accordance with the service plan and as billed.
    - Billing for ID or DD Targeted Case Management services must be supported by a minimum of one direct or individual-related contact, activity, or communication and must be documented each month relevant to the Individual Support Plan during any month for which a claim for ID or DD Targeted Case Management is submitted. Written work and travel time are excluded. Billing for 90-day ID Targeted Case Management may only occur for a maximum of three months.
    - Billing for group day services, community coaching, community engagement, and group supported employment services must be supported by attendance documentation that verifies individual participation in the service in accordance with the Plan for Supports. The billing should indicate a total number of hours that is equal to or greater than the number of hours billed each day in a month.

The documentation must include, at a minimum, the date services were rendered, the number of hours provided, the activities to support the type of service delivered.

- In instances where group day services staff are required to ride with the individual to and from group day service, the group day service staff time may be billed as group day service, provided that the billing for this time does not exceed 25% of the total time the individual spent in the group day service activity for that day. Documentation will be maintained to verify that billing for group day service staff coverage during transportation does not exceed 25% of the total time spent in the group day service for that day.

- Additionally, there must be documentation to support the one (1) staff to one (1) individual ratio required for community coaching, the one (1) staff to three (3) individuals ratio required for community engagement and the one(1) staff to seven (7) individuals ratio required for group day service. There must be documentation to support that no more than 10% of the total number of authorized hours per month is used for planning community activities for community engagement.

- Billing for individual supported employment services, and workplace assistance services must be supported by documentation of actual interventions or collateral contacts by the provider, not for the amount of time the individual is in the supported employment situation. A log or similar document which shows the date, hours, and type of service rendered, in accordance with the Plan for Supports must be maintained.

- Billing for residential support services:

    - In-home services are billed for actual service hours. Independent living supports is authorized for monthly/partial monthly units. Documentation must include dates, the amount of time, and services that were provided in accordance with the Plan for Supports. When unavoidable circumstances occur such that a provider is at an individual's home at the designated time, but cannot provide services for the entire period scheduled, billing is allowed for the entire number of hours scheduled that day, as long as some portion of the Plan for Supports is implemented. It is expected that this will occur rarely, and there will be detailed documentation of the date, original schedule, time services were actually provided, and specific circumstances which prevented provision of all of the scheduled services. If this occurs on a regular basis over a 90-day period, the Support Coordinator should determine the reasons, and a new Plan for Supports with fewer hours or a change in schedule must be developed.

    - Billing for shared living services should be supported by documentation related to the portion of rent, food, and utilities reasonably attributed to the person who

resides with the individual as well as the provision of services noted in agreement.

- Group home residential, supported living, and sponsored residential services are billed using a daily rate based on the supports level assignment for each individual. Documentation of support activities provided in accordance with the Plan for Supports will be maintained by the provider in a daily format and should demonstrate that the individual is regularly receiving services as scheduled and support the assigned supports level.

- Billing for therapeutic consultation, community-based crisis supports, crisis support services, center-based crisis supports, private duty nursing, skilled nursing, and agency-directed (AD) respite, agency-directed personal assistance, or agency-directed companion services must be supported by documentation of the types of supports, dates and the amount of time required for actual service delivery.

- Billing for consumer-directed (CD) services is supported by employee work shift entries that are submitted by the attendant and approved by the Employer of Record.

- For services that utilize Electronic Visit Verification (AD and CD personal assistance, respite, and companion), this includes the provider being able to present the appropriate DMAS-90 or electronic equivalent for the shifts being reviewed.

- Billing for environmental modifications and assistive technology must be supported by bills from contractors, rehabilitation engineers (if required), and equipment purchase receipts.

- Billing for personal emergency response systems (PERS) and Electronic Home-Based Supports (EHBS) must be supported by documentation regarding the installation of and training required to use the required device(s). Monthly billing for the ongoing monitoring services must be supported by documentation of the provision of this monitoring service occurred. In the case of PERS, this takes the form of at least monthly testing of the PERS device as well as documentation of each emergency signal which results in action being taken of behalf of the individual.

- Billing for transition services must be supported by item purchase receipts with a description of the item(s) included.

- Billing for Individual and Family Caregiver Training must be supported with documentation to verify the training took place, the individual or family/ caregiver participated in training and what information was taught during the training.

- It is not permissible to automatically bill each month at the maximum amount authorized. For all services, if the amount billed for a given service in the month audited does not correspond to documented hours/units of services delivered it may result in disallowance of payment during compliance reviews.

- All billing must be supported by the required documentation as outlined throughout this manual. As a result of reviews conducted by DMAS, areas of non-compliance will be cited in the written report of findings. A CAP will be requested if citations result from the quality management review. The following is a non-inclusive list of circumstances that may result in a request for a CAP or may result in denial of payment during compliance reviews:

    - Absence of a current Plan for Supports;

    - Services not delivered as described in the Plan for Supports;

    - Services rendered to an ineligible individual: if diagnostic assessment and/or VIDES do not reflect eligibility for ID or DD Targeted Case Management or DD Waivers;

    - Support coordination face-to-face contacts that are not completed in a timely manner (every 90 days with a 10-day grace period);

    - Any periods of services billed for which there is an absence of or inadequate documentation to support that the services were rendered (amounts, type, absence of data, assessment information, etc.);

    - Any periods of service billed during which the staff were not certified, qualified, properly trained or for which there was no documentation of competency, the provider had not fulfilled the terms of the Participation Agreement, and/or the required license/certification/approval had been revoked or converted to a provisional license;

    - Any identified billing errors, such as inaccuracies in service amounts, incorrect or absent deductions of patient-pay amount, incorrect dates of service, duplication of services, etc.;

    - Absence of documentation reflecting the need for a service or for that level of service; and

    - Absence in the Support Coordinator's record of a current VIDES or the presence of a most recent VIDES that does not meet the requirements for eligibility.

- The provider must meet all other criteria and documentation requirements found elsewhere in this manual, as well as in applicable regulations and laws.

- If the individual has a patient-pay amount, a provider will use the electronic patient pay process. Local departments of social services (LDSS) will enter data regarding an individual's patient pay amount obligation into the Medicaid Enterprise System (MES) at the time action is taken regarding an individual either as a result of an application for long-term care services, redetermination of eligibility, or reported change in an individual's situation. These types of occurrences will cause the LDSS to initiate data entry of patient pay into the MES.

  When more than one provider furnishes services to an enrollee or the provider responsible for collecting the patient pay changes, the DMAS-225 will be used to advise the LDSS staff of which provider is responsible for collecting the individual's patient pay obligation. The Support Coordinator should complete the Provider NPI# (or API) data field on the DMAS-225. The DMAS-225, when completed by the LDSS, will then be used to inform the LTC provider of his or her responsibility.

  For communication of information other than patient pay, the Medicaid LTC Communication Form (DMAS-225) will be used by the Support Coordinator to report changes in an individual's situation. This form is available on the Virginia Medicaid Enterprise System (MES) website under provider forms library and is used to provide information on a new address, a different support coordination agency, income, interruption in DD Waivers services for more than 30 days, discharge from all DD Waivers services, admission to an ICF/IID (even for one day), or death. The Support Coordinator must forward the DMAS-225 to notify the LDSS when such changes occur. The Support Coordinator should document communications with LDSS.

- If a patient-pay amount is required, the billing indicates the correct amount.

  If there is a patient-pay amount, the CMS-1500, the billing invoice required by DMAS, must indicate that amount.

- Designated DD Waivers services are not used when available from the primary source.

  - The individual's Support Coordinator must document before the onset of service delivery that supported employment services are not available through the Department of Aging and Rehabilitative Services (DARS) or special education funding (as through the Individuals with Disabilities Education Act or IDEA) for individuals under 22 years.

  - There must be documentation that it was determined that equipment or supplies provided to an individual under assistive technology services are not available

under the *State Plan for Medical Assistance (State Plan)*. This may be documented in the individual's support coordination record by noting the results of reviewing the "Durable Medical Equipment (DME) and Supplies" list available in the DMAS DME and Supplies provider manual for a given item or the results of a telephone inquiry to the DMAS Helpline about the item's availability through the *State Plan*, or both. There must be documentation for any equipment, supplies, and technology not purchased from a DME provider showing that it was not available from a DME provider. See Chapter IV for additional information.

ANNUAL LEVEL OF CARE REVIEWS

Federal regulations under which waiver services are made available mandate that every individual receiving services be reviewed each year to assure the individual continues to meet level-of-care criteria for that waiver. Reassessments will be conducted at least annually, as determined by the individual's needs and at any time when a change in the individual's condition indicates the need for reassessment.

Support Coordinators will be required to submit documentation to DBHDS each year to verify that the individual continues to meet eligibility using the VIDES; this documentation will be reviewed by DBHDS staff.

If it is found that an individual no longer meets the level of care, the Support Coordinator will inform all providers and services will be terminated in accordance with the procedures detailed in Chapter IV of this manual. DMAS can require repayment of overpaid money if agencies continue to serve individuals who do not meet the level of care for which they are authorized without notifying DBHDS of the change in level of care and the need for discontinuation of services.