Commonwealth Coordinated Care Plus Waiver

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General Information

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The Virginia Medicaid Provider Manual describes the role of the provider in the Virginia Medical Assistance Program (Medicaid). To provide a better understanding of the Medicaid Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid members.

The manual can also be an effective training and reference tool for provider administrative personnel, since it conveys basic information regarding the Medicaid Program, covered and non-covered services, and billing procedures. Proper use of the manual will result in a reduction of errors in claims filing and, consequently, will facilitate accurate and timely payment.

In addition to the Medicaid Program, other programs administered by the Department of Medical Assistance Services (DMAS) include the Family Access to Medical Insurance Security (FAMIS) program, the State and Local Hospitalization (SLH) program, and the Uninsured Medical Catastrophe Fund. If you have any questions concerning the Medicaid Program or any of the other programs listed above, please contact the provider "HELPLINE" at:

- 804-786-6273 Richmond Area
- 1-800-552-8627 All other areas

Program Background

In 1965, Congress created the Medical Assistance Program as Title XIX of the Social Security Act, which provides for federal grants to the states for their individual Medical

Assistance programs. Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965. This enactment is popularly called "Medicaid" but is officially entitled "Grants to States for Medical Assistance Programs." The purpose of Title XIX is to enable the states to provide medical assistance to eligible indigent persons and to help these individuals if their income and resources are insufficient to meet the costs of necessary medical services. Such persons include dependent children, the aged, the blind, the disabled, pregnant women, and needy children.

The Medicaid Program is a jointly administered federal/state program that provides payment for necessary medical services to eligible persons who are unable to pay for such services. Funding for the Program comes from both the federal and state governments. The amount of federal funds for each state is determined by the average per capita income of the state as compared to other states.

Virginia's Medical Assistance Program was authorized by the General Assembly in 1966 and is administered by the Virginia Department of Medical Assistance Services (DMAS). The Code of Federal Regulations allows states flexibility in designing their own medical assistance programs within established guidelines. Virginia Medicaid's goal is to provide health and medical care for the Commonwealth's poor and needy citizens using the health care delivery system already in place within the state. In 2003, the Virginia General Assembly changed the name of the Medicaid program covering most children to FAMIS Plus. The change in name was intended to facilitate a coordinated program for children's health coverage including both the FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus programs. All covered services and administrative processes for children covered by FAMIS Plus remain the same as in Medicaid. While the Virginia Medicaid Program is administered by DMAS, the eligibility determination process is performed by local departments of social services through an interagency agreement with the Virginia Department of Social Services. The *State Plan for Medical Assistance* for administering the Medicaid Program was developed under the guidance of the Advisory Committee on Medicare and Medicaid appointed by the Governor of the Commonwealth of Virginia. The State Plan is maintained through continued guidance from the Board of Medical Assistance Services, which approves amendments to the *State Plan for Medical Assistance* with policy support from the Governor's Advisory Committee on Medicare and Medicaid. Members of the Governor's Advisory Committee and the Board of Medical Assistance Services are appointed by the Governor.

Individuals originally became eligible for Medicaid because of their "categorical" relationship to two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s resulted in dramatic changes in Medicaid eligibility provisions. Now individuals, in additional selected low-income groups, are eligible for Medicaid solely on the relationship of their incomes to the Federal Poverty Guidelines. New Federal Poverty

Guidelines are published annually in the *Federal Register* and become effective upon publication.

On June 7, 2018, Governor Northam approved the state budget that expanded eligibility to include the Modified Adjusted Gross Income (MAGI) adult group, also known as the Medicaid Expansion covered group. The MAGI adult group includes adults between the ages of 19 and 64, who are not eligible for or enrolled in Medicare, and who meet income eligibility rules. After receiving the necessary approvals from the Centers for Medicare and Medicaid Services (CMS), DMAS began enrolling individuals in the MAGI adult group on January 1, 2019.

Medicaid is a means-tested program. Applicants' income and other resources must be within program financial standards, and different standards apply to different population groups, with children and pregnant women, the MAGI adult group, and persons who are aged, blind, or disabled. Reference Chapter III of this manual for detailed information on groups eligible for Medicaid.

General Scope of the Program

The Medical Assistance Program (Medicaid) is designed to assist eligible members in securing medical care within the guidelines of specified State and federal regulations. Medicaid provides access to medically necessary services or procedures for eligible members. The determination of medical necessity may be made by the Utilization Review Committee in certain facilities, a peer review organization, DMAS professional staff or DMAS contractors.

Covered Services

The following services are provided, **with limitations** (certain of these limitations are set forth below), by the Virginia Medicaid Program:

- BabyCare - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.

- Blood glucose monitors and test strips for pregnant women

- Case management services for high-risk pregnant women and children up to age 1 (as defined in the State Plan and subject to certain limitations)
- Christian Science sanatoria services
- Clinical psychology services
- Clinic services
- Community developmental disability services
- Contraceptive supplies, drugs and devices
- Dental services
- Diabetic test strips
- Durable medical equipment and supplies
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) – For individuals under age 21, EPSDT must include the services listed below:
- Screening services, which encompass all of the following services:
    - Comprehensive health and developmental history
    - Comprehensive, unclothed physical exam

  - Appropriate immunizations according to age and health history
  - Laboratory tests (including blood lead screening)
  - Health education

- Home health services

- Eyeglasses for all members younger than 21 years of age according to medical necessity

- Hearing services

- Inpatient psychiatric services for members under age 21

- Environmental investigations to determine the source of lead contamination for children with elevated blood lead levels

- Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above

- Skilled nursing facilities for persons under 21 years of age

- Transplant procedures as defined in the section “transplant services”

- All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid State Plan for Medical Assistance. Services

requiring preauthorization under the State Plan for Medical Assistance will continue to require pre-authorization. DMAS reserves the right to utilize medical necessity criteria for non-State Plan services under EPSDT.

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver services - Individuals who meet the criteria for a nursing facility level of care can be authorized to receive adult day health care, personal care (agency directed or consumer directed) services, Respite Care and Skilled Respite Care services, Personal Emergency Response

System (PERS), Services Facilitation services, Transition Coordination, and Transition services

- Emergency hospital services

- Emergency services for aliens

- Enteral nutrition (EN) - Coverage is limited to circumstances in which the nutritional supplement is the sole source of nutrition except for individuals authorized through the CCC Plus Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formula.

- Extended services for pregnant women, pregnancy-related and postpartum services for 60 days after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other member groups)

- Eye refractions

- Plan First (family planning services) – Medicaid fee-for-service program for men and

women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.

- Federally Qualified Health Center services
- Home and Community-Based Care Waiver services
- Home health services
- Hospice services for individuals certified as terminally ill (defined as having a medical prognosis that life expectancy is six months or less)
- Family and Individual Support Waiver
- Gender dysphoria treatment services
- Inpatient care hospital services
- Inpatient Psychiatric Hospital Services for Individuals under 21 years of age (medically needy are not covered)
- Intensive rehabilitation services

- Intermediate care facility – Individuals with Intellectual Disabilities Services (medically needy members are not covered)

- Laboratory and radiograph services

- Legend and Non-legend drugs are covered with some limitations or exclusions. (See the Pharmacy Manual for specific limitations and requirements)

- Mental health, with limitations, covered under mental health and intellectual disability community services listed below:

- Mental Health:

- Crisis stabilization
- Mental health support
- Assertive community treatment
- Intensive in-home services for children and adolescents
- Therapeutic day treatment for children and adolescents
- Partial hospitalization Program
- Intensive Outpatient Program
- Psychosocial rehabilitation
- Crisis intervention
- Case management

- Substance Use Disorder:

- Residential treatment for pregnant and postpartum women
- Day treatment for pregnant and postpartum women
- Crisis Intervention
- Intensive Outpatient
- Day Treatment

- Case Management
- Opioid Treatment
- Outpatient Treatment

- Community Living Waiver:

- Nurse-midwife services
- Nursing facility services

- Occupational therapy

- “Organ and disease” panel test procedures for blood chemistry tests

- Optometry services

- Outpatient hospital services

- Over-the-counter alternatives to certain classes of legend drugs. Upon a doctor’s prescription or order, a pharmacy may provide and Medicaid will cover a drug that no longer requires a prescription to dispense. See the Pharmacy Manual for specific limitations and requirements.

- Papanicolaou smear (Pap) test

- Payment of deductible and coinsurance up to the Medicaid limit less any applicable payments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid.
- Physician services

- Podiatry services

- Prostate specific antigen (PSA) test (1998)

- Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be pre-authorized by the DMAS central office. Also breast prostheses for any medically necessary reason and ocular prostheses for reason for loss of eyeball regardless of age of the member or the cause of the loss of the eyeball.

- Psychiatric Hospitals for the Aged (65 Years and Older)

- Psychological testing for persons with intellectual disability as part of the evaluation prior to admission to a nursing facility (January 1, 1989)

- Reconstructive surgery - post-mastectomy (1998)

- Rehabilitation services (physical therapy – effective 1969; other rehabilitation services – effective 1986)

- Renal dialysis clinic services

- Routine preventive medical and dental exams and immunizations, sensory and developmental screenings and immunizations are covered for all eligible members under the age of 21

- Routine preventive and wellness services, including annual wellness exams, immunizations, smoking cessation, and nutritional counseling services for the MAGI Adult (Medicaid Expansion) covered group.

- Rural Health Clinic services

- School-based services

- Services for individuals age 65 and older in institutions for mental diseases

- Specialized nursing facility services

- Speech-language therapy services

- CCC Plus Waiver services - For children and adults who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and require substantial and ongoing skilled nursing care to avert further disability or to sustain their lives. Authorized services include Private Duty Nursing, Private Duty Respite Care services, Personal Care (Adults Only), Assistive Technology, Environmental Modifications and Transition services.

- Telemedicine for selected services.

- Tobacco Cessation screening, counseling and pharmacotherapies.

- Transplant services: kidney and corneal transplants, heart, lung, and liver transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures

that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is allowed for a diagnosis of lymphoma or breast cancer, leukemia, or myeloma.

- Transportation services related to medical care

- Treatment Foster Care Case Management

General Exclusions

Payment cannot be made under the Medicaid Program for certain items and services, and Virginia Medicaid will not reimburse providers for these non-covered services. Members have been advised that they may be responsible for payment to providers for non-covered services. Prior to the provision of the service, the provider must advise the member that he or she may be billed for the non-covered service. The provider may not bill the member for missed or broken appointments, which includes transportation services arranged by the member who is not at the pickup point or declines to get into the vehicle when the provider arrives.

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered

- Acupuncture

- Artificial insemination or in vitro fertilization

- Autopsy examinations

- Cosmetic surgery

- Courtesy calls - visits in which no identifiable medical service was rendered
- Custodial care
- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration)
- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare or EPSDT)
- Experimental medical or surgical procedures
- Eyeglass services for members age 21 and over
- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered
- Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay
- Items or services covered under a workers' compensation law or other payment sources

- Meals-on-Wheels or similar food service arrangements and domestic housekeeping services which are unrelated to patient care

- Medical care provided by mail or telephone (not including telemedicine)

- Medical care provided in freestanding psychiatric hospitals except through EPSDT and SUD waiver, or for individuals aged 65 and over

- Personal comfort items

- Physician hospital services for non-covered hospital stays

- Private duty nursing services – Other than for children under an appropriate waiver or EPSDT and adults under the appropriate waiver

- Procedures prohibited by State or federal statute or regulations

- Prostheses (other than limbs, and the items necessary for attaching them, and breast prostheses)

- Psychological testing done for purposes of educational diagnosis or school admission or placement

- Routine foot care

- Screening services: Exceptions: Pap smears, mammograms, and PSA tests consistent with the guidelines published by the American Cancer Society.

- Services determined not to be reasonable and/or medically necessary

- Services to persons age 21 to 65 in mental hospitals
- Sterilizations when the patient is under age 21 or legally incompetent

- Supplies and equipment for personal comfort, such as adult diapers except when provided as durable medical equipment, "Lifecall" systems (except under the EDCD, DD, and Intellectual Disability Waivers), and air cleaners

- Unkept or broken appointments

- Unoccupied nursing facility beds except for therapeutic leave days for nursing facility patients

- Weight loss programs

MEMBER COPAYS

COPAYS ARE THE SAME FOR CATEGORICALLY NEEDY MEMBERS, QUALIFIED MEDICARE BENEFICIARIES (QMBS), AND MEDICALLY NEEDY MEMBERS. COPAYS AND THEIR AMOUNTS ARE EXPLAINED IN CHAPTER III OF THIS MANUAL.

Managed Care Programs

Coverage for the vast majority of Medicaid enrolled individuals is provided through one of the DMAS managed care programs, Medallion 4.0 or Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 and CCC Plus programs contract with the same six managed care organizations (MCOs), and all MCOs offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. For more information on the current health plans, please visit www.dmas.virginia.gov.

Medallion 4.0 serves as the delivery system for children, pregnant women, and individuals in the MAGI Adult Group who are not determined to be "medically complex." CCC Plus provides a higher acuity of care coordination services and serves as the delivery system that provides coverage for individuals who are aged, blind or disabled, or who are dually eligible for Medicare and Medicaid, or who receive long-term services and supports, or individuals in the MAGI adult group determined to be "medically complex." "Medically complex" is defined as individuals who have complex medical and/or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

Individuals awaiting managed care enrollment will receive coverage through the DMAS feefor-service program for a brief period (approximately 15-45 days) until they are enrolled in managed care. Additionally, some services for managed care enrolled individuals are covered through fee-for-service; these are referred to as managed care carved-out services. Detailed information about managed care-excluded populations and carved out services for Medallion 4.0 and CCC Plus is available on the DMAS website at http://www.dmas.virginia.gov, under Managed Care Benefits.

Once enrolled in managed care, members have up to 90 days to change their plan for any reason. Members also have the ability to change their plan during their annual open enrollment period. Open enrollment varies by population and program. For the MAGI Adult (expansion) population, open enrollment is from November 1 through December 31 each year. For CCC Plus, open enrollment is from October 1through December 18 each year. For Medallion 4.0 open enrollment varies by program region. (See Managed Care Enrollment Broker section below for additional information.)

Managed Care Enrollment Broker (Maximus)

DMAS contracts with an enrollment broker, Maximus, which provides information to help Medallion and CCC Plus members select or change health plans. Members can find out which health plans contract with their primary care provider (PCP) or other provider. Providers should also let their members know which Medicaid health plans they accept. Members may use the following Maximus contact information for the Medallion 4.0 and CCC Plus managed care programs.

- **Medallion 4.0**

  Maximus has designed a mobile app for managed care enrollment for the Medallion 4.0 program. The app is available to download in the Apple App Store and Google Play for both iPhone and Android users.

To get the free mobile app, search for Virginia Managed Care on the Apple App Store or Google Play and download. After downloading the app, members will log in using a two-step identification process, Medicaid ID, and social security number, or social security number and date of birth; non-members can log-in as guests.

Similar to the website, the main capabilities of the app allow members to view their profile, compare health plans, enroll in a health plan, change health plans, and search for providers and health plan information. For more information, members can also visit the Medallion 4.0 enrollment website at: https://virginiamanagedcare.com/ or call 1-800-643-2273 or TTY: 1-800-817-6608.

- **CCC Plus**

  Members can visit the enrollment website for the CCC Plus managed care program at https://cccplusva.com/ to view the health plan comparison chart and to choose or change their health plan. Members can also call the CCC Plus Helpline at 1-834374-9159 or TTY 1-800-817-6608 for more information.

MCO Provider Reimbursement

In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for service individuals. For more information, please contact the individual 's managed care plan directly. Providers interested in contracting with the plans should also contact the MCO directly. MCO contact information for contracting and credentialing is available on the DMAS website:

- **Medallion 4.0** The managed care helpline for the Medallion program is 800-6432273 and the web address is https://www.virginiamanagedcare.com/
- **CCC Plus** (http://www.dmas.virginia.gov/#/cccplusinformation See “Medical Provider Update October 2017”)

DMAS reimburses the health plans a monthly capitated fee for each member. These fees are preset, and are determined by demographics such as patient’s age, sex, program designation, and locality of residence. Each MCO is responsible for developing its own network of providers and for ensuring that its delivery system has an adequate number of facilities, locations, and personnel available and accessible to provide covered services for its members. Providers who contract with a MCO must meet the MCO’s contracting requirements.

Medicaid-contracted MCOs must provide all the services covered by Medicaid, at least within an equal, amount, duration, and scope as Medicaid, except for certain "carved-out services." "Carved-out" means that the client remains enrolled in the MCO plan but the carved-out services are covered and reimbursed by DMAS within DMAS program guidelines. **DMAS will NOT provide reimbursement for services provided to MCO enrolled members EXCEPT for those services carved-out specifically from the MCO contracts.** Carved-out services vary by program and are listed in the CCC Plus and Medallion 4.0 Contracts, available on the DMAS Website, in the Managed Care Benefits section. The member must present his or her Medicaid plastic ID card when receiving carved-out services.

Eligibility and MCO Enrollment Verification

Medicaid eligibility and managed care enrollment coverage must be verified before treatment is provided. Medallion and CCC Plus members will have a MCO identification card and a Medicaid card. Medallion and CCC Plus MCO providers must adhere to their contract with the MCO regarding referrals, prior authorization, and billing requirements. Service authorization from the member's MCO is required for any out-of-network services, *except for emergency and family planning services.* The provider is responsible for ensuring that proper referrals and service authorizations are obtained. If the MCO denies authorization for a service, the member may exercise his right to appeal to the MCO. Members can also appeal to DMAS after first exhausting the MCO's appeal process. A provider may bill a member only when the provider has provided advanced written notice to the member, prior to rendering services that their MCO/Medicaid will not pay for the service. The notice must also share that the provider is accepting the member as a private pay patient, not as a Medicaid patient and the services being provided are the financial responsibility of the patient. Failure to confirm Medicaid eligibility and MCO coverage can result in a denial of payment.

To verify eligibility, call the MCO's enrollment verification system or the DMAS MediCall line at 1-800-772-9996 or 1-800-884-9730 (outside of Richmond), or (804) 965-9732 or (804) 965-9733 for Richmond and the surrounding counties. Eligibility information is also available using the web-based Automated Response System (ARS). When using the DMAS MediCall line or the ARS system, MCO information, if applicable, follows Medicaid eligibility information.

Continuity of Care

The Department attempts to make the transition between fee-for-service Medicaid and the MCO seamless whenever possible. As a result there is a process to ensure that the Medicaid information and authorization information is transferred and honored. In order to assure continuity of care for members enrolled in MCOs, the following procedures are used:

- The Member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the MCO enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the member's MCO shall continue authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider;
- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the feefor-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider;
- If the prior authorized service is an inpatient stay, the claim should be handled as follows: o If the provider contracts with the MCO under a per diem payment methodology, the financial responsibility shall be allocated between the member's current MCO and either DMAS or the new MCO. In the absence

  of a written agreement otherwise, the member's current MCO and DMAS or the new MCO shall each pay for the period during which the member is enrolled with the entity.

  o If the provider contracts with the MCO under a DRG payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge, including any outlier charges.

- If services have been authorized using a provider who is out of network, the member's MCO may elect to reauthorize (but not deny) those services using an in-network provider.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the

provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;

  - Assistive technology

  - Blood lead testing

- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:

  - Intensive in-home services

  - Therapeutic day treatment

- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations

- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a

physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	**Co-pay Status 1**	**Co-pay Status 2**
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for specified aliens when these services are provided in a hospital emergency room or inpatient hospital setting. (See Chapter III for details on eligibility.)

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks
- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (i.e., appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care
- Physician services
- Inpatient hospitalization not to exceed limits established for other Medicaid members
- Ambulance service to the emergency room or hospital
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

Client Medical Management (CMM)

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC

30-130-820. (See the “Exhibits” section at the end of this chapter for detailed information on the CMM Program.)

Providers may refer Medicaid patients suspected of inappropriately using or abusing

Medicaid services to DMAS's Recipient Monitoring Unit. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program.

Referrals may be made by telephone or in writing. The number for the Recipient Monitoring

Unit is (804) 786-6548 or toll-free (888) 323-0589. Referrals can also be faxed to (804) 3718891. Office hours are 8:15 a.m. – 5:00 p.m., Monday through Friday except state holidays. Voice mail receives after-hours referrals.

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

When making a referral, provide the member's name and Medicaid number and a brief statement regarding the nature of the utilization problems. Copies of pertinent documentation, such as emergency records, would be helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Sources of Information

MediCall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to confirm member

eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. Specific instructions on the use of the verification systems are included in “Exhibits” at the end of this chapter.

Automated Response System (ARS)

Providers may use the Internet to verify member eligibility and perform other inquiry functions. Inquiries can be submitted in real-time. Specific instructions on the use of the ARS are included in “Exhibits” at the end of this chapter.

HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

- (804)786-6273 Richmond Area & out-of-state long distance
- 1-800-552-8627 In-state long distance (toll free)

The HELPLINE is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.

The Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for member eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to members, and members who have questions about the Medicaid Program should be directed to their local departments of social services. If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to members.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

The Virginia MMIS will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.

Although not mandated by HIPAA, DMAS has opted to produce an unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Provider Manual Updates

This manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by the Department of Medical Assistance Services (DMAS) as needed.

Notice of Provider Responsibility

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or State laws.

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

The Virginia Medical Assistance MediCall System offers Medicaid providers twenty-four hour-a-day, seven-day-a-week access to current member eligibility information, check status, claims status, prior authorization information, service limit information, pharmacy prescriber identification number cross reference, and information to access member eligibility and provider payment verification via the Internet. MediCall is an enhancement to the previous Medicaid Audio Verification Response System (AVRS).

Not only does MediCall offer providers flexibility in choosing the time of day for their inquiries, but it also makes efficient use of staff time. A valid provider number and a touchtone telephone are required to access MediCall.

To reach an operator while using the member eligibility verification feature of MediCall, key

“0” at any prompt within the Member Eligibility menu. Operator assisted calls are limited to three name searches per call. The operator will not be able to return the caller to MediCall for further inquiries. Operators are available from 8:30 a.m. to 4:30 p.m. Eastern time, Monday through Friday except for state holidays.

MediCall prompts the caller throughout the inquiry, giving and receiving only essential,

pertinent information. The data provided is the most up-to-date information available, direct from the Medicaid eligibility, claims and remittance databases. If the caller waits too long to respond to a system prompt, the call will be disconnected.

System downtime will be scheduled during non-peak hours. If the caller dials MediCall during this time, the caller will be informed that the system is unavailable. System downtime is typically scheduled for:

2:00 a.m. to 4:00 a.m. Daily 2:00 a.m. to 6:30 a.m. Thursday

10:00 p.m. Saturday to 6:00 a.m. Sunday

The telephone numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

If you have any questions regarding the use of MediCall, contact the Medicaid Provider "HELPLINE." The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The HELPLINE numbers are:

1-804-786-6273 Richmond Area and out of state long distance

In state long distance (toll-free) 1-800-552-8627

HOW TO USE THE SYSTEM

To access MediCall, the provider must have a currently active Medicaid provider number. The provider's number is verified before access to MediCall is authorized.

Responses by the caller to MediCall are required within a specified period of time. If the time limit is exceeded, the call will be disconnected. The caller should have the following information available before calling:

- 10 digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Member Medicaid Number (12 digits) or Social Security Number (9 digits) **and**

  Date of Birth (8 digits) in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status)
- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status). The caller will have the following limits when entering dates of service:
- The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.
- Future month information is only available in the last week of the current month.
- Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

After dialing the MediCall number, the system will ask for the NPI or API. Enter the 10 digit number and select from the following options:

- Press “1” for member eligibility verification.

- Press “2” for claims status.
- Press “3” for recent check amounts.
- Press “4” for service authorization information.
- Press “5” for service limit information.

MEMBER ELIGIBILITY VERIFICATION

Enter the From and Thru dates of service. **The service dates for member eligibility verification cannot span more than 31 days.** When the dates of service have been entered, MediCall will verify the information and respond by speaking the first six letters of the last name and the member's Medicaid number for confirmation.

Remain on the line to obtain important member information that might affect payment, such as:

- Special Indicator Codes (Copayment)
- Client Medical Management Information Including Pharmacy/Physician Telephone Number
- Medicare Eligibility
- Other Insurance Coverage

- Special Coverage (QMB, QMB--Extended)
- "MEDALLION" Participation (prior to July, 2012)
- Managed Care Organization provider name and assignment dates

At this point, MediCall will prompt the caller for the next action. The caller may ask for additional dates of service on this member, or may inquire on another member.

The caller may check up to **three** dates of service for each member and inquire on up to **three** members per call.

If the caller is using a Social Security Number instead of the member ID number, the dates of service will relate to the first member ID reported. If multiple open records exist for the same Social Security Number, you will be advised to contact the local department of social services. You will be given a 3-digit city/county code of the appropriate agency and a 5-digit caseworker code. A cross-reference list of the city/county codes is provided as an exhibit to this chapter.

The caller will receive a "not eligible" response if the future dates about which he or she inquires are beyond the information on file.

A response, "not eligible," will be given if the member is not eligible for all days within the time span entered.

PROVIDER CHECK LOG

The most recent check information is presented by invoice type. This inquiry permits the provider to receive check dates and amounts from the most recent three remittances.

CLAIMS STATUS

For claims status information, the MediCall system will prompt the provider to choose the among the following invoice types (additional information in italics).

- For inpatient care, press 01.
- For long-term care, press 02.
- For outpatient hospital, home health or rehabilitation services, press 03.
- For personal care, press 04.
- For practitioner (physician CMS-1500 billing), press 05.
- For pharmacy, press 06.
- For independent labs (outpatient lab services), press 08.
- For Medicare crossover, press 09.
- For dental, press 11.
- For transportation, press 13.

For claims status, the From date cannot be more than 365 days in the past. The Thru date cannot be more than 31 days later than the From date. After keying the member identification number and the From and Thru date(s) of service, MediCall will provide the status of each claim up to and including five claims. MediCall will prompt for any additional claims or return to the main menu.

SERVICE AUTHORIZATION INFORMATION

The From and Thru dates for prior authorization cannot span more than 365 days. When the 12-digit member ID number and the 8-digit from and through dates of service have been entered, you will be prompted to enter the 11-digit prior authorization number, if known. If you do not know the prior authorization number, then press the pound (#) key. MediCall will verify prior authorization data on file. The system will prompt you to return additional prior authorization data for the same member and dates, enter new dates for the same member, another prior authorization number for the same member or to enter another member ID number to begin a new inquiry.

SERVICE LIMITS INFORMATION

Service limits can be obtained by service type or procedure code:

- For occupational therapy, press 1. For physical therapy, press 2 For speech therapy, press 3.
- For home health aide, press 4.
- For home health skilled nursing, press 5.
- For DME purchases, press 6 and for DME rentals, press 7.

For occupational therapy, speech therapy or physical therapy the MediCall system will return non-school based and school based service limits separately.

PRESCRIBING PROVIDER ID

Only enrolled Pharmacy providers can access this choice. When prompted, the caller should enter the license number of the prescriber. MediCall will return the first six letters of the prescriber’s last name and Medical Assistance provider number. If the prescriber is not

active in Virginia Medicaid, you will receive a message that the number is not on file.

The Automated Response System (ARS)

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-fourhour-a-day, seven-day-a week Internet access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This weenabled tool helps provide cost-effective care for members, and allows providers to access current information quickly and conveniently.

The ARS can be accessed through the Virginia Medicaid Web portal at www.virginiamedicaid.dmas.virginia.gov. Please visit the portal for information on registration and use of the ARS.

CITY/COUNTY CODES

(The Three-Digit Numerical Identifier of the Local Social Services/Welfare Agency Currently Handling the Case)

If two or more member records using the same SSN are active on the same date of service, inquirers are prompted to contact the Social Services agency for resolution.

COUNTIES

001	Accomack	049	Cumberland	097	King and Queen
003	Albermarle	051	Dickenson	099	King George
005	Alleghany	053	Dinwiddie	101	King William
007	Amelia	057	Essex	103	Lancaster
009	Amherst	059	Fairfax	105	Lee
011	Appomattox	061	Fauquier	107	Loudoun
013	Arlington	063	Floyd	109	Louisa
015	Augusta	065	Fluvanna	111	Luneburg
017	Bath	067	Franklin	113	Madison
019	Bedford	069	Frederick	115	Mathews
021	Bland	071	Giles	117	Mecklenburg

023	Botetourt	073	Gloucester	119	Middlesex
025	Brunswick	075	Goochland	121	Montgomery
027	Buchanan	077	Grayson	125	Nelson
029	Buckingham	079	Greene	127	New Kent
031	Campbell	081	Greensville	131	Northampton
033	Caroline	083	Halifax	135	Nottoway
035	Carroll	085	Hanover	137	Orange
037	Charlotte	087	Henrico	139	Page
041	Chesterfield	089	Henry	141	Patrick
043	Clarke	091	Highland	143	Pittsylvania
045	Craig	093	Isle of Wight	145	Powhatan
047	Culpeper	095	James City	147	Prince Edward
149	Prince George	167	Russell	179	Stafford
153	Prince William	169	Scott	181	Surry
155	Pulaski	171	Shenandoah	183	Sussex
157	Rappahannock	173	Smyth	185	Tazewell
159	Richmond	175	Southampton	187	Warren
161	Roanoke	177	Spotsylvania	191	Washington
193	Westmoreland	195	Wise	197	Wythe
199	York				

CITIES

510	Alexandria	620	Franklin	710	Norfolk
515	Bedford	630	Fredericksburg	720	Norton
520	Bristol	640	Galax	730	Petersburg
530	Buena Vista	650	Hampton	735	Poquoson
540	Charlottesville	660	Harrisonburg	740	Portsmouth
550	Chesapeake	670	Hopewell	750	Radford
570	Colonial Heights	678	Lexington	760	Richmond
580	Covington	680	Lynchburg	770	Roanoke
590	Danville	683	Manassas	775	Salem
595	Emporia	685	Manassas Park	780	South Boston
600	Fairfax	690	Martinsville	790	Staunton
610	Falls Church	700	Newport News	800	Suffolk
810	Virginia Beach	820	Waynesboro	830	Williamsburg
840	Winchester				

976 Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983 Southern Virginia Mental Health Institute

985. Southeastern State Hospital
986. Northern Virginia Training Center
987. Virginia Treatment Center
988. Northern Virginia Mental Health Institute

990. Central Virginia Training Center
991. Western State Hospital
992. Southwestern State Hospital
993. Piedmont State Hospital
994. Eastern State Hospital

996. Hiram Davis Hospital
997. Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 456.3 and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30130-810.

MEMBER RESTRICTION

Utilization Review and Case Management

Federal regulations allow states to restrict members to designated providers when the members have utilized services at a frequency or amount that is not medically necessary.

Restricted members are identified and managed by the Recipient Monitoring Unit (RMU) in the Division of Program Integrity.

CMM enrollment is based upon review of the individual member's utilization patterns. All Medicaid members except MCO members and institutionalized long-term care residents are eligible for utilization review by RMU staff. If the member's utilization patterns meet the criteria for enrollment in CMM, the member is notified to select designated primary providers. Examples of inappropriate utilization are:

- Emergency room use for medical problems that could be treated in a physician's office;
- Using more than one physician and/or pharmacy to receive the same or similar medical treatment or prescriptions; and
- A pattern of non-compliance which is inconsistent with sound fiscal or medical practices.

Each CMM member is assigned a case manager in the Recipient Monitoring Unit to assist both members and providers with problems and questions related to CMM. The case manager is available to:

- Resolve case problems related to CMM procedures and provider assignments;
- Counsel the member on the appropriate access to healthcare;
- Approve/deny requests for provider changes; and
- Complete a utilization review prior to the end of the enrollment period to determine if CMM restriction should be extended.

Member Enrollment Procedures

Members identified for CMM enrollment receive a letter explaining the member/provider relationships under medical management. The letter includes the Member/Primary Provider Agreement forms (see the sample forms at the end of this section) with directions for completing and returning the form to the Recipient Monitoring Unit. Members are given thirty (30) days to select their primary providers by obtaining their signatures on the form.

The provider's signature indicates agreement to participate as the CMM provider for the member. DMAS reviews member requests for specific providers for appropriateness and to ensure member accessibility to all required medical services.

Members also have thirty (30) days from the receipt of the restriction notice to appeal enrollment in CMM. Assignment to designated providers is not implemented during the appeal process.

CMM enrollment is for 24 months. Assignment to both a physician and pharmacy is made with few exceptions.

When members do not return choices to the Recipient Monitoring Unit or have difficulty in finding providers, RMU staff will select providers for them. RMU staff contact providers directly to request participation as a CMM provider for the member and follow-up by mailing or faxing the agreement form for the provider's signature.

When completed agreement forms are received, the member is enrolled in CMM effective the first of the next month in which a restricted Medicaid card can be generated. Both members and selected providers are notified by mail of the enrollment date.

Members enrolled in the Client Medical Management can be identified through the process of eligibility verification. A swipe of the Medicaid ID card will return the names and telephone numbers of the primary care physician and designated pharmacy. The dates of assignment to each provider are also included. This information is also available through the MediCall System and the web-based Automated Response System (ARS). Instructions for both resources are provided in this chapter.

Each CMM member also receives an individual Medicaid coverage letter with the name(s) and address of the designated primary health care provider and/or designated pharmacy printed on the front each time there is a change in providers.

Designated Primary Care Physicians (PCP)

Any physician enrolled in Medicaid as an individual practitioner may serve as a designated primary care physician (PCP) except when:

- The physician's practice is limited to the delivery of emergency room services; or
- The physician has been notified by DMAS that he or she may not serve as a designated provider, covering provider, or referral provider for restricted members.

Federally Qualified Community Health Centers (FQHCs) and Rural Health Clinics (RHCs) may serve as PCPs also. Other provider types such as ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.

Primary care physicians are responsible for coordinating routine medical care and making referrals to specialists as necessary. The PCP must arrange 24-hour coverage when they are not available and explain to their assigned members all procedures to follow when the office is closed or when there is an urgent or emergency situation.

The provider's *NPI number* is used for billing and referral purposes.

Designated Pharmacies

Any pharmacy enrolled as a community pharmacy billing on the Pharmacy Claim Form or other acceptable media may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.

Designated pharmacies must monitor the member's drug regimen. The pharmacist should fill prescriptions from the PCP, referred physicians, and emergency prescriptions. Referrals can be confirmed by reviewing the member's copy of the referral form or by contacting the

PCP's office. Close coordination between the PCP and the pharmacist, particularly if a medication problem has been identified, is a very important component of the program.

Changing Designated CMM Providers

The member or designated provider may initiate a request for a change of a designated provider by contacting the Recipient Monitoring Unit. Designated providers requesting a change must notify the member in addition to contacting RMU. If the designated provider requests the change and the member does not select a new provider by the established deadline, RMU shall select for them.

All changes must be preauthorized by DMAS RMU staff. The member's RMU case manager may contact the provider before making a final decision on the change request to try to resolve questions or issues and avoid unnecessary changes. If DMAS denies a member's request, the member shall be notified in writing and given the right to appeal the decision. Changes are allowed for:

1. Relocation of the member or provider;
2. Inability of the designated provider to meet the routine medical/pharmaceutical needs of the member; or
3. Breakdown of the relationship between the provider and member.

Provider changes can occur any time of the month because the effective date is the date the new provider signs the Member/Primary Provider Agreement form. When a new provider is assigned, RMU mails a letter to the member confirming the effective date of the change. The letter instructs the member *to show the letter with the Medicaid identification card*. Letters go to the affected providers also. All verification inquiries will return the new primary provider from the date it is entered into the computer system.

A PCP No Longer in Practice

If a provider leaves the practice or retires, he or she must notify CMM so that the restricted member can be reassigned to a new PCP.

Covered Services and Limitations

Under CMM, DMAS will pay for covered outpatient medical and/or pharmaceutical services only when they are provided (1) by the designated providers, (2) by physicians seen on written referral from the PCP, (3) by covering providers linked with the designated provider in a CMM Affiliation Group, or (4) in a medical emergency. A medical emergency means that a delay in obtaining treatment may cause death or serious impairment of the health of the member. Payment for covered outpatient services will be denied in all other instances (unless the covered services are excluded from Client Medical Management Program requirements), and the member may be billed for the services.

All services should be coordinated with the designated provider. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

Physician Services

A Medicaid-enrolled physician who is not the PCP may provide and be paid for outpatient services to these members only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the member.

- On written referral from the PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.

- When they are a part of a CMM provider affiliation group that includes the PCP.

- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

Services Excluded from PCP Referral

These services should be coordinated with the primary health care provider whose name appears on the member's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program.

Covered services that do not need a referral include:

- Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) wellchild exams and screenings (members under age 21);

- Immunizations (member under age 21);

- Family planning services;

- Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants;

- Dental services (members under age 21);

- Services provided under Home and Community-Based Care Waivered Services;
- Hospice services;
- Renal dialysis services;
- Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21). Medical treatment for diseases of the eye and its appendages still requires a written referral;
- Audiology services;
- Podiatry services;
- Prosthetic services;
- MH/ID community rehabilitative services;
- Psychiatric diagnostic and therapeutic services (limited sessions of outpatient treatment);
- Inpatient hospital services;
- Life-threatening medical emergencies; and

- School-based services.

CMM Provider Affiliation Groups

Physician affiliation groups allow covering physicians to see each other's patients without a written referral. CMM affiliations may be set up for physicians within a practice or for the single practitioner who arranges coverage by a physician not sharing office space. Affiliations can be open-ended or for a specified period of time (such as when the PCP is away from the office for days or weeks). CMM affiliations may include physicians, Rural Health Clinics, Federally Qualified Health Clinics (FQHC), and nurse practitioners.

Affiliations are not member-specific. This means that once provider numbers are affiliated, claims will pay for all CMM members who receive services from a member of an affiliation group that includes the member's PCP on the date of service.

The PCP requests affiliation by completing the CMM Provider Affiliation Form (see sample form at the end of this section) and returning it to the Recipient Monitoring Unit (RMU). The form is used to set up a new affiliation group or to update a group. Providers are responsible for notifying DMAS when a new provider joins the group or a provider leaves the group to ensure claims are processed correctly. Contact the Recipient Monitoring Unit at (804) 786-6548 in Richmond, or toll-free at 1-888-323-0589, to request a form.

Emergency Room Services

Outpatient hospital emergency room services for restricted members are limited to reimbursement for medical emergencies. Emergency hospital services means that the threat to the life or health of the member necessitates the use of the most accessible hospital facility available that is equipped to furnish the services. Reimbursement may be conditional upon the review of the emergency-related diagnosis or trauma ICD diagnosis codes and the necessary documentation supporting the need for emergency services. Additional guidelines for payment of medical services provided in the outpatient hospital emergency room setting are listed in Chapter IV "Covered Services" in this manual.

CMM clients must have a written PCP referral in order for non-emergency services provided in the emergency room to be reimbursed at an all-inclusive rate. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the member is responsible for the full cost of the emergency room visit.

CMM also requires a PCP referral form for:

- Reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting, and
- Reimbursement for any follow-up outpatient or office consultations resulting from an ER visit.

Emergency Pharmacy Services

Prescriptions may be filled by a non-designated pharmacy only in emergency situations (e.g., insulin or cardiac medications) when the designated pharmacy is closed or the designated pharmacy does not stock or is unable to obtain the drug.

Provider Reimbursement and Billing Instructions

Management Fees

Each physician, FQHC, or Rural Health Clinic that serves as a CMM primary care provider (PCP) receives a monthly case management fee of $5.00 for each assigned CMM member. Payment is made through a monthly remittance process. PCPs receive a monthly report listing the CMM members assigned the previous month for whom payment is made.

PCP and Designated Pharmacy Providers

DMAS pays for services rendered to CMM members through the existing fee-for-service

methodology. Designated providers (PCP's and pharmacies) bill Medicaid in the usual manner, but non-designated providers who are not affiliated with the CMM provider must follow special billing instructions. Complete instructions for the CMS 1500 (08-05) and UB-04 billing invoices as well as Point-of-Sale (POS) billing can be found in the billing instruction chapter of this manual.

Affiliated Providers

Providers who are affiliated with a designated CMM provider in the Medicaid system bill Medicaid in the usual manner with no special billing instructions. Claims process with a look-up to the CMM Affiliation Groups in the system.

Referral Providers

To receive payment for their services, referral providers authorized by the client's PCP to provide treatment to that client must place the Provider Identification Number of the PCP in Locator 17a (1D qualifier followed by the API number) or 17b (National Provider Identifier number of referring physician – 17B requirement effective 5/23/08) of the CMS-1500 (0805) and attach the Practitioner Referral Form.

Physicians Billing Emergency Room Services

When billing for emergency room services on the CMS-1500, the attending physician bills evaluation and management services with CPT codes 99281-99285 and enters "Y" in Block 24-C. When the PCP has referred the client to the emergency room, place the PCP's NPI number in Block 17b on the CMS -1500 and attach the Practitioner Referral form.

Facilities Billing Emergency Room Services with a Referral

When billing for emergency room services on the on the UB-04 CMS 14-50, place the PCP's provider number in space 78, and attach the Practitioner Referral Form.

Non-designated Pharmacy Providers

When billing on the Pharmacy Claim Form or as a Point-Of-Sale (POS) provider, enter code

"03" in the "Level of Service" field to indicate emergency.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate members on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the member and a brief statement about the nature of the utilization problems. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

PROVIDER RESTRICTION

Restricted providers are identified and managed by the DMAS Provider Review Unit. States may restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally recognized standards of health care. State regulations allow DMAS to restrict providers' participation as designated providers, referral providers, or covering providers for CMM restricted members when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.

Provider restriction is for 24 months. Providers may appeal any proposed restriction in accordance with the *Code of Virginia*, Section 2.2-4000 et seq., as discussed in the chapter containing utilization review and control information in this manual. Restriction is not implemented pending the result of a timely appeal request.

Provider Participation Requirements (CCC Plus Waiver)

Updated: 8/1/2022

Managed Care Enrolled Members (CCC Plus Waiver)

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through DMAS contracted Managed Care Organizations (MCOs) and their network of providers. All providers must check eligibility (Refer to Chapter 3) prior to rendering services to confirm which MCO the individual is enrolled. The MCO may require a referral or prior authorization

for the member to receive certain services. However, all MCO's follow the program rules for CCC Plus Waiver services as defined in this manual. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations.

Even if the individual is enrolled with a MCO, some of the services may continue to be covered by Medicaid Fee-for-Service. Providers must follow the Fee-for-Service rules in these instances where services are "carved out." The carved-out services are the same for both managed care programs. Members who are enrolled in managed care and the CCC Plus Waiverwill be moved to the CCC Plus MCO benefit, which has the responsibility of covering long-term supports and services. Refer to each MCO program's website for detailed information and the latest updates.

There are several different managed care programs (Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE) for Medicaid individuals. For providers to participate with one of the DMAS-contracted managed care organizations/programs, they must be credentialed by the MCO and contracted in the MCO's network. The credentialing process can take approximately three (3) months to complete. Go to the websites below to find which MCOs participate in each managed care program in your area:

- https://www.dmas.virginia.gov/for-providers/managed-care/ccc-plus/ (CCC Plus)
- https://www.dmas.virginia.gov/for-providers/managed-care/medallion-40/ (Medallion 4.0)
- https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care/ (PACE)

At this time, individuals enrolled in the three HCBS waivers that specifically serve individuals with intellectual and developmental disabilities (DD) (the Building Independence (BI) Waiver, the Community Living (CL) Waiver, and the Family and Individual Supports (FIS) Waiver) will be enrolled in CCC Plus for their non-waiver services only; the individual's DD waiver services will continue to be covered through the Medicaid fee-for-service program.

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, MCO enrollment, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: https://vamedicaid.dmas.virginia.gov/. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

Provider Participation Requirements (CCC Plus Waiver)

PARTICIPATING PROVIDER

A participating provider is an institution, facility, agency, partnership, corporation, or association that is certified by the Virginia Department of Health and/or other licensing agencies and that has a current, signed participation agreement with the Department of

Medical Assistance Services (DMAS).

Freedom of Choice (Hospital)

The patient shall have freedom of choice in the selection of a provider of services. Generally, however, payments are limited under the Medical Assistance Program to providers who are qualified to participate in the Program under Title XVIII and who have signed a written agreement with DMAS.

Provider Enrollment (CCC Plus Waiver)

Any provider of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid individuals. All providers must sign the appropriate Participation Agreement via electronic signature on the online enrollment application or sign the paper enrollment application and return it to the Provider Enrollment and Certification Unit. The authorized agent of the provider must sign an agreement for a group practice, hospital, or other agency or institution. The Virginia Medical Assistance Program must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

The Medicaid Participation Agreement may be time-limited depending on the licensing required. All participating Medicaid providers are required to complete a new application and agreement with Provider Enrollment Services as a result of any name change or change of ownership.

Upon the receipt of the signed contract, and the approval with signature by DMAS, a ten-digit Atypical Provider Identifier (API) or National Provider Identifier (NPI) number will be assigned as the provider identification number to each provider category (i.e., case management, private duty nursing, and personal/respite care). **DMAS will not reimburse the provider for any services rendered prior to the assigning of this provider identification number to your file.** This number must be used on all billing invoices and correspondence submitted to DMAS or Provider Enrollment Services.

Requests for Enrollment (CCC Plus Waiver)

All providers who wish to participate with Virginia Medicaid are directed to complete their request via the online enrollment through our Virginia Medicaid web-portal. If a provider is unable to enroll electronically through the web, they can download a paper application from the Virginia Medicaid web-portal and follow the instructions for submission. Please go to https://vamedicaid.dmas.virginia.gov/ to access the online enrollment system or to download a paper application.

DMAS strongly encourages providers to enroll or make updates electronically via our web portal. An application for participation submitted on paper will add additional time to the processing of your enrollment and to your request to update your provider file.

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at.

If you have any questions regarding the online or paper enrollment process, please contact Provider Enrollment Services toll free at: 1-888-829-5373 or local 1-804-270-5105.

Provider Screening Requirements

All providers must undergo a federally mandated comprehensive screening as part of their enrollment process. An abbreviated screening is also performed on a monthly basis for any provider who participates with the Virginia Medicaid Program. The full screening is conducted at the time of revalidation, and providers are required to revalidate at least every 5 years.

The requirement for screening is in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid Program agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers' categorical risk levels are defined as "limited", "moderate" or "high".

Limited Risk Screening Requirements

The following screening requirements apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type; (2) Verification that a provider or supplier meets applicable licensure requirements; and (3) Verification that a provider or supplier has not been excluded from providing services in federally funded programs. The verification process includes a review of applicable federal and state databases checks and is completed on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre-and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider

categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening.

Application Fees

Institutional providers may be required to pay a federally-required fee at the time of application for enrollment, re-enrollment or reactivation. This includes when adding new locations. If a provider is required to pay an application fee, it will be outlined in the provider enrollment application and/or revalidation notice. Please refer to the table at the end of this chapter for more information on provider types that may be charged an application fee.

CMS determines the application fee each year. This fee is not required to be paid to DMAS if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request for CMS approval with their enrollment application. If CMS does not approve the hardship request, then providers have 30 calendar days from the date of the CMS notification to pay the application fee or the application for enrollment will be rejected.

An appeal of a hardship exception determination must be made to CMS pursuant to 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers with a primary servicing address located outside of the Virginia border and, due to their provider risk-level, require a site visit, must have a site visit conducted by either their state’s Medicaid program or by CMS prior to enrollment in DMAS. If the application is received by DMAS prior to the completion of the site visit, as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E), the application will be pended for proof this information.

Revalidation Requirements

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via our web portal.

Registration into the Virginia Medicaid Web Portal will be required to access and use the online enrollment and revalidation system.

All enrolled providers in the Virginia Medicaid program will be notified in writing of a revalidation date and informed of the new provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

Ordering, Referring, and Prescribing (ORP) Providers

Code of Federal Regulations 42 CFR 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members they must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

Please go to Chapter V of this provider manual to review the new billing procedures related to the implementation of these new screening requirements.

Provider Responsibilities to Identify Excluded Individuals and Entities (CCC Plus Waiver)

In order to comply with Federal Regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities.

Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps on a monthly basis to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.
2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs.
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Suite 1300

Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmas.virginia.gov

Participation Requirements (CCC Plus Waiver)

Requirements for providers approved for participation include, but are not limited to, the following:

- Immediately notify Provider Enrollment Services Unit by logging into the Virginia Medicaid Web Portal and click on the Provider Participation System, or in writing, whenever there is a change in any of the information that the provider previously submitted.

- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid individuals.

- Ensure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.

- Ensure the individual's freedom to reject medical care and treatment.

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.

- Provide services, goods, and supplies to individuals in full compliance with the requirements of § 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794),

which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.

- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public.

- Charge DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public.

- Not require, as a precondition for admission, any period of private pay or a deposit from the patient or any other party.

- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission.

- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill an individual for a covered service regardless of whether the provider received payment from the state. A provider may not seek to collect from a Medicaid individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. The provider may not bill DMAS or individuals for broken or missed appointments. Example: If a third party payer reimburses $5 out of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference from Medicaid, the individual, a spouse, or a responsible relative;

- Reimburse the patient or any other party for any monies contributed toward the patient's care from the date of eligibility. The only exception is when a patient is spending down excess resources to meet eligibility requirements.

- Accept assignment of Medicare benefits for eligible Medicaid individuals.

- Use DMAS-designated billing forms for submission of charges.

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records must be retained for a period of not less than six (6) years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section in this manual on documentation of records.)

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by DMAS, all financial, beneficial ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to individuals of medical assistance.

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding individuals. A provider shall disclose information in his or her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the DMAS. DMAS shall not disclose medical information to the public.

Requirements of the Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers are responsible for making provision for disabled individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring

the compliance of individual providers. In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

Utilization of Insurance Benefits (CCC Plus Waiver)

The Virginia Medical Assistance Program is a "last pay" program. Benefits available under Medical Assistance shall be reduced to the extent that they are available through other federal, state, or local programs; coverage provided under federal or state law; other insurance; or third-party liability.

Health, hospital, workers' compensation, or accident insurance benefits shall be used to the fullest extent in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

- Title XVIII (Medicare) - Virginia Medicaid will pay the amount of any deductible or coinsurance for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.

- Workers' Compensation - No Medicaid program payments shall be made for a patient covered by Workers' Compensation.

- Other Health Insurance - When an individual has other health insurance (such as CHAMPUS/TRICARE, Blue Cross-Blue Shield, or Medicare), Medicaid requires that these benefits be used first. Supplementation shall be made by the Medicaid program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

- Liability Insurance for Accidental Injuries - The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid individuals who receive medical care as the result of the negligence of another. If an individual is treated as the result of an accident and the Virginia Medical Assistance Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to enforce its lien established under § 8.01-66.9 of the Code of Virginia. In liability cases, providers may choose to bill the third party carrier or file a lien in lieu of billing Medicaid.

In the case of an accident in which there is a possibility of third-party liability, or if the individual reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the hospital is requested to forward the DMAS-1000 to:

Third-Party Liability Casualty Unit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Use of Rubber Stamps for Physician Documentation

[Effective Date: 1/23/92]

All physician or other health care professionals' documentation, including certifications, must be signed with the initials, last name, and title. DMAS will allow the use of rubber stamps for physician signatures when the use is consistent with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation requirements and physician documentation. When a rubber stamp is used, the individual whose signature the stamp represents must provide DMAS with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. All rubber-stamped signatures are also required to be accompanied by the initials of the physician.

The signature waiver form must be received 30 days prior to the date of the anticipated use of the rubber stamp. (See "Exhibits" at the end of this chapter for a sample of this form.) All documentation must be completely dated with the month, day, and year.

Electronic Signatures (CCC Plus Waiver)

An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Use of the electronic signatures, for clinical documentation purposes, shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Providers must have written policies and procedures in effect regarding use of electronic signatures. In addition to complying with security policies and procedures, providers who use electronic signatures, must sign a statement assuring that they alone will have access to and use the key or computer password. The policies and procedures and statements of exclusive use must be maintained and available at the provider's location.

Additionally, the use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. These requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records. For guidance on billing, please refer to Chapter V of this manual.

Addendum or Corrections to Medical Record Documentation

If an addendum or additional documentation is needed in a medical record, standard medical practice is to note the additional documentation as an "addendum", and sign and fully date the addendum documentation at the time of the additional entry.

If a correction is needed to a medical record entry that is discovered as an error, the standard medical practice is for the responsible staff member to strike through the error, note the correction and either sign or initial the correction, and fully date the correction.

There is a difference between an addendum and correction to a medical record and an alteration to a medical record. Providers cannot alter existing documentation. For example, once an audit has been initiated, a document cannot be altered as a result of a DMAS audit in order to correct any identified deficiencies found during the audit. This action is falsifying medical documentation and is prohibited. Another example is a staff individual signing and dating orders or documentation for a physician. Only the physician can sign and date his/her orders or medical record entries. All signatures, titling, and

dating of record entries must be done at the time the documentation is written and not backdated or photocopied signatures. Alteration of medical record documentation can result in a referral to the Medicaid Fraud Control Unit at the State Attorney General's Office for further investigation.

Documentation of Records

The Provider Agreement requires that the medical records fully disclose the extent of services provided to Medicaid recipients. The following elements are a clarification of Medicaid policy regarding documentation for medical records:

- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. Care rendered by personnel under the direct personal supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.
- The record must contain a preliminary working diagnosis and the elements of a history and physical examination upon which the diagnosis is based.
- All services, as well as the treatment plan, must be entered in the record. Any drugs prescribed as part of a treatment, including the quantities and the dosage, must be entered in the record.
- The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written for every office, clinic, or hospital visit billed to Medicaid.

Review and Evaluation

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 of providers and by recipients. This function is handled by the Virginia Medical Assistance Program's Prepayment and Postpayment Review Sections.

Provider and recipient utilization patterns to be reviewed are identified either from computerized exception reports or by referrals from agencies or individuals. To ensure a thorough and fair review, trained professionals review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Providers will be required to refund Medicaid if they are found to have billed Medicaid contrary to policy, failed to maintain records to support their claims, or billed for medically unnecessary services. Due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Providers selected for review will be contacted directly by personnel with detailed instructions. This will also apply when information is requested about a recipient or when a recipient is restricted to the physician or pharmacy, or both, of his or her choice because of misutilization of Medicaid services.

Additional information on hospital utilization review activities and on physician certification of the need for care may be found in Chapter VI, Utilization Review and Control.

Fraud (CCC Plus Waiver)

Provider fraud is willful and intentional diversion, deceit, or misrepresentation of the truth by a provider or his or her agent to obtain or seek direct or indirect payment, gain an item of value for services rendered or supposedly rendered to individuals under Medicaid. It includes any act that constitutes fraud under applicable federal or state law. A provider participation agreement will be terminated or denied in cases where a provider is found guilty of fraud.

Investigation of allegations of provider fraud is the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General of Virginia. Provider records are to be made available to personnel in this unit for investigative purposes. Further information on submission of fraudulent claims may be found in Chapter V of this manual.

Termination of Provider Participation (CCC Plus Waiver)

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and the Provider Enrollment Services Unit thirty (30) days prior to the effective date. The addresses are:

Director

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid – PES Unit

PO Box 26803

Richmond, Virginia 23261-6803

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to individuals subsequent to the date specified in the termination notice.

Termination of a Provider Contract Upon Conviction of a Felony

Section 32.1-325 D.2 of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Medicaid Program Information (DD)

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing information is associated with the provider number on the enrollment file, which assures that each assigned provider receives program information. Providers enrolled at multiple locations or who are individuals of a group using one central office may receive multiple copies of updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the Contractor – Provider Enrollment Services at the address provided in "Requests for Participation" earlier in this chapter.

All Medicaid provider manuals are available on-line on the DMAS MES website at https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library (Provider Risk table – see page 18)

Areas of Service

The provider applicant notes on the application what localities (cities and counties) the provider wishes to serve. The provider must be able to adequately staff and supervise staff in any locality served by the provider's office. The provider may maintain separate provider agencies.

The provider should submit a provider application for each separate office which, upon approval, will be issued a separate provider identification number and will be expected to maintain all files related to individuals served by the office and to bill for those individuals from the office.

A differential rate is established for providers that are providing services to individuals residing in the Northern Virginia localities to reflect the higher cost of operating in these localities (both higher capital and wage costs).

Provider Mailings

Providers may choose to have their payments sent to one location and their other mailings, such as memorandums or letters, sent to another location within their organization. Please

visit the DMAS website or contact the Provider Enrollment Services Unit if this is an option you would like to explore.

Direct Marketing

All participating Medicaid providers are prohibited from performing all types of direct marketing activities to Medicaid individual. "Direct marketing" means directly or indirectly conducting door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; mailing directly; paying "finder's fees"; offering financial incentives, rewards, gifts, or special opportunities to eligible individuals as inducements to use their services; continuous, periodic marketing activities to the same prospective individual (e.g., monthly, quarterly, or annual giveaways) as inducements to use their services; or engaging in marketing activities that offer potential customer rebates or discounts in conjunction with the use of their services or other benefits as a means of influencing individuals' use of providers' services.

Business Office

The provider must operate from a business office, which is staffed and provides accessible staff space, files, business telephones for the individual to contact the provider when necessary, and an address for receipt of mail and forms.

Individual Choice of Provider

If services are authorized and there is more than one approved provider in the community, the individual will have the option of selecting the provider of his or her choice.

At the time individuals are approved for services, the Long Term Services and Supports (LTSS) Hospital or Community Screening Team must inform the individual of available service providers and (1) that they have the option of selecting their providers and (2) provide a list of service providers from which to choose.

Advance Directives (CCC Plus Waiver)

At the time of their admission to services, all providers participating in the Medicare and Medicaid programs must provide adult individuals with written information regarding each individual's right to make medical care decisions as outlined in this section. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable

power of attorney for health care, recognized under state law and relating to the provision of such care when the individual is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive.

Under the law, providers must:

Provide all adult individuals with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment, and the right to execute advance directives, as well as the provider's written policies respecting the implementation of such rights;

Inform individual about the provider's policy on implementing advance directives;

Document in the individual's medical record whether he or she has signed an advance directive;

Not discriminate against an individual based on whether he or she has executed an advance directive; and

Provide staff and community education on advance directives.

Criminal Background Checks

In accordance with Virginia Code § 32.1-162.9:1, any licensed home care organization as defined in § 32.1-162.7 or any home care organization exempt from licensure under subdivision 3 a or b of § 32.1-162.8 or any licensed hospice as defined in § 32.1-162.1, shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in Code of Virginia § 32.1-162.9:1 or an original criminal history record from the Central Criminal Records Exchange. However, no employee shall be permitted to work in a position that involves direct contact with a patient until an original criminal record clearance or original criminal

history record has been received, unless such person works under the direct supervision of another employee for whom a background check has been completed in accordance with the requirements of § 32.1-162.9:1 of the Code of Virginia.

Subsection C. of Virginia Code § 32.1-162.9:1 states as follows: "A person who complies in good faith with the provisions of this section shall not be liable for any civil damages for any act or omission in the performance of duties under this section unless the act or omission was the result of gross negligence or willful misconduct." Accordingly, this provision does not apply to audits or administrative actions by DMAS to recover a Medicaid overpayment made to a provider.

Participating Agency-Directed Personal/Respite Care Provider

A participating personal/respite care provider is an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed Participation Agreement with DMAS. The duties and responsibilities of the provider are the same for both services. Each service requires a separate Participation Agreement and provider identification (ID) number. The term “personal/respite care” is used throughout this manual wherever procedures and policies are alike for both services. A provider may, however, choose to offer only one of the two services.

Personal/respite care providers provide services designed to prevent or reduce institutional care by providing eligible individuals with personal care aides who perform basic health-related services. This chapter sets forth the requirements for approval to participate as a Medicaid provider of personal/respite care as a part of the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The personal/respite care provider will be reimbursed according to the fee schedule (available on the DMAS website (www.dmas.virginia.gov). Any provider contracting with Medicaid to provide these services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

Provider Participation Standards for Agency-Directed Personal/Respite Care Services

A participating personal/respite care provider is an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed Participation Agreement with DMAS. The duties and responsibilities of the provider are the same for both services. Each service requires a separate Participation Agreement and provider identification (ID) number. The term “personal/respite care” is used throughout this manual wherever procedures and policies are alike for

both services. A provider may, however, choose to offer only one of the two services.

Personal/respite care providers provide services designed to prevent or reduce institutional care by providing eligible individuals with personal care aides who perform basic health-related services. This chapter sets forth the requirements for approval to participate as a Medicaid provider of personal/respite care as a part of the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The personal/respite care provider will be reimbursed according to the fee schedule (available on the DMAS website (www.dmas.virginia.gov). Any provider contracting with Medicaid to provide these services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

In order to be enrolled as a Medicaid provider for the personal care or respite service, the provider must be licensed or accredited by one of the following:

- Accreditation Commission for Health Care, Inc. Certification (ACHC)
- Centers for Medicare and Medicaid Services (CMS) Certification
- Community Health Accreditation Program Certification (CHAP)
- Joint Commission on Accreditation for Health Care Organizations (JCAHO)
- Virginia Department of Health (VDH) Home Care Organization (HCO) License

Nursing Qualifications for Private Duty Nursing Services

RN Supervisors

- RN supervisors shall be verified as currently licensed to practice nursing in the Commonwealth;
- Have at least one year of verified related clinical nursing experience which may include work in an acute care hospital, long stay hospital, rehabilitation facility, or specialized care nursing facility; and
- Previous nursing experience shall be documented in his/her agency personnel file.

Private Duty Nurse – RN or LPN

- The private duty nurse (PDN) must either be a licensed practical nurse (LPN) or a registered nurse (RN) with a current and valid Virginia license;
- The decision to assign a RN or LPN must be based on the needs of the individual and the nurse's license restrictions;
  - A LPN cannot be assigned to perform activities which fall outside the nursing practices allowed and which should be performed by a RN;
- RN “applicants” do not meet the Medicaid requirement of having a valid Virginia nursing license; and
- A private duty nurse must demonstrate specialized experience and proficiency with delivery of nursing care to any population which has specialized needs (e.g., a ventilator-dependent individual) prior to assignment to such an individual.

All RNs and LPNs who provide skilled private duty nursing (PDN) services shall have either:

1. A minimum of six months of clinical experience related to the care needs of the assigned waiver individual such as ventilator, tracheostomy, nasogastric tube, etc. (documented in their personnel file), that may include work in acute care hospitals, long stay hospitals, rehabilitation facilities, or specialized care nursing facilities; or

2. Have completed a provider training program related to the care and technology needs of the assigned waiver individual; and

3. Have a completed TB test and current CPR certification.

Nursing agencies that do not have a training program that meets the DMAS training program criteria shall continue to provide nurses with at least six (6) months of previous experience in the skills applicable to CCC Plus waiver individuals to provide safe care (tracheostomies, ventilators, etc.).

Training programs established by providers shall include, at a minimum, the following:

1. Trainers (RNs or Respiratory Therapists (RT) shall have at least six months clinical ("hands-on") experience in the areas they are providing training in such as ventilators, tracheostomies, peg tubes, and nasogastric tubes. This experience must be documented in their personnel file or training records.

2. Training shall include classroom time as well as direct clinical ("hands-on") demonstration of mastery of these skills by the trainee.

3. The training program shall include the following subject areas as they relate to the care to be provided by the PDN nurse:

    a. Human Anatomy and Physiology
    b. Medications frequently used by technology dependent individuals
    c. Emergency management of equipment and individuals
    d. The operation of the relevant equipment.

4. Providers shall assure the competency and mastery of the above skills necessary to successfully

care for the CCC Plus waiver individual by the nurses prior to assigning them to the individual. Documentation of successful completion of such training course and mastery of these skills shall be maintained in the provider's personnel records. The documentation shall be provided to DMAS or its contractors, upon request.

Documentation of the PDN's knowledge, skills, abilities and experience in the care of individuals with special needs and current CPR certification must be included in the nurse's personnel file. This information is recorded on the "CCC Plus Waiver Private Duty Nursing Skills Checklist" (DMAS 259) which must be fully completed, signed and fully dated by the nurse supervisor prior to the assignment of a PDN to a waiver individual. The DMAS-259 Skills Checklist is recommended for use by all PDN providers and can be located on the Medicaid Web Portal under *the MES Forms Library*. A skills checklist may be developed by the provider which contains all of the components of the DMAS-259 form.

For a newly admitted waiver individual, the DMAS 259 must be completed by the nursing supervisor for all nurses assigned to the individual. When a waiver individual has been receiving services and a new nurse is assigned, the primary nurse can complete the orientation if he or she is an RN. If the primary nurse is a LPN, the nursing supervisor is responsible for the orientation and completion of the DMAS-259.

Nurses providing skilled PDN or respite care services cannot be parents (i.e.: natural, step-parent, adoptive, foster, or legal guardians), spouses, siblings, grandparents, grandchildren, adult children, other legal guardians, or any person living under the same roof with the individual for the purpose of Medicaid reimbursement under the CCC Plus waiver.

Participating Adult Health Care (ADHC) Provider

A participating Adult Day Health Care (ADHC) provider is a facility that is licensed by the Virginia Department of Social Services (DSS) as an adult day care center, meets the standards and requirements set forth by DMAS, and has a current, signed Participation Agreement with DMAS.

ADHCs offer community-based day programs providing a variety of health, therapeutic, and social services designed to meet the specialized needs of older adults and individuals who have a physical disability. ADHC services enable individual to remain in their communities and to function at the highest level possible by augmenting the social support system already available to the individual, rather than replacing the support system with more expensive institutional care. The ADHC is reimbursed according to the fee schedule available on the DMAS website (www.dmas.virginia.gov). Any provider contracting with Medicaid to provide these services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this provider manual.

Provider Participation Standards For Adult Day Health Care (ADHC) Services

Licensing Requirement

To be enrolled as a Medicaid Adult Day Health Care (ADHC) provider, the ADHC Center must be an Adult Day Care Center licensed by the Virginia Department of Social Services (VDSS). A copy of the current license must be available to the Provider Enrollment Services Unit for verification purposes prior to enrollment as a Medicaid provider. DMAS will notify VDSS when an ADHC agreement is issued to a licensed center. VDSS will notify DMAS whenever a change to the ADHC's status as a licensed Adult Day Care Center is made by VDSS.

Each ADHC Center participating with Medicaid is responsible for adhering to the VDSS Adult Day Care Center standards. The DMAS special participation conditions included here are standards imposed in addition to VDSS standards, which must be met to perform Medicaid ADHC services.

HCBS Settings Compliance

Home and Community-Based Services (HCBS) Waivers provide Virginians enrolled in Medicaid long-term services and supports the option to receive community based services as an alternative to an institutional setting. Per federal regulations (42 CFR 441.301), provider operated or controlled settings must have the following characteristics:

- The setting must be integrated in and supports full access to the greater community. This includes opportunities to engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting must ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- The setting must optimize, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- The setting must facilitate individual choice regarding services and supports, and who provides them.
- Use the information and resources provided to critically evaluate each setting's compliance with these standards and to develop strategies to ensure individual's rights are supported and achieved.

Prior to ADHC enrollment, providers must complete a HCBS Provider Self Assessment. The provider can get access to the assessment and further instructions by emailing hcbssettings@dmas.virginia.gov. Once completed, the assessment is reviewed and compliance is verified by DMAS staff. Once the ADHC is determined compliant, they will receive a DMAS Compliance Letter. The ADHC will send a copy of the letter to DMAS Provider Enrollment Services Unit when applying for the NPI number.

Individual Staff Requirements

The number of staff required for an ADHC Center depends upon the level of care required by its participants. Each ADHC Center is required to employ sufficient interdisciplinary staff to adequately meet the health, maintenance, and safety needs of each individual. The following staffing guidelines are required by DMAS. However, DMAS reserves the right to require an ADHC Center to employ additional staff, if, on review, DMAS staff find evidence of unmet individual needs.

“Staff” is defined as professional and aide staff.

“Professional staff” is defined as the Director, Activities Director, RN, Therapist, Social Worker, or LPN.

Adult Day Health Care (ADHC) Minimum Staffing Requirements

1. The ADHC Center will always maintain a minimum staff-individual ratio of one staff member to every six individuals (Medicaid and other participants).

2. There shall be at least two (2) staff persons at the ADHC Center at all times when there are Medicaid individuals in attendance.

3. In the absence of the Director, a professional staff member shall be designated to supervise the program.

4. Volunteers shall be included in the staff-individual ratio only when they meet the qualifications and training requirements of paid staff, and, for each

volunteer, there shall be at least one paid employee also included in the staff-individual ratio.

5. Any ADHC Center that is co-located with another facility shall count only its own separate identifiable staff in the Center's staff-individual ratio.

6. The ADHC Center must employ staff sufficient to meet the needs of the individuals.

These staff include the:

Director - Responsible for the overall management of the ADHC Center's programs and employees. This individual is the provider contact person for the service authorization contractor and is responsible for participation agreements and receiving and responding to communication from DMAS. The Director is responsible for ensuring the initial development of the Plan of Care (DMAS-301) for individuals;

Personal Care Aides - Responsible for overall care and assistance to the individual (assistance with activities of daily living, recreational activities, and other health and therapeutic related activities); and

Registered Nurse (RN) - Responsible for administering and monitoring the health needs of the individual. The RN is responsible for the planning, organization, and management of a Plan of Care (POC) involving multiple services where specialized health care knowledge must be applied in order to attain the desired result. The RN must be present a minimum of 8 hours each month at the ADHC Center. The nurse must be available to meet the nursing needs of all individuals receiving Medicaid ADHC individual services. DMAS does not require that the nurse be a full-time staff position, but the nurse's schedule must be arranged so that each individual is seen every month. There must be a RN available by telephone at a minimum to the ADHC Center's staff and individuals receiving ADHC services during all times

the ADHC Center is in operation. The ADHC Center may contract with either an individual or agency to provide these services, but the ADHC Center must ensure quality service delivery and coordination of the Plan of Care.

The ADHC Center may use one person to fill more than one professional position as long as the requirements for both positions and other staffing requirements are met. The ADHC Center may employ staff as either full-time or part-time as long as the person hired can fulfill the duties of the position and meet the needs of the individuals receiving services. DMAS will enter into Participation Agreements only with ADHC Centers employing a sufficient number of staff whose employment status (full-time, part-time, or contracted RN services) is determined to be sufficient based on the number of individuals in the ADHC Center and the overall functional level or specialized needs of those individual.

7. The Director will assign a professional staff member to act as ADHC Coordinator for each individual. The identity of the ADHC Coordinator must be documented in the individual's file. The ADHC Coordinator is responsible for management of the individual's Plan of Care and reviews the individual's Plan of Care with the program aides. In cases where the individual only receives ADHC and PERS the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.

8. All staff must be 18 years of age or older.

It is the ADHC Coordinator's responsibility to inform the program aides of changes in the Plan of Care and give instruction and direct supervision with any new tasks. If the individual's Plan of Care requires a particular task a program aide is not familiar with, any professional staff available is expected to provide the aide with instruction and direct supervision of the task.

Each professional staff member is responsible for providing input to the Plan of Care, sharing expertise with other staff members through in-service training, providing direct supervision to aides or providing direct care to the individuals, or both.

A multi-disciplinary approach to problem identification, individual goal setting, development and implementation of the Plan of Care and supervision of nonprofessional staff is essential to ensure the provision of quality ADHC services. However, the Center Director has the ultimate responsibility for directing the ADHC Center program and supervision of its staff.

Minimum Qualifications of Adult Day Health Care Staff

I. Personal Care Aide

Each program aide hired must be evaluated by the provider to ensure compliance with minimum qualifications required by DMAS. Basic qualifications for ADHC personal care aides include:

- Ability to read and write in English to the degree necessary to perform the expected tasks;
- Physically able to do the work; and
- Special training in the needs of the elderly and individuals with disabilities through the completion of a minimum 40-hour training program consistent with DMAS requirements. The provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements.
- DMAS requirements may be met in one of the following ways:

1. Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration, which contains a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as an ADHC Aide. A copy of the state certification must be maintained in the aide's

personnel record. If the certification has expired and the aide has not renewed the certification, the provider must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons. DMAS does not require Board of Nursing Nurse Aide Certification in order to perform ADHC aide services; it is merely one type of certification that meets DMAS requirements.

2. Graduation from an Approved Educational Curriculum: The Board of Nursing has an approved list of educational curricula offered by educational institutions throughout the Commonwealth of Virginia which award certificates qualifying the graduate as a Nursing Assistant, Geriatric Assistant, or Home Health Aide. If an aide has successfully completed one of the Board of Nursing-approved courses, the provider must obtain a copy of the applicant's certificate, verify that it is from a Board of Nursing-accredited institution, and maintain the documentation in the aide's personnel file for review by DMAS staff.

3. Training from an Educational/Medical Institution: Numerous hospitals, nursing facilities, and educational institutions provide nursing assistant training that is not Board of Nursing-approved (e.g., out-of-state curricula). This type of nursing assistant training is acceptable to meet DMAS requirements for personal care aides. Providers must obtain documentation from the educational or medical institution confirming the personal care aide successfully completed the course. This must be done prior to offering employment for Medicaid-reimbursed services.

4. Provider-Offered Training: A provider may develop and offer a 40 hour training program incorporating all the following elements:

Goals of Personal Care, Prevention of Skin Breakdown, Physical and Biological Aspects of Aging, Physical and Emotional Needs of Older Adults, Physical Disabilities, Personal Care and Rehabilitative Services, Body Mechanics, Safety and Accident Prevention, Policies and Procedures Regarding Accidents and Injuries, Food Nutrition, and Meal Accommodation, Care of Personal Belongings, Documentation Requirements for Medicaid Individuals.

This training must be conducted by a registered nurse who meets the RN staffing requirements for personal care/respite providers. ALL graduates from the 40-hour provider training program must have a certificate of completion with the RN instructor's signature, printed name, and date of course completion.

5. Completion of the VADSA (Virginia Adult Day Services Association) Aide Note: An aide who has completed the VADSA training does not meet the qualifications as an aide for in-home personal/respite care services.

6. Completion of the most current National Adult Day Services Association curriculum. (Information for this curriculum can be accessed by mailing a request in writing to the address below or by checking their website at:

The National Adult Day Services Association

11350 Random Hills Road, Suite 800
Fairfax, VA 22030
Email: info@nadsa.org
memberservices@nadsa.org
Phone: 1-877-745-1440

Regardless of the method of training received, documentation must be present indicating the training has been received prior to assigning an aide to individuals receiving ADHC services. The provider must verify all information on the employment application prior to hiring an ADHC program aide. It is important that the minimum qualifications be met by each hired aide to ensure the health and safety of individuals.

The aide must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or

exploitation of incapacitated or older adults and children. If the aide has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The personal care aide must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. **The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the *Code of Virginia* or has a founded complaint confirmed by the CPS Central Registry.** The provider must have documentation proving that a criminal background check and central registry check if applicable was obtained. This documentation must be made available to DMAS staff or its contractors, upon request.

Providers shall obtain references from the educational facility, vocational school, or institution where the aide's training was received, if possible. Documentation of the date of the reference check, the individual contacted and his or her relationship to the aide (friend, co-worker, supervisor), and the content of the reference check must be maintained in the employee's personnel record. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff or its contractors.

II. Registered Nurse (RN)

The RN must:

- Be registered and currently licensed to practice nursing in the Commonwealth of Virginia;
- Have one year of related clinical experience as an RN. Clinical experience may include work in an acute care hospital, rehabilitation hospital, public health clinic, home health agency, or nursing facility; and

- The RN must have a satisfactory work history as evidenced by documentation of two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the RN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is be acceptable.

- Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia or has a founded complaint confirmed by the CPS Central Registry.

- Documentation of both license and clinical experience must be maintained in the provider's personnel file for review by DMAS staff or its contractors. A copy of the RN's current license must be in the personnel record.

III. Director

The Director must meet the qualifications of the Director as specified in the VDSS standards for Adult Day Care Centers.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The Director must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia or has a founded complaint confirmed by the CPS Central Registry.

Provider Participation Standards For Personal Emergency Response Systems (PERS) and Medication Monitoring Systems

A participating Personal Emergency Response System (PERS) and Medication Monitoring provider is a certified home health or personal care agency, a Durable Medical Equipment (DME) provider, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring. The PERS provider must meet the standards and requirements set forth by DMAS, and have a current, signed Participation Agreement with DMAS. All PERS providers must enroll as DME providers in order to provide this service to Medicaid individual and to receive reimbursement from Medicaid. Enrollment as a DME provider does not obligate the PERS provider to provide any other DME services. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

In addition to meeting the general conditions and requirements for home- and community-based care participating providers, PERS providers, which provide PERS and Medication Monitoring, must also meet the qualifications described below.

PERS and Medication Monitoring services are designed to prevent or reduce inappropriate institutional care by providing eligible individuals with services that will allow them to live independently while having access to emergency services. This chapter specifies the requirements for approval to participate as a Medicaid provider of the PERS and Medication Monitoring services as a part of the CCC Plus Waiver. The provider will be reimbursed according to the fee schedule available on the DMAS website (www.dmas.virginia.gov). Any provider contracting with Medicaid to provide services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

The PERS provider must provide an emergency response center staff with fully trained operators who are capable of receiving signals for help from an individual’s PERS equipment 24 hours a day, 365, or 366 as appropriate, days per year; determining whether an emergency exists; and notifying an emergency response organization or an emergency responder that the PERS individual needs emergency help.

The PERS provider must comply with all applicable Virginia statutes and all applicable regulations of DMAS and all other governmental agencies having jurisdiction over the

services to be performed.

- The PERS provider must properly install all PERS equipment into a PERS recipient's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

- The PERS provider must maintain all installed PERS equipment in proper working order.

- The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It is the PERS provider's responsibility to ensure that the monitoring agency and the agency's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from the individual's PERS equipment.

The monitoring agency's equipment must include the following: a primary receiver and a back-up receiver, which must be independent and interchangeable; a back-up information retrieval system; a clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test; a back-up power supply; a separate telephone service; a toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and a telephone-line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The monitoring agency must maintain detailed technical and operation manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

In addition to the above, all PERS providers enrolled in the Virginia Medicaid program must adhere to the conditions outlined in their individual Participation Agreements.

Participation Services Facilitation (SF) Provider

A participating Consumer-Directed (CD) Services Facilitator (SF) is a facility, agency, person, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and has a current, signed Participation Agreement with DMAS.

Services facilitation agencies provide supportive services designed to prevent or reduce inappropriate institutional care by offering assistance to eligible waiver individuals for the hiring, training, supervising, and firing responsibilities of the CD attendants, who perform basic health-related services. This chapter specifies the requirements for approval to participate as a Medicaid provider of services facilitation services. The services facilitation provider will be reimbursed according to the fee schedule available on the DMAS website (www.dmas.virginia.gov). Any provider contracting with Medicaid to provide services agrees, as part of the provider Participation Agreement, to adhere to all of the policies and procedures in this Provider Manual.

Provider Participation Standards For Services Facilitation

In addition to meeting the general conditions and requirements for home- and community-based care participating providers, services facilitation providers must meet the following special participation conditions:

1. CD Services Facilitator (SF) Requirements

   The CD Services Facilitator (SF) provides ongoing supervision of the individual's Service Plan. SFs employed after January 11, 2016 shall possess, at a minimum, either an associate's degree or higher from an accredited college in a health or human services field or be a registered nurse currently licensed to practice in the Commonwealth of Virginia. The SF must be 18 years of age or older. The SF must possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults; or possess a bachelor's degree or higher in a non-health or human services field and have a minimum of three years of satisfactory direct care experience supporting individuals with disabilities or older adults.

All SFs shall complete required training and competency assessments with a score of 80% prior to working as a SF. Satisfactory competency assessment results shall be kept in the service facilitator's record. The training and competency assessment can be accessed at: http://www.vcu.edu/partnership/servicesfacilitators/index.html.

All SFs must possess the following knowledge, skills, and abilities:

A. Knowledge of:

a. Types of functional limitations and health problems that may occur in older adults or individuals with disabilities,

as well as strategies to reduce limitations and health problems;

b. Physical assistance typically required by people who have physical disabilities or older adults, such as transferring, bathing techniques, bowel and bladder care, and the approximate time those activities normally take;

c. Equipment and environmental modifications that are commonly used and required by people who have physical disabilities or older adults which reduce the need for human assistance and improve safety;

d. Various long-term services and supports program requirements, including nursing facility level of care criteria, Medicaid waiver services, and other federal, state, and local resources that provide personal assistance and respite services;

e. DMAS consumer-directed personal care attendant and respite services program requirements, as well as the administrative duties for which the individual will be responsible;

f. Conducting assessments (including environmental, psychosocial, and functional factors) and their uses in services planning;

g. Interviewing techniques;

h. The waiver individual's right to make decisions about, direct the provisions of, and control his or her services, including hiring, training, managing, approving time sheets, and firing a personal care aide;

i. The principles of human behavior and interpersonal relationships; and

j. General principles of record documentation.

B. Skills in:

a. Negotiating with individuals and service providers;

b. Assessing, supporting observing, recording, and reporting behaviors;

c. Identifying, developing, and providing services to individuals who have disabilities or older adults; and

d. Identifying services within the established services system to meet the individual's needs.

C. Ability to:

a. Report findings of the assessment or onsite visit, either in writing or in an alternative format for persons who have visual impairments;

b. Demonstrate a positive regard for individuals and their families;

c. Be persistent and remain objective;

d. Work independently, performing position duties under general supervision;

e. Communicate effectively both orally and in writing; and

f. Develop a rapport and communicate with individuals from diverse cultural backgrounds.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The SF must submit to a search of the VDSS Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the Code of Virginia or has a founded compliant confirmed by the CPS Central Registry.

If the services facilitator is not an RN, then the services facilitator shall inform the primary health care provider for the individual who is enrolled in the waiver that services are being provided within 30 days from the start of such services and request consultation with the primary health care provider, as needed. This shall be done after the services facilitator secures written permission from the individual to contact the primary health care provider. The documentation of this written permission to contact the primary health care provider shall be retained in the individual's medical record. All contacts with the primary health care provider shall be documented in the individual's medical record.

Consumer Directed (CD) Personal Care Attendant Requirements

It is the individual's or their chosen Employer of Record (EOR) individual's responsibility to hire, train, supervise, and, if necessary, fire the personal care attendant. The EOR is considered the employer and can be the waiver individual or someone chosen by the individual to represent them. Each personal care attendant hired by the EOR/individual must be evaluated by the EOR/individual to ensure compliance with the minimum qualifications as required by DMAS.

Basic qualifications for personal care attendants include:

- 18 years of age or older;
- Ability to read and write in English to the degree necessary to perform the expected tasks and possess basic math skills;
- Have the required skills to perform care as specified in the individual's Plan of Care;
- Have a valid Social Security Number;
- Submitting to a criminal history record check and a child protective services central registry check for attendants that provide services care for minor children. The personal care attendant will not be compensated for services provided to the individual once the records check verifies the personal care attendant has been convicted of any of the crimes that are described in § 32.1-162.9:1 .
- Attend or receive training at the EOR's/individual's/family's request; and
- Understand and agree to comply with the consumer-directed personal/respite services requirements.

A personal care attendant cannot be the parent (natural, step-parent, adoptive parent, foster parent, legal guardian) of the minor child or the spouse of the individual receiving waiver services. Payment may be made for services rendered by other family members or caregivers living under the same roof as the individual receiving waiver services only when there is written, objective documentation as to why no other attendant is able to provide services for the individual. The family member or caregiver providing personal care services must meet the same requirements as other personal care attendants.

- Personal care attendants are prohibited from also serving as the EOR for the individual receiving waiver services.

SFs are not directly responsible for finding personal care attendants for the individuals; however, they are required to support the individual by providing hiring resources. SFs are also not responsible for verifying personal care attendants' qualifications; this is the responsibility of the EOR.

Assistive Technology (AT) and Environmental Modification (EM) Provider Qualifications

- AT and EM providers must be a durable medical equipment (DME) provider enrolled with DMAS in order to bill for these services for a waiver individual.

- Providers of AT and EM services cannot be spouses, parents (natural, step-parent, adoptive parent, foster parent, legal guardian), of individuals requesting services.

- Providers who supply AT and EM to waiver individuals shall not perform assessments/consultations or write AT or EM specifications for such individuals.

- Providers who supply AT or EM for a waiver individual may not perform design or inspect AT or EM.

Utilization Review and Quality Management Review

Utilization Reviews (UR) conducted by the Program Integrity Division, and Quality Management Reviews (QMR) are conducted periodically by DMAS QMR staff. DMAS Review Analysts, will review provider compliance with participation standards during Utilization Review/QMR. DMAS may retract funds based on documentation reviewed. (See Chapter VI for more information about Utilization Review/QMR.)

Annual Level-Of-Care-Reviews

DMAS will conduct annual level-of-care (LOC) reviews of each individual according to established procedures described in Appendix F of this manual.

If during an annual level of care review, it is determined that an individual who is using consumer-directed services no longer meets the established criteria for waiver services, the SF must inform the individual and EOR. It is the responsibility of the individual and EOR to ensure that the personal care attendants are made aware that the individual no longer meets the level of care criteria to be eligible for CCC Plus waiver services. Payment to attendants on behalf of individuals who no longer meet criteria for waiver services will not continue and any additional payments will be the responsibility of the individual/EOR. The notification from the SF must be made in writing to the individual/EOR within 10 days (plus 3 days for mailing) of receipt of official notification by DMAS.

Individual Rights and Responsibilities

The provider must have a written statement of individual rights, which clearly states the responsibilities of both the provider and the individual in the provision of services. This statement of individual rights must be signed by the individual and the provider representative at the time services are initiated. This statement must be maintained in the individual's file, and a copy must be given to the individual.

The statement of individual rights must include the following:

- The provider's responsibility to notify the individual in writing of any action taken which affects the individual's services;

The provider's responsibility to render services according to acceptable standards of care;

The provider's procedures for patient pay collection;

The individual's obligation for patient pay, if applicable;

The provider's responsibility to make a good faith effort to provide care according to the scheduled Plan of Care and to notify the individual when unable to provide care;

The provider must inform the individual of his or her responsibility to have some planned back-up for times when the provider is unable to secure coverage and to identify which staff the individual should contact regarding schedule changes;

The provider's responsibility to treat the individual with respect, to respond to any questions or concerns about the care rendered, and to routinely check with the individual about his or her satisfaction with the services being rendered;

Offer the individual choice of provider agencies and waiver services;

The individual responsibility to notify the appropriate provider staff whenever the individual's schedule changes or assigned staff fail to appear for work; and

The individual's responsibility to treat provider staff with respect and to communicate problems immediately to the appropriate provider staff.

The Individual's Rights/Responsibilities Statement must include the following notification of the appropriate resources for complaint resolution:

"The DMAS (Medicaid) pays (provider name) to provide (type of service) to you. If you have a problem with these services you should contact (RN, Services Facilitator, ADHC Coordinator, Provider Director, or PERS provider) at (provider telephone)."

If the staff at the agency is unable or unwilling to help you resolve the problem, if you are a CCC Plus member, you may contact your Health Plan Care Coordinator to assist you. For fee for service (FFS) members, you may contact the DMAS Office of Community Living by e-mail at cccpluswaiver@dmas.virginia.gov or the DMAS Recipient Helpline by calling 1-804-786-6145, or by mail at the following address:

DMAS

Office of Community Living

600 East Broad Street, Suite 1300

Richmond, VA 23219

DMAS may terminate a provider from participating upon 30 days' written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to individuals after the date specified in the termination notice.

Termination of a Provider Contract Upon Conviction of a Felony (CCC Plus Waiver)

Subsection § 32.1-325 (D) of the *Code of Virginia* mandates that any Medicaid agreement or contract shall terminate upon conviction of the provider of a felony. A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325(D) and (E). The provider may appeal the

decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial.

Provider Reconsiderations and Appeals (MCO and FFS)

Non-State Operated Provider

For services that have been rendered, providers have the right to appeal adverse actions. However, before appealing to the Department, providers must first exhaust any MCO's or DMAS Contractor's reconsideration process. Providers in an MCO's network may not appeal enrollment or terminations decisions made by the MCO to the DMAS Appeals Division. Providers enrolled with DMAS through the DMAS Contractor may appeal enrollment or termination decisions made by the DMAS Contractor to DMAS once they have exhausted the reconsideration process with the DMAS Contractor.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in Virginia Code § 2.2-4000 *et. seq.* and 12 VAC 30-20-500 *et. seq.*

All provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or the MCO's or DMAS Contractor's adverse reconsideration decision. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues in the reconsideration decision being appealed. Failure to file a written notice of informal appeal within 30 calendar days of receipt of the MCO's or DMAS Contractor's reconsideration decision shall result in an administrative dismissal of the appeal. The notice of appeal must be transmitted to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Appeal requests may be faxed to (804) 452-5454

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. shall be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date shall be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision shall result in dismissal of the appeal. The notice of appeal must be transmitted to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Appeal requests may be faxed to (804) 452-5454.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified

overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director’s decision, that the DMAS Agency Director or his/her designee review

the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Member Appeals (CCC Plus Waiver)

Member Appeals (MCO)

Members or their authorized representatives have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted or deemed exhausted, due to the failure of the MCO to adhere to the notice and timing requirements, prior to a member filing an appeal with the DMAS Appeals Division.

Any member or member's authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. If the member does not request an expedited appeal, the member must follow an oral appeal with a written, signed appeal. For individuals with special needs or who do not understand English, the appeal rights must be provided in such a manner as to make it understandable by the individual.

A member may request continuation of services during the MCO's internal appeal and DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal

may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be faxed to (804) 452-5454. If sent by mail, the appeal request should be mailed to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

Member Appeals (FFS)

Members receiving FFS services through a DMAS Contractor may be required to file an internal appeal with the DMAS Contractor before appealing to DMAS. Providers under contract with a DMAS Contractor seeking to file an appeal on behalf of their client should consult their contract with the DMAS Contractor.

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the member will be expected to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The DMAS Contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS Contractor may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing. Appeals filed orally or electronically must be

received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. The member or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

Appeal requests may be faxed to (804) 452-5454.

If sent by mail, the appeal request should be mailed to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

APPEALS OF ADVERSE ACTIONS

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the

reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered, and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. must be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date must be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision must result in dismissal of the appeal. The notice of appeal must be transmitted through AIMS or sent to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Formal appeal requests may also be faxed to (804) 452-5454.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Member Eligibility

Updated: 2/22/2019

Determining Eligibility

The Department of Medical Assistance Services (DMAS) administers Virginia's medical assistance programs: Medicaid (called FAMIS Plus for children), FAMIS for children under age 19 years, and FAMIS MOMS for pregnant women. FAMIS and FAMIS MOMS offer coverage similar to Medicaid but have higher income thresholds. Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at www.CoverVA.org. DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") Once an applicant has been found eligible, coverage for Medicaid can be retroactive for up to three months before the month in which the application was filed. A member's eligibility must be reviewed when a change in the member's circumstances occurs, and all members are subject to an annual renewal (redetermination) of eligibility.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet. Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. . Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients
- Aged, blind or disabled (ABD) recipients of Supplemental Security Income (SSI) and certain

former SSI recipients with “protected” status
- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older and/or who are eligible for or enrolled in Medicare.
- Low-Income Families with Children (parents with a dependent child under age 18 years in the home)
- Pregnant women, and postpartum women through the end of the 60-day postpartum period (Medicaid, FAMIS MOMS)
- Newborns up to age one year born to mothers who were eligible for Medicaid or covered by FAMIS or FAMIS MOMS at the time of the birth
- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.
- Children under age 19 years (FAMIS Plus, FAMIS)
- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare. These individuals are referred to as Modified Adjusted Gross Income (MAGI) Adults.
- Individuals under age 21 in institutional care
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)—women and men who were certified through the Breast and Cervical Cancer Early Detection Program.
- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care

The following individuals may be eligible for limited Medicaid coverage if they meet the nonfinancial and financial requirements for their covered group:

- Qualified Medicare Beneficiaries (QMBs) with income over 80% of the FPL but within 100% of the FPL. This group is eligible for **Medicaid coverage of Medicare premiums, deductibles, and coinsurance only**.
- Special Low-Income Medicare Beneficiaries (SLMB) with income less than 120% of the FPL. This group is eligible for Medicaid coverage of **Medicare Part B premiums only**.
- Qualified Individuals (QI) with income equal to or greater than 120% but less than 135% of the FPL. This group is eligible for Medicaid coverage of the **Medicare Part B premiums only**.
- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of **Medicare Part A premiums only**.
- Plan First – any individual with income equal to or less than 200% of FPL. This group is eligible for limited Medicaid coverage of family planning services only and not covered for full Medicaid benefits. If a member does not wish to be enrolled in Plan First, he or she should contact the local DSS to be disenrolled.

Medically Needy Covered Groups and Spenddown

Through a process known as “spenddown,” Medicaid provides a limited period of full coverage for certain groups of “Medically Needy” individuals who meet all of the Medicaid eligibility requirements but have excess income for full benefit Medicaid. Individuals to which spenddown may apply include:

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18

- Individuals under Age 21 in institutional care, under supervision of the Department of Juvenile Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

To be eligible for Medicaid, the individual must have incurred medical expenses that at least equal the spenddown liability. If the individual's allowable medical expenses equal the spenddown liability amount before the end of a budget period (six-month period for noninstitutionalized individuals or a one month period for institutionalized individuals), the applicant may receive a limited period of Medicaid coverage which will stop at the end of the budget period. The spenddown liability is the difference between the individual's income and the Medically Needy income limit for the individual's locality, multiplied by the number of months in the individual's spenddown period. Eligibility must be re-determined in order to establish eligibility in subsequent budget periods.

An individual placed on a spenddown does **not** have full Medicaid coverage until the spenddown is met, however they may be eligible for limited Medicaid coverage, Plan First, during the spenddown period. Medicaid cannot pay medical expenses incurred prior to the date the spenddown is met.

Emergency Medicaid Services for Aliens

To be eligible for full Medicaid benefits, FAMIS or FAMIS MOMS, an individual must be a resident of Virginia and a U.S. citizen or an alien qualified for full benefits. Individuals who do not qualify for full Medicaid benefits due to their alien status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage.. The FAMIS and FAMIS MOMS programs do not cover emergency services for undocumented immigrants.

LDSS staff determine eligibility for receipt of emergency Medicaid coverage based on regular eligibility criteria and documentation from the provider of services that emergency services were provided. The provider may refer the individual to the LDSS or Cover Virginia (see Chapter I for information on the covered services and the coverage criteria.) For the purposes of this section, labor and delivery are considered emergency services.

Receipt of the emergency treatment will be verified by the LDSS through the member's medical record obtained from the provider. The LDSS will send a written request to the provider for the necessary documentation of the emergency service. This documentation must include all required Medicaid forms and a copy of the member's complete medical record. For inpatient hospital stays, this documentation will be the medical record for the entire hospitalization up to the 21-day limit for those over age 20.

The LDSS is authorized to approve labor and delivery services of up to three days for a vaginal delivery and five days for a cesarean section. All other services will be referred to DMAS for approval of the coverage of treatment and for establishment of the time for which this coverage will be valid.

If the member is found eligible and the emergency coverage is approved by DMAS, each provider rendering emergency care will be notified via the Emergency Medical Certification Form

(#032-03-628) of the member's temporary eligibility number for coverage of the treatment of the conditions during the time stated on this form. This form will also be used to notify providers if an alien is not eligible for emergency care (See “Exhibits” at the end of this chapter for a sample of this form.).

Medicaid Eligibility for Institutionalized Individuals

An institutionalized individual is defined as one who is receiving long-term services and supports (LTSS) as an inpatient in a medical institution or nursing facility or in the home or community setting. Home and community based services (HCBS) include waiver services such as personal care, adult day health care, respite care, and the Program for All Inclusive Care for the Elderly (PACE).

To be approved for Medicaid-covered LTSS, the individual must be institutionalized in a nursing or other medical facility or have been screened and approved for HCBS. and be eligible for Medicaid in a full-benefit covered group.

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual’s eligibility in the one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person., An married institutionalized individual's spouse at home is referred to as the community spouse. The community spouse is able to retain a specified amount of resources in order to continue to meet maintenance needs in the community. Some of the institutionalized spouse’s monthly income may also be allocated to the community spouse if certain criteria are met. Atthe time of application for Medicaid, the LDSS completes the resource assessment document, which produces a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be allocated to the community spouse). An institutionalized spouse with a community spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

Most individuals receiving LTSS have an obligation toward the cost of their care, known as the patient pay. MAGI adults do not have a patent pay responsibility.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children’s Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia’s Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia’s children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the

state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;

  - Assistive technology

  - Blood lead testing

- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:

  - Intensive in-home services

  - Therapeutic day treatment

- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations
- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)

- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)

- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	**Co-pay Status 1**	**Co-pay Status 2**
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Member Eligibility Card

A blue and white plastic eligibility card is issued to members to present to participating providers. Plan First members receive a green and white identification card. **The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card.** The provider has the responsibility to request such identification as he or she deems necessary. Presentation of a plastic ID card is not proof of coverage nor guarantee of payment. A sample of an eligibility card is included under “Exhibits” at the end of this chapter.

Eligibility must be confirmed each time service is rendered. Verification can occur through a verification vendor, the voice response system or the web-based verification system. LDSS do not provide verification of eligibility to providers.

Some individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral and

authorization from the MCO. These members will have an MCO card in addition to the Medicaid/FAMIS card. The verification response will advise if the member has restrictions such as a contracted MCO enrollment, or a primary payer.

The provider must determine if the service is within the dates of eligibility. These dates must be checked prior to rendering any service. Benefits are available only for services performed during the indicated period of eligibility; Medicaid/FAMIS will not pay for care or services rendered before the beginning date or after the end date of eligibility.

Bank Identifier
The top six numbers on the plastic card represent the Bank Identifier Number (BIN), which is required for pharmacy benefit cards under the National Council of Prescription Drug Programs (NCPDP).

Name of Eligible Person
An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Members enrolled in Plan First receive a green and white identification card. Check the name against another proof of identification if there is any question that the card does not belong to the member.

Member's Eligibility Number
The member's complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or moves into another case, or has a break in eligibility, he keeps the same number and the same card. When members are enrolled in Plan First, they will receive a green and white identification card. This number serves as a "key" in verifying current eligibility status.

All 12 digits must be entered on Medicaid forms for billing purposes.

Date of Birth
The date of birth indicates the member's age and identifies eligibility for those services with age restrictions, such as dental care for members under age 21 and pregnant women. The date of birth should be checked prior to rendering any services. The provider should verify the age of the member. If the provider has a question as to the age of the member, means of identification other than the Medicaid/FAMIS card should be examined.

Sex
The member's gender is indicated on the card.

Card #
The sequential number of the member's card is given. If a card is lost or stolen and another Manual Title All Manuals Chapter III Page 7 Chapter Subject Member Eligibility Page Revision Date 02/22/2019 is issued, the prior card will be de-activated and will not confirm eligibility using the magnetic "swipe" mechanism.

Cardholder's Signature (signature line on back)
The signature line provides another element of verification to confirm identity

Verification of Member Eligibility

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. It is in the best interest of the provider to review the card each time services are rendered. Possession of a card does not mean the holder is currently eligible for benefits. The member does not relinquish the card when coverage is cancelled. Replacement cards must be requested.

Program/Benefit Package Information

Members' benefits vary depending upon the program in which they are enrolled. The eligibility verification will provide information on which program the member is participating in. Examples of these programs include Medallion 3.0, Medicaid fee-forservices, FAMIS MCO, CCC Plus, FAMIS fee-for-service and Medicare premium payment.

Limited Benefit Programs for Which Members Receive Eligibility Cards

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to QMBs. There are two levels of coverage for QMBs, based on financial eligibility.

QMB Coverage Only—Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the member's copayment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage—Members in this group are dually-eligible for full Medicaid coverage and Medicare. They are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These members are responsible for copays for pharmacy services, health department clinic visits, and vision services.

SLMBs and QIs do not receive member eligibility cards because they are not eligible for the payment of medical services rendered.

Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a green and white plastic Plan First identification card. This group's Medicaid verification provides the message, "PLAN FIRST - FAMILY PLANNING SERVICES ONLY." See the Plan First Manual for more information.

All Others—Members without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

Special Indicator Code (Copayment Code)

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services. These codes are:

Code	Message
A	Under 21 - No copay exists.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care - No copay is required for any service.
C	All Other Members - Copays apply for inpatient hospital admissions, outpatient hospital clinic visits, clinic visits, physician office visits, other physician visits, eye examinations, prescriptions, home health visits, and rehabilitation service visits. (Some verification methods may return a yes/no response. Yes = copays apply. No = copays do not apply)

The following copay exemptions apply:

- Members in managed care organizations may not have to pay copays.
- Pregnancy-related services or family planning clinic visits, drugs, and supplies are exempt from copays for all members.
- No copayments apply for any emergency services for any member, with one exception for members in Client Medical Management with a pharmacy restriction. Please refer to the Client Medical Management exhibit in Chapter I for more information on this exception.

The Medicaid member co-pays are located in Chapter IV.

The FAMIS member co-pays are:

Service*	Co-pay Status 1	Co-pay Status 2
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Insurance Information The “Insurance Information” in the verification response indicates any type of insurance coverage the member has in addition to Medicaid. This information includes specific insurance companies, dates of coverage, policy numbers, and a code that specifies the particular type of coverage of the policy. These items are:

Carrier Code	A three-digit code indicating the name of the insurance carrier, e.g. 001 for Medicare (See Insurance Company Code List for these code numbers in “EXHIBITS” at the end of this chapter.) If the carrier code is 003 (not listed), call the member’s local eligibility worker for assistance in obtaining the name of the insurance carrier.
Begin Date	The first date on which this insurance policy was effective
Type Code	An alpha character describing the type of coverage provided by the policy, such as a "D" for dental coverage. (See the Type of Coverage Code List under “EXHIBITS” at the end of this chapter for a list of these codes.)
Policy Number/ Medicare Code	The specific policy or Medicare number for the insurance identified by the Carrier Code

Only insurance information for active policies during the period for which eligibility is requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to his or her LDSS eligibility worker to correct the data so bills will be processed correctly.

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier. Workers' Compensation and other liability insurances (e.g., automobile liability insurance or home accident insurance) are always considered as primary carriers for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-injury information be obtained from the member.

Primary Care Providers (PCPs) for the Client Medical Management Program

A primary care designation or restriction is imposed by the Member Monitoring Unit of DMAS as a result of high utilization of services by the member causing unnecessary or duplicate services. Eligibility verification will list the names of designated primary care providers (physician and/or pharmacy). The designated providers must agree to the relationship prior to the designation appearing on the member's card. Unless it is an emergency, do not provide services without contacting the primary care provider first for authorization.

Managed Care Programs

Most Medicaid members are enrolled in one of the Department’s managed care programs (Medallion 3.0, Medallion 4.0, CCC Plus, PACE). Each program has specific eligibility requirements and health plan assignment criteria for its members. For more information, please contact the individual’s managed care plan/PACE provider directly.

Contact and/or eligibility and assignment information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 3.0: http://www.dmas.virginia.gov/#/med3
- Medallion 4.0:

http://www.dmas.virginia.gov/#/med4
- Commonwealth Coordinated Care Plus (CCC Plus): ttp://www.dmas.virginia.gov/#/cccplus
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/#/longtermprograms

Member Without an Eligibility Card

A member who seeks services without a current eligibility card should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

Assistance to Patients Possibly Eligible for Benefits

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover Virginia Call Center at 1-855-242-8282 for an application for health care coverage. The LDSS or Cover Virginia will notify the patient of eligibility or ineligibility. Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility. The effective date of Medicaid eligibility may be retroactive up to three months prior to the month in which the application was filed, if the patient was eligible during the retroactive period. Once a patient is found eligible, providers may bill Medicaid for covered services, and upon receipt of payment from Medicaid, must reimburse the patient for the out-of-pocket expenses; Medicaid does not reimburse members for out-of-pocket expenses.

Medicaid Applications -- Authorized Representative Policy

Medicaid eligibility requirements are strict and require an applicant or someone conducting business on his or her behalf to attest to citizenship or alien status, declare all income and assets, and make assignment of insurance and medical support benefits. In order to accurately determine eligibility, LDSS must ensure that an individual who files an application or someone conducting business on behalf of the applicant has full knowledge of the applicant’s situation and can provide correct information.

A Medicaid applicant must sign the application form unless the application is filed and signed by the applicant’s legal guardian or conservator, attorney-in-fact, or other person who is authorized to apply on the applicant’s behalf. If the applicant is unable to sign his or her name but can make a mark, the mark must be designated “his/her mark” and witnessed by one person.

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless he or she is legally emancipated from his or her parents. If a child is not legally emancipated, his or her parent or legal guardian, an authorized representative designated by the parent or legal guardian,

or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age may apply for Medicaid on behalf of his or her own child.

A legally competent individual age 18 or older may authorize anyone age 18 or older to file a Medicaid application on his or her behalf provided that the authorization is in writing, identifies the individual or organization authorized to conduct business on his or her behalf, and is signed by the individual giving the authorization.

When an individual has been determined by a court to be legally incompetent or legally incapacitated, the individual's legally appointed guardian or conservator is the individual's authorized representative and can apply for Medicaid on the individual's behalf. If an individual does not have a legal guardian or authorized representative and is mentally unable to sign an application or designate a representative, the individual's spouse will be considered the authorized representative for Medicaid purposes. In situations where the individual is not married, is estranged from his or her spouse, or the spouse is unable to represent him or her, a relative of the individual who is willing to take responsibility for the individual's Medicaid business may be considered his or her authorized representative. Relatives who may be considered authorized representatives in this situation are, in the following order of preference: the individual's adult child; parent; adult sibling; adult niece or nephew; or adult aunt or uncle.

If it is determined that an individual cannot sign an application and does not have an attorney in-fact or authorized representative, a Medicaid application may be filed by someone other than an authorized person provided the individual's inability to sign the Medicaid application is verified by a written statement from the individual's doctor. The statement must indicate that the individual is unable to sign and file a Medicaid application because of his or her diagnosis or condition. The LDSS will pend the application until it can be appropriately signed if it is determined that court action has been initiated to have a guardian or committee appointed for the individual or until an Adult Protective Services investigation concludes that guardianship proceedings will not be initiated. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.

An application may be filed on behalf of a deceased person by his or her guardian or conservator, attorney-in-fact, executor or administrator of his or her estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within a three-month period subsequent to the month of the individual's death. Medicaid coverage can be effective no earlier than three months prior to the application month. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

Non-Medicaid Patient Relationship

Medicaid-eligible members who elect to be treated as private patients or who decline to verify their Medicaid eligibility with providers will be treated as private pay patients by the provider and by DMAS. Providers are required to furnish supporting documentation whenever patients fall into either of these categories.

Newborn Infant Eligibility

All newborn days, including claims for “well babies,” must be submitted separately. “Well baby” days cannot be processed as part of the mother’s per diem, and no information related to the newborn must appear on the mother’s claim.

A newborn is automatically considered eligible for Medicaid or FAMIS through age 1 year if the newborn’s mother was eligible for full coverage Medicaid or enrolled in FAMIS or FAMIS MOMS at the time she gave birth. A medical assistance application must be filed for any child whose mother was not eligible for Medicaid or enrolled in FAMIS/FAMIS MOMS at the time of the child’s birth.

An easy, streamlined way for hospitals to report the birth of the newborn is through the Medicaid Web Provider Portal www.virginiamedicaid.dmas.virginia.gov under the link “E213”. Any hospital staff that have approval from their hospital and have access to the portal may report the newborn’s birth and receive the newborn’s Member ID within 2 business days via email. The provider can verify newborn eligibility from the card using two other identification keys, including name, social security number, and the date of birth. These can be used to access MediCall, the verification vendors, and the web-based system, ARS.

See Chapter I: General Information for more information on eligibility verification.

Medicaid Eligibility for Hospice Services

To be eligible to elect hospice as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked concurrently under both programs.

Guidelines on Institutional Status

Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution, and
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and

- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds.

Incarcerated Individuals

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer, provided they meet all other Medicaid eligibility requirements.

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and
- individuals held in regional and local jails, including those on work release.

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

Once an individual is released from the correctional facility, he can be enrolled in full benefit Medicaid, provided he meets all Medicaid eligibility requirements.

Juveniles

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and postdisposition situations, and types of facilities.

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- Juvenile who is in a detention center due to criminal activity
- Juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site: http://www.djj.virginia.gov/Residential_Programs/Secure_Detention/pdf/Detention_Home_Contacts_02242011rev.pdf.

If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center. A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible for full-benefit Medicaid if he/she is a resident of an ineligible public residential facility. He can be eligible for Medicaid coverage limited to inpatient hospitalization if he is admitted to a medical facility for inpatient services.

Who is Not an Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- The individual is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- The individual is in a public institution for a temporary period pending other arrangements appropriate to his needs. Individuals in public institutions for a temporary period include:
  - individuals admitted under a TDO
  - individuals arrested then admitted to a medical facility
  - inmates out on bail
  - individuals on probation (including a juvenile on conditional probation or probation in a secure treatment center), parole, or conditional release
  - juveniles in a detention center due to care, protection or in their best interest.

Member Appeals

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized

representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. Members who are enrolled in an MCO may appeal to the MCO or directly to DMAS. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was sent, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the member may be expected to repay DMAS for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If services are continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Member appeals must be requested in writing and postmarked or submitted within 30 days of receipt of the notice of adverse action. The member or his authorized representative may complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

If the member is not able to get the form, he may write a letter. The letter must include the name of the person whose request for benefits was denied, reduced, or cancelled. Also, the letter must include the person’s date of birth, social security number, case number, the agency that took the action, and the date of the action.

A copy of the notice or letter about the adverse action should be included with the appeal request. The appeal request must be sent to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, 6th Floor
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

The Appeals Division will notify members of the date, time and location of the hearing if the appeal is valid and a hearing is granted. The hearing will be conducted by a DMAS Hearing Officer. Most hearings will be done by telephone.

The Hearing Officer’s decision is the final administrative decision by DMAS. If the member does not agree with the Hearing Officer’s decision, he/she may appeal it directly to the circuit court in the city or county of residence.

Covered Services and Limitations (CCC Plus Waiver)

Updated: 8/1/2022

The Commonwealth of Virginia offers the following home- and- community- based waivers under the

Medical Assistance Program:

Commonwealth Coordinated Care (CCC Plus) Waiver;

Family and Individual Supports (FIS) Waiver;

Building Independence (BI); and

Community Living (CL) Waiver

These waivers differ according to the populations they serve, the medical and functional criteria for eligibility, the long-term services and supports screening (LTSS Screening) process, and the services offered. Under no circumstances can an individual be enrolled in and receive services under more than one home- and community-based waiver during the same time period. However, individuals may be on a waiver and on a waiting list for another waiver at the same time if they meet criteria for both waivers.

The Medallion 4.0 managed care program focuses on providing high quality care for the Commonwealth's pregnant moms, children, and adults. The Medallion 4.0 Program covers new populations and FAMIS populations. Covered populations also include individuals with Third Party Liability (TPL) and those who receive Early Intervention (EI) Services.

The following link is to the Virginia State Law Portal where the Virginia Administrative Code (VAC) State Regulations are listed at: https://law.lis.virginia.gov/admincode/title12/agency30/.

Providers are responsible for knowing all of the regulations applicable to the programs and services they provide. This provider manual is a guidance document for services offered under the CCC Plus Waiver. It is written for the fee for service (FFS) providers. MCO health plans are expected to offer what is outlined in this manual; however, they may also choose to offer more services or benefits.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) WAIVER

The Department of Medical Assistance Services (DMAS) provides reimbursement for the services provided in the Commonwealth Coordinated Care Plus (CCC Plus) Waiver, which offers individuals an alternative to nursing facility placement. These services include: personal care (agency and consumer-directed), respite (agency and consumer-directed) or skilled respite (agency directed), Adult Day Health Care (ADHC), Personal Emergency Response Systems (PERS) which may include medication monitoring, private duty nursing (PDN), assistive technology (AT), environmental modifications (EM), and transition services (for those individuals meeting criteria who are transitioning back to the community from a Nursing Facility, Specialized Care Facility or Long Stay Hospital).

The LTSS Screening Team (Community or Hospital screeners) must determine if the individual is eligible for CCC Plus Waiver services. DMAS or its service authorization (srv auth) contractor must authorize all waiver services in order for any provider, including

consumer-directed attendants, to be reimbursed. Individuals may be authorized to receive services based on the documented need for the service(s) and the individual's choice of services and providers. For individuals participating in the CCC Plus program, the chosen Managed Care Organization (MCO) will provide srv auth functions.

Screening Procedures for CCC Plus Waiver Services

The LTSS Screening Team must have explored the individual's functional, medical, and nursing needs. If the individual is at risk of institutionalization within 30 days, the screeners must have also analyzed the specific service needs of the individual, and evaluated whether a service or combination of existing services is available to meet these needs. The LTSS Screening Team must educate individuals and their family/caregiver on alternative settings and services to provide the required care before making a referral for CCC Plus Waiver services. Refer to the Screening Provider Manual for Long Term Services and Supports (LTSS) available on the Medicaid web portal located at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library. The VAC Screening Regulations can be found on the Virginia State Law Portal located at: https://law.lis.virginia.gov/admincode/title12/agency30/ (12 VAC 30-60-301 through 12 VAC 30-60-315).

Federal regulations governing Medicaid coverage of home- and community-based services in an approved waiver specify that services must only be provided to individuals who have a need for the level of care provided in the alternative institutional placement when there is a reasonable indication that an individual might need the services unless he or she receives home- or- community-based services. Under the CCC Plus Waiver, services may be furnished only to individuals:

1. Who meet the nursing facility criteria as outlined in the Medicaid Long Term Services and Supports (LTSS) Screening Manual;

2. Who are eligible for Medicaid;

3. For whom an appropriate, cost-effective Plan of Care can be established, including a viable back-up plan;

4. Who are not residents of nursing facilities (licensed by the Virginia Department of Health), or assisted living facilities (licensed by DSS) that serve 5 or more individuals;

5. When there are no other or insufficient community resources to meet the individuals needs; and

6. Whose health, safety, and welfare in the home environment can be ensured.

CCC Plus Waiver services must be the critical services that enable the individual to remain at home rather than being placed in a nursing facility.

Authorization For Medicaid Payment of CCC Plus Waiver Services

Screening by the LTSS Screening Team and authorization of CCC Plus Waiver services by

the service authorization contractor is mandatory before Medicaid will reimburse for CCC Plus Waiver services.

Medicaid will not reimburse for any CCC Plus Waiver services delivered prior to the authorization date of the physician's signature on the DMAS-96. The date of this authorization cannot be made prior to the date on which the screening assessment is completed and the LTSS Screening Team makes a decision and signs the completed screening.

Reimbursement for CCC Plus Waiver services can only be made when there is a valid, approved service authorization that states the individual, specific service and units, dates of service, and the provider/services facilitator (SF). For more information regarding service authorization requirements, please refer to Appendix D of this manual.

Determination of Medicaid Eligibility

Every individual who applies for Medicaid-funded long-term services and supports must have his or her Medicaid eligibility evaluated, or re-evaluated, if already Medicaid eligible, by the local department of social services (LDSS) in the city or county in which he/she resides.

Medicaid will pay for CCC Plus Waiver services only after the LDSS has determined that the individual is eligible for medical assistance for the dates services are to be provided. For questions about eligibility criteria or an individual's eligibility status, contact the local LDSS eligibility worker.

Medicaid Application Pending

DMAS cannot reimburse for CCC Plus Waiver services unless:

1. The screening has been completed by the LTSS Community Screening Team or hospital screener with a determination that the individual meets CCC Plus waiver criteria and waiver services are appropriate;

2. The authorization of CCC Plus Waiver services by the service authorization contractor has been completed;

3. The individual is Medicaid-eligible on the dates that services are rendered; and

4. The individual receives services that are covered under the CCC Plus Waiver as defined by DMAS.

There may be cases in which the individual has been assessed through the LTSS screening process and determined eligible for the CCC Plus Waiver, but Medicaid financial eligibility has not been determined/re-determined. In these cases, the provider/SF/consumer directed attendant may choose to provide services, while awaiting the financial eligibility decision by the LDSS regarding Medicaid financial eligibility, but does so without a guarantee of payment from DMAS. The provider/SF/attendant cannot bill for services provided until the provider/SF verifies that Medicaid has been approved for waiver services via a review either through the Medicall system or the Automated Response System (ARS) verification through the Medicaid web portal and service authorization has been obtained for the service, units, and dates of service.

In some instances, the provider/SF may accept a referral when the individual's Medicaid eligibility is in a pended status. In these instances, the provider/SF must continue to hold the enrollment package until obtaining a valid Medicaid number. If there is difficulty confirming the individual's eligibility status, contact the eligibility worker's supervisor in the LDSS and, if that person is unable to resolve the questions, contact the regional eligibility specialist. Information on regional offices can be found at the following Virginia Department of Social Services site: http://www.dss.virginia.gov/division/regional_offices/index.cgi.

The service authorization request must be submitted to the srv auth contractor within 10-business days of the receipt of verification of Medicaid eligibility in order for services to be authorized retroactively to the start of care date. No payment will be made for services until Medicaid eligibility is established and authorization has been obtained from the srv auth contractor.

No correspondence or invoices should be included with the enrollment or services requests other than the required forms and documentation as specified in Appendix D of this manual,

and the Service Authorization Contractor's website. The srv auth contractor will ensure that level of care criteria and the appropriateness of CCC Plus Waiver services have been met. Any enrollment or service authorization request which is incomplete or submitted incorrectly will be pended by the srv auth contractor, and the provider/SF will be notified. The information must be submitted within the timeframe given on the request for additional information notice or the request may be rejected, denied, or partially approved.

A computer-generated letter from the Medicaid Management Information System (MMIS) will be sent to the provider/SF and waiver individual confirming the authorized service, dates and units. For Consumer Directed (CD) services, the Fiscal/Employer Agent (F/EA) receives the authorization information when the letter is generated. Claims and CD timesheets may be paid at this time for services rendered.

LONG TERM CARE COMMUNICATION FORM (DMAS-225)

The LTC Communication Form (DMAS-225) is used by the LDSS to inform providers of Medicaid eligibility and to exchange information.

Immediately upon initiation of services, the provider/SF must send a DMAS-225 to the eligibility unit of the appropriate local LDSS indicating the provider/SF's first date of service delivery. The LDSS eligibility worker will complete an eligibility determination and notify the individual confirming the date the individual's Medicaid eligibility is effective, provide the Medicaid identification number and will notify the provider via the DMAS-225 of the outcome of the eligibility determination. The provider will be given the begin date of eligibility and the Medicaid identification number for the individual. A copy of this completed DMAS-225 must be kept by the provider/SF in the individual's record. The provider/SF must ensure that a completed DMAS-225 has been received from LDSS and is on file in the individual's record prior to billing for services rendered.

The personal/respite care agency, Adult Day Health Care (ADHC), or SF with the most authorized hours must forward a copy of the DMAS-225 form to all service providers when obtained. All providers must notify each other of any change, including discontinuation of services that occurs in the provision of services via the DMAS-225. When multiple providers are involved in the individual's care, the providers must coordinate the DMAS-225 process. A respite provider is responsible for the DMAS-225 only if respite is the sole service provided.

The provider/SF must notify the LDSS via the discharge DMAS-225 and the srv auth contractor electronically via Atrezzo Connect of the provider's/SF's last date-of-service delivery when any of the following circumstances occurs:

An individual dies - include the date of death;

An individual is discharged or discontinued from services - The date of discharge or discontinuation should be the last date services were rendered for that individual. This includes when the individual is discharged from one provider agency/SF and admitted to another; is admitted to a nursing facility or inpatient rehabilitation hospital (even for one day); or transfers from the CCC Plus waiver to another HCBS waiver or PACE; or

Any other circumstances that cause services to cease or become interrupted for more than thirty (30) consecutive calendar days. Refer to the *Medicaid LTSS Screening* Provider Manual for more information on requirements for updated and new screenings.

The provider/SF must notify DMAS at: LOCreview@dmas.virginia.gov and request a level of care review when an individual no longer meets criteria for the services or the level of care is in question. For providers working with the MCOs, refer to the Broadcast DMAS-31 notification for more information related to DMAS-225 process. The DMAS-31 notification is posted on the DMAS site under the Eligibility Section.

Patient Pay Amount

Patient pay refers to the individual's obligation to pay towards the cost of long-term care services and supports, if the individual's income exceeds certain thresholds. The patient pay amount is determined by the LDSS. The LDSS calculates the monthly patient pay in the Virginia Case Management System (VaCMS) and notifies the individual of the amount. VaCMS transmits the patient pay amount to the MMIS. A patient pay determination is initiated when the provider notifies the LDSS via the Medicaid LTC Communication form (DMAS-225) that an individual on Medicaid has been approved for long-term care services or supports. Whenever there has been a change in the individual's income or circumstances the individual's patient pay amount must be re-evaluated.

The monthly patient pay amount is available to providers through multiple methods: the Automated Response System (ARS), the Virginia Medicaid Web Portal, Medicall and an electronic Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

Patient pay is tracked monthly as claims are processed and deducted from each claim for long-term care services and supports included in the patient pay processing on a first in (date of adjudication) first out basis until fully deducted. These claims will post edit EOB 1750 (Patient Pay Processing Logic Applied). Patient pay will not be dedicated to a specific provider. Patient pay may be deducted from multiple providers for individuals receiving more than one service included in the automated patient pay processing in the month.

Providers must submit claims for all services, even if the provider does not expect reimbursement for a claim due to patient pay. MMIS is only able to track patient pay when a claim is submitted. Providers are responsible for collecting only the amount of patient pay that is deducted from their claim.

Providers can use the patient pay in the MMIS as the initial basis for requesting payment from individuals but should be prepared to refund any excess amount collected to reconcile to the amount deducted from claims. This can happen when more than one provider bills for services furnished in a month.

Providers must send in the Medicaid LTC Communication form (DMAS-225) on a timely basis so that the LDSS can update patient pay in the VACMS/MMIS before new claims are processed. Providers should follow up with the LDSS if patient pay has not been updated in 30 days and escalate it to a supervisor if patient pay has not been updated in 45 days. Providers should contact the DMAS Provider HELPLINE if patient pay has not been updated in 60 days.

If patient pay is updated after claims are processed, those claims will not automatically be reprocessed. DMAS will receive a discrepancy report at the beginning of each month listing the paid claims associated with retroactive patient pay changes made during the prior month. DMAS will make manual adjustments for those claims using adjustment reason 1026 (Patient Payment Amount Changed). Depending on the volume, adjustments will be made within 30-60 days after receipt of the discrepancy report. Providers are to contact the DMAS HELPLINE if an adjustment is not made within this time frame.

Agency providers need to document how the actual patient pay amount was obtained. The

Fiscal/Employer Agent (F/EA) is responsible for ensuring the patient pay amount is withheld from CD reimbursement.

Patient Pay Collection for Consumer Direction (CD)

The only exception to application of patient pay rules stated above is for those choosing to self-direct (consumer direct) their personal care services. When consumer-directed personal care services are authorized, the Fiscal Employer Agent will be responsible for deducting patient pay from any payments made for consumer-directed services. In this situation, patient pay will not be deducted from other claims paid through the MMIS.

Patient Pay when Respite Care is the Sole Service

Respite care providers are only responsible for collecting the patient pay when respite care is the sole service authorized.

Nursing Facility or Inpatient Rehabilitation Hospital Admission

When a CCC Plus Waiver individual is admitted to a Nursing Facility (NF) or an Inpatient Rehabilitation Hospital, the waiver enrollment and service authorizations are automatically terminated. Upon discharge, the waiver provider/SF must submit an enrollment DMAS-225 to the LDSS, perform a new assessment, plan of care, etc. and request a new service authorization for services. Failure to request a new service authorization will result in non-payment to the waiver provider/SF/attendant until such time as all documentation requirements are met and a service authorization has been approved. Requests for readmission must be submitted within the same timeframes as new requests. If a service authorization is not approved for all dates of service or units, providers/SFs/attendants will not be reimbursed by DMAS for denied dates/units.

Hospitalization Of Individuals

When an individual is hospitalized, the provider should contact the hospital discharge planner or hospital case management department to facilitate discharge planning. Information regarding transfers or plans for admission to a Nursing Facility or Inpatient Rehabilitation Hospital can be obtained through discussions with the hospital discharge planner. If the individual will not be returning to community-based services, the provider must discontinue services and send a DMAS-225 to the LDSS and a discharge request to the srv auth contractor that indicates the individual’s last date of service with the provider.

If the individual or family member requests an increase in personal care hours following a hospitalization, the RN/SF must make a post-hospitalization visit to the individual’s home

and assess the need for the increase. The srv auth contractor will not approve an increase in hours until the individual is discharged home and the RN/SF has made the post hospital assessment visit.

AGENCY-DIRECTED (AD) AND CONSUMER-DIRECTED (CD) MODELS OF SERVICE

Individuals may receive Personal Care, ADHC, Respite (skilled and non-skilled), PDN and Personal Emergency Response System (PERS) through an agency-directed model of care. Individuals may also receive Personal Care and Non-skilled Respite through a consumer-directed model of care. The choice of the model of care is made freely by the individual or the caregiver, if the individual is not able to make a choice.

Medicaid payment is available only for services provided when: the individual is present, in accordance with an approved Plan of Care, the services are authorized, and a qualified provider is providing the services to the individual. DMAS will not pay for services rendered to or for the convenience of other members of the household (e.g., cleaning rooms, cooking meals, washing dishes or doing laundry etc. for the family).

An individual may receive CD services along with AD services. For example, an individual receiving CD personal care services can also receive ADHC or agency-directed personal care. However, individuals cannot simultaneously (same billable hours) receive multiple/duplicative services. Simultaneous billing of personal care and respite care services is not permitted. For both AD and CD care, the individual must have a viable back-up plan (e.g. a family member, neighbor or friend willing and available to assist the individual, etc.) in case the personal care aide/attendant is unable to work as expected or terminates employment without prior notice. This is the responsibility of the individual and family and must be identified and documented on the Plan of Care. Individuals who do not have viable back-up plans are not eligible for waiver services until viable back-up plans have been developed.

For AD care, the provider must make a reasonable attempt to send a substitute aide; however, if this is not possible, the individual must have someone available to perform the services needed.

Response to Referral: All Services

The provider/SF shall not begin services for which they expect Medicaid payment until the screening packet is received from the LTSS Screening Team and not before the date authorized by the physician's signature on the DMAS-96. The provider must ensure the receipt of a complete and correct LTSS screening packet prior to starting care.

Individuals who are already receiving a CCC Plus Waiver service and have a need to receive an additional service must have this additional service authorized through the srv auth contractor. The provider shall not begin services prior to the date on the MMIS generated letter authorizing the additional service.

The provider/SF must determine, prior to accepting the referral from the LTSS Screening Team, whether they can adequately provide services to the individual. No referral shall be accepted unless the provider/SF has the staff to provide services, and the individual being referred appears appropriate for the provider's/SFs services. However, there may be instances where the provider/SF is unaware of a problem that will prohibit service delivery until the assessment is completed.

RESPONSE TO INAPPROPRIATE REFERRAL FOR SERVICES

The provider/SF should not initiate services if any one of the following is determined during the initial assessment:

- The individual is not appropriate for CCC Plus Waiver services due to health, safety, or welfare concerns;
- The provider cannot meet the individual's care needs; or
- An appropriate Plan of Care cannot be developed to meet the individual's needs.

If the provider/SF determines that services should not be initiated, the provider/SF must send a denial letter to the individual which includes appeal rights and notify the eligibility worker at LDSS of this decision immediately. The individual will have 30 calendar days to appeal the decision.

If the provider does not initiate care because of the provider's inability to staff the case adequately, the provider must assist the individual with locating another provider. If there is no provider available in the community that is available to staff the case, the provider must inform the individual of this in writing. Providers should explore the possibility of ADHC, CD services, or AD services as an alternative service. If the lack of services creates a concern about the health, safety, or welfare of the individual, Adult Protective Services/Child Protective Services must be notified.

Personal Care Services: Agency and Consumer Directed

Personal care services means a range of support services necessary to enable the individual to remain at or return home rather than enter a nursing facility or Long Stay Hospital and which includes assistance with (activities of daily living) (ADLs), and instrumental activities of daily living, (IADLs) access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition.

Personal care services shall be provided by aides, within the scope of their licenses/certificates, as appropriate, under the agency-directed model; or by personal care attendants under the CD model of service delivery. Personal care is available as either agency-directed (AD) or consumer-directed (CD). These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community, or to participate in community activities. The individual must require assistance with ADLs in order for personal care services to be authorized.

Agency-Directed Model

Individuals may choose agency directed services and select a personal care agency to provide their services. Once an agency has accepted the referral, services must be initiated by the RN Supervisor.

Initial Assessment Visit

The RN Supervisor must make an initial assessment visit on or before the start of care. An assessment visit must also be made when an individual is re-admitted after discharge from services or upon transfer from another provider. During this visit, the RN Supervisor must conduct and document all of the following activities:

- Discuss the individual's support needs, preferences and review of the screening documents from the LTSS Screening Team;
- Assessment and completion of the Community-Based Care Individual Assessment Report

(DMAS-99);

- The RN will identify, with the individual or family/caregiver, all individual needs to be addressed in the Plan of Care (DMAS 97-A/B) and develop a safe, appropriate Plan of Care that will meet the identified needs of the individual.

Children may receive personal care services under the waiver just as the adults.

- The RN will review the Plan of Care with the individual and/or the individual's family and the aide (if present), to ensure that there is complete understanding of the services that will be provided.

- The DMAS-97A/B must be completed with the individual's name, 12-digit Medicaid number, provider name and identification number, ADL composite score, RN signature, individual's signature and start-of-care date. (This is the date that the personal care aide actually begins providing care, and this date should also be the one used on the DMAS-225).

- Introduction of the aide to be assigned to the individual, if services start the same day. Each regularly assigned aide must be introduced to the individual by the RN Supervisor, or other staff (this may be done by telephone) and oriented to the individual's Plan of Care on or prior to the aide's start of care for that individual. The RN/LPN Supervisor must closely monitor every situation when a new aide is assigned to an individual so that any difficulties or questions are dealt with promptly.

- The RN must discuss and determine the appropriate frequency of supervisory visits with the individual/caregiver and document the discussion to include the individual's choice on the DMAS-99. The determination of supervisory visit frequency must be based on the individual's health and safety needs. The minimum frequency of these visits is every 90 calendar days.

The assessment by the RN/LPN Supervisor must be done in the home of the waiver individual. The RN/LPN Supervisor will need to access the surroundings of the individual so that an appropriate Plan of Care can be developed based on the individual's needs in the home where the individual will be receiving the care.

Follow-up Visit

It is recommended that the RN/LPN return for a follow-up visit within 30 calendar days of the initial visit to assess the individual's needs and to make a determination as to whether the plan of care sufficiently meets the individual's needs. When conducted, this visit must be documented on the DMAS-99. At the conclusion of the visit, the DMAS-99 should be signed by the waiver individual. If the individual is a minor or otherwise unable to sign, the primary caregiver, as identified on the DMAS-99, should sign on behalf of the waiver individual. The paid agency aide is not permitted to sign as the individual or primary caregiver.

RN Supervisory Visits

The RN Supervisor must conduct home visits for the purpose of assessing the LPN Supervisor's

performance as well as to assess the on-going needs of the individual and services received. The RN Supervisor must identify any gaps in the LPN's supervisor's ability to function competently and shall provide training as appropriate. The RN Supervisor must also conduct a reassessment of the individual's needs and evaluate the plan of care to ensure the services meets the individual's on-going needs. This visit must be conducted every 90 calendar days and documented in the individual's records.

RN/LPN Supervisory Visits

The RN/LPN Supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of services and to supervise personal care aides. The minimum frequency of these visits is every 90 calendar days.

During the RN/LPN Supervisory visit, the RN/LPN must determine if the Plan of Care continues to meet the individual's needs, and document the review of the plan. If it does not, then a new DMAS 97 A/B must be developed and if a change in the amount of hours is needed, the RN/LPN must submit the request to the srv auth contractor for review. Supporting documentation must be included for hours over the Level of Care (LOC) cap.

A RN/LPN Supervisor must be available to the aides by telephone at all times that an aide is providing services to an individual. A provider may contract with a RN to provide this service. Ongoing assessment of the aide's performance by the RN/LPN Supervisor is also expected to ensure the health, safety, and welfare of the individual.

If the supervising RN/LPN is unable to conduct the regular supervisory visit within required timeframes, it shall be documented in the waiver individual's record with the reasons for the delay. Such supervisory visits shall be conducted within 15 calendar days of the waiver individual's first availability.

Based on continuing evaluations of the aide's performance and the individual's needs, the RN/LPN Supervisor shall identify any gaps in the aide's ability to function competently and shall provide training as necessary. The RN/LPN Supervisor must also perform any subsequent evaluations or changes to the supporting documentation.

Consumer-Directed (CD) Model

Individuals choosing to receive services through the CD model may do so by choosing a SF to provide the training and guidance needed to be an employer. As the employer, the individual is responsible for hiring, training, supervising, and firing attendants. The individual may choose to designate a person to serve as the employer on his/her behalf. The individual or the chosen designee is the Employer of Record (EOR). If the individual is under 18 years of age the parent or responsible adult must serve as the EOR. A person serving as the EOR cannot be the paid caregiver, attendant, or SF. An EOR can only serve on behalf of one individual. The only exception to this is that EORs can serve on behalf of multiple individuals only if the individuals reside at the same address.

Individuals have the right to choose, hire, and employ an attendant whom they know has been convicted of a crime that is not prohibited in the applicable sections of the Code of Virginia (32.1-162.9:1), as may be amended from time to time. When doing so, individuals and family

members/caregivers must understand this decision and that the consequences thereof are their sole responsibility. The Individual/Employer Acceptance of Responsibility for Employment form must be completed and submitted to the F/EA.

All CD services must be authorized by the srv auth contractor and require the services of a SF.

Specific duties of the individual or EOR, as the employer of the CD personal care attendant, include checking references, determining that the employee meets basic qualifications, submitting required hiring documentation to the fiscal employer agent (F/EA), training, supervising performance, and submitting time sheets to the F/EA on a consistent and timely basis. CD attendants are not eligible for Worker's Compensation.

Service Facilitation H2000 Comprehensive Visit: The SF initiates services with the individual upon accepting the referral of service from the LTSS Screening Team. The SF must make an initial comprehensive home visit prior to the start of care by an attendant. During the visit, the SF will work with the individual or family/caregiver to identify all support needs of the individual to be addressed in the Plan of Care. Based on the information discussed and together with the individual or family/caregiver the SF will develop a safe, appropriate Plan of Care that will meet the identified needs of the individual. The initial comprehensive visit is done only once upon the individual's entry into the service. If an individual changes SFs or the individual subsequently adds another CD service, the new provider must conduct and bill for a reassessment visit in lieu of a comprehensive visit.

The initial assessment by the SF, whether a comprehensive or reassessment visit, must be done in the home of the waiver individual. The SF will need to access the surroundings of the individual so that an appropriate Plan of Care can be developed based on the individual's needs in the home where the individual will be receiving the care.

Consumer (Individual) Training (S5109): The SF, using the Employer of Record Manual must provide the individual/EOR with training on the responsibilities as an employer within seven days of the completion of the comprehensive visit (SFs may complete the comprehensive visit and individual training in the same day, if appropriate). To assure that the training content for Employee Management Training meets the acceptable requirements, the SF must use the DMAS CD EOR Manual found on the DMAS website at www.dmas.virginia.gov. The SF must also follow the checklist outlined in the Consumer-Directed Individual Comprehensive Training Form (DMAS-488). This is an outline of the subjects that DMAS requires the SF to cover during the training. The SF must check each subject on the form after it has been covered, and obtain the required signatures and dates. This form must be maintained in the individual's record and be available for review by DMAS staff or DMAS contracted entity. The SF will ensure that the individual/EOR understands his/her rights and responsibilities in the program and signs all of the Participation Agreements including the DMAS-486 and DMAS-489. These forms must be signed before the individual can begin employing an attendant in the program, and a copy of these forms should be kept in the individual's file. The SF should also provide assistance in filling out employer forms in the Employer of Record Welcome Packet that is received from the F/EA.

NOTE: This training is for the employer of the attendant. The SF must not offer training of any type to the attendant.

The consumer training visit (S5109) is only performed once per EOR. If the individual changes EOR, that EOR, so long as the person is not or has not previously fulfilled that role, is required to receive a consumer training visit in order to learn his/her responsibilities as the EOR. Services facilitators should bill for management training (S5116) when an EOR that has received a consumer training visit needs additional training.

If the consumer training takes longer than one visit during that seven-day period, the services facilitator will only submit for one consumer training visit upon completion of all items on the checklist with signatures and dates.

Routine On-site Visits (99509): After the comprehensive visit, it is recommended that the SF conduct two in-home routine visits within 60 calendar days of the comprehensive visit (once every 30 calendar days), to monitor the individual/EOR's ability to hire and maintain attendants, to monitor the individual's Plan of Care and assess both the quality and appropriateness of the services being provided.

After the first two routine in-home visits, the SF and individual can decide how frequent the routine on-site visits will be based on the individual's needs and documented in the record; however, a face-to-face meeting with the individual must be conducted at least every 90 days for personal care. The frequency of these visits shall be documented on the DMAS-99. For respite care, a face to face meeting with the individual must be conducted every six months, or upon the usage of 240 hours of respite, whichever comes first, when it is provided as a sole service, to ensure appropriateness of services (including reassessments at least every 6- months). The SF must review the individual's status, make any needed adjustments to the plan of care, and provide any necessary information to the individual and record all significant contacts in the individual's record.

If the SF is unable to make a visit due to inclement weather or the individual is not available, the SF must document on a progress note in the individual's record the reason for the delay in the visit and document when the next visit will occur. Such routine on site visits shall be conducted within 15 calendar days of the waiver individual's first availability.

During visits with the individual, the SF must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate and document the adequacy and appropriateness of the CD services with regard to the individual's current functioning and cognitive status, medical and social needs, and the established Plan of Care on the DMAS-99. The individual's satisfaction with the type and amount of service must be discussed. The SF must determine if the Plan of Care continues to meet the individual's needs, and document the review of the plan. If it does not, then a new DMAS-97 A/B must be developed and if a change in the amount of hours is needed, the SF must submit the request to the srv auth contractor for review. For hours over the LOC maximum, supporting documentation must be submitted with the service authorization request and the requested hours are not approved retroactive.

The SF must also review copies of the work hours of attendants at least quarterly or more frequently as appropriate to ensure that the hours of service provided are consistent with the Plan of Care. Timesheets may be viewed on the F/EA web portal. If discrepancies are identified in the time sheets in relation to the plan of care, the SF must contact the individual or EOR to resolve discrepancies. If there are consistently discrepancies in the time sheets and training has been offered to the

individual/EOR, the SF must meet with the individual/EOR to determine if CD services remain appropriate (i.e., that the individual or EOR can manage the services).

The SF's documentation of the routine on-site visit must include:

- Whether CD services are adequate to meet the individual's needs and whether changes to the Plan of Care need to be made;
- Any suspected abuse, neglect, or exploitation and to whom it was reported. This must be reported to the Virginia Department of Social Services; Adult Protective Services (APS) or Child Protective services (CPS), as appropriate;
- Hospitalization or change in medical condition, functioning, cognitive status, or social support;
- The individual's or family's /caregiver's (as appropriate) satisfaction with services;
- The presence or absence of the attendant in the home during the visit;
- Any change in who is employed as the attendant. The F/EA cannot pay for any services until a completed packet is received for each employee;
- Dates of and reasons for any service lapses (hospitalization admission, attendant not available, etc.); and
- In addition to the information that must be documented in the SF's routine visit summary, there are several areas (such as bowel/bladder programs, range of motion exercises, catheter and wound care, etc.) that, when they are part of an individual's Plan of Care due to physician's orders, require monitoring by the individual's primary health care professional or a RN and special documentation by the SF of their ongoing completion and the personal care attendant's qualifications to perform these tasks. See this chapter for additional information about the delegation of skilled services.
- A signature from the waiver individual or primary caregiver on the DMAS-99. If the individual is a minor or otherwise unable to sign, the primary caregiver or EOR, as identified on the DMAS-99, should sign on behalf of the waiver individual. The paid attendant is not permitted to sign as the individual or primary caregiver.

Reassessment Visit (**T1028)**: At least every six months for personal care or when respite is the sole service, the SF must meet with the individual or family member/caregiver to conduct a reassessment of the individual's current functional and social support status and a complete summary of all services reviewed. Documentation of the reassessment visit must include a complete review of the individual's needs and available supports and a review of the Plan of Care. The reassessment visit must be documented on a DMAS-99.

On-going Monitoring Activities: The SF is responsible for counseling an individual/EOR regarding the responsibilities as an employer; requesting from the srv auth contractor any changes of the individual's Plan of Care as needed; consulting with the individual/EOR or family member/caregiver as needed; and discussing with the individual the need for additional community based services. The SF

must be available by telephone to individuals receiving CD services during normal business hours, have voice mail capability, and return phone calls within one business day. The SF is not responsible for supervision of personal care attendants and has no authority in hiring/firing attendants. The EOR is solely responsible for attendant supervision.

If the SF determines that the health, safety, or welfare of the individual may be in jeopardy, the SF is responsible for making the appropriate referrals that may include APS/CPS, or if the person is unable to self-direct services a referral to an agency directed service provider may be appropriate.

Management Training (**S5116):** This training is provided by the SF upon the request of the individual/EOR or to address program rules. This training provided to the individual/EOR is to assist in understanding employer-related activities. Management training is not intendent to be needed on-going. Should the EOR need management training consistently, the SF should reassess to determine if the individual is appropriate to serve as the EOR. Management training provided must be documented in the individual's record. Management training must not be used to train the attendant.

Management training can also be used to reimburse the SF for the costs of tuberculosis screening, cardiopulmonary resuscitation certification (CPR), and annual flu immunizations for attendants, as needed. The SF can bill DMAS for the costs of these requirements on behalf of the individual by billing for these costs in management training units and maintaining documentation of these costs in the individual's file.

Verification of Work Hours: The SF shall review attendant hours worked quarterly or more frequently as appropriate to ensure that the hours of service provided are consistent with the Plan of Care. Attendant hours worked may be viewed on the F/EA web portal.

If discrepancies are identified in the work hours in relation to the plan of care, etc., the SF must contact the individual or EOR to resolve discrepancies. Changes in the Plan of Care are warranted if the individual's needs or circumstances have changed. Services provided should be consistent with the Plan of Care. If there are consistently discrepancies in the work hours and training has been offered to the individual/EOR, the SF must meet with the individual/EOR to determine if CD services remain appropriate (i.e., that the individual or EOR can manage the services).

Consumer Directed (CD) Services and Fiscal/Employer Agent (F/EA) Functions

The F/EA performs payroll activities on behalf of the EOR. This allows the individual to use waiver funds to hire and pay attendants. DMAS contracts with the F/EA to ensure that payment to the attendant is based on the approved service authorization which documents the number of hours and services and time sheets approved by the EOR. Time worked by attendants is paid based on 15 minute units. The F/EA keeps payment records, and follows all tax rules on the EOR's behalf.

The SF or F/EA will provide a packet of employment information and necessary forms to the individual/EOR. The forms must be completed and returned to the F/EA before the attendant can be employed. The F/EA will handle responsibilities for the individual for paying the attendant and the related employment taxes. The F/EA will process all necessary employer related forms with the Internal Revenue Services (IRS) in order to complete these duties.

Criminal Record and Child Protective Services (CPS) Registry Check: The F/EA performs required criminal record checks for all attendants. When an attendant is providing services to an individual under 18 years of age the F/EA will screen attendants through the DSS CPS Central Registry. See the Employment Packet for more information. The F/EA will provide the individual/EOR with the results of the criminal record request and/or the CPS check and document in the individual's F/EA record that the individual or family member/caregiver has been informed of the results of the criminal record or CPS registry check. If the attendant has been convicted of crimes described in 12 VAC 30-90-180, or if the registry confirms a founded complaint on the attendant, the attendant will no longer be reimbursed under this program for services provided to the individual effective on the date the individual or EOR was notified of the criminal record/CPS registry finding.

Service Units and Limitations

The unit of service for personal care services is one hour. Payment is available only for allowable activities that are authorized and provided by a qualified provider in accordance with an approved Plan of Care when the individual is present. Personal care services are limited to the hours specified in the Plan of Care.

NOTE: There is a 56 hour per week limit for personal care services. For individuals who require more than 56 hours per week of personal care services, specific exception criteria must be met.

Exception Criteria

The following criteria will be applied by providers when seeking an exception to the 56 hour per week limit for personal care services (whether the services are agency directed or consumer directed or a combination of agency and consumer-directed services).

The waiver individual must have one or more of the following which documents the increase risk of institutionalization:

1. Documentation of dependencies in all of the following activities of daily living: bathing, dressing, transferring, toileting, and eating/feeding, as defined by the current admission screening criteria. (Verification submitted to the srv auth contractor and documented on the questionnaire); OR

2. Documentation of dependencies in both Behavior and Orientation as defined by the current admission screening criteria. (Verification submitted to the srv auth contractor and documented on the questionnaire); OR

3. Documentation from the LDSS that the individual currently has an open case with either Adult Protective Services (APS) or Child Protective Services (CPS) (as described in subdivisions (1) and (2) of this subdivision) and is in need of additional services above the 56 hour per week cap. Documentation can be in the form of a phone log contact or any other documentation provided. (Submitted to the srv auth contractor via attestation.)

- APS: Is defined as a substantiated APS case with a disposition of needs for protective services and the adult accepts the needed services.
- CPS: Is defined as being open to CPS investigation if it is either founded OR a completed family assessment documents the case with moderate or high risk.

When submitting attestation information, upon post payment review and/or Quality Management Review (QMR), should documentation regarding proof of attestation submitted to the srv auth contractor is absent in the clinical record, the provider's reimbursement may be subject to retraction and/or a referral to the Medicaid Fraud Control Unit (MFCU) initiated.

Allowable Activities

Allowable activities for personal care tasks that are performed in accordance with the *Virginia Administrative Code 18VAC90-19-240 et.seq. Delegation of Nursing Tasks and Procedures and the Code of Virginia § 54.1-3001(12)* regarding health care tasks directed by the consumer are also allowable. See this chapter for additional information. For services or tasks delegated in accordance with nurse delegation requirements, the RN must be available to the aide/attendant and be able to respond to any complications immediately. Whenever an aide/attendant is performing any physician-ordered procedure, the delegating RN must document on the DMAS-99 or nursing progress note that the aide/attendant's correct performance of the procedure is being observed and supervised by the RN. This must be documented at least quarterly.

The allowable activities for personal care services include the following:

1. Assistance with activities of daily living (ADLs) such as: bathing or showering, toileting, dressing, transferring, etc.;
2. Assistance with monitoring health status and physical condition;
3. Assistance with self–administration of medication (not to include in any way determining the dosage of medication or the direct administration of medication) and other medical needs;
4. Assistance with preparation and eating of meals, cleaning dishes and eating areas related to the individual's meal (preparation of only the individual's meal is allowed);
5. Assistance with instrumental activities of daily living (IADLs) related to the care needs of the individual such as participant focused housekeeping activities including bed making, dusting, vacuuming, laundry, and grocery shopping, etc., when specified in the individual's Plan of Care and essential to the individual's health or welfare. These activities are limited to those areas that are affected by the individual's direct use and not expected to be performed by the primary caregiver;
6. General support to assure the safety of the individual;

7. Providing routine skin care, such as applying lotion to dry skin, not to include topical medications or any type of product with an "active ingredient";

8. 8. Assistance and support needed by the individual to assure safety and allow the individual to participate in social, recreational, and community activities;

9. Accompanying the individual to appointments or meetings when personal care is needed. For AD services, this must be approved by the agency RN supervisor;

10. Administration of bowel programs by the aide/attendant under special training and supervision, as allowed via nurse delegation or in accordance with the *Code of Virginia. § 54.1-3001(12*). Certain conditions exist that would contraindicate having the aide/attendant perform a bowel program (i.e., patients prone to dysreflexia such as high level quadriplegics, head and spinal cord injured patients, and some stroke patients). Enemas and laxatives cannot be administered by the aide, even if they are included as part of the bowel program. (Suppositories are an exception to this and can be administered if ordered by the physician as part of a bowel program). Replacement of a colostomy bag as part of the bath is included and may be performed by the aide/attendant. Removal of feces, impacted material, and digital stimulation are not permitted and must be performed by a qualified health professional when these activities are included in the bowel program. The above procedures must only be administered with a physician order;

11. Administration of range-of-motion (ROM) exercises by the aide/attendant under special training and supervision, as allowed via nurse delegation. For nurse-delegated ROM, a physician must order ROM exercises every six (6) months or more frequently if changes in the individual's condition occurs. This order from the physician must specify that the individual requires ROM and the frequency to be administered. The aide/attendant may perform ROM when he/she has been instructed by the RN Supervisor in the administration of ROM exercises, and the aide/attendant's correct performance of these exercises has been witnessed and documented by the RN Supervisor. This does not include strengthening exercises, resistance exercises, or exercises aimed at retraining muscle groups. The aide/attendant is only permitted to perform those ROM exercises used to maintain current range of motion without encountering resistance. The RN Supervisor will check the ROM on the supervisory visits and will make adjustments to the exercises as often as necessary according to the physician's orders;

12. Wound Care: The aide can perform routine wound care, which does not include sterile treatment or sterile dressings. A physician must order wound care (even routine which does not include sterile technique) every six (6) months or more frequently if changes in the individual's condition occurs. This includes care of a decubitus, which is superficial or does not exceed Stage I. Normal wound care includes washing the area, drying the area, and applying dry dressings as instructed by the RN Supervisor. This does not include the application of any creams, ointments, sprays, powders, or occlusive dressings (such as hydrocolloids and transparencies);

13. Catheter Care: When routine care of a urinary catheter is to be provided by the personal care aide, the RN Supervisor must indicate in the initial RN Supervisor note that the aide is

providing catheter care and what instructions the aide has received from the RN Supervisor regarding this care. For condom catheters, the RN Supervisor must observe the initial application of the condom catheter and documentation must indicate the aide's ability to perform this procedure. The same procedure must be followed when substitute aides provide condom catheter care. Instruction by the RN Supervisor must include training of the aide regarding knowledge of the circumstances that require immediate reporting to the RN Supervisor;

14. Checking the temperature, pulse, respiration, and blood pressure with recording and reporting as required;

15. Supervision for those individuals who meet the criteria for Supervision as a component of personal care and whose supervision needs are not otherwise met by formal or informal support systems; and

16. Home Maintenance Activities: These activities, which are related to the maintenance of the home or preparation of meals, should only be included in the Plan of Care for individuals who do not have an available caregiver. Caregivers living in the home with the individual would be expected to perform housekeeping and cooking activities for themselves and the individual, while completing their own home maintenance activities. However, this should be done on a case-by-case basis taking into account whether the caregiver is able to perform these activities for the individual (and willing to do so, for adult waiver individuals).

For individuals who do not have someone either living in the home or routinely providing assistance, the following activities may be performed for the individual only (not for other members of the family):

- Preparing and serving meals, not to include menu planning for special diets;
- Washing dishes and cleaning the kitchen;
- Making the bed and changing linens;
- Cleaning the individual's bedroom, bathroom, and rooms used primarily by the individual;
- Listing for purchase supplies needed by the individual;
- Shopping for necessary supplies for the individual if no one else is available to

perform the service;

- Washing the individual's laundry if no other family member is available or able; and emptying trash in rooms primarily used by the individual, if no other family member is available or able;

DMAS will pay the provider only for services rendered to the waiver individual. DMAS will not pay the provider for services rendered to or for the convenience of other members of the individual's household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing family dishes, family laundering, etc.); It is, however, only in very unusual circumstances that a Plan of Care would contain more than two (2) hours per day for housekeeping and meal preparation (combined). These unusual circumstances should be clearly documented on the DMAS-97 A/B and DMAS-99;

17. For CD services, attending training requested by the individual or family member/caregiver that relates to services described in the Plan of Care; and

18. Social activities: The aide/attendant may accompany the individual to community and social activities to assist the individual with personal care needs or allow the individual the opportunity to participate in these activities. Social time cannot be used for the attendant to sit with or socialize with the individual in the home.

Attending To Personal Care Needs of Individuals During Work or Post-Secondary School

Individuals who receive CCC Plus Waiver services may work and/or attend post-secondary school, while receiving services under this waiver and the personal care aide/attendant may accompany the individual to work/post-secondary school, and may assist the individual with personal care needs while the individual is at work/post-secondary school (i.e. communication needs, toileting, or assistance with eating).

DMAS will not pay for the aide to assist the individual with functions related to the individual completing job/school functions or for supervision time during work or post-secondary school, with the exception of physical assistance provided due to the individual's inability to perform this function due to disability.

The srv auth contractor will review the individual's needs when determining the services that will be provided to the individual in the workplace/post-secondary school. The provider/SF must develop an individualized Plan of Care that addresses the individual's needs at home, work, and/or in the community.

DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) or the Rehabilitation Act of 1973. For example, if the individual's only need is for assistance during lunch, DMAS would not pay for the aide for any time extending beyond lunch. For an individual whose speech is such that they cannot be understood without an interpreter (not translation of a foreign language), or the individual is physically unable to speak or make herself/himself understood even with a communication device, the aide's services may

be necessary.

Delegation of Skilled Services

Personal care and respite services shall not include either practical or professional nursing services as defined in the Nurse Practice Act with the exception of skilled nursing tasks that may be delegated pursuant to the *Virginia Administrative Code 18 VAC 90-20-420 et seq*. The delegating RN is responsible for identifying and assessing if the personal care aide/attendant is capable of performing the skilled nursing activity.

If the RN delegates this activity to an aide/attendant, the provider/SF must maintain the following documentation:

- The name of the RN, a copy of the RN's current license, and license number, and qualifications as stated in Chapter II of this manual;
- A description of the assessment conducted by the RN that includes the clinical status and stability of the individual's condition;
- The specific tasks that are to be delegated to the aide/attendant;
- A description of the instruction given to the aide/attendant, and confirmation by the RN that the aide/attendant has been witnessed successfully giving the care;
- Review notes by the RN demonstrating the delegated activity is monitored and supervised by the RN at least every 90 calendar days, or more often if determined appropriate; and
- A current physician's order for the service(s). A new physician's order must be obtained every six (6) months or more frequently if changes in the individual's condition occur.

Exemption of Nurse Delegation Requirements

For CD services, the *Code of Virginia § 54.1-3001(12)* states: "any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks" is exempted from the Nurse Practice Act and nurse delegation requirements.

Key requirements for the exemption from nurse delegation requirements:

- Applies to consumer-directed services only
- Applies to tasks that are "typically" self-performed
- The individual receiving service must be capable of directing the attendant in the appropriate performance of the task.
- The individual must live in a private residence
- The individual must be unable to perform the tasks due to a disability

DEVELOPMENT OF THE PLAN OF CARE (DMAS-97A/B): AGENCY- AND CONSUMER-DIRECTED PERSONAL CARE

The DMAS-97A/B Plan of Care must be completed by the provider/SF at the time of initial evaluation for all individuals. The LTSS Screening documents indicate to the provider/SF the general needs of the individual. The provider/SF should allocate time for the four service categories (which include specific personal/respite care tasks) listed on the DMAS-97A/B. The RN/SF's assessment should note any special considerations for service provision and the support available to the individual. Time does not need to be allocated for each of the tasks on the Plan of Care; these may be checked or a description given, if necessary. Each service category should be totaled if time has been allotted to that category (ADLs, Special Maintenance, Supervision, and IADLs).

Each individual is assigned a level of care based on his/her composite ADL score as calculated on the DMAS-97A/B. The composite ADL score is the sum of a rating of the ADL categories. These categories are bathing, dressing, transfers, ambulation, eating, and continence. The provider/SF must assign a rating for each ADL category that best describes the individual based on the RN/SF's assessment and observation at the time of the initial home evaluation and subsequent reassessments. Once the individual's composite score is derived, a level of care is designated for that individual as a Level A, B, or C. The designation of a level of care determines the **maximum** number of hours per week of personal care services that the individual may have allocated to his/her Plan of Care prior to service authorization. Each level of care category has a **maximum** amount of hours that may be initiated without authorization for that level. The LOC, corresponding composite scores, and **maximum** hours are as follows:

LOC A

(score 0-6)

Maximum Hours prior to service authorization - 25 per week

LOC B

(score 7-12)

Maximum Hours prior to service authorization - 30 per week

LOC C

(score 9+ wounds, tube feedings, etc.)

Maximum Hours prior to service authorization - 35 per week

Prior to designating the level of care, the provider/SF must develop the Plan of Care to reflect the needs of the individual and not necessarily the **maximum amount** of service that the individual is able to have based on the level of care. This **maximum** is based on a seven-day-per-week Plan of Care.

Since the level of care may not reflect the medical needs of the individual based on diagnosis, recent history or the individual's personality or environment, the guidelines may not fully capture the range of needs and support that the provider may encounter. It is only in very unusual circumstances that a Plan of Care would contain more than two (2) hours per day for housekeeping and meal preparation (combined). These unusual circumstances must be clearly documented on the DMAS-99 or DMAS-97A/B. The provider is expected to use professional judgment to determine the amount of service needed by the individual. Documentation must support the amount of hours included in the Plan of Care.

The hours requested on the DMAS-97A/B must be the actual time it takes aide/attendant to assist the individual to perform the tasks for the individual. Although the provider/SF may use the **maximum** allowed for the level of care, it is expected that individuals will not routinely require **maximum amounts** of care.

The level of care maximum composite score may not always reflect the range of needs and supports that the individual may need. Service authorization requests must include documentation to support the hours needed.

A copy of the current provider Plan of Care (DMAS 97 A/B) must be kept in the individual's home. The aide/attendant should be instructed to use the provider Plan of Care as a guide for daily service provision.

For AD services the aide should chart tasks performed that are not included in the individual's Plan of Care if the individual has a need for the task to be done. The aide should note why this task was performed. If the need for this task continues to exist, it is then the responsibility of the RN/LPN, who reviews the aide records, to determine whether there is a need for the task to be included on the Plan of Care on an ongoing basis and make the appropriate changes.

Level of Care A - The individual's score is 6 or less on the ADL composite rating. Individuals in Level of Care (LOC) A are the most functionally capable group and, therefore, should usually require the least amount of services (anywhere from 7.5 to 17.5 hours per week). The **maximum amount** of time per week that an individual in LOC A may be provided services has been established at 25 hours per week prior to service authorization. This **maximum** is based on a seven-day-per-week Plan of Care with an average daily need for ADL care of two (2) hours/day and housekeeping of one and one half (1.5) hours per day, when the individual lives alone. Within the level of care, the amount of time required to perform ADL/IADL and housekeeping tasks will vary.

The following guidelines are intended to assist the provider/SF to determine the appropriate allocations of ADL/IADL time for individuals within LOC A.

1. Minimal Needs – Individual is the least dependent, often borderline in meeting the criteria for nursing facility care (ADL score 2-3). The individual may require prompting rather than hands-on assistance, may use mechanical help more than human help with a need for standby assistance:

   Suggested time allocated for ADLs - .75 - 1 hour/day

   Suggested time for Housekeeping - 1 - 1.5 hours/day

2. Average Needs - Individual has somewhat more need for hands-on help, standby assistance, and are somewhat more dependent (ADL score 3-4):

   Suggested time allocated for ADLs - 1 - 1.5 hours/day

   Suggested time for Housekeeping - 1 - 1.5 hours/day

3. Heavy Needs - Individual will require some help in all areas of ADL care although they will usually be mobile and can probably eat without assistance (ADL score 4-6):

   Suggested time allocated for ADLs - 1.5 - 2 hours/day

   Suggested time for Housekeeping - 1 - 1.5 hours/day

Level of Care B - The individual's score is between 7-12 on the ADL composite rating. Typically, these individuals will require an average of 15 to 28 hours of service per week. The **maximum amount** of time per week that an individual in LOC B may be provided prior to service authorization is 30 hours per week, with an average daily need for ADL care of 2.5 hours/day and housekeeping of 1.75 hours per day, when the individual lives alone. This **maximum** is based on a seven-day-per-week Plan of Care.

The following guidelines are intended to assist the provider/SF to determine the appropriate allocations of ADL/IADL time for individuals within LOC B. Within this level of care, the amount of time required to perform ADL/IADL and housekeeping will vary. Individuals in LOC B probably require between the heavy time allocated in LOC A and an average amount of time for housekeeping tasks.

1. Minimal Needs - Individual may require assistance to ambulate, but are still able to

perform some tasks for themselves (ADL score 7-8):

Suggested time allocated for ADLs - 1.5 - 2 hours/day

Suggested time for Housekeeping - 1 - 1.75 hours/day

2. Average Needs -Individual may require assistance with most ADLs, including transferring, ambulating, eating, and toileting, (ADL score 9-10):

Suggested time allocated for ADLs - 2 - 2.5 hours/day

Suggested time for Housekeeping - 1 - 1.75 hours/day

3. Heavy Needs - Individual will require the maximum amount of help in all areas of ADL care. They will usually be bed-confined and, therefore, may actually take less time to render services than the individual who performs some self-care but requires assistance (ADL score 11-12):

Suggested time allocated for ADLs - 1.5 - 2.5 hours/day

Suggested time for Housekeeping - 1 - 1.75 hours/day

Level of Care C - The individual's score is 9 or more on the ADL composite rating. Individuals in LOC C are the least functionally capable group and must have skilled medical/nursing needs. Examples of skilled needs are wound care requiring the intervention or observation of a licensed nurse or MD, tube feedings, intravenous infusions, etc. Note: These needs merely qualify an individual to be rated as LOC C. These individuals will probably require an average of from 20 to 30 hours per week. The maximum amount of time per week that an individual in LOC C may be provided prior to service authorization has been established at 35 hours per week, with an average daily need for ADL care of three (3) hours per day and IADL/housekeeping of two (2) hours per day, when the individual lives alone.

The following guidelines are intended to assist the provider/SF with determining the appropriate allocations of ADL/IADL time for individuals within LOC C. Within this level of care, the amount of time required to perform ADL/IADL and housekeeping tasks may vary.

1. Minimal Needs - Individuals may have the **maximum** in-home support and minimal special maintenance needs. Some of the individuals in this minimum range of needs within LOC C will actually be quite dependent, but may be cared for quickly merely because they do not participate in their own care:

Suggested time allocated for ADLs - 1.5 - 2 hours/day

Suggested time for Housekeeping - 1 - 2 hours/day

2. Average Needs - Individuals will generally require more ADL time to prevent skin breakdown by frequent turning, may require wound care, feedings completed by the family, etc., and have only moderate support to assist with this care:

Suggested time allocated for ADLs - 2 - 3 hours/day

Suggested time for Housekeeping - 1 - 2 hours/day

3. Heavy Needs – May be individuals living with complex medical needs or their condition provides constant barriers to performance of ADLs without human help and at risk for rapid deterioration if daily supports are not in place.

Suggested time allocated for ADLs - 2 - 3 hours/day

Suggested time for Housekeeping - 1 - 2 hours/day

The **maximum amount** of care established for all levels of care were not established with regard to the need for supervision as a personal care task. Additional time can be added to the Plan of Care beyond the **maximum amount** of time for that individual's level of care, but requires authorization from the srv auth contractor before it can be initiated. The time allocated on the Plan of Care for ADLs, IADLs, Special Maintenance and Supervision shall not be inflated to provide extra personal care time.

Supervision

Personal care services allow for individualized hands on care that is based on the needs of the participant. While individuals may not always require constant ADL supports, there may be a need for the individual to have services authorized during times when they cannot safely be left alone.

Supervision is an allowable activity within the personal care Plan of Care when the purpose is to supervise or monitor those individuals who require and have a documented need for the physical presence of the aide/attendant to ensure their safety during times when no other support system is available. The inclusion of supervision in the Plan of Care is appropriate only in the following situations:

- The individual cannot be left alone **at any time** due to mental or severe physical incapacitation;
- The individual is unable to call for help in case of an emergency and there are no competent adults in the home who are capable of dialing 911 in the event of an emergency; and
- When supervision is deemed necessary to ensure the health, safety, or welfare of the individual.

When members demonstrate a support need that is intermittent in nature, supervision must be considered as an option to provide coverage for participants who are not safe or have health risks that require immediate attention when the member is left alone.

Supervision will not be authorized for family members to sleep either during the day or during the night unless the individual is dependent in orientation and behavior pattern (documented on the DMAS-99) and cannot be left alone at any time due to documented safety issues or wandering risk. Supervision cannot be considered necessary because the individual's family or provider is generally concerned about leaving the individual alone, or would prefer to have someone with the individual. There must be a clear and present danger to the health, safety, or welfare of the individual as a result

of being left unsupervised.

Supervision as a component of personal care must be authorized prior to being rendered and cannot be authorized retroactively. The effective date of authorization for supervision hours will be no earlier than the date of receipt by the srv auth contractor, with the exception of provider transfers, as detailed later in this chapter. In no case shall more than eight hours (8) per day of Supervision as a component of personal care be authorized.

In every case in which the provider/SF has identified the need for supervision to be included in the individual's Plan of Care, the following documentation requirements must be met:

- The RN Supervisor/SF must complete a DMAS-100 (Request for Supervision Form).
- The DMAS-100 form must include:
  - the reason supervision is needed,
  - the amount of supervision needed,
  - the schedules of all adult residents in the home and formal and informal caregivers, and
  - must identify who will provide supervision in the absence of the personal care aide. Supervision cannot be authorized prior to the signature/date of completion of this document.

Supervision time must not include time allotted for ADL, Special Maintenance, or IADL care. The supervision component of the Plan of Care does not include assistance needed for ADL's, Special Maintenance or IADL's. Time for these components must be included in the appropriate section of the Plan of Care. Supervision is not intended as additional time to perform these tasks.

If the individual's primary caregiver has a business or works in the home, supervision will be considered if the individual is documented as being dependent in orientation and behavior pattern on the UAI and/or documented on the DMAS-99. Supervision may be needed when the primary caregiver is working in the home and is unable to provide the required supervision because of work requirements.

The amount of supervision time in the Plan of Care must be no more than is necessary to prevent physical deterioration or injury to the individual and ensure health, safety, and welfare needs are met.

If the individual requires more supervision and time beyond that which is provided through the personal care time allowed for ADLs, Special Maintenance, Supervision and IADLs, the individual must have a support system that is willing and able to provide the additional assistance/supervision. Individuals who have supervision time in the Plan of Care must have documentation that someone is with them 24 hours a day.

If supervision is being requested while the caregiver works, the provider/SF may be asked to submit a note from the caregiver's employer to the srv auth contractor verifying the work schedule.

Personal Emergency Response Systems (PERS) may be an appropriate service for an individual who does not meet all of the requirements for supervision. An individual may not have supervision and PERS simultaneously.

Special Maintenance

Special maintenance is a covered service within the Plan of Care when an individual has an identified need for skilled care that may be performed by an aide/attendant as specified above under Allowable Activities. These tasks may include vital signs and recording of findings, assistance with medications, bowel program, ROM and wound care.

Personal Care Services to More than One Individual in the Same Household

There may be instances in which two or more individuals residing in the same household receives personal care through the same agency or SF. When this occurs, tasks such as meal preparation, cleaning rooms, laundry, and shopping considered as Instrumental Activities of Daily Living (IADL) must be provided for both individuals simultaneously. Each individual will need a Plan of Care with separate ADL hours and shared IADL hours. Should the individuals choose to have separate agencies to provide care or separate SFs, these hours are not shared.

Annual Plan of Care

The provider/SF must either complete a new Plan of Care at least annually or document on the current Plan of Care (DMAS 97A/B) annually that the Plan of Care was reviewed, then date and sign that no changes are necessary. Copies of all Plans of Care must be maintained in the individual's record.

Changes to the Plan of Care

The provider/SF is responsible for making modifications to the Plan of Care as needed to ensure that the aide/attendant and individual/EOR or family/caregiver are aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the individual. Any time there is a need to change the number of hours for an individual, the provider/SF must develop a new Plan of Care. The most recent Plan of Care must always be in the individual's home and available for the aide/attendant to review prior to delivery of services

The provider/SF is permitted to develop a Plan of Care and subsequently make changes to the Plan of Care without prior approval from the srv auth contractor as long as the individual's amount of service does not exceed the **maximum amount** established for that individual's level of care and as long as supervision is not being added as a new service. For changes within the LOC maximum, the provider/SF must submit to the srv auth contractor the change of hours for billing purposes, within the timelines established for submission. Reimbursement for the full amount of services included in the Plan of Care may be denied when the individual's Plan of Care is inflated beyond the actual, documented needs of the individual.

Any hours beyond the maximum for the individual's level of care must be authorized by the DMAS srv auth contractor. DMAS will not reimburse retroactively for hours over the LOC maximum which were provided prior to the date the request was submitted to the srv auth contractor, with the exception of provider transfers, as outlined later in this chapter.

Changes of hours must be submitted to the srv auth contractor. If the hours on the new Plan of Care exceed the individual's current level of care on the DMAS-97A/B, the provider/SF must submit to the srv auth contractor information from the new Plan of Care reflecting the revised hours and updated

composite ADL score reflecting the level of care. The srv auth contractor may request Plans of Care, or any supporting documentation at any time. Providers/SFs are required to submit changes in hours when they occur.

The provider/SF must follow the procedures to request a revised service authorization whenever a change in the individual's condition (physical, mental, or social) indicates that:

- The individual requires supervision to be added to the Plan of Care even if the individual's hours will be within the level-of-care category; or
- An increase or decrease in the Plan of Care is needed regardless of whether it is within or outside of the amount allowed according to the level of care, in order to assure appropriate reimbursement for services.

When multiple providers/SF are working with the individual and a change to the Plan of Care is required all providers/SF involved shall consult to coordinate the changes to the Plan of Care. An individual can have only one SF, but there could be one or more agency providers. This applies to changes upon admission of a new individual or after services have been initiated. This communication must be documented in each provider/SF's individual record.

See Appendix D of this manual for information regarding submittal of service authorization requests.

The srv auth contractor will transmit authorizations or denials into the MMIS. Once the entry has been made, the provider/SF and individual will receive a computer-generated letter notifying them of the decision and providing appeal rights if a partial approval or denial is issued. Individuals have the right to appeal any adverse action taken by the srv auth contractor. A copy of this letter must be maintained in the individual's record. If a denial is issued, the provider/SF will also be notified via fax by the srv auth contractor.

Personal Care Split-Shift Service Delivery (Agency and Consumer-Directed)

There are situations in which the individual may benefit from services offered during two distinct shifts during the day (i.e., morning and evening). For example, an individual may need assistance with ADLs in the morning and additional ADL assistance in the evening. A split shift is indicated when there are at least two hours between each shift. When a split shift is desired, the provider/SF must complete two Plans of Care, labeled AM and PM, to indicate each shift of services. The total number of hours on morning and afternoon Plans of Care combined cannot exceed the number of hours allowed for the individual's level of care without prior approval from the srv auth contractor.

For agency-directed services, when a split-shift service is provided and a different aide is working on each shift, the RN/LPN Supervisor must alternate the supervisory visit between both shifts in order to provide supervision to each aide. If weekend or night service is the only time when the services are provided (example: 11:00 p.m. until 7:00 a.m.), the RN/LPN must make a supervisory visit at least every other visit during the time the aide is working. If the individual is also receiving services during the day hours, and the aide that is providing the weekend or night services is different than the weekday aide, the RN/LPN can make the supervisory visit during the weekday and discuss the other shifts with the individual and/or family/caregiver.

Scheduled Services Not Provided

The personal care aide/attendant is responsible for following the current Plan of Care (DMAS-97A/B). If the aide/attendant does not work the total number of hours during a scheduled day, as it is listed on the DMAS-97A/B, the aide/attendant may use the unused hours on another day within that same week only if:

1. The individual/EOR and/or primary caregiver requests that the unused time be used on another day of that week; and
2. The reason for the hours to be carried over to another day is for extraordinary circumstances that cannot be accommodated by the Plan of Care, and the leftover time is needed to meet the needs of the individual. For Agency Directed care, the need must be documented by the aide on the Provider Aide Record (DMAS-90) and by the RN/LPN in the individual's record. The reason cannot be to allow the aide/attendant to make up the unused hours of the week; and
3. The total amount of hours worked during the week does not exceed the number of authorized hours for the week as noted on the DMAS-97A/B.

Inability Of An Aide To Provide Services And Substitution Of Aides- Agency-Directed (AD) Model If a provider cannot supply an aide to render authorized services, the provider may either obtain a substitute aide from another provider, if the lapse in coverage is expected to be less than two weeks in duration, or may transfer the individual's services to another provider. If the provider obtains a substitute aide from another agency, the two providers are responsible for negotiating the financial arrangements of paying the substitute aide.

When a substitute aide is secured from another provider, the following requirements apply:

- The authorized provider is responsible for providing the supervision for the substitute aide;
- Only the authorized provider may bill DMAS for services rendered by the substitute aide;
- The authorized provider must ensure that all DMAS requirements continue to be met; and
- The agency providing the substitute aide must send to the provider having individual care responsibility a copy of the aide's daily records signed by the individual and the substitute aide. All documentation of services rendered by the substitute aide must be in the individual's record. The documentation of the substitute aide's qualifications must also be obtained and recorded in the personnel files of the responsible provider.

Substitute aides obtained from other providers should be used only in cases where no other arrangements can be made for personal care services coverage, and should be used on a temporary basis. If a substitute aide is needed for more than two weeks, the case must be transferred to another provider that has the aide capability to serve the individual(s).

If no other provider can supply an aide, the provider shall notify the individual or family and explain the possible availability of CD services or ADHC. Service authorization is required in those cases in which the services are transferred to another provider, to CD services, or ADHC.

Some waiver individuals take turns staying with different relatives throughout the year in different parts of the state. Rather than transferring a case back and forth, one primary provider (which could be an ADHC or a personal care provider) may contract with a provider in another city or county to

provide services. In that event, the same procedure should be followed for obtaining a substitute aide.

Respite Care

Respite services are unskilled services (AD or CD) or skilled services of a nurse. Agency-directed respite can be performed either in the home and community of the individual by a personal care aide or at a licensed Children's Residential Facility for children with a developmental disability where multiple staff may provide care during the individual's stay. Respite is for the relief of the **unpaid primary caregiver** due to the physical burden and emotional stress of providing support and care to the waiver individual. The maximum amount of all types of respite care services that an individual may receive is **480 hours** in a state fiscal year (July 1 – June 30).

For AD respite care, the provider agency is responsible for tracking the number of hours used. If the individual is using both AD and CD respite services, the SF and the provider agency must coordinate the tracking of the respite care hours used. Respite care must be authorized by the srv auth contractor before being rendered. If more than 480 hours per state fiscal year are provided, DMAS will only pay for the first 480 hours that are billed.

Individuals who exhaust their maximum amount of hours prior to the end of the authorization period must be informed that no additional hours will be authorized. In these cases, they must wait until the state fiscal year has expired. The provider/SF must ensure that the individual continues to meet the criteria, as stated above, to receive respite services.

An initial Plan of Care (DMAS-97A/B) must be developed by the provider/SF and updated annually.

Note: Respite care can be authorized as a sole waiver service, or it can be offered in conjunction with other services. Medicaid payment is available only for services authorized and provided according to the Plan of Care and provided by a qualified provider.

Skilled Respite Care (Agency-Directed Only)

Providers may be reimbursed for respite services provided by a LPN or an RN with a current, active license and able to practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the individual's skilled needs. DMAS will reimburse for LPN respite care for those individuals who require the skilled level of care and who meet the criteria below.

The circumstances that warrant provision of skilled respite care by a LPN or RN are:

- The individual receiving care has a need for routine skilled care that cannot be provided by unlicensed personnel [i.e., individual requiring nasogastric or gastrostomy feedings, injections, wound care etc. that is not or cannot be delegated or provided in accordance with the *Code of Virginia § 54.1-3001(12)*];
- No other individual in the individual's support system is able to provide the skilled component of the individual's care during the caregiver's absence;
- The individual is unable to receive skilled nursing visits from any other source which could

provide the skilled care usually given by the caregiver; and
- A physician's orders for services is obtained for the skilled care, prior to the service begin date and updated every six months. The DMAS-300 or CMS-485 may be used for this purpose.

Under respite care services, a LPN can perform selected nursing procedures under the direction and supervision of a RN. Such selected procedures may include:

- Administration of medications;
- Care of tracheotomies, feeding tubes, etc.; and
- Wound care requiring sterile technique.

When a nurse is required, the nurse must also provide services normally provided by an aide and shall document the tasks performed on the Skilled Respite Record (DMAS-90A). These records are to be kept in the individual's respite record. For skilled respite services, the nurse's skills and knowledge necessary to provide the services must be documented.

If the individual receives skilled respite services, a separate record or a separate section of the individual's record must contain the forms and necessary documents addressing respite services and authorization.

These respite forms include:

- Skilled Respite Record (DMAS-90A) signed and dated by the nurse and the individual or family/caregiver. It must contain weekly notes on the individual's care and status;
- Respite Care Needs Assessment and Plan of Care (DMAS-300) or CMS-485, if respite is the sole service the individual is receiving;
- The RN Supervisor's documentation using the DMAS-99; and
- A physician's order/CMS-485/DMAS-300 for skilled services. The order must specify the skilled services the nurse will render.

Supervision of Respite: Agency-Directed (AD) Model

The respite care agency shall employ or contract with and directly supervise a RN/LPN who will provide ongoing supervision of respite care aides. A RN shall provide supervision to all direct care LPNs.

When respite care services are received on a routine basis, the minimum acceptable frequency of the required RN/LPN supervisor's visits shall not exceed every 90 calendar days, based on the initial assessment. If an individual is also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN supervisory visits. However, the RN supervisor shall document supervision of respite care separately from the personal care documentation. For this purpose, the same individual record may be used with a separate section for respite care documentation.

When respite care services are not received on a routine basis but are episodic in nature, a RN/LPN supervisor shall not be required to conduct a supervisory visit within a specified number of days. Instead, a RN/LPN supervisor shall conduct the home supervisory visit with the aide/LPN on or before the start of care and make a second home supervisory visit during the second respite care visit. If a

waiver individual is also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN/LPN supervisory visit.

When respite/skilled respite services are offered in conjunction with personal care, the supervisory visit conducted for personal care may serve as the supervisory visit for respite. The RN/LPN must document on the DMAS-99 whether respite is being used and the reason why. The RN/LPN supervisor must document on the DMAS-99 that the supervisory visit is for both personal care and respite care. This documentation may be kept in one record but must be maintained with a separate section for respite services documentation. The supervisor must document supervision of respite services separately. If a separate record is used for both personal care and respite care, the DMAS-99 must be in each record. When the supervisory visit is for both personal care and respite, the DMAS-99 form must be used. A copy of the DMAS-99 may be filed in the respite record or section of the chart; however, the original document must be available in the personal care record or section.

When respite care services are received through a licensed Children's Residential Facility, the RN/LPN supervisor should review the Plan of Care prior to each utilization of respite care services. If the individual's status or health condition have changed, the RN/LPN supervisor should update the Plan of Care as necessary with the family/caregiver. The RN/LPN supervisor shall conduct the supervisory visits with the individual and family/caregiver at the Children's Residential Facility. The RN/LPN supervisor will not be required to perform the visit in the home of the individual.

AGENCY-DIRECTED MODEL OF PERSONAL CARE AND RESPITE SERVICES

Required Documentation for Individual Records for Personal and Respite Care

The provider shall maintain a record for each individual. These records must be separated from those of other services, such as home health services. If an individual receives personal care and respite care services, one record may be maintained, but separate sections must be reserved for the documentation of the two services.

The individual record must include the following documentation:

- If the individual is newly enrolled in the waiver, the LTSS Screening Packet which includes: Uniform Assessment Instrument (UAI); the Screening Authorization signed by all members of the LTSS Screening Team (DMAS-96); the Individual Choice Form (DMAS-97 or DMAS-300 for only Respite Care services);
- All provider Plans of Care (DMAS-97A/B); Supervision Request Form (DMAS-100), if applicable; Community Based Care Individual Assessment Report (DMAS 99); Aide Records (DMAS-90) and all LTC Communication Forms (DMAS-225);
- The initial assessment by the RN must be completed on or before the start of care date on the DMAS-99. This must be filed in the individual's record within two (2) weeks from the date of the visit. Only the DMAS-99 can be used for nursing assessments. The Comprehensive Adult Nursing Assessment form, or OASIS form, is not acceptable;
- All RN/LPN Supervisor notes must be completed and filed within two weeks of the supervisory visit. Any supervisory visit not documented and present in the individual's record will be considered as not having been made;
- The frequency of the RN/LPN Supervisor visit must be conducted within the timeframe that was

agreed upon by the individual and/or caregiver and documented by the RN on the DMAS-99;

- The aide must be present during the RN/LPN Supervisor's visit at least every other visit. If the aide is always present during the Supervisory visit, then every other month the RN/LPN must arrange to speak with the individual/family privately to assess the family and individual's satisfaction with services. If it is not possible to arrange a private conversation with the individual and/or family, the RN/LPN must make a telephone call to the family or individual during non-personal care hours. This telephone conversation must be documented in the individual's record. This gives the family or the individual, or both, the ability to address any concerns or issues without the presence of the aide;
- The RN/LPN Supervisor's documentation, using the DMAS-99, must include the observations of the individual made during the visits as well as any instruction, supervision, or counseling provided to the aide working with the individual. The RN/LPN Supervisor's notes must also clearly document that he/she has discussed with the individual or family member the appropriateness and adequacy of service. Individual/family/caregiver satisfaction with the services should be documented;

    · The RN/LPN Supervisor summary must note:

Any change in the previously documented individual's medical condition, functional status, and social support. The RN/LPN Supervisor is expected to know the nursing facility criteria and to apply the criteria when assessing whether the individual continues to meet nursing facility criteria to receive personal/respite care services. If the RN/LPN Supervisor determines that the individual does not meet criteria for personal/respite care services, the RN Supervisor must contact DMAS for a level of care review and to discuss discontinuation;

Whether the Plan of Care is adequate to meet the individual's needs or if changes need to be made;

Dates of any lapse of services and why (e.g., hospitalization, nursing facility or inpatient rehab hospital admission and discharge dates, aide not available, etc.);

The presence or absence of the aide in the home during the visit; and Any other services received by the individual;

- All provider contacts with the individual, family members/caregivers, health professionals, formal and informal service providers, the srv auth contractor, DMAS, etc., must be documented. All notes must be filed in the individual's records within two (2) weeks from the date of the contact;
- All DMAS-99 and DMAS 97-A/B forms, signed and fully dated by the RN/LPN;
- All personal care/respite aides' records (DMAS-90);

    · Personal/respite services must have an individualized Plan of Care that reflects the results of an assessment completed prior to or on the date services are initiated (and subsequent reassessments annually and as needed) and includes the activities that will be provided during the personal/respite care period and the approximate hours that will be allowed for each activity. The Provider Agency Plan of Care Form (DMAS-97A/B) must be used for this purpose;

The provider must copy the questionnaire and any information entered by direct data entry that is submitted electronically via the srv auth contractor's portal system; and

- During visits to the waiver individual's home, the RN/LPN supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal and/or respite care services with regard to the waiver individual's current functioning status and medical and social needs. The aide's/LPN's record shall be reviewed and the waiver individual's or family's/caregiver's, or both, satisfaction with the type and amount of services discussed and documented.

The provider is responsible for documenting the monitoring of the ongoing provision of services to each Medicaid individual. This monitoring documentation includes:

· The quality of care provided by the aide, LPN (when utilized) and the RN;

· The functional and medical needs of the individual and any modification necessary to the Plan of Care due to a change in these needs; and

· The individual's need for support in addition to care provided by personal/respite care aide. This includes an overall assessment of the individual's health, safety and welfare in the home with personal/respite care.

Aide Responsibilities/Required Documentation: Agency-Directed (AD) Model

The aide is responsible for following the Plan of Care, notifying the RN or LPN Supervisor of any change in condition, support, or problem that arises and documenting the performance of duties on the DMAS-90.

The DMAS-90 must be completed on the day the service was delivered. The DMAS-90 is designed to contain one calendar week of service provision. Agencies may not, in any way, make changes to the DMAS-90. If the same aide renders personal care and respite care services to the individual, a separate DMAS-90 must be used for the different services, even if the two services are rendered on the same day.

Documentation on the DMAS-90 must include:

· the specific services delivered to the waiver individual by the aide;

· the personal care/respite aide's actual daily arrival and departure times;

· the aide's weekly comments or observations about the waiver individual, including the individual's physical and emotional condition, daily activities, and responses to services rendered;

· any other information appropriate and relevant to the waiver individual's care and need for services;

· Signatures: the personal care aide's and individual's or responsible caregiver's weekly signatures, including the date, to verify that personal care services have been rendered during that week as documented in the record. An employee of the provider cannot sign for the individual unless

he/she is a family/caregiver of the individual. This family member cannot be the same family member who is providing the service. In instances where the individual is unable to sign and there is no family member or other legal representative to do so, the reason for the absence of this signature must be thoroughly documented on the DMAS-90. If the individual is unable to sign his/her signature on the DMAS-90, the individual may make an "X". The RN Supervisor must document on the DMAS 99 that the "individual is unable to sign the DMAS-90";

- documentation on the DMAS-90 must be in the English language; and
    - signatures, times and dates shall not be placed on the personal care aide record prior to the last date that the services are actually delivered. The aide record sheets must be in the individual's record within two (2) weeks.

Corrections to any form in the record must be made by drawing a line through the incorrect entry, then re-enter and initial and date the correct information. Correction fluid ("white-out") must never be used for correction in medical records. Copies of all documents are subject to review by state and federal Medicaid staff or representatives. The records contained in the chart must be current within two (2) weeks at all times of the date of service delivery.

It is the responsibility of the provider to ensure that the DMAS-90 are delivered to the provider and filed in the individual's record within two (2) weeks. A periodic review of the DMAS-90 must be done prior to filing it in the individual's record to ensure that the RN Supervisor is aware of any changes in the individual's needs or any changes in the Plan of Care, which may be indicated by the aide's documentation on the DMAS-90. An accurately signed and dated DMAS-90 is the only authorized documentation of services provided for which DMAS will reimburse. DMAS will not accept employee payroll time sheets in place of the DMAS-90.

When respite care services are performed in a licensed Children's Residential Facility, the start and end times of each aide providing care to the minor waiver individual shall not be required on the DMAS-90. Instead, the start and end times of the waiver individual's stay at the facility should be documented. Each aide that provides care to the waiver individual may attach individual notes to the DMAS-90 with a corresponding signature.

Electronic Visit Verification (EVV)

Personal care agencies utilizing HIPAA compliant EVV systems may do so by using a system that records and contains the same elements as the DMAS-90 and permits the system to verify the location from which the services are provided and the individual for whom the services are provided.

The EVV shall: 1.) Ensure daily back-up for all data collected; 2.) Protect data securely and reliably; 3.) Demonstrate a disaster recovery mechanism allowing for use within twelve hours of disruption to services (subject to exceptional circumstances such as war and other disasters of national scope); and 4.) Be capable of producing reports of all services and supports rendered, the individual's identity, the start and end time of the provision of services and supports and the date/s of service in summary fashion that constitute documentation of service that is fully compliant with regulation.

The EVV system, at a minimum, must be able to capture the following required data elements:

1. Type of service performed (personal care or respite);
2. Individual receiving the service;
3. Date of the service;
4. Location of the service delivery (beginning and ending);
5. Individual providing the service; and
6. Time the service begins and ends.

Each personal care aide and individual/family receiving services will have a unique personal identification number or a biometric identification system. The personal care aide shall not be able to enter or modify the time and date. The unique identification system shall constitute the necessary electronic signatures for services. No additional electronic or "wet" signatures shall be required.

Adjustments may be allowed when necessary to EVV shifts. Adjustments must be made by an RN, supervisor, agency owner, or other designee who has the authority to make independent verification. Personal care aides are not permitted to adjust their own shifts nor those of other personal care aides. Each manual entry and/or adjustment must include documentation as to why manual entry was performed and why the visit was not electronically verified at the time of service. If there is an ongoing need to perform a manual entry for an individual's shifts, it must be documented on the DMAS-99 with the explanation, such as no cell phone service, GPS, or landline to verify location.

Claims submitted for reimbursement must not exceed the actual time worked based on the EVV data. Agency staff authorized to make edits should not edit clock-in and clock-out times to match the aide's scheduled start and end times.

Electronic Visit Verification (EVV) and DMAS-90

- Record sheets must be in the individual's record within two (2) weeks.

EVV systems that are used in place of the DMAS-90 must contain the same elements and must be consistent with the DMAS-90 requirements starting on page 41. Personal care agencies should verify that their EVV system matches all of the same fields as located on the DMAS-90. Furthermore, the EVV version of the DMAS-90 should not differ from the paper version. Additional tasks or fields not present on the DMAS-90 should not be listed or made available as tasks to mark as completed.

The aide should adhere to the DMAS-97A/B Plan of Care when rendering services and completing a work shift. EVVsystems must not systematically require task completion in order for the aide to complete the end of the shift. The aid should only document tasks that were actually completed.. I When the Plan of Care includes a task that the aide does not perform during his/her shift, the EVV system should allow the aide to proceed with leaving the task unchecked. As with a paper DMAS-90, the aide should notate why tasks listed in the Plan of Care were not performed via the electronic DMAS-90.

If the EVV system does not capture or have all of the same fields available to complete, the electronic

version does not meet DMAS standards, and the paper DMAS-90 form is required for each service delivery and must be kept in the individual's file.

Attendant Responsibilities/Required Documentation: Consumer-Directed (CD) Model

Documentation must clearly indicate the dates and times of CD personal care services delivery (i.e., shifts submitted to the F/EA contractor). CD attendants may document services on the DMAS-487 (at the discretion of the employer of record, this is optional for CD attendants).

Required Services Facilitation Documentation

The SF must maintain records for each individual served. These records must be separated from those of any other services that may be provided by the SF/SF's employer. All documentation must be filed in the individual's record within two (2) weeks from the date of the visit/contact.

The individual medical record must include the following:

- If the individual is newly enrolled in the waiver, the LTSS Screening Packet which includes: the Uniform Assessment Instrument (UAI); the Pre-Admission Screening Authorization signed by all members of the LTSS Screening Team (DMAS-96); the Individual Choice Form (DMAS-97 or DMAS-300 for Respite Care services, as applicable);
- All provider Plans of Care (DMAS-97A/B); Supervision Request Form (DMAS-100), if applicable; Community Based Care Individual Assessment Report (DMAS 99);
- All copies of the CD Services Plans of Care (DMAS-97 A/B), the results of the SF's initial comprehensive home visit (or initial reassessment visit) completed on or before the start of care date (and subsequent reassessment visits, as needed) on the DMAS-99. Only the DMAS-99 may be used for assessments/reassessments. The start date on the Plan of Care will be the start date of service facilitation services for the individual;

· The SF must copy the questionnaire and any information entered by direct data entry that is submitted electronically via the srv auth contractor's portal system;

- All DMAS-225 forms;

· All correspondence and SF notes recorded and dated documenting contacts with the individual/EOR and family/caregiver, DMAS, and the srv auth contractor;

· Records of contacts made with physicians, formal and informal service providers, and all professionals concerning the individual;

· All management training provided to the individual/EOR or member/caregiver, including the individual's or family/caregiver's responsibility for the accuracy of the attendant's time sheets;

· All documents signed by the individual or the family/caregiver that acknowledge the responsibilities for receipt of the services;

· If tasks are performed requiring nurse delegation, the RN's documentation of training, supervising,

and all other related information and documentation must be maintained by the service facilitation provider.

- All DMAS-99 forms. Documentation must include the observations of the individual made during the visits. The notes must also clearly document that he/she has discussed with the individual or family the appropriateness and adequacy of services.

- **The SF's assessment and reassessment documentation must note:**

  - Any change in the previously documented individual's medical condition, functional status, and social support, which may require modifications to the Plan of Care. The SF is expected to know the nursing facility criteria and to apply the criteria when assessing whether the individual continues to meet nursing facility criteria to receive CCC Plus waiver services. If the SF determines that the individual does not meet criteria for personal/respite care services, the SF must contact DMAS for a level of care review and to discuss discontinuation of services;

  - A review of the Plan of Care with the individual/EOR and family/caregiver (as appropriate) to determine if it is adequate to meet the individual's needs or if changes need to be made;

  - Dates of any lapse of services and why (e.g., hospitalization, nursing facility or inpatient rehab hospital admission and discharge dates, aide not available, etc.);

  - The presence or absence of the attendant in the home during the visit. The individual/EOR and family/caregiver satisfaction with the services should be documented; and

  - Any other services received by the individual.

All criteria and documentation requirements must be met for the entire time the service is provided in order to be reimbursed under the CCC Plus Waiver. The SF will not be reimbursed for services unless the individual is authorized for waiver services by the srv auth contractor.

Transportation (CCC Plus Waiver)

Transportation is available to CCC Plus waiver members; however, is not a service available under the CCC Plus waiver. Transportation to providers of Medicaid services may be arranged through the DMAS transportation broker or through the appropriate CCC Medicare and Medicaid Plan. There are times that the aide/attendant or nurse may accompany the waiver individual to medical appointments or to other activities in the community. In no case will DMAS pay, through the CCC Plus Waiver, for mileage or other costs associated with transportation. The individual and/or aide/attendant assume all risks and responsibilities associated with transportation.

Transportation: Agency-Directed (AD) Services

Aides or nurses (for skilled respite services) may accompany the waiver individual to medical appointments, dialysis or community activities based on the following criteria:

The agency will not be reimbursed for time beyond the already approved Plan of Care hours, or for vacations or overnight trips;

The aide/nurse is essential for the safe transport of the individual (to assist in transfers, ambulation, behavior management, etc.);

No other individual is available and physically able to accompany the individual;

The total time required by the aide/nurse for the day, including the time required to accompany the individual, does not cause the individual's weekly authorized hours to be exceeded. If, due to events beyond the provider's control, the number of hours is exceeded, the provider shall contact the srv auth contractor the next business day with the actual hours used for authorization of hours exceeded in the previous day's visit. The record must document why the hours were exceeded or the additional time may be deducted from another day as long as this does not jeopardize the individual's health and safety. The RN/LPN Supervisor must be notified in advance of the appointment, and must document (with the date) this approval in the RN notes in the individual's record;

When the aide/nurse is required to accompany the individual based on the above criteria, DMAS will pay the agency for the time the aide/nurse is accompanying the individual to such appointments. This must be documented on the aide's/nurse's record; and

DMAS will not pay the provider when the individual is accompanied by the

aide to the hospital or essential medical appointments when the individual is being transported by ambulance.

Transportation: Consumer-Directed (CD) Services

As the attendant is the employee of the individual receiving CD services, any arrangements for transportation not paid for by the Medicaid program are between the attendant and the individual. This includes transportation necessary to implement the CD services Plan of Care (for example, to permit community access and activities). It is permissible for the attendant to transport the individual in the attendant's, the individual's, or the caregiver's vehicle with prior consent from the vehicle owner.

It is the responsibility of the individual or family member/caregiver to determine that the attendant has a valid Virginia driver's license, is registered in the Commonwealth of Virginia, and has vehicle insurance. Proof of the insurance coverage shall be received and shall cover the following.

The vehicle insurance shall cover the insured and/or the other person:

- Against loss from any liability imposed by law for damages;
- Against damages for care and loss of services, because of bodily injury to or death of any person;
- Against injury to or destruction of property caused by accident and arising out of the ownership, use, or operation of such motor vehicle or motor vehicles within the Commonwealth of Virginia, any other state in the United States, or Canada;
- Subject to a limit exclusive of interest and costs, with respect to each motor vehicle of $25,000 because of bodily injury to or death of one person in any one accident and, subject to the limit for one person, to a limit of $50,000 because of bodily injury to or death of two or more persons in any one accident; and

- Subject to a limit of $20,000 because of injury to or destruction of property of others in any one accident.

The total time required by the attendant for the day, including the time required to drive the individual, cannot exceed the individual's authorized weekly hours. If the total time required exceeds daily hours, additional time may be deducted from another day as long as this does not jeopardize the individual's health and safety, or the SF may submit a request within one business day to the srv auth contractor for a temporary increase in hours to provide reimbursement for the extra time in that day.

DMAS will not pay the attendant when the individual is accompanied by the attendant to the hospital or essential medical appointments when the individual is being transported by ambulance.

ADULT DAY HEALTH CARE (ADHC) SERVICES – AGENCY-DIRECTED (AD) ONLY

Service Definition

Adult day health care (ADHC) means long term maintenance or supportive services offered by a DMAS-enrolled community-based adult day care program, licensed by the Virginia Department of Social Services (DSS) as an Adult Day Care Center (ADCC). ADHC provides a variety of health, therapeutic, and social services designed to meet the specialized needs of waiver individuals.

ADHC may be offered either as the sole home-and community-based care service or in conjunction with other CCC Plus waiver services. A multi-disciplinary approach to developing, implementing, and evaluating each individual's POC is essential to ensuring quality ADHC services.

Services Units and Limitations

The services offered by the ADHC Center must be designed to meet the needs of the individual. The range of services provided by the ADHC Center to each individual may vary to some degree and there must be a minimum range of services available to every individual attending ADHC through the CCC Plus waiver to include nursing, rehabilitation services coordination, nutrition, transportation coordination, social services, recreation, and socialization services.

DMAS will reimburse a per-diem fee to a DMAS-enrolled ADHC provider who has received authorization from the srv auth contractor for the claim dates of service. This is considered payment in full for all services rendered to that individual as a part of the individual's approved ADHC Plan of Care. A day is defined as attendance at the ADHC Center for six hours or more.

ADHC services shall not be provided, for the purpose of Medicaid reimbursement, to individuals who reside in NFs, ICFs/IID, hospitals, assisted living facilities that are licensed by VDSS that serve five (5) or more individuals, or group homes which are licensed by DBHDS.

ADHC services may take the place of personal care services either completely or for several days a week if it is determined that this would meet the needs of the individual. ADHC augments the social support system available to the individual by providing some assistance with activities of daily living. An individual may attend ADHC during the day and also receive personal care services in the morning or evening, or both, as appropriate to meet the identified needs.

Staff Responsibilities

Aide Responsibilities: The aide must provide assistance with ADLs (e.g., ambulating, transferring, toileting, eating or feeding, bathing, dressing), supervision of the individual, and assistance with the management of the individual's Plan of Care.

Nursing Responsibilities: These services include periodic evaluation, at least every 90 calendar days, of the nursing needs of each individual; provision of the indicated nursing care and treatment; responsibility for monitoring, recording, and administering prescribed medications; supervising the individual in self-administered medication; or general supervision of provider staff, who are certified through the Board of Nursing, in medication management and administering medications. Nursing functions also include the support of families in their home care efforts through education and counseling, and helping families identify and appropriately utilize health care resources.

Rehabilitation Services Coordination Responsibilities: These services are designed to ensure the individual receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include the coordination and implementation of physical therapy, occupational therapy, and speech therapy. The ADHC Center may arrange for individual rehabilitation treatment with an outpatient facility or independent rehabilitation provider. The coordination and implementation responsibilities of the ADHC Center include:

A referral for an evaluation by the appropriate rehabilitative discipline when necessary;

If the ADHC chooses to offer rehabilitation on-site, then the provision of rehabilitation therapy in the ADHC Center by an independent rehabilitation provider may be offered, if the individual chooses to receive this service during ADHC service hours. Reimbursement for rehabilitation services are not part of the reimbursement fee for ADHC; and

Coordination of any rehabilitative treatment plan into the individual's overall Plan of Care to include arrangement for transportation from the ADHC to the rehabilitation provider if necessary, and implementation by ADHC staff (designated by the Coordinator) of activities typically considered part of a home program prescribed by the therapist in conjunction with ongoing therapy.

Transportation Responsibilities: Every DMAS-approved ADHC Center must provide transportation when needed in emergency situations for any Medicaid individual to his or her home (e.g., the

primary caregiver has an accident and cannot transport the individual home). Any ADHC Center which is able to provide individuals with transportation routinely to and from the center can be reimbursed by DMAS based on a per-trip fee (to and from the individual's residence). Refer to Chapter V for more billing information.

Nutrition Responsibilities: The ADHC Center must provide at least one meal per day, which supplies one-third of the daily nutritional requirements established by the U.S. Department of Agriculture. Special diets and counseling must be provided as necessary.

ADHC Coordination: The ADHC Coordinator, designated by the ADHC Director, must coordinate the implementation of the Plan of Care, make updates to the Plan of Care, record 30-day progress notes, and review the individual's daily log each week (when the log is completed by a program aide). The designation of a professional staff member as the ADHC Coordinator is intended to promote the maintenance of the individual's physical and mental health by coordinating services and providing assistance with any personal or social problems. This may be accomplished by individual or group discussion of problems, coordination with family, home, and other community agencies, counseling and referral to available community resources. In cases where the individual only receives ADHC and PERS, the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.

Recreation and Social Activities Responsibilities: The ADHC Center must provide planned recreational and social activities suited to the needs of the individuals and designed to ensure community integration, encourage physical exercise, prevent deterioration, and stimulate social interaction.

A multi-disciplinary approach to developing, implementing, and evaluating each individual's Plan of Care is essential to quality ADHC services.

Skilled Services and ADHC

An ADHC Center may choose to admit individuals who have skilled needs. Centers that do not employ professional nursing staff on site shall not be permitted to admit waiver individuals who require skilled nursing care to their centers. Examples of skilled nursing care may include: (i) tube feedings; (ii) Foley catheter irrigations; (iii) sterile dressing changing, or; (iv) any other procedures which require sterile technique. The ADHC shall not permit aide employees to perform such procedures unless it is performed in accordance with the Virginia Administrative Code 18VAC90-19-240 through 18VAC90-19-280, *Delegation of Nursing Tasks and Procedures*.

Re-Evaluation of the Adult Day Health Care (ADHC) Individual

The ADHC Center professional staff will continually assess the adequacy of ADHC services for each individual and shall meet and document changes in the individual's condition and Plan of Care at least every three months (this does not mean every 90 days). ADHC services may be authorized for up to seven (7) days of service based on the individual's needs and the center's availability. Any time the number of days an individual attends ADHC changes, the Plan of Care must be modified. The ADHC Coordinator must contact the srv auth contractor to request authorization for the change. The most recent Plan of Care must always be in the individual's record.

Whenever the professional staff determines that ADHC services, either alone or in combination with other community resources, are no longer appropriate for an individual, the ADHC Center will contact

the srv auth contractor for authorization to conduct a re-evaluation of the individual's needs to ensure that the individual is receiving services which meet his/her needs and ensure the individual's continued health and safety in the community in a cost-effective health care setting.

DMAS will conduct annual level of care reviews of each individual according to established procedures described in Chapter VI of this manual.

ADHC Provider Individual Experience Survey

The individual experience survey is intended to determine an individual's experience in the setting where ADHC services are provided and to ensure their experience is consistent that of a home and community based setting. This requirement is for those members receiving ADHC services only.

The contractor shall require that all providers of CCC Plus Waiver ADHC services maintain compliance with the provisions of the CMS HCBS rule as detailed in the provider agreement.

As part of the annual assessment and plan of care review, the managed care organization's care coordinator or another entity as approved by the department shall conduct, an Individual Experience Survey in order to ensure that the member's services and supports are provided in a manner that comports with the setting provisions of the HCBS regulations in 42 CFR § 441.301(c) (4)-(5).

Each member receiving Medicaid ADHC services must receive an annual individual survey to determine their experience with their services and awareness of HCBS rights and requirements.

Conducting the Survey

The Individual Experience Survey must be conducted in person. The survey must include the member and also may include a family member or representative, as appropriate. ADHC services staff may participate as requested by the member and his/her family member/representative.

Inability to Provide ADHC Services

The provider is responsible for providing reliable, continuous care to any individual receiving Medicaid ADHC services for the number of hours per day or days per week as outlined on the Plan of Care. Any time the provider is unable to furnish ADHC services as determined in the Plan of Care, the individual or family/caregivers, as appropriate, must be notified immediately, to initiate other care arrangements for these individuals. Documentation of the contact must be recorded in the individual record. An ADHC provider may either sub-contract with another ADHC provider or may transfer the individual to another ADHC if they cannot provide the number of days per week as written in the Plan of Care.

The provider should explore with the individual, prior to the start of services, the individual's back-up plan or ability to go without service (in the event the provider cannot provide ADHC services). Back-up support can be provided by an informal network of family, friends or neighbors who can be called on as needed as long as this ensures the individual's needs are met.

The center may discharge waiver individuals from the center's services but not from the waiver. Written notice of discharge shall be provided, with the specific reason or reasons for discharge from

the ADHC, at least 10 calendar days prior to the effective date of the discharge. In cases when the individual's or any other person's safety may be in jeopardy, the 10-calendar day notice shall not apply.

ADHC Provider Documentation Requirements

The ADHC Center shall maintain all records of each ADHC individual. These records shall be reviewed periodically by the DMAS staff or its designated agent who is authorized by DMAS to review these records.

At a minimum, the ADHC records shall contain, but shall not necessarily be limited to:

- If the individual is newly enrolled in the waiver the LTSS Screening packet which includes: the Uniform Assessment Instrument (UAI), the Screening Authorization (DMAS-96), and the Screening Team Plan of Care (DMAS-97);
- The Interdisciplinary Plan of Care (DMAS-301) developed in collaboration with the waiver individual or family/caregiver, or both as may be appropriate, by the center's director, RN, and therapist, as may be appropriate, and any other relevant ADHC staff or individual's support persons;
- Documentation of interdisciplinary staff meetings that shall be held at least every three (3) months to reassess each waiver individual and evaluate the adequacy of the POC and make any necessary revisions. The initial ADHC POC can be used for documentation of interdisciplinary staff meetings and to make up to three (3) updates to the Plan of Care as long as the individual's status has not significantly changed. A new Plan of Care should be developed whenever re-evaluation indicates a need for significant changes to the Plan of Care;
- At a minimum, 30-day goal oriented progress notes recorded by the designated ADHC care coordinator. If a waiver individual's condition and treatment POC changes more often, progress notes shall be written more frequently than every 30 days;

  Progress notes must:

  1. Describe the individual's medical and functional status;
  2. Note contacts made to or from the primary caregiver;
  3. Indicate any change in social supports;
  4. Indicate any other services received by the individual; and
  5. Reference a review of the 30-day rehabilitative progress report and updated Plan of Care, if appropriate.

  Note: DMAS does not require a form for recording the progress notes. However, the DMAS-99 form may be used for this purpose. At a minimum, the functional status section of the DMAS-99 form must be completed every 30 days by the RN or ADHC Coordinator;

- The ADHC Center must obtain, or should document efforts to obtain, a rehabilitative progress

report and updated treatment plan from any professional discipline involved in the individual's care every 30 days (e.g., physical therapy, speech therapy, occupational therapy, etc.);

- Daily logs of service provided (DMAS-302) - The daily log must contain the specific services delivered by ADHC Center staff. The log must also contain the actual arrival and departure time of the individual and a weekly signature by either the director, activities director, RN, social worker, or therapist employed by the center. The daily log must be completed on a daily basis, not before or after the date of service delivery. At least once a week, a staff member must chart significant comments regarding care given to the individual. If the staff member writing comments is different from the staff signing the weekly record, that staff member shall sign the weekly comments. A copy of this record shall be given weekly to the individual or family/caregiver and maintained in the individual-specific medical record;
- All contacts shall be documented in the individual's medical record, including correspondence, made to and from the individual, with family/caregivers, physicians, DMAS, the srv auth contractor, formal and informal service providers, and all other professionals related to the waiver individual's Medicaid services or medical care; and
- All Plans of Care.

The provider must use the approved DMAS forms or exact duplicates, where indicated.

Initiation of ADHC Services

Upon receipt of the referral and no later than the individual's fifth (5th) visit to the ADHC Center, the Plan of Care must be developed based on the needs identified by the ADHC professional staff's evaluation of the individual's need for nursing, transportation coordination, nutrition, social services, rehabilitation services coordination, PERS, recreation services, and socialization.

The staff will meet to develop a Plan of Care for that individual, using the ADHC Interdisciplinary Plan of Care (DMAS-301) to document the goals and objectives for each of the major areas of individual needs. The DMAS-301 must include the individual's name and Medicaid number, the ADHC provider identification number, signatures of the interdisciplinary team members present, the date services actually began, and the content of the Plan of Care. The DMAS-301 must also address all medications the individual takes, not just those received at the center.

If, the ADHC Center evaluates the individual's needs and determines a change is needed to the number of days or hours the individual attends the ADHC, the ADHC Center must contact the srv auth contractor to request a change in authorization and at any other time the number of days an individual attends ADHC changes.

If ADHC is the individual's sole CCC Plus Waiver service, the provider must notify the eligibility worker at LDSS and DMAS Level of Care (LOCERI) staff of this decision immediately and provide DMAS with the documentation supporting its decision. If DMAS agrees that the provider should not start services, DMAS will send a letter of notification to the individual informing him/her of this decision and provide appeal rights.

The individual will have 30 calendar days to appeal the DMAS decision. Copies of the DMAS letter to the individual will be sent to the provider.

If DMAS disagrees with the provider's decision not to initiate care, DMAS will contact the provider in writing and inform them that services can be initiated.

If the ADHC determines that they should not initiate services and the individual is receiving at least one other CCC Plus Waiver (not PERS), the ADHC must send a letter of notification to the individual informing them of the decision not to provide services and provide appeal rights.

Monitoring the Individual's Condition and Changes to the Plan of Care for ADHC Services

The ADHC provider must assess the individual's functional, cognitive, and health status and record as necessary any changes to his/her condition in the 30-day progress notes and quarterly on the DMAS-301. The provider must know the DMAS criteria for ADHC services and take action to modify the Plan of Care as needed to ensure that the days and type of care and services are appropriate to meet the current needs of the individual.

If the ADHC determines the individual is no longer appropriate for attendance at the center, the provider may discharge the individual from their center, but not from the waiver. It is the responsibility of the provider to notify DMAS for a level of care review and to discuss discontinuation of services when the provider believes the individual no longer meets criteria for the waiver. Only DMAS may terminate the individual from the waiver. The provider should complete a Level-of-Care Review Instrument (DMAS-99LOC) and send it electronically through the DMAS ePAS system. If the provider has discharged the individual from its services, the provider must also send the Medicaid LTC Communication Form (DMAS-225) with the last date of service to DMAS. The DMAS-225 must also be sent to the LDSS to notify them of the individual's discharge from the provider's services. The discharge request must be made to the srv auth contractor.

Change in Service Procedures for ADHC

Increase in Days of Service

The srv auth contractor must authorize any increase in days of service, either at the time of enrollment or afterward. The ADHC Center must contact the srv auth contractor as described in Appendix D of this manual and provide the following information:

- The reason the increase in days of service is needed; and
- The effective date of the increase.

(Note: If the individual receives personal care under the CCC Plus Waiver, the ADHC Center must have the provider information for the personal care provider/SF and must know how personal care services will be affected by the increase in the days of service.)

If the increase is denied, the srv auth contractor will indicate that the increase was denied and the reason for the denial. The srv auth contractor will send this copy to the ADHC Center. The srv auth contractor will transmit the authorizations or denials in the MMIS system. Once the entry has been made, the provider and individual will receive a computer-generated letter notifying them of the decision and providing appeal rights if a denial is issued. Individuals have the right to appeal any adverse action taken by the srv auth contractor. A copy of this letter must be maintained in the individual's record. If a denial is issued, the provider will also be notified by the srv auth contractor.

The srv auth contractor will not retroactively approve increases.

Decrease in Days of Service (ADHC-Initiated Decrease)

- The ADHC Center will send the individual a letter giving the reason for the decrease, the effective date of the decrease, the individual's Medicaid number, and the individual's right to appeal.
- The decrease request must be submitted to the srv auth contractor, as described in Appendix D, who will process the change requests.
- Once the change request is processed, the provider and individual will receive a computer-generated letter verifying that the change was made.

It is not necessary for the ADHC to send the srv auth contractor the revised Plan of Care or supporting documentation unless this information is requested. The Plans of Care and the Community-Based Care Authorization Forms must be maintained in the individual's record. The Plans of Care and documentation-of-service delivery must be consistent with the information communicated to the srv auth contractor.

Personal Emergency Response Systems (PERS) (CCC Plus Waiver)

Service Definition

Personal Emergency Response System (PERS) is an electronic device that shall be capable of being activated by a remote wireless device and enables individuals to secure help in an emergency. PERS electronically monitors individual's safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation via the individual's home telephone line or other two way voice communication system. When appropriate, PERS may also include medication monitoring devices.

DMAS will only reimburse services as defined in the service description, documented in the individual's approved Plan of Care, and that are within the scope of practice of the providers performing the service.

Criteria

PERS services are limited to those individuals, ages 14 and older, who live alone, are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency. Individuals must be receiving PERS services and another CCC Plus Waiver service simultaneously. While medication monitoring services are also available to those receiving PERS services, medication monitoring units must be physician ordered and are not considered a stand-alone service.

An individual may not receive PERS if he/she has a severe cognitive impairment. The individual must be alert and cognitively able to operate the device appropriately.

Service Units and Limitations

There is a one-time reimbursement for installation of the unit(s) per provider, which shall include installation, account activation, individual and family/caregiver instruction, and removal of equipment when it is no longer needed. The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line or other two way voice communication system within seven (7) days of the request unless there is appropriate documentation of why this time frame could not be met. The provider must furnish all supplies necessary to ensure that the system is working properly. A unit of service for PERS monitoring is a one-month rental price and for nursing services for the purpose of refilling the medication monitoring device is one-half hour.

In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a registered nurse, a licensed practical nurse, or a licensed pharmacist. The units can be refilled every 14 days.

Additional PERS Requirements

The PERS installation shall include local seize line circuitry, which guarantees the unit to have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

A PERS provider must maintain all installed PERS equipment in proper working order and have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

Standards for PERS Equipment

All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The console shall be waterproof; shall automatically transmit to the response center a low-battery alert signal prior to the battery losing power; be able to be worn by the individual; and have the capacity to be automatically reset by the response center after each activation in order to allow subsequent signals to be transmitted without requiring a manual reset by the individual or family/caregiver.

A PERS provider shall furnish education, data, and ongoing assistance to DMAS and/or the srv auth contractor to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and shall instruct the individual, family/caregiver, and responders in the use of the PERS service.

The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices, or medication monitoring unit while the original equipment is being repaired.

The emergency response activator must be activated, either by breath, touch, or by some other means, and must be usable by persons who have visual or hearing impairments or a physical disability. The emergency response console must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24 hours and automatically transmit a low-battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the individual resetting the system in the event it cannot get its signal accepted at the response center.

Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It shall be the PERS provider's responsibility to assure that the monitoring agency and the provider's equipment meets all requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from individuals' PERS equipment.

The monitoring agency's equipment must include the following:

- A primary receiver and a back-up receiver, which must be independent and interchangeable;

- A back-up information retrieval system;

- A clock printer, which must print out the time and date of the emergency signal, the individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;

- A back-up power supply;

- A separate telephone service;

- A toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and

- A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The PERS provider must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

Provider Documentation Requirements

1. The PERS Request Form (DMAS-100A) or the current DMAS approved electronic request, to be completed by the provider/SF may serve as the PERS Plan of Care provided it adequately documents the need for the service, the type of device to be installed, and description of ongoing services, including training regarding the use of the PERS. Information from this form must be submitted to the srv auth contractor for authorization to occur and also maintained in the individual's record;

2. A PERS provider must maintain a data record for each individual utilizing PERS at no additional cost to DMAS or the individual. The record shall document all of the following:

- Delivery date and installation date of the PERS;

- Individual/caregiver signature verifying receipt of PERS device;

    - At a minimum monthly testing to verify that the PERS device is operational;

- Updated and current individual responder and contact information, as provided by the individual, or the individual's care provider; and

- A case log documenting individual system utilization and individual, family/caregiver, provider, SF, or responder contacts/communications;

3. The PERS provider shall document and furnish, within 30 days of the action taken, a written report to the primary provider for each emergency signal, which results in action taken on behalf of the individual. This shall exclude test signals or activations made in error.

This written report must be furnished to the agency provider/SF, or in cases where the individual only receives ADHC services, to the ADHC provider. This information must be maintained in the individual's record at the PERS provider agency. The PERS provider must retain a copy of the DMAS-100A in the individual records.

4. THE PERS PROVIDER MUST OBTAIN AND KEEP ON FILE A COPY OF THE MOST RECENTLY COMPLETED DMAS-225 FOR THE INDIVIDUAL. THE PROVIDER MUST DOCUMENT EFFORTS TO OBTAIN A COPY OF THE DMAS-225 UNTIL IT IS RECEIVED FROM THE PERSONAL CARE, RESPITE CARE, SF OR ADHC PROVIDER.

Private Duty Nursing (PDN)

Service Definition

PDN means in-home nursing services provided for individuals enrolled in the CCC Plus waiver with a serious medical condition and/or complex health care need. The individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse. PDN services may include consultation and training for the primary caregiver, or other providers of care.

PDN is offered to individuals (21 years of age or older) who would otherwise require a specialized care nursing facility placement and supplemented care rendered by a primary caregiver; PDN may be used:

1. To provide supports in the individual's home setting;
2. To accompany the individual to medical appointments; or
3. To facilitate community integration (church, theater, etc.).

Other waiver services can be used in conjunction with PDN such as personal care and skilled respite care, but may not be performed at the same time or duplicate any other service received.

PDN services are authorized by DMAS or its contractors and rendered according to a plan of care (CMS-485) certified by a physician as medically necessary to enable the individual to remain at home rather than in a hospital or nursing facility. PDN may be provided to individuals living in the community who have been authorized to receive certain HCBS as an alternative to receiving services in an institutional setting. PDN includes specific treatments, procedures and individual/primary caregiver training/education related to the developed and certified plan of care goals. PDN services will also meet the medical needs and ensure the health, safety and welfare of the individual while residing in the community.

Private Duty Nursing (PDN) Criteria

Private Duty Nursing (PDN) may be authorized through the CCC Plus waiver for individuals who are chronically ill or have a significant disability, needing a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability.

To qualify for PDN, the *PDN Adult Referral Form (DMAS-108)* or the *PDN Pediatric Referral Form (DMAS-109)* must be completed and the individual must be determined to meet Category A- be dependent on a ventilator, or Category B-must meet all eight (8) specialized care criteria for complex tracheostomy care:

Category A:

Individual dependent on mechanical ventilator; or

Category B:

Individuals who have a complex tracheostomy as defined by:

- Tracheostomy with the potential for weaning off of it, or documentation of attempts to wean with subsequent inability to wean;
- Nebulizer treatments ordered at least four times a day or nebulizer treatments followed by chest physiotherapy provided by a nurse or respiratory therapist at least four times a day;
- Pulse oximetry monitoring at least every shift due to unstable oxygen saturation levels;
- Respiratory assessment and documentation every shift by a licensed respiratory therapist or nurse;
- Have a physician's order for oxygen therapy with documented usage;
- Receives tracheostomy care at least daily;
- Has a physician's order for tracheostomy suctioning; and
- Deemed at risk to require subsequent mechanical ventilation.

PDN is generally provided in the waiver individual's primary residence, as determined on initial enrollment into the waiver.

For individuals receiving PDN services through FFS Medicaid, DMAS will monitor the individual's status and provision of nursing services by telephone contact with the provider as needed and review required documentation routinely submitted by the provider. DMAS will perform annual Level of Care (LOC) assessments in the individual's home. For individuals enrolled with a MCO, these functions will be performed by a care coordinator.

PDN hours are based on the assessed skilled needs of the individual. These hours may be authorized up to a maximum of 112 hours per week, per the DMAS-108.

Primary Caregiver Responsibilities

It is the responsibility of the primary caregiver to assure and provide all care when the private duty nurse is not available. Documentation in the medical record must state the name and phone number of the trained primary caregiver. This trained primary caregiver shall also have a back-up system (i.e.: caregiver) available in emergency situations. Due to the complex medical care needed for individuals receiving PDN services, they may not be left alone at any time.

When an individual approved for PDN services also receives personal care, the primary caregiver is responsible for providing all of the skilled nursing needs. The aide/attendant may only provide the individual with personal care services and cannot be left alone with the individual at any time.

The trained primary caregiver and a back-up caregiver name and phone number should be documented in the medical record of the individual. The back-up caregiver shall accept responsibility

for the oversight and direct care of the individual in case of an emergency, and ensure the health, safety and welfare of the individual when the primary caregiver is ill, incapacitated, or unavailable for any reason. The back-up caregiver will do so without Medicaid compensation and shall be trained in the skilled technologies required by the individual.

When care for enrolled individuals is interrupted due to their primary caregiver's emergency unavailability and an adequate back-up system is not available, hospitalization or placement in a specialized nursing facility shall occur as a temporary last resort alternative.

Private Duty Nursing Agency Response To Referral

Individuals choosing to receive PDN services must do so by choosing a PDN provider enrolled with DMAS to provide the services. Once the agency has accepted the PDN referral, the RN supervisor must make the initial home assessment visit on or before the actual initial start of services date.

Providers shall not begin PDN services until the LTSS Screening packet is received from the screening team or DMAS, and DMAS has approved PDN services. It is the provider's responsibility to review and ensure the receipt of a complete and accurate LTSS Screening packet.

The first date of PDN services cannot be before the physician signature date on the DMAS-96 and must be on the same date as the DMAS PDN service effective date as identified on the Skilled Private Duty Nursing Authorization.

DMAS will coordinate with the chosen nursing provider to assist with a smooth transition to PDN services. The PDN provider shall make available any documentation requested by DMAS as part of the required assessments and home visits.

The RN or LPN providing PDN services will do so according to the nursing services ordered by the physician, in accordance with all Medicaid regulations, policies and provider policies.

DMAS PDN Initial Review

DMAS will work with the screening entities, the physician, the individual/primary caregiver and providers to assure a safe and smooth transition to HCBS. In conjunction with the referral assessment for eligibility criteria, the DMAS review shall include:

1. Verification that the primary caregiver's training needs have been met to ensure the safety of the individual while living in the community;
2. Verification that the discharge planner has included the delivery of medical equipment to the home;
3. Verification that the PDN provider initial assessment home visit has been performed and completed by the RN supervisor; and
4. Verification of the DMAS authorized first date of PDN services.

DMAS will perform an initial assessment within 14 business days of PDN service initiation. The purpose of this assessment is to assure services are rendered according to the physician orders and the assessed needs of the individual. This assessment will include all documentation submitted to DMAS and the required documentation available in the home. DMAS will assure the individual is living

in a safe environment, verifies the primary caregiver/back-up caregiver and ensure choice of services and providers.

Private Duty Nursing Services Visit Requirements

At At a minimum, supporting documentation in the form of physician's orders on the CMS-485, PCA plans of care (97A/B), daily PDN nurses notes and Supervisory Monthly Summary (DMAS-103) forms must clearly describe the following:

- The type of skilled procedures to be performed by the skilled private duty nurse and the type of personal care services being performed;
- The complexity of steps needed to complete each procedure;
- The extent to which the skilled private duty nurse is called upon to use nursing knowledge and expertise to make an assessment, follow-up with a physician, or adjust orders/plans of care; and
- Documentation of all care provided by the skilled private duty nurse.

Initial PDN Assessment Visit

The initial PDN assessment visit is performed by the provider RN Supervisor before the start of PDN or any other waiver services. This visit serves as the admission visit of the individual and involves an assessment of all of the health care needs, social and psychological needs, and additional service needs found as a result of this visit. The provider RN supervisor should also ask and document any signals or alerts the individual uses in the event of an emergency or when the individual is under duress. This visit must occur in the individual's home and be documented on the Provider RN Home Assessment (DMAS-116). A copy of the assessment (DMAS-116) must be sent to DMAS within two (2) business days of the initial visit.

The Physician's Home Health Certification and Plan of Care – CMS- 485 (with or without MD signature) must also be sent to DMAS within two (2) business days of the initial visit. The CMS-485 must include the specific number of nursing hours needed per day (i.e. not a range of hours). The provider must submit a service authorization request for the number of hours the agency is able to adequately staff. Once the assessment and CMS-485 is received and reviewed by DMAS, the authorization will be completed. DMAS will work with the individual/primary caregiver to identify additional nursing agencies to cover the remaining PDN hours the agency is unable to staff; for individuals enrolled with a MCO, this function will be performed by a care coordinator. Medicaid reimbursement cannot be made until the provider receives service authorization from DMAS. Failure of the provider to ensure timely submission of the required assessments may result in retraction of all PDN payments for the period of time of the delinquency.

An initial assessment visit must also be made when an individual is re-enrolled after discharge from services or is a transfer from another provider or another payer source.

PDN services are documented on Skilled Nursing Notes for dates rendered in accordance with the physician orders.

Monthly Supervisory Visits

The RN Supervisory Visit must be performed every 30 days to provide oversight for PDN services offered to the individual in the home. These visits include:

1. An assessment of the individual based on their skilled needs;
2. Review of the home medical record;
3. A determination that health care needs are met in the home;
4. Documentation of the individual's satisfaction and choice of services;
5. Documentation of satisfaction of service plan meeting their personal goals;
6. A review of the CMS-485 to ensure physician orders are accurate, current and being followed; and
7. An assessment of personal care services when provided by the PDN provider agency.

The Monthly Supervisory Visit (DMAS-103) must be submitted to DMAS within 5 days following the end of the month in which the visit is due.

These visits are documented on the PDN Supervisory Monthly Summary Visit (DMAS-103). At least every other month, the supervisory visit shall be made in the primary residence of the individual. The individual receiving PDN services must be present during every supervisory monthly visit.

The home medical record shall be easy to find, organized and legible. The provider shall assure the information in the home record is current. The agency may purge the home record but must assure at least two weeks of data remain in the home record.

PHYSICIAN SUPERVISION/CERTIFICATION AND RECERTIFICATION FOR THE PLAN OF CARE

Individuals receiving PDN services must be under the care of a licensed physician authorized to practice in the Commonwealth of Virginia.

The following documentation is required:

- A written physician's certification statement, which may be documented on the CMS-485 Plan of Care, in the form of physician orders, must be in the individual's medical record in the PDN provider's office and at the individual's home. Provider agencies that elect not to use the CMS-485 may develop their own form that must contain all of the elements and requirements as set forth in regulation and in this manual for the CMS-485. The statement of certification of medical necessity must be found on the form and must include:

- Physician certification statement of the individual's need for PDN care;
- Identification of primary care physician who has agreed to manage the medical care of the individual;
- Order must include the identification of the type, scope, amount, duration and frequency of services;
- Name and current address, home and cell phone numbers of the individual;
- Individual's date of birth, Medicaid ID number, PDN start of care date as well as the 60 day certification period;
- Choice of services made by the individual;
- Personal goals of the individual;
- A plan and certification for furnishing services to the individual which is reviewed, updated and signed by the physician every 60 days;
- The diagnosis of the individual which is directly associated with the services ordered and ICD code;
- A list of current medications, treatments, allergies and equipment ordered;
- Measurable goals for care/services;
- Both the dated RN and Physician signatures; and

- Current signed CMS-485 to be kept in the individual's home.

All new or modified orders must be signed and dated by the physician and kept with the current CMS-485. These orders must be included on the next CMS-485, if appropriate.

Verbal orders may be received by a registered nurse. When a verbal order is taken by a LPN, the agency provider RN Supervisor must assure the accuracy of the order and its inclusion in the next CMS-485. All verbal orders must be signed and dated by the physician, per medical standards of practice (typically within 3 days).

To assure all of the care needs of the individual are met, the most recent CMS-485 must be kept in the individual's home and easily accessible at all times. This CMS-485 will assist the nurse in cases of emergencies, substitution or when there is more than one nurse providing care.

Orders for Skilled Care (CMS-485, Block 21)

Discipline and Treatments orders must include the following information for these specific technologies:

BIPAP/ CPAP/ Ventilators

- Machine or Vent model
- Current MD ordered Vent settings
- Orders for Vent use, i.e.- time to be used, weaning schedule (if ordered)

Tracheostomy

- Trach manufacturer, size, and back up trach size
- With cuff use - Please specify when cuff is to be inflated (with vent use, with sleep only, while eating, etc.). Inflate with air or water and amount

- Trach Care to include:

  Frequency of change and LOCATION if not done at home

  Specific ostomy site care and frequency per day

  Inner cannula care or change, if applicable

  Trach suction catheter size and frequency

Oxygen

- Should be ordered as a medication to include: dose/amount, time to be used (PRN/with sleep/continuous), route

Pulse Oximeter

- Include high/low limits and orders in response to exceeding those limits
- Frequency of use

Nutrition

- Specify PO, enteral feeding or TPN
- Include specific PO diet, i.e. consistency and indicate if thickener is required for liquids
- Enteral feeding should specify formula name, amount, frequency and delivery method
- Gastrostomy site care, frequency of care, tube size, and changing schedule must be ordered

Catheter Care

- Foley, size, change frequency, irrigation if ordered
- Straight catheter, size, scheduled or PRN, irrigation if ordered

Wound Care

- Site, type, specific treatment orders, measurements of wound if applicable
- Include name and phone number of any agency that provides RN skilled wound care visits

Infusion Therapy

- Type of infusion fluids
- IV site, care orders
- Dosage and daily time schedule for giving the infusion
- Include name and phone number of any agency that provides infusion therapy visits

RN Supervisor Responsibilities

Using a person-centered planning team approach to nursing services, the provider RN supervisor shall:

- Ensure choice of services is made by the individual, legally authorized guardian, or responsible party if a minor;
- Ensure personal goals of the individual are respected;
- Conduct the initial evaluation visit to initiate PDN services in the primary residence;
- Regularly evaluate the individual's status and nursing needs and notify DMAS if the individual no longer meets the LOC criteria for the waiver;
- Complete the CMS-485 every 60 days and as necessary for revisions. The new CMS-485 should be sent to DMAS at the beginning of each new certification period;
- Perform monthly skilled nursing assessment, every 30 days, using the *Monthly Supervisory Visit (DMAS-103)* (the monthly nursing assessment cannot be made by the

nurse providing care in the home);

- Coordinate services;
    - Inform the physician, DMAS and other personnel of changes in the individual's condition and needs;
    - Contact DMAS if an individual does not meet PDN criteria;
    - Educate the individual/primary caregiver in meeting nursing and related goals;
    - Supervise and educate other personnel involved in the individual's care;
- Ensure all nurses have a *PDN Skills Checklist (DMAS-259) form* completed by the RN supervisor *prior* to assignment to an individual; review with each nurse all skills listed on the DMAS-259 and have the nurse demonstrate or explain in detail how they would perform each task. Nurses may not complete the DMAS-259 form on themselves. PDN staff may not complete this form on their nursing peers;
- Ensure availability of a supervising RN for 24 hours per day to address concerns that may arise with PDN individuals;
- Notify DMAS of any major problem or changes in an individual's family/social situation or primary residence;
- Ensure nurse supervisors do not work as a private duty nurse on cases they supervise;

- Ensure that all nurses and caregivers are aware that timesheets must be accurate with arrival and departure time of the nurse and that falsifying timesheets is fraudulent; and

- Ensure that respite documentation is kept separate from regular nursing documentation and labeled as respite.

Two Agencies Providing Private Duty Nursing

When two agency providers share an individual's care, the agencies must coordinate the services between each other. Weekly communication between agencies in shared cases is encouraged regarding PDN hours, billing, and health, safety or welfare issues.

Both providers shall:

- Maintain an individual's medical record with all required documentation;

- Maintain CMS-485 and medication sheets;

- Send all verbal orders to the co-sharing agency;

- Track the annual respite hours being used;

- Perform monthly supervisory visits every 30 days; and.

- Maintain weekly communication between agencies in shared cases is encouraged regarding PDN hours, billing, and health, safety or welfare issues.

Congregate PDN

Congregate PDN is skilled nursing simultaneously provided to three or fewer waiver individuals who reside in the same primary residence.

Congregate PDN may be authorized in conjunction with PDN in instances when individuals must be out of the home for part of the authorized PDN hours.

Only one nurse shall be authorized to care for no more than two waiver individuals receiving congregate nursing. When three individuals share a home, nursing ratios shall be determined by DMAS or its designated agent, based on the care needs of all of the individuals who are living together.

DMAS ONGOING REVIEW

For FFS individuals, DMAS will monitor the individual's status and the provision of nursing services by telephone contact with the provider, review provider Supervisor Monthly Visit Notes, review skilled nursing notes, as needed, and will perform the annual DMAS visits.

Annual eligibility assessment visits, performed by DMAS for all individuals receiving PDN services, shall include, but are not limited to:

- Reviewing the most recent CMS-485 for appropriateness of the level, amount, type, and quality of services provided;
- Monitoring the cost-effectiveness of the individual's care in the community;
- Reviewing the last three months of Supervisory Monthly Summary notes (DMAS 103);
- Discussing customer satisfaction and choice;
- Assessing that health, safety and welfare needs are being identified and met by the provider; and,

- Reviewing skilled nurse's notes.

Private Duty Nursing Service Units and Limitations

Adults are eligible for a maximum of 112 hours per week of PDN hours due to complex care needs and must be ventilator dependent or meet complex tracheostomy criteria on the Private Duty Nursing Adult Referral form (DMAS-108).

The following are service units and limitations:

- PDN is billed in hourly units.
- A day is defined as 24 hours which begins at 12:00 AM and ends at 11:59 PM.
- A week is defined as Sunday through Saturday for the purpose of authorization.
- Payment is available for allowable activities which are authorized and provided by qualified providers and in accordance with an approved CMS-485.
- Nurses shall not transport individuals receiving PDN. Medicaid will not reimburse for transportation to school, or other localities as these are the primary caregiver's responsibility.
- In no instances are PDN services to be provided for the convenience of other family members living in the individual's home.
- PDN services cannot be provided simultaneously with respite care or personal care.
- PDN services shall not be billed to include time the individual is receiving hospital emergency room care or during emergency transport of the individual to such

facilities and/or hospitalization. The RN or LPN shall not transport the waiver individual to such facilities.

Decrease or Increase In PDN Hours

DMAS or its designated agent shall have the final authority to approve or deny a requested change to an individual's PDN hours. Any request for an increase to an individual's PDN hours shall be authorized by DMAS or its contractors and accompanied by adequate documentation justifying the increase.

The provider may request a decrease in the amount of authorized PDN hours if the revised PDN hours are appropriate and based on the needs of the individual. The provider agency shall work with DMAS staff for coordination and final approval of any decrease in service delivery. A revised PDN authorization shall be completed by DMAS for final authorization and forwarded to the provider agency.

When the RN Supervisor determines that a decrease/increase in hours of service is warranted, he or she will contact the DMAS Health Care Coordinator (HCC) assigned to the individual immediately. DMAS will work with the RN Supervisor to re- evaluate the needs of the individual based on the assessed information from the provider.

A PDN authorization will be provided by DMAS to the nursing agency and will include the number of PDN hours to be provided per week and the effective date the change will occur.

The provider shall be responsible for documenting the physician's verbal orders and for inclusion of the changes on the recertification POC (CMS-485) in accordance with the DMAS PDN Authorization form. The provider agency's RN supervisor, who is responsible for supervising the individual's care, shall use a person-centered approach in discussing the change in PDN hours with the individual and individual's representative to include documentation in the individual's record. The DMAS or its service authorization (SA) contractor shall notify in writing the individual or individual representative of the change. Reimbursement will not occur without authorization from DMAS staff. The provider must ensure tasks performed meet the current needs of the individual.

If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the individual's right to appeal the adverse decision, in accordance with

42 CFR §200 et seq. and *12VAC30-120-1780 et seq*. The provider also has the right to appeal adverse decisions to DMAS.

Regardless of the type of change (increase/decrease of hours/services), DMAS will send a letter to the individual/primary caregiver with the change in hours, the effective date of the change, and include appeal rights. Appeal rights can be found at the end of this chapter. A copy of this letter must be filed in the individual's record at the agency.

PDN Documentation Requirements

Provider Required Documentation - Office Records

The provider shall maintain all records of each individual receiving PDN services. These records shall be separated from those of non-HCBS, such as companion or home health services. These records shall be reviewed periodically by personnel who are authorized by DMAS.

At a minimum, these records shall contain:

1. All assessments and plans of care, all PDN and all LTC Communication forms (DMAS-225), all medical orders-verbal orders as well as the CMS-485 authorizing PDN, and the age appropriate PDN Adult Referral form (DMAS-108);

2. The physician's certification for services (CMS-485) obtained prior to the service start date and updated every sixty (60) days;

3. The initial assessment (DMAS-116) completed in the home by a registered nurse;

4. The Monthly Supervisory Visit (DMAS-103) completed every 30 days;

- RN supervisor's notes documented and dated during significant contacts with

the case and during supervisory visits to the individual's home;

- Include AM and PM behind time notation, such as "in" and "out" time of visits; include printed name and initials and title when documenting; assure time sheets and nursing notes are completed daily, at the end of each shift, and copies or originals are left in the individual's home record;

- When the supervisory visit is missed, documentation must include the reason and the make-up assessment must occur within five (5) days. When there is an interruption in services such as hospitalization, the post hospital RN supervisory visit may serve as the supervisory visit and following visits will resume accordingly;

5. The PDN note must include, but is not limited to, all PDN care provided, as ordered, on the CMS-485, assistance with activities of daily living, administration of medications and any other medical needs and the monitoring of the individual's health status and physical condition. When there are health, safety and welfare concerns, documentation must indicate supervisory and DMAS notification and the appropriate Adult Protective Services/Child Protective Services referrals. The PDN notes must be signed and dated by the nurse providing the care;

6. All correspondence with the individual, DMAS, and the designated SA contractor;

7. Reassessments made during the provision of services;

8. Contacts made with family, physicians, formal and informal service providers, and all professionals involved in the individual's Medicaid services or medical care;

9. The name and phone number of a back-up caregiver who will provide the alternate care usually provided by the trained primary caregiver, in the event of an emergency;

10. Comments or observations recorded about the individual. The nurse's comments shall include, but not be limited to, observation of the individual's physical and emotional condition, daily activities, and the individual's response to services

rendered; and

11. To assure all services are rendered, the signatures of the individual or primary caregiver and the private duty nurse must be documented once each shift when PDN and Respite care is completed. Signatures, times, and dates shall not be placed on the notes prior to the delivery of service for that day. An employee of the provider shall not sign for the individual or caregiver. Documentation verified by signature of the individual or primary caregiver must include arrival and departure time of the nurse.

Provider Required Documentation – Home Records

Documentation in the home record shall be kept in the home at all times. Documentation should be kept in a binder which is kept organized and in a designated place in the home. Caregivers should know the location of the nursing binder.

This home record/binder shall include all of the following:

1. Current CMS-485
2. Medication Administration Records (MAR)
3. Two (2) weeks of nursing shift notes
4. Additional physicians orders received during the certification period
5. Treatment records
6. Nursing assessments and documentation

7. Emergency contact information

8. DNR orders (if applicable)

Nursing documentation must be completed during the shift in which the PDN care is provided. Information documented after the shift is provided must be identified as a "late entry".

HIPAA law shall be observed regarding all documentation and medical records. All nursing documentation must be maintained in the home record.

ENVIRONMENTAL MODIFICATIONS (CCC Plus Waiver)

Service Definition

Environmental Modifications (EM) are physical adaptations to the individual's primary residence, and/or primary vehicle used by the individual, which provide direct medical or remedial benefit to the individual. These adaptations are necessary to ensure the health, welfare, and safety of the individual, or directly enable the individual to function with greater independence in the home. Without these adaptations, the individual would require institutionalization. The purpose of Environmental Modifications is to modify, not make general improvements to the home. Environmental Modifications are for pre-existing structures.

Criteria

The EM services are available to individuals in the CCC Plus waiver. Individuals who qualify for these services must have a demonstrated need for equipment or modifications of a remedial nature or medical benefit offered in an individual's primary residence, or primary vehicle used by the individual, community activity setting, or day program to specifically improve the individual's personal functioning and is medically necessary. These physical adaptations shall be necessary to ensure the health, welfare and safety of the individual. These services are not considered a "stand alone" service and can only be authorized in conjunction with at least one other authorized waiver service.

Medically necessary includes those services or specialized medical equipment or supplies that are not covered for reimbursement under the State Plan for Medical Assistance that are reasonable, proper, and necessary for the treatment of an illness, injury or deficit.

Allowable Activities

· Physical adaptations to the individual's primary residence necessary to ensure an individual's

health, safety and welfare; or

· Physical adaptations to the individual's primary residence that enable an individual to live in a non-institutional setting and to function with greater independence that do not increase the square footage of the primary place of residence; or

· Modifications to the primary vehicle being used by the waiver individual. This service does not include the purchase or lease of vehicles or general repair of vehicles. Repairs of modifications that have been reimbursed by DMAS shall be covered.

Examples of Environmental Modifications

Such modifications may include, but be limited to the following:

·—Installation of non-portable wheelchair ramps and grab-bars at the primary residence;

·—Widening of doorways and other adaptations to accommodate wheelchairs;

·———Modification of bathroom facilities to accommodate wheelchairs (not strictly for cosmetic purposes);

·—Installation of specialized electrical and plumbing systems required to accommodate the medical equipment and supplies which are necessary for the individual's welfare; and

· Modifications may include a generator for individuals who are dependent on mechanical ventilation for 24-hours a day and when the generator is used to support the medical equipment and supplies necessary for the individual's welfare.

Collaboration

The provider and the waiver individual may collaborate with multiple providers in order to complete a modification, for example:

1. A Physical Therapist, Speech Therapist or Occupational Therapist may be accessed to evaluate the needs for environmental modifications; and/or

2. 2. A Rehabilitation Engineer or Rehabilitation Specialist may be used to evaluate the individual's needs and subsequently act as Project Manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. Alternatively, the Rehabilitation Engineer may actually design and personally complete the modification.

For example, a Rehabilitation Engineer might be required if:

· The Environmental Modification involves combinations of systems which are not designed to go together; or

· The structural modification requires a Project Manager to assure that design and

functionality meet ADA accessibility guidelines.

3. A building contractor may design and complete the structural modification;
4. A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the building contractor or Rehabilitation Engineer; or
5. A durable medical equipment (DME) provider enrolled with DMAS may be used to bill for modifications.

Collaborative funding is allowed for Medicaid covered services; however, due to the Federal rules, the provider would need to break down the parts. For example, if an individual needs a wheelchair van lift, the provider needs to determine the cost for the floor of the van, the cost for the ties, and the cost for the lift. For the parts funded with Medicaid dollars, the provider must accept payment as payment in full. The provider will need to delineate which parts are Medicaid funded and which are private pay or another funding source, e.g., DARS, Assistive Loan Fund Authority, church or other private funding, etc.

Service Units and Service Limitations

a. EM shall be available for a maximum Medicaid-funded amount of $5,000 per household per SFY (State Fiscal Year – July 1 to June 30).

b. Costs for EM cannot be carried over from one plan of care year to the next. Each item shall be service authorized by the DMAS Srv Auth contractor for each SFY year. Unexpended portions of this maximum amount shall not be accumulated across one or more years to be expended in a later year.
c. When two or more individuals receiving waiver services live in the same home, the EM shall be shared to the extent consistent with the type of requested modification.
d. Only the actual cost of material and labor is reimbursed. There shall be no additional markup. Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered non-covered.
e. EM shall be carried out in the most cost effective manner possible to achieve the goal required for the individual's health, safety, and welfare.
f. All services shall be provided in the individual's primary residence in accordance with applicable state or local building codes and appropriate permits or building inspections, which shall be provided to the DMAS designated Srv Auth contractor.
g. Proposed modifications that are to be made to rental properties must have prior written approval of the property's owner. Modifications to rental properties shall only be valid if it is an independently operated rental facility with no direct or indirect ties to any other Medicaid service provider.
h. Modifications may be made to a vehicle if it is the primary vehicle used by the waiver individual. This service shall not include the purchase of, or the general repair of, vehicles (repairs of modifications which have been reimbursed by DMAS shall be covered).
i. Under the *State Plan for Medical Assistance*, Physical, Occupational, and Speech Therapy services must be authorized through the DMAS Srv Auth Contractor if more than five (5) visits have been provided to the individual. Visits are individual-specific, not provider-specific.
j. The EM provider shall ensure that all work and products are delivered, installed and in good working order prior to seeking reimbursement from DMAS. The date of service on this provider's claim shall be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced during the approval dates.
k. The service authorization shall not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) shall be submitted to the DMAS designated Srv Auth contractor for revision to the previously issued service authorization and shall include justification and supporting documentation of medical needs.

l. A copy of the provider's cost estimate for labor and materials for an environmental modification must be submitted to the service authorization contractor.

Service Exclusions

· Environmental Modifications cannot take place at any site owned and operated by a residential program.

· Environmental Modifications are to modify, not furnish, new additions to a home.

· Environmental Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. The EM service does not include those adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit to the individual. Such non-covered items include, but shall not be limited to: carpeting, roof repair, central air conditioning, general maintenance and repairs to a home, additions or maintenance of decks, maintenance/replacement addition of sidewalks, driveways, carports, or adaptations which only increase the total square footage of the home, etc.

· Environmental Modifications shall not be covered by Medicaid for general leisure, or diversion items, or those items that are recreational in nature or those items that may be used as an outlet for behavioral supports. Such non-covered items include, but shall not be limited to, swing sets, playhouses, climbing walls, trampolines, hot tubs, elevators, fences, pools, basketball or other courts, protective matting or ground cover, sporting equipment or exercise equipment, such as special bicycles or tricycles, etc.

· DMAS does not repurchase items paid for with waiver funds unless those items have specific timeframes of usefulness (i.e., quarterly maintenance on lifts). Additional repairs are considered on an individual basis.

· Providers that supply environmental modifications for an individual may not perform assessment/consultation, design or inspect environmental modification for that individual.

· There shall be no duplication of EM services within the same plan of care year or EM services within the same primary residence, such as multiple wheelchair ramps or previous modifications to the same room.

· EM shall not include the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source.

  · Excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), and the Rehabilitation Act (20 USC§ § 794).

· Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under Environmental Modifications. DME and Supplies information can be found on the DMAS Web Portal by accessing the *DME Provider Manual, Appendix B* at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

EM Provider Documentation Requirements

1. Supporting documentation must demonstrate the medical need for the service, the process to

obtain the service (contacts with potential contractors of service, costs, etc.), and the timeframe during which the service is to be provided. This includes a separate written notation of the evaluation, design, labor, and supplies or materials (or both). The supporting documentation and plan of care must include documentation of the reason that a Rehabilitation Engineer is needed, if one is to be involved;

2. Documentation of the date services are rendered and the amount of services and supplies;
3. Any other relevant information regarding the modification;
4. Documentation of the completion of the modification and written receipt and satisfaction of the individual/primary caregiver with the service provided;
5. Instructions are to be provided to the individual/primary caregiver regarding warranty coverage, repairs, maintenance and complaint resolution;

6. The EM provider will ensure that all work and products are delivered, installed and in good working order prior to the end of the plan of care year and prior to billing DMAS;

7. The date of service on the provider claim must be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced during the service authorization approval dates; and

8. The service authorization will not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) must be submitted to the DMAS designated Service Authorization Contractor for revision and must include justification and supporting documentation of medical needs.

ASSISTIVE TECHNOLOGY (CCC Plus Waiver)

Service Definition

Assistive Technology (AT) services are specialized medical equipment and supplies, including those devices, controls, or appliances, that are medically necessary to enable individuals to increase their ability to perform ADLs or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment medically necessary for the proper functioning of such items. AT cannot be provided as a "stand alone" waiver service. AT devices are expected to be portable.

Medically necessary includes those services or specialized medical equipment or supplies that are not covered for reimbursement under the *State Plan for Medical Assistance* that are reasonable, proper, and necessary for the treatment of an illness, injury or deficit.

Criteria

In order to be eligible for these services, the individual must have a demonstrated need for AT equipment for remedial or direct medical benefit primarily in the individual's primary residence to specifically serve to improve the individual's personal functioning.

Collaboration

An independent, evaluation shall be obtained from qualified professionals who are knowledgeable of the recommended item for each AT request prior to approval by the Srv Auth contractor. All evaluations must be signed by the qualified professional. The professional evaluation includes the trial period of time for the individual to use the device and documentation of any follow up training provided for the recommended items. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists. A prescription alone shall not meet the standard of an evaluation.

Examples of Assistive Technology Devices (not a comprehensive list)	**Professional Evaluation Required**
Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Computer/software or Communication Device	Speech Language Pathologist or Occupational Therapist
Orthotics, such as braces for hands, arms, feet, legs, etc.	Physical Therapist, Physician or Orthotist
Writing Orthotics	Occupational Therapist or Speech Language Pathologist
Support Chairs	Physical Therapist or Occupational Therapist
Specialized Toilets	Occupational Therapist or Physical Therapist
Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist, or Occupational Therapist; depending on the device or equipment
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist, Psychologist, or Behavioral Consultant

Items such as furniture shall not be approved if they are of general utility and are not of direct medical benefit.

The AT provider's quote must be compatible with the evaluation completed by the qualified professional.

The provider and the waiver individual may collaborate with multiple providers in order to complete a

request for AT, for example:

1. A Physical Therapist, Speech Therapist or Occupational Therapist may be accessed to evaluate the needs for AT; and/or
2. A Rehabilitation Engineer or Rehabilitation Specialist may be used to evaluate the individual's AT needs. The Rehabilitation Engineer may actually design and personally complete the AT, if needed.

For example, a Rehabilitation Engineer might be required if:

- The AT involves combinations of systems (which may include EM), which are not designed to go together; or
- An existing AT device must be modified or a specialized AT device must be designed and fabricated.

Collaborative funding is allowed for Medicaid covered services; however, due to the Federal rules, the provider would need to break down the parts. For the parts funded with Medicaid dollars, the provider must accept payment as payment in full. The provider will need to delineate which parts are Medicaid funded and which are private pay or another funding source, e.g., DARS, Assistive Loan Fund Authority, church or other private funding, etc.

Service Units and Service Limitations

- The service unit is always one, for the total cost of all AT requested for a specific timeframe. The service unit is the total cost of the item and any supplies, or hourly Rehabilitation Engineering costs.
- The maximum Medicaid-funded expenditure per individual for all AT covered procedure codes combined shall be $5,000 per individual per SFY (State Fiscal Year – July 1 to June 30). Unexpended portions of the maximum amount shall not be carried over from one SFY to the next.
- AT shall be covered in the least expensive, most cost-effective manner. An AT provider's written cost estimate for labor and materials for AT must be submitted to the Srv Auth contractor. AT shall be provided primarily in the individual's home or community setting.
- Each item shall be authorized by the Srv Auth contractor prior to providing the service and cannot be authorized retroactively. The service authorization will not be modified to accommodate delays in product deliveries. In such situations, new service authorizations must be sought by the provider.
- Computer software purchased for an individual must be owned by the individual and accessible by the individual/caregiver to make changes, download updates, etc.
- All products must be delivered, demonstrated, installed and in working order prior to submitting any claim to Medicaid. The date of service on the claim must be within the service authorization approval dates, which may be prior to the delivery date as long as the initiation of services commenced during the approved dates.
- When two or more individuals receiving waiver services live in the same home, the AT shall be shared to the extent practicable consistent with the type of AT.

Under the *State Plan for Medical Assistance*, Physical, Occupational, and Speech Therapy services must be authorized through the DMAS Srv Auth Contractor if more than five (5) visits have been provided to the individual. Visits are individual-specific, not provider-specific.

- AT shall not be available to waiver individuals younger than 21 years of age. AT for these individuals shall be accessed through the EPSDT benefit.

Service Exclusions

- AT is not covered for purposes of convenience for the caregiver or for restraint of

  the waiver individual, or for recreation, leisure, diversional purposes, or for an outlet for behavioral supports, or for educational purposes. Such items include, but are not limited to, swing sets, playhouses, bowling balls, tricycles/bicycles, trampolines, television sets, video equipment/games, computer games, playing cards, printers, scanners, musical, educational, vocational software or hardware, sporting equipment, exercise equipment, etc. are not covered.

- Providers that supply AT for the individual may not perform the professional evaluation, or write specifications for that individual.
- AT equipment and supplies shall not be rented but shall be purchased through an AT provider.
- DMAS does not repurchase items paid for with AT funds unless those items have specific timeframes or usefulness (i.e. computer - 5 years).
- DMAS does not pay for duplicate items such as software and later updates to original purchases. This is considered carry over from one year to the next.
- Only the actual cost of material and labor is reimbursed. There shall be no additional markup. Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered non-covered.
- Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under Assistive Technology. DME and Supplies information can be found on the DMAS Web Portal by accessing the *DME Provider Manual, Appendix B.* at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

Provider Documentation Requirements

The document requirements are as follows:

1. The evaluation must be completed by the independent professional consultant;

   Supporting documentation, which includes the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the timeframe during which the service is to be provided. This includes separate notations of design, labor, supplies, and materials. The supporting documentation must include the reason that a Rehabilitation Engineer or Certified Rehabilitation Specialist is needed, if one is to be involved. A Rehabilitation Engineer or Certified Rehabilitation Specialist may be involved if a need for such expertise is documented;

2. Written documentation regarding the process and results of ensuring that the item is not

covered by the *State Plan for Medical Assistance* as Durable Medical Equipment and Supplies and that it is not available from a DME provider when purchased elsewhere;

3. Documentation of the date services are rendered and the amount of service needed; other relevant information regarding the device or modification;
4. Documentation of the individual/caregiver's receipt of and satisfaction with the AT provided as well as any training provided to the individual/primary caregiver on the usage of the AT;
5. The date of service on the claim must be within the service authorization approval dates, which may be prior to the delivery date as long as services commence during the approved dates;
6. The AT provider is required to deliver and ensure the individual is trained to use the equipment prior to the end of the plan of care year and provide instructions regarding any warranty, repairs, complaints, or servicing that may be needed;
7. The AT provider will ensure that all work and products are delivered, installed and in good working order prior to the end of the plan of care year and prior to billing DMAS;
8. Any request for a change in cost (either an increase or a decrease) requires justification and supporting documentation of medical need and authorization by the SA contractor; and
9. The AT provider must receive a copy of the professional evaluation in order to purchase the items recommended by the professional**.** If a change is necessary, then the provider must notify the assessor to ensure the changed items meet the individual's needs.

Transition Services (CCC Plus Waiver)

Service Definition

Transition Services are a means of providing for set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Individuals may receive Transition Services for up to nine (9) months through the CCC Plus waiver. Individuals who leave a qualified institution prior to enrolling in CCC Plus waiver, but demonstrate a need for Transition Services have 30 days to apply for the service post transition.

Transition Services shall be service authorized for nine (9) months. If the waiver individual chooses consumer directed services, the DMAS designated fiscal employer agent (F/EA) shall manage the reimbursement for the transition services. If the waiver individual chooses agency directed services, the health plan shall manage the reimbursement to the agency or

provider for the transition services.

All individuals using the CCC Plus waiver must have the transition services included on a person-centered transition service plan prior to seeking service authorization from the health plan.

Criteria

Transition services are furnished only to the extent that:

- they are reasonable and necessary as determined through the transition service plan development process,
- they are clearly identified in the transition service plan,
- the person is unable to meet such expenses, and
- the goods/services cannot be obtained from another source.

This service does not include services or items that are covered under other waiver services, or state plan options, or by other providers.

Service Units and Service Limitations

Services are available for one transition per waiver individual per lifetime limit and must be expended within nine (9) months from the date of authorization. The funds shall not be available to the individual after that period of time.

The total cost of these services shall not exceed $5,000 per person per lifetime limit, coverage of transition costs to residents of Nursing Facilities, Long Stay Hospitals, ICFs/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities), PRTFs (Psychiatric Residential Treatment Facilities) or IMDs (Institute for Mental Disease) who are Medicaid participants and are able to return to the community.

Transition Services may be requested within 30 days after a transition. If not requested within that timeframe, the individual will not be considered for transition services.

The provider shall work closely with the individual to assure that all costs are reasonable and necessary for transitioning from the institution to the home-and-community-based setting.

Allowable costs include, but are not limited to:

- Security deposits that are required to obtain a lease on an house, condo, apartment or other residence; Essential household furnishings and appliances required to occupy and use a community domicile, for example furniture, window coverings, food preparation items, and bed/bath linens;
- Connection or set-up fees or deposits for utility or services access, such as telephone, electricity, heating and water;
- Services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy;
- Moving expenses;
- Needed clothing items; and
- Fees to obtain a copy of a birth certificate, photo identification card, or driver's license.

Non-allowable costs include, but are not limited to:

- Re-occurring charges such as monthly rental or mortgage expenses;
- Food;
- Regular utility charges;
- Household items that are intended for decoration, diversional or recreational purposes; and
- Services or items that are covered under other waiver services such as chore, homemaker, environmental modifications and adaptations, or specialized supplies and equipment.

DISCONTINUANCE OR CHANGE IN SERVICES BY THE PROVIDER (CCC Plus Waiver)

Advance Notice required for Personal Care/Respite/SF/ADHC/PERS/PDN

There are various financial, social, and health factors that might cause a provider to discontinue, increase, or decrease services to a Medicaid individual. The provider must make adjustments to services as indicated by any change in the individual's needs or situation. The provider must give the individual or family ten (10) calendar days written notification plus three days for mailing of any decision to discontinue or to change the amount of services received (unless the individual requests a date which is less than ten (10) calendar days and the provider documents the individual's request).

The provider may discontinue services if the individual fails to pay the required patient pay amount that is due. If services are discontinued by the provider, this notice must **not** contain appeal rights since the individual has not been terminated from Medicaid services.

Decrease in Hours

If the RN Supervisor/SF has determined that a decrease in hours of service is warranted, the RN Supervisor/SF must discuss the decrease in hours with the individual or family during a home visit and document the visit and conversation in the individual's record. If there is to be a decrease in hours, the provider must develop a new Plan of Care and notify the individual, the caregiver, and submit a request for the decrease in hours to the srv auth contractor. The provider/SF must state in writing the specific reasons for the decrease, the new number of hours to be provided per week, and the effective date of the decrease in hours. The provider/SF must give the individual a copy of the new DMAS-97A/B. The srv auth contractor must also receive the new DMAS-97A/B,

If the individual requests a decrease in hours by telephone, the RN Supervisor/SF is not required to make an extra visit to the individual's home. The provider/SF will send a letter confirming the individual's request, the new number of hours, the new DMAS-97 A/B, and the effective date of the change. The new DMAS-97 A/B must be signed by the individual at the next visit.

If the individual disagrees with the decrease or the new Plan of Care, the effective date of the decrease shall be ten (10) calendar days from the notification date. The provider must develop the Plan of Care based on the assessment, but request from the srv auth contractor the actual number of hours that the individual/caregiver wants. The request to the srv auth contractor must clearly state that the individual/caregiver does not agree with the decrease. The srv auth contractor will review all of the information submitted. If unable to authorize what the individual/caregiver requests, the srv auth contractor will process the change request as a partial denial, and appeal rights will be offered in the letter automatically generated through the MMIS system.

The individual may file an appeal with DMAS, in accordance with *12 VAC 30-110-100*.

Increase in Hours

The provider/SF is able to establish the amount of service in the Plan of Care, which is appropriate to meet the individual's needs as long as the maximum number of hours per week for that individual's

level of care is not exceeded. (Under no circumstances can the individual receive more hours of care than his or her level of care allows without prior approval from the srv auth contractor).

The provider/SF must send a request to the srv auth contractor to authorize the increase if a change in the individual's condition indicates that either (i) supervision needs to be added to the Plan of Care or (ii) the individual's level of care has changed and an increase to the Plan of Care is needed for more than the amount allowed according to the individual's current level of care. This contact must be documented in the individual's record with the date and time of the call, to whom the RN Supervisor/SF spoke with, the requested information, and the outcome of the call. The updated DMAS-97 A/B and any other documentation necessary to justify the need for and use of hours may be requested by the srv auth contractor.

The srv auth contractor will transmit authorizations or denials to the MMIS. Once the entry has been made, the provider/SF and individual will receive a computer-generated letter notifying them of the decision and providing appeal rights if a denial or partial approval is issued. Individuals have the right to appeal any adverse action taken by the srv auth contractor. A copy of this letter must be maintained in the individual's record.

Transfer of Cases

When a SF or Personal Care Agency chooses to end services or when an individual chooses to change providers for a service, the prior SF/agency should supply the new SF/agency provider with a copy of the last Plan of Care, a copy of the discharge 225, and a copy of the screening (if available). The new provider should request this documentation from the prior SF/agency provider to assist the new provider in developing an appropriate Plan of Care for the individual.

For a transfer admission, the new provider/SF must submit a request to the srv auth contractor and complete the required questionnaire. The information from the DMAS-97A/B or DMAS-301, the DMAS-99 and the DMAS-100 (if the Plan of Care includes supervision time) will be needed when completing the questionnaire. **The new provider must complete a new assessment and Plan of Care for authorization of services.** If the previous provider/SF has not discharged the individual through the srv auth contractor, the new provider/SF must answer the questions on the questionnaire regarding transfers using the information found on the discharge DMAS-225, or a transferring letter from the previous provider indicating the last billable date of service.

NOTE: If there has been a lapse in time between services, the provider is responsible for ensuring that the screening is still valid, as specified in the Medicaid Long Term Services and Supports (LTSS) Screening Provider Manual.

If the individual's previous Plan of Care included supervision or was for hours over the individual's level of care and the new (receiving) provider/SF has evaluated and found that these same hours are needed and criteria are met for the supervision or hours over the level of care, the new provider should verify that these hours were previously approved.

In transfer situations, supervision and hours over the LOC cap may be approved to the start of care date when the request is submitted within 10 business days of the start of care. Supervision and hours over the LOC maximum will only be authorized by the service authorization contractor when the

new provider/SF provide documentation showing criteria are met and with appropriate documentation/justification for the hours included in the plan of care.

If the new provider/SF's Plan of Care is a decrease in hours from what the individual was previously receiving, the provider/SF must send the individual a decrease notification letter. These decreased hours may be implemented if the individual is in agreement with the new hours and Plan of Care. If the individual disagrees with the decrease and the new Plan of Care, the effective date of the decrease shall be ten (10) calendar days from the notification date. The provider must develop the plan of care based on the assessment, but request from the srv auth contractor the actual number of hours that the individual/caregiver wants. The request to the srv auth contractor must clearly state that the individual/caregiver does not agree with the decrease. The srv auth contractor will review all of the information submitted. If unable to authorize what the individual/caregiver requests, the srv auth contractor will process the change request as a partial denial, and appeal rights will be offered in the letter automatically generated through the MMIS system.

The individual may file an appeal with DMAS, in accordance with *12 VAC 30-110-100*.

Disenrollment from Consumer-Directed Services

There may be instances in which a waiver individual must be disenrolled from consumer-directed services, either voluntarily or involuntarily. The following situations may be cause to remove an individual from consumer-directed services:

- It is determined that the waiver individual cannot complete the duties of the EOR and no one else is able to assume this role;
- The waiver individual has medication or skilled nursing needs or has medical or behavioral conditions that cannot be met through CD services or other services;
- The waiver individual, or EOR, as appropriate, is consistently unable to retain or manage the attendant as may be demonstrated by, but not necessarily limited to, a pattern of serious discrepancies with the attendant's work shift entries or non-compliance with CD EOR requirements.

Under these circumstances, the Services Facilitator must offer agency-directed services as the alternative to the waiver individual and provide the individual the freedom of choice to select the personal care agency.

In situations where the attendant's work shift entry discrepancies are known, the services facilitator should assist the waiver individual's transfer to agency-directed services by doing the following:

1. Verify that training has been provided to the waiver individual or EOR, as appropriate;
2. Document in the waiver individual's record the conditions creating the necessity for the individual's disenrollment and actions taken by the services facilitator;
3. Discuss with the waiver individual and/or EOR, as appropriate, the option of agency-directed services and the actions needed to arrange for such services as well as offer the individual the choice of potential agency providers;
4. Provide written notice to the waiver individual of the right to appeal such involuntary termination of consumer direction. The written notices must give at least 10 calendar days

plus 3 for mailing prior to the effective date of this termination. In cases when the individual's or provider personnel's health, safety, or welfare may be in jeopardy, the 10 day notice does not apply.

PDN Transfer

The PDN provider must transfer an individual's care to another PDN agency whenever the provider is no longer able to sufficiently staff the individual's case or the individual requests a transfer to another provider of their choice.

- The transferring skilled PDN provider is instructed to contact DMAS to inform them of the need to transfer the individual, the provider chosen to accept the transfer and the effective date of the transfer.
- The transferring skilled PDN provider must send to the accepting skilled PDN provider and DMAS:

    1. The last date of service to be rendered by the transferring provider and the reason for the transfer;
    2. A copy of the current POC/CMS-485;
    3. The individual's waiver PDN Needs Assessment or the LTSS Screening packet including the DMAS 96, 97, UAI, and DMAS-108 with the individual's PDN admission date to the waiver;
    4. The most recent Waiver PDN Monthly Supervisory Visit (DMAS-103) form; and
    5. The DMAS-225 communication form sent to DMAS and DSS.

Note: The accepting provider is responsible for ensuring the above information is received and seeking approval from DMAS prior to the initiation of services. Once services start, the accepting provider must send to DMAS the RN Initial Home Assessment form (DMAS-116) and a copy of their initial POC/CMS-485.

Advance Notice Not Required

CCC Plus waiver services may be discontinued without prior notice, if the provider's staff or SF is in immediate danger, or the individual requests immediate discontinuation of services, or the provider does not have staff available to render services and is unable to secure a substitute aide or transfer services. However, the provider/SF must send a letter to the individual indicating that the discontinuation of waiver services and the effective date. A copy of this letter must go to the local department of social services, and Adult Protective Services, if applicable. The discharge request must be submitted to the srv auth contractor. A copy must also be kept in the individual's record.

If the provider does not have staff, the provider must attempt to transfer services to another provider agency. If the individual has adequate back-up support and requests that the provider not transfer the services, the individual must be informed of progress or lack of progress and alternatives. This must be documented in the individual's record. The provider must inform the individual that, if services are not received for 30 consecutive days, continued waiver eligibility will be affected.

Transitioning to Developmental Disability (DD) Waiver for Individuals under Managed Care

When a managed care enrolled member is transitioning from the CCC Plus Waiver to a DD Waiver, DD waiver enrollment, service authorizations, and services cannot begin earlier than the first day of the month after the month in which the CCC Plus Waiver service authorization ended. For example, if an individual is enrolled in the CCC Plus Waiver and is assigned a DD Waiver slot on December 10th, the earliest that any DD Waiver services may be authorized to begin is January 1st. The CCC Plus Waiver service authorization will automatically end based on the effective date of the DD Waiver enrollment.

For individuals transitioning from the CCC Plus Waiver to a Community Living (CL) or Family and Individual Supports (FIS) Waiver, the same number of personal care hours authorized by the MCO for an individual enrolled in the CCC Plus Waiver will be honored for 30 days. To ensure a seamless transition and mitigate service interruption, providers should follow the continuity of care service authorization process as follows:

1. The SF/agency should expect contact from the Support Coordinator for the individual's DD Waiver services. The SF/agency should make sure the waiver individual has consented to allow an exchange of information with the Support Coordinator.
2. The SF/agency uploads the most recent Plan of Care (DMAS-97A/B) into WaMS. In the justification box in WaMS, the SF/agency will enter "continuity of care service authorization request". If the Support Coordinator finds the hours on the Plan of Care do not match those authorized by the MCO, the SF/agency must submit a revised Plan of Care that reflects the hours authorized by the MCO.
3. The Services Facilitator/Agency provider completes and submits to the Department of Behavioral Health and Disability Services (DBHDS) all required assessments and documentation for CL or FIS Waiver service authorization of personal care services by the 20th of the month that the continuity of care service authorization is in effect. Any delay on the part of the provider shall result in the service authorization start date being the date the request was submitted.
4. For consumer-directed services, the Services Facilitator must submit the Fiscal Agent Request Form to Consumer Direct Care Network and initiate the change in Fiscal/Employer Agent, if applicable, and the change from CCC Plus Waiver services to DD Waiver services.

For questions regarding this procedure, contact the Division of High Needs Supports at DDwaiver@dmas.virginia.gov.

Individual Health, Welfare, and Safety Issues

If the provider/SF becomes aware that the services being provided and the individual's current support system may not adequately provide for the individual's safety, the provider/SF should immediately determine whether the individual's current status represents a potential risk or an actual threat to his or her health, welfare or safety.

A potential risk is identified as deterioration in either the individual's condition or environment, or both, which, in the absence of additional support, could result in harm or injury to the individual.

An actual threat is the presence of harm or injury to the individual which can be attributed to the individual's deterioration and lack of adequate support (e.g., the individual becomes anemic, malnourished, or dehydrated due to the inability to obtain food and water; the individual develops decubitus due to lying in urine or feces, etc.).

To determine whether an actual threat may exist, the provider should consider the following:

1. Is the individual capable of calling for help when needed?

2. Is there a support system available for the individual to call?

3. Can conditions be arranged for the individual to care for basic needs when the support system is absent?

4. Is the individual medically at risk when left alone?

5. Has some harm or injury to the individual been reported?

6. Does the individual express fear or concern for his/her welfare?

If answers to any of the above listed concerns indicate a potential risk, the provider/SF is required as a mandated reporter by State Law to report to Adult Protective Services (APS)/Child Protective Services (CPS) at first suspicion.

When reviewing service authorization requests, when a real threat to the individual's health, safety, and/or welfare exists, the srv auth contractor will attempt to assess whether

additional services can be obtained to maintain the individual in a home environment. If continued maintenance in the home is not possible, the contractor will initiate procedures to terminate services and advise the provider/SF or the individual that nursing facility services should be considered. The provider/SF shall report the situation to APS/CPS. For the provider's/SF's protection, a letter from the provider should follow up a telephone call to APS/CPS. Waiver services may be discontinued if a safe Plan of Care cannot be developed.

Suspected Abuse or Neglect (CCC Plus Waiver)

If the provider suspects that a CCC Plus Waiver individual is being abused, neglected, or exploited, or is at risk for abuse, neglect or exploitation, Virginia law (*§§ 63.2-1606 and 63.2-1509 Code of Virginia*) mandates that the party having knowledge or suspicion of the abuse, neglect, and/or exploitation, immediately make a report to either the LDSS where the individual resides or to the toll-free, 24-hour hotlines:

APS: 1-888-83 ADULT (1-888-832-3858)

CPS: 1-800-552-7096 (out of state); 804-786-8536 (in- state).

Local departments of social services are responsible for the investigation of alleged adult abuse, neglect, and exploitation and alleged child abuse and neglect. The contact with the local departments may be made anonymously, but the provider record must note the alleged abuse, neglect, or exploitation and state that the appropriate report has been made. The provider/SF must also report the suspicions to DMAS.

Relation to Other Medicaid-Funded Home Care Services (CCC Plus Waiver)

Home Health

Home health services are provided by a certified home health agency on a part-time or intermittent basis to an individual in their place of residence. An individual's place of residence does not include a hospital or nursing facility. Home health services are intended to provide skilled intervention with an emphasis on individual/caregiver teaching. For additional information and covered home health services, refer to the Department of Medical Assistance Services Home Health Provider Manual, which can be found on the Medicaid web portal located at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

Hospice Care

Hospice is an autonomous, centrally administered, medically-directed program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill individual and the family.

It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic challenges, which are experienced during the final stages of illness and during bereavement. The goal is to maintain the individual at home for as long as possible while providing the best care available to the individual thereby avoiding institutionalization. For additional information and covered hospice services, refer to the Department of Medical Assistance Services Hospice Provider Manual found on the Medicaid web portal located at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

Simultaneous Provision of CCC Plus Waiver Services and Hospice Services

The following information is applicable regardless of whether the hospice receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Hospice enrollment does not limit the waiver services an individual may receive. Waiver services must be authorized by the srv auth contractor. The waiver services provider/SF is required to coordinate services with the hospice provider for those individuals also enrolled in a hospice benefit.

Refusal of Services by the Individual

Individuals have the right to refuse services. This refusal must be documented in the individual record. If all services for the day are refused, the aide should contact the provider agency, leave the home and document the early departure time. If services are refused frequently, a reduction in care hours may be warranted (see “Decrease in Hours” in this chapter). This refusal must be documented by the provider in the individual’s record and an evaluation should be conducted, and the service-authorization contractor staff should be contacted, if appropriate.

The provider may not bill Medicaid for the individual for any time services are scheduled, but the aide/attendant is not able to provide care (e.g., the aide arrives and the individual is not home).

Change of Residence

If an individual’s residence changes, the provider must record this change in the individual’s record and notify the LDSS immediately and in writing (using the DMAS-225).

Individuals With Communicable Diseases

Current information regarding the transmission of Acquired Immune Deficiency Syndrome (AIDS) and other similar communicable diseases indicates that these diseases are not transmitted through casual contact, and isolation techniques or procedures are not required for providing care to these individuals in their homes.

Certain routine hygienic precautions designed to prevent the spread of all communicable diseases, including blood borne infections, should be taken by all providers when rendering care to any individual, regardless of his/her known medical condition. These precautions should include care in handling sharp objects such as needles, the wearing of disposable gloves when one could become exposed to blood or other body fluids, and scrupulous hand washing before and after caring for each individual.

Providers are prohibited from discriminating against individuals who have been diagnosed as having Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) and other communicable diseases.

INDIVIDUALS WITH MENTAL ILLNESS, INTELLECTUAL DISABILITIES, DEVELOPMENTAL DISABILITIES, OR RELATED CONDITIONS APPROVED FOR SERVICES (CCC Plus Waiver)

Federal waiver programs are designed to serve a specific targeted population. The CCC Plus Waiver can only serve individuals who are at risk of nursing facility placement and meet all eligibility requirements for the waiver. Individuals who qualify for the CCC Plus waiver may also be on waiting lists for other waivers. Refer to the DMAS web site for more information on waivers for individuals with developmental or intellectual disabilities.

Billing Instructions (CCC Plus Waiver)

Updated: 3/25/2021

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

General Information - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.

Billing Procedures - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

Electronic Submission of Claims (CCC Plus Waiver)

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. For more information access on the Medicaid Web Portal.

DIRECT DATA ENTRY (DDE)As part of the 2011 General Assembly Appropriation Act - 300H

which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider.

Timely Filing (Podiatry)

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed

to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims – Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be

untimely and no further action shall be taken. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits)

Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Other Insurance - The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

Billing Invoices (CCC Plus Waiver)

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below is the billing invoice to be used:

- Health Insurance Claim Form, CMS-1500 (02-12)

The requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

NOTE: Virginia Medicaid will accept an original Health Insurance Claim Form, CMS-1500, printed in red ink with the appropriate certifications on the reverse side (bar coding is optional). Previous editions or other versions of this form will not be accepted.

The requirement to submit claims on an original CMS-1500. Claim Form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form. Therefore, these statements become part of the original billing invoice.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid

Billing Instructions: Automated Crossover Claims Processing (IFDD)

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processors will submit claims based

on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as “crossovers” since the claims are automatically crossed over from Medicare to Medicaid.

To make it easier to match to providers to their Virginia Medicaid provider record, providers are to begin including their Virginia Medicaid Identification as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a Virginia Medicaid Identification, the claim will be processed by DMAS using the Virginia Medicaid number rather the Virginia Medicare vendor number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Medicaid provider number and use qualifier “1D” in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the Virginia Medicaid Identification on the original claim to Medicare will reduce the need for submitting follow-up paper claims.

DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

Requests for Billing Materials

Health Insurance Claim Form CMS-1500 (02-12)

The CMS-1500 (02-12) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Document

s
Washingto
n, DC
20402

(202)512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12) will not be provided by DMAS.

The request for forms or Billing
Supplies must be submitted
by: Mail Your Request To:

Com
monw
ealth
Maili
ng
1700
Venab
le St.,

Richmond, VA 23223

Calling the DMAS order desk at Commonwealth Martin 804-780-0076 or, by faxing the DMAS order desk at Commonwealth Martin 804-780-0198

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

Billing Procedures (CMH)

Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid members. Each member's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services

Practitioner

P.O. Box 27444

Richmond, Virginia 23261-7444

Or

Department of Medical Assistance Services
CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

Billing Instructions: Electronic Filing Requirements

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)

276/277 Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)

277 - Unsolicited Response (5010)

820 - Premium Payment for Enrolled Health Plan Members (5010)

834 - Enrollment/ Disenrollment to a Health Plan (5010)

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

NCPDP - National Council for Prescription Drug Programs Batch (5010)

NCPDP - National Council for Prescription Drug Programs POS (5010) Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides or contact EDI Support at 1-866-352-0766 or Virginia.EDISupport@conduent.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov.

Claimcheck (CCC Plus Waiver)

- Since June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject the the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to

timely filing, etc. are still applicable.

- PTP Edits:

  CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note:** Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- MUE Edits:

  DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.

- Exempt Provider Types:

  DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federal Health Center (FQHC), Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.

- Service Authorizations:

  DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.

- Modifiers:

  Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of "1"or "0" in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of "1", a modifier is allowed and both codes will pay. If the modifier indicator is "0", the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

  Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

Reconsideration

Providers that disagree with the action taken by a ClaimCheck/NCCI edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a

request to the following mailing address:

Payment Processing Unit, Claim Check

Division of Program Operations

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

There is a 30-day time limit form the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

Billing Instructions Reference for Services Requiring Service Authorization

Please refer to the “Service Authorization” section in Appendix D of this manual.

NORTHERN VIRGINIA LOCALITIES (CCC Plus Waiver)

For purposes of billing rates provided under the CCC Plus Waiver, the following are considered the Northern Virginia localities:

Alexandria City	Arlington City
Clarke County	Fairfax County
Fairfax City	Fauquier County
Falls Church City	Manassas City
Fredericksburg City	Prince William County
Loudon County	Stafford County
Manassas Park City	Spotsylvania County
Warren County	Culpeper County
	Rappahannock County

RATES OF REIMBURSEMENT FOR AGENCY-DIRECTED PERSONAL CARE SERVICES

To comply with federal and state mandates, a ceiling for the cost of personal care services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to the geographic location of the member. The fee for personal care services is an hourly fee that reimburses for authorized personal care services. This fee must cover all expenses associated with the delivery of personal care services, including nursing visits. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The amount of personal care services required by each member shall be determined by the service authorization contractor. Once authorization is approved and the services are provided, the maximum number of personal care hours, which can be billed, is the amount on the provider's approved Plan of Care.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided over the course of a calendar month, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR AGENCY-DIRECTED RESPITE CARE SERVICES

To comply with federal and state mandates, a ceiling for the cost of respite care services has been calculated for regions of the state and must be applied uniformly on a statewide basis according to the geographic location of the member. The unit of service for respite care will be defined by the number of hours of service which are provided. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The reimbursement must cover all expenses associated with the delivery of respite care services.

The amount of personal care services required by each member shall be determined by the Screening Team and the pre-authorization contractor. This authorization for units of service will establish the maximum number of units and the allowable payment for the service. The maximum amount of respite care service hours allowed in the waiver per individual per State Fiscal Year (SFY) is 480 hours.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR ADULT DAY HEALTH CARE (ADHC) SERVICES

To comply with federal and state mandates, a ceiling for the cost of Adult Day Health Care (ADHC) services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to geographical locality. The fee for ADHC services is a per-diem fee. A day is defined as attendance at the ADHC Center for six hours or more. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

This fee must cover all expenses associated with the delivery of services for the time the member is attending an ADHC Center. The per-diem reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs.

If a member attends the ADHC Center for less than six hours on any given day, it is considered a half day of service. At the end of the month, the half days of service may be added and rounded to the nearest whole day of service. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

Any ADHC Center which is able to provide members with transportation routinely to and from the center can be reimbursed by DMAS based on a per-trip (to and from the member's

residence) fee. This reimbursement for transportation must be service authorized by either the Screening Team or the service authorization contractor review staff. The per-trip reimbursement rate can be found on the DMAS web site at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) SERVICES

The monthly rate (one unit) includes administrative costs, time, labor and supplies associated with the installation, maintenance, and monitoring of the PERS.

The one-time installation of the unit includes installation, account activation, member and caregiver instruction, and removal of equipment.

The rates of reimbursement for PERS monitoring and installation can be found on the DMAS web site at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR MEDICATION MONITORING SERVICES

The rates of reimbursement for medication monitoring installation, monthly monitoring, and the bimonthly (twice per month) rate of reimbursement for PERS nursing visits to fill the medication monitoring unit can be found on the DMAS website at www.dmas.virginia.gov.

The one-time installation of the unit includes installation, account activation, member and caregiver instruction, and removal of equipment.

RATES OF REIMBURSEMENT FOR SERVICES FACILITATION SERVICES

The reimbursement for service facilitation services varies according to the type of services provided to the member. The fees must cover all expenses associated with the delivery of service facilitation services, including nursing visits. The reimbursement rates are considered by the Department of Medical Assistance Services (DMAS) as payment in full for all administrative overhead and other administrative costs that the provider incurs. Service facilitation reimbursement rates can be found on the DMAS website at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR CONSUMER-DIRECTED (CD) PERSONAL

CARE AND RESPITE CARE SERVICES

The reimbursement rates for consumer-directed (CD) personal care services and respite care services can be found on the DMAS web site at www.dmas.virginia.gov. CD personal care and respite care services are reimbursed in 15 minute increments.

PATIENT PAY AMOUNT AND COLLECTION (CCC Plus Waiver)

Purpose

This form is used by a local Department of Social Services (DSS) and CCC Plus Waiver services provider to exchange information with respect to:

The responsibility of an eligible member to make payment toward the cost of care;

The admission or discharge of the member or death of the member; and

Other information known to the provider that might involve a change in eligibility or patient pay responsibility.

The form shall be prepared by the provider to request a Medicaid number, eligibility determination, or confirmation of the patient pay amount or to notify the local DSS of changes in the member's circumstances. A new form must be prepared by the local DSS at the time of each re-determination of eligibility and whenever there is any change in the member's circumstances that results in a change in the amount of the patient pay.

DISPOSITION OF COPIES

The provider should initiate the form upon receiving a referral from the Hospital or Community Screening Team in order to notify the local DSS that he or she has admitted the member to services and provided the begin date of service. Upon determination of eligibility, the DMAS-225 form will be returned to the provider with the following information:

Whether the member does or does not have financial responsibility toward

the cost of care;

The amount and sources of finances; and

The date on which the patient pay responsibility begins.

There must be a completed DMAS-225 form in the member's file prior to billing DMAS. The provider with the most authorized hours is responsible for the DMAS-225 form. The provider with the most authorized hours of service per month is considered the primary service provider (PSP). Providers involved in the member's care must coordinate the DMAS-225 activities. For CD services, the Services Facilitator must also provide a copy of the DMAS-225 form to the Fiscal Agent. If there is a change in the patient pay amount for members receiving CD services, the CD Services Facilitator must send a copy of the revised DMAS-225 to the pre-authorization contractor and the Fiscal Agent.

The patient pay amount is the member's contribution toward his or her care received in a calendar month. If the amount of services received by a member in a calendar month is equal to or less than such member's patient pay amount, only the amount for the services rendered should be collected from the member, and DMAS should not be billed for that month. If the amount of services rendered is greater than the amount of patient pay, an invoice should be submitted showing the total allowable charges and the patient pay amount. The provider will be reimbursed by DMAS for the total allowable charges less the patient pay amount. For consumer-directed services, if the amount of services rendered is greater than the amount of the patient pay, the Fiscal Agent will subtract the patient pay amount from the CD personal care aide's payroll. The member is responsible for paying the employee the patient pay directly.

The patient pay amount is that amount of a Medicaid member's income that must be contributed to the cost of his or her care. The amount of patient pay is determined by the DSS based on the member's income and medically related deductions. It is the responsibility of the DSS to notify the member and the provider of any change in the patient pay amount. Patient pay **estimates** are obtained by the Screening Team to inform the member of the estimated patient pay amount and should be included on the DMAS-97 form. The provider should immediately initiate a DMAS-225 form and send it to the local DSS upon beginning services so that the DSS can notify the provider of the actual patient pay

amounts. The provider should compare these actual figures against the Screening Team's estimates. If the two do not correspond, the provider should notify the member and the Fiscal Agent (if applicable) of the patient pay amount on the DMAS-225 form and bill DMAS accordingly.

Upon receipt of a referral in which a patient pay amount for services is indicated, the primary care provider (PCP) should verify that the member understands and agrees to his or her patient pay obligations. Medicaid suggests that this verification be in the form of a signed statement of obligation and that the patient pay amount be collected at the beginning of the month. It is the responsibility of the provider to collect the patient pay amount. For consumer-directed services, it is not the responsibility of the Service Facilitator to collect the member's patient pay amount. It is the member's responsibility to ensure the patient pay amount is given to the personal care aide to cover the amount of personal care services authorized. DMAS will not reimburse a provider for any portion of the patient pay amount.

In those instances where the patient pay responsibility usually exceeds the amount of services authorized for one provider, the provider will divide the amount of patient pay so that the statement obligation signed by the participant indicates the amount the participant will pay monthly to one provider and the amount the participant will pay monthly to a second service provider. The primary service provider must provide a copy of this statement to the secondary service.

For additional information and examples of patient pay collection when a member is receiving more than one waiver service, see Chapter IV's Patient Pay Amount section.

In the event that the member does not pay the patient pay amount in a timely manner, the provider must make a reasonable effort to notify the member/family of the situation in an effort to collect the required amount. A reasonable effort shall be defined as three written notifications

to the member.

The member's failure to pay the patient pay amount may affect his or her Medicaid eligibility. Therefore, if the provider is unable to collect the patient pay amount, the

provider must also notify the local DSS eligibility worker having case responsibility for the member. For consumer-directed services, if the Service Facilitator becomes aware that the member is not paying the patient pay amount to the personal care aide, the Service Facilitator must also notify the local DSS eligibility worker having case responsibility for the member. This notification must be in writing and a copy retained in the member's record by the provider. It is the responsibility of the member to pay the patient pay to the provider or, if applicable, to the consumer-directed personal care aide. The provider or the personal care aide, if applicable, has the right to decide whether to continue service delivery to a member who neglects to pay his or her patient pay amount. DMAS will not reimburse the provider or the personal care aide, if applicable, for the patient pay amount that is not paid by the member.

If, after a reasonable effort to collect the patient pay amount, the provider decides to discontinue services, the provider must give the member/family five days' written notice of discontinuance of services. Such notice must include the reason for discontinuance and the effective date. A copy of this notification must be sent to the local DSS eligibility worker. A copy of all correspondence must be retained in the member's record with the provider and a copy sent to the pre-authorization contractor.

MEDICAID BILLING INVOICES FOR COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) WAIVER SERVICES

The billing invoice for CCC Plus Waiver services is the CMS-1500 Claim Form.

INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM STARTING 04/01/2014 AND AFTER (CCC Plus Waiver)

INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORMSTARTING 04/01/2014 AND AFTER

The Direct Data Entry (DDE) CMS-1500 claim form on the Virginia Medicaid Web Portal will be updated to accommodate the changes to locators 21 and 24E on 4/1/2014. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

To bill for services, the Health Insurance Claim Form, CMS-1500 (02-12), invoice form must be used for paper claims. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12). The purpose of the CMS-1500 (02-12) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid members.

SPECIAL NOTE: The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

Locator	Instructions	
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Detention Order (EDO).**
1a	**REQUIRED**	**Insured's I.D. Number -** Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	**REQUIRED**	**Patient's Name -** Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: -** Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.
10d	Conditional	**Claim Codes (Designated by NUCC)** Enter "ATTACHMENT" if documents are attached to the claim form.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	**REQUIRED** **If applicable**	**Insurance Plan or Program Name** Providers that are billing for non-Medicaid MCO copays only- please insert "HMO Copay".
11d	**REQUIRED** **If applicable**	**Is There Another Health Benefit Plan?** Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	**REQUIRED** **If Applicable**	**Date of Current Illness, Injury, or Pregnancy** **Enter date MM DD YY format** **Enter Qualifier 431 – Onset of Current Symptoms or Illness**
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation

Locator	Instructions	
17	**REQUIRED** **If applicable**	**Name of Referring Physician or Other Source** – Enter the name of the referring physician.
17a **shaded red**	**REQUIRED** **If applicable**	**I.D. Number of Referring Physician** - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	**REQUIRED** **If applicable**	**I.D. Number of Referring Physician** - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**REQUIRED** **If applicable**	**Additional Claim Information** Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21 **A-L**	**REQUIRED**	**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. **Note: ICD Ind. Not required at this time.**
22	**REQUIRED** **If applicable**	**Resubmission Code – Original Reference Number**. Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	**REQUIRED** **If applicable**	**Prior Authorization (PA) Number** – Enter the PA number for approved services that require a service authorization.
	NOTE: The locators 24A thru 24J have been divided into open areas and a shaded line area. **The shaded area is ONLY for supplemental information**. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. **ENTER REQUIRED INFORMATION ONLY.**	
24A **lines** **1-6** **open area**	**REQUIRED**	**Dates of Service -** Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01/01/14). **DATES MUST BE WITHIN THE SAME MONTH**

Locator		Instructions
24A lines 1-6 red shaded	**REQUIRED If applicable**	**DMAS requires the use of qualifier 'TPL'.** This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is $27.08; red shaded area would be filled in as **TPL27.08**. No spaces between qualifier and dollars. No $ symbol but the decimal between dollars and cents is required. **DMAS requires the use of the qualifier 'N4'.** This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number. **NOTE: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity** **Unit of Measurement Qualifier Codes:** **F2 – International Units** **GR – Gram** **ML – Milliliter** **UN – Unit** **Examples of NDC quantities for various dosage forms as follows:** **a. Tablets/Capsules – bill per UN** **b. Oral Liquids – bill per ML** **c. Reconstituted (or liquids) injections – bill per ML** **d. Non-reconstituted injections (I.E. vial of Rocephin** **powder) – bill as UN (1 vial = 1 unit)** **e. Creams, ointments, topical powders – bill per GR** **f. Inhalers – bill per GR** **BILLING EXAMPLES:** **TPL, NDC and UOM submitted:** **TPL3.50N412345678901ML1.0** **NDC, UOM and TPL submitted:** **N412345678901ML1.0TPL3.50** **NDC and UOM submitted only:** **N412345678901ML1.0** **TPL submitted only:** **TPL3.50** **Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples)** **All supplemental information is to be left justified.**

Locator		Instructions
		SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed: • If there is nothing indicated or 'NO' is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2. • If locator 11d is checked 'YES' and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. **An EOB/documentation must be attached to the claim to verify non-payment**. • If locator 11d is checked 'YES' and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of $15.50. This relates to the old coordination of benefit code 3.
24B open area	**REQUIRED**	**Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.
24C open area	**REQUIRED If applicable**	**Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**
24D open area	**REQUIRED**	**Procedures, Services or Supplies – CPT/HCPCS – ter HCPCS Code, which d**-Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. **Modifier -** Enter the appropriate CPT/HCPCS modifiers if applicable.
24E open area	**REQUIRED**	**Diagnosis Code -** Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than A-L in Locator 24-E or blank may be denied.
24F open area	**REQUIRED**	**Charges -** Enter your total usual and customary charges for the procedure/services.
24G open area	**REQUIRED**	**Days or Unit -** Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	**REQUIRED If applicable**	**EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	**REQUIRED If applicable**	**NPI –** This is to identify that it is a NPI that is in locator 24J
24 I red-shaded	**REQUIRED If applicable**	**ID QUALIFIER –T**he qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.
24J open	**REQUIRED If applicable**	**Rendering provider ID# -** Enter the 10-digit NPI number for the provider that performed/rendered the care.
24J red-shaded	**REQUIRED If applicable**	**Rendering provider ID#** - The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number
26	**REQUIRED**	**Patient's Account Number** – Up to **FOURTEEN** alpha-numeric characters are acceptable.

Locator	Instructions	
27	NOT REQUIRED	Accept Assignment
28	**REQUIRED**	**Total Charge -** Enter the total charges for the services in 24F lines 1-6
29	**REQUIRED** **If applicable**	**Amount Paid – For personal care and waiver services only** – enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block.
32	**REQUIRED** **If applicable**	**Service Facility Location Information –** Enter the name as first line, address as second line, city, state and 9-digit zip code as third line for the location where the services were rendered. **NOTE:** For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9-digit zip code.
32a open	**REQUIRED** **If applicable**	**NPI # -** Enter the 10 digit NPI number of the service location.
32b red shaded	**REQUIRED** **If applicable**	**Other ID#:** - The qualifier '1D' is required for the API entered in this locator. The qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line.
33	**REQUIRED**	**Billing Provider Info and PH # -** Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid**.** **NOTE: Do NOT** use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9-digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	**REQUIRED**	**NPI –** Enter the 10-digit NPI number of the billing provider.
33b red shaded	**REQUIRED** **If applicable**	**Other Billing ID -** The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 33a open line. **NOTE: DO NOT** use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

Special Note: Taxonomy

With the implementation of the National Provider Identifier (NPI), it will become necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS, and SLH. Prior to using the NPI, DMAS assigned a unique

number to a provider for each of the service types performed. In regard to the NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudicated and paid based on the service type, the DMAS system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

Type of Waiver Service	Taxonomy Code	Procedure Code (CPT)	Modifier	Units
Personal Care	3747P1801X	T1019	N/A	Hour
Respite Care	385H00000X	T1005	N/A	Hour
CD Attendant Care	3747P1801X	S5126	N/A	Hour
CD Respite Care	385H00000X	S5150	N/A	Hour
Private Duty Nursing	163WC2100X	T1002 (RN) T1003 (LPN)	N/A	Hour
Private Duty Nursing Respite	163WC2100X	S9125	For RN =TD For LPN = TE	Hour
Congregate Nursing	163WC2100X	T1000 (RN) T1001 (LPN)	U1	Hour
Congregate Nursing Respite	163WC2100X	T1030 (RN) T1031 (LPN)	For T1030 = TD For T1031 = TE	Hour
Adult Day Health Care	261QA0600X	A0120 (per trip) S5102 (per diem)	N/A	Per Trip Per Diem
PERS (includes PERS Nursing Services, PERS Installation, PERS Medication Monitoring, and PERS Monitoring)	332B00000X	S5160, S5161, S5185, H2021	For S5160 = U1 H2021 (RN) = TD H2021 (LPN) = TE	S5160=Per Visit; S5161=Month; S5185=Month; H2021 = 30 minutes
Environmental Modifications	332B00000X	99199, S5165	For 99199 = U4	Per Item/Request

Assistive Technology	332B00000X	T1999	Maintenance Costs Only = U5	Per Item/Request
Transition Services	N/A	T2038	N/A	Per Item/Request
Services Facilitation	251B00000X	99509, H2000, S5109, S5116, T1028	N/A	Per Visit

Rejection codes: (When the Taxonomy is denied)	
EDI Remark: Medicaid Edit-Reject	
N94:	1359 - Billing Taxonomy Code Does Not Cross-reference to Provider Type
N94:	1392 - Taxonomy Code Does Not Cross-reference to Provider Type
N288:	1393 - No service Taxonomy Code on the Claim
N255:	1394 - No Billing Provider Taxonomy Code on the Claim

Rejection Codes: (When the Taxonomy is Denied)

EDI Remark: Medicaid Edit- Reject

N94:	1359- Billing Taxonomy Code Does Not Cross-reference to Provider Type
N94:	1392- Taxonomy Code Does Not Cross-reference to Provider Type
N288:	1393- No service Taxonomy Code on the Claim
N255:	1394- No Billing Provider Taxonomy Code on the Claim

INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM, CMS 1500 (02-12), AS AN ADJUSTMENT INVOICE

The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator	Medicaid Resubmission
22	Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.
	1023 Primary Carrier has made additional payment
	1024 Primary Carrier has denied payment
	1025 Accommodation charge correction
	1026 Patient payment amount changed
	1027 Correcting service periods
	1028 Correcting procedure/service code
	1029 Correcting diagnosis code
	1030 Correcting charges
	1031 Correcting units/visits/studies/procedures
	1032 IC reconsideration of allowance, documented
	1033 Correcting admitting, referring, prescribing, provider identification number
	1053 Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be adjusted through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead, which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services

Attn: Fiscal & Procurement Division, Cashier

600 East Broad St., Suite 1300

Richmond, VA 23219

INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM CMS 1500 (02-12), AS A VOID INVOICE

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead, which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services

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600 East Broad St., Suite 1300

Richmond, VA 23219

Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility-based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS-1500 (02-12), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov

Negative Balance Information

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the

total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, “less the negative balance” and it may also show “the negative balance to be carried forward”.

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00 a check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

Billing Instructions: EDI Billing (Electronic Claims)

Please refer to X-12 Standard Transactions & our Companion Guides that are listed in the chapter.

Special Billing Instructions for Personal/Respite Care

Locator 14 Date of Current Illness, Injury, or Pregnancy
Date care began is located on the DMAS-93 (P.A. Letter)
Locator 24D Procedures, Services or Supplies

CPT/HCPS – Enter the appropriate procedure code from the following list:

T1019	Personal Care
T1005	Respite care services, aide/hr.
S9125	Respite care services, LPN/hr.

Locator 29 for CMS-1500 (02-12)	Amount Paid Enter the patient pay amount except for Personal Care. (For Personal Care see instructions for Locator 29). Patient pay and primary carrier payments can be combined if applicable. EOB should be attached to claim.
Locator 29	Amount Paid Enter the patient pay amount for Personal Care only.

SPECIAL BILLING INSTRUCTIONS FOR ADULT DAY HEALTH CARE (ADHC)

The providers of ADHC must complete the CMS-1500 Claim Form. The claim form must be completed as normal with a few special billing instructions:

Locator 24D	CPT/HCPCS - Enter the appropriate procedure code from the following list for the service rendered: S5102 Adult Day Health Care Services A0120 Adult Day Health Care Transportation
Locator 24J	COB (Primary Carrier Information) 3 - Billed and Paid (Use for patient pay.)
NOTE:	For claims submitted on CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area of previous billing instructions.
Locator 24K	Reserved for Local Use Enter the payment from other insurance, if applicable.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine Patient Pay and TPL since this revised form allows separation.

Locator 29 All claims submitted to DMAS on or after April 15, 2005, with a patient pay amount, must have the patient pay amount recorded in block 29 of the claim form.

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

Locator 24D Procedures, Services, or Supplies

CPT/HCPCS – Enter the appropriate procedure code from the following list:

S5160 PERS Installation

S5161 PERS Monitoring

Locator 24K Reserved for Local Use

Enter the payment from other insurance, if applicable.

SPECIAL BILLING INSTRUCTIONS FOR MEDICATION MONITORING

Locator 24D Procedures, Services, or Supplies

CPT/HCPCS – Enter the appropriate procedure code from the following list:

S5160 with modifier U1

Medication Monitoring unit installation

S5185 Medication Monitoring unit monthly monitoring

H2021 with modifier TD

Medication Monitoring RN visit

H2021 with modifier TE

Medication Monitoring LPN visit

Locator 24K Reserved for Local Use

Enter the payment from other insurance, if applicable.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine patient pay and TPL since this revised from allows separation.

SPECIAL BILLING INSTRUCTIONS FOR SERVICE FACILITATION SERVICES FOR CONSUMER-DIRECTED (CD) SERVICES

Locator 24D Procedures, Services, or Supplies

It is essential that the provider submit all claims in a timely manner, preferably within 30 days of the date that the service was provided.

CPT/HCPS - Enter the appropriate procedure code from the following list.

NATIONAL CODE	MODIFIER	DESCRIPTION
H2000		Comprehensive Visit
S5109		Consumer Training
99509		Routine Visit
T1028		Reassessment Visit
S5116		Management Training
99199	U1	Criminal Record Check
99199		CPS Registry Check
S5126		Personal Care
S5150		Respite Personal Care

SPECIAL BILLING INSTRUCTIONS FOR RECEIVING SERVICES FROM MULTIPLE PROVIDERS ON THE SAME DAY

For individuals who receive the same service from two different providers on the same day, the first provider's claim is to be billed with modifier 77 on the claim. The second provider must submit their claim with the national code and modifier 77. Otherwise, the second provider's claim will be denied due to duplication of services from the first provider. The modifier is placed in block 24D on the CMS-1500 Claim Form.

NOTE:

Claim Form CMS-1500 (Revision 02/01/2012) can be found at: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html

Claim Attachment Form DMAS-3 (Revision 06/2003) can be found on the DMAS Medicaid Web Portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/ (under Provider Services/Provider Forms Search - enter DMAS-3)

Utilization Review and Quality Management Review (CCC Plus Waiver)

Updated: 5/1/2019

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 services of providers and individuals. These reviews are mandated by 42 CFR §§ 455-456 and may be conducted by the Department of Medical Assistance Services (DMAS) or its designated agent.

The DMAS staff conduct quality management reviews (QMRs) on all programs. In addition, the DMAS Division of Program Integrity staff conduct compliance reviews

on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals (12VAC30-120-1760).

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from the Department of Medical Assistance Services (DMAS). Under the Provider Participation Agreement with the DMAS (see Chapter II), the provider also agrees to give access to records and facilities to the DMAS representatives, the Attorney General of Virginia or authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization reviews, documentation requirements, and control requirement procedures conducted by the DMAS or its designee.

UTILIZATION COMPLIANCE REVIEW (UR) – DIVISION OF PROGRAM INTEGRITY (CCC Plus Waiver)

DMAS staff from the Division of Program Integrity or a DMAS designated contractor routinely conduct utilization compliance reviews (URs) 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 CFR, Part 455. Providers are identified for review by systems-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. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

DMAS staff or a DMAS designated agent review all cases using available resources, including appropriate consultants, and conduct on-site or desk reviews of medical and other individual and provider records as necessary.

The purpose of a utilization review conducted by Division of Program Integrity is to determine whether services delivered were appropriate, whether services continue to be needed, and the amount and kind of services required. Utilization review is mandated to ensure that the health, safety, and welfare of the individuals are protected and to assess the quality, appropriateness, level, and cost-effectiveness of care.

The use of statistical sampling may be used during a utilization review. The Department may use a scientific random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample is compared to the total invalid payments for the same time frame, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time frame.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, 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 as a result of any of the above problems, Medicaid, as set forth in the Provider Agreement, may restrict, limit, suspend, or terminate the provider's participation in the program.

If the provider review results in an overpayment of funds that are due to DMAS, the Fiscal Division at DMAS will be contacted and will coordinate the collection of any payments due to DMAS. If the provider requests an appeal of the overpayment decision from the review, the provider must notify the Fiscal Division of the Appeal request.

DMAS analysts will conduct utilization review of all documentation submitted by the provider that shows the individual’s needs, available social supports, and level of care. Utilization review is conducted on-site or as desk reviews and will most often be unannounced. The utilization review is accomplished through a review of the individual’s record, evaluation of the individual’s medical and functional status, review of the provider qualifications, consultation with the individual and family members, and a review of personnel records and the provider’s billing records.

When the team arrives at the provider’s place of business/offices, the team will request a minimum number of records per team member in order to begin the review process. The utilization review team will also request the provider to provide the rest of the records on the review list within two (2) hours of their arrival time for open records and by close of business on the arrival day for closed records.

During an on-site review, the analyst will review the individual's record in the provider's/Service Facilitator's (SFs) place of business/offices, paying specific attention to Plan of Care, supervisory notes (RN) and (SF), daily records, progress notes, screening packages, and any other documentation that is necessary to determine if appropriate payment was made for services rendered. The DMAS analyst will also meet or talk with at least one individual or primary caregiver to determine individual satisfaction with the CCC Plus 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 DMAS review of the individual's care.

During the review process, the analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. A letter will be sent to the provider in a timely manner after the review is complete to either document the results of the review or provide an update on the status of the review.

QUALITY MANAGEMENT REVIEWS (QMR) – DIVISION OF PROGRAM INTEGRITY (CCC Plus Waiver)

A typical QMR encompasses the follow elements:

Discovery: The review of documentation findings

and individual interviews.

Remediation: Based on Discovery, the

provision of technical assistance or provision

of a corrective action plan ensure needed

changes are implemented. Corrective action

is taken by Provider to ensure compliance.

Improvement: The follow up activities to

assure that recommended or mandated corrective

action and/or improvements to service delivery have been initiated**.**

By federal law, DMAS is the single state authority responsible for the supervision of the administration of home and community-based waivers in the Commonwealth of Virginia and shall perform routine QMRs of waiver services and providers. QMRs are not to be confused with URs, which is a separate review, as described in this chapter.

When the team arrives at the provider's place of business/offices, the team will request a minimum number of records per team member in order to begin the review process. The QMR review team will also request the provider to provide the rest of the records on the review list within two (2) hours of their arrival time for open records and by close of business on the arrival day for closed records.

DMAS analysts with the Division of Integrated Care or its contractors shall conduct ongoing monitoring of compliance of a provider with DMAS participation standards and policies. 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, and/or referral to the Division of Program Integrity.

DMAS analysts shall conduct QMRs of waiver services provided to ensure the health, safety, and welfare of the individual and individual satisfaction with services. The reviews shall focus on the Centers for Medicare and Medicaid's (CMS) assurances of health, safety and welfare, level of care determination, plan of care, and qualified providers, including individual preferences and choices, services being delivered in accordance with the plan of care and the identification of inclusion and risk. In addition to assessing the individual's ongoing need for Medicaid-funded home and community based services (HCBS), another purpose of the reviews is to ensure a waiver individual's satisfaction with waiver services and providers, and that individual choice of services and person-centered planning are being carried out.

During the on-site QMR review, DMAS analysts monitor the provider's compliance with overall provider participation requirements. Particular attention is given to qualifications of provider staff such as work references (or proof in the personnel file of a good faith effort to obtain such references) and documentation of criminal background checks within 30 days of the date of hire, as described in Chapter II of this manual. However, no employee shall be permitted to work in a position that involves direct contact with an individual in the waiver until an original criminal background record clearance has been received unless such person works under the direct supervision of another employee for whom a background check or CPS (Child Protective Service) check has been completed in accordance with the Code of Virginia. DMAS analysts will request to see health professionals' licenses, training certificates for personal care aides, etc. and required documentation that staff who have provided services meet all qualification requirements as identified in DMAS regulations and policies. The provider is responsible for ensuring that all staff of the provider meets the minimum requirements and qualifications at the start of the employment.

During the QMR, DMAS analysts will discuss with the provider's administration the provider's overall status as a Medicaid provider, any areas of concern, technical assistance needs, the plans for addressing those needs, and any recommendations that staff may have. DMAS may also require additional documentation to verify that the provider is in compliance with DMAS provider agreements and policies, including 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 the provider is authorized to provide per a Medicaid participation agreement.

Providers are continually assessed to ensure that they conform to Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to individuals who are receiving services through the Commonwealth Coordinated Care Plus (CCC Plus) waiver. Information used to make this assessment may include desk reviews of the documentation submitted by the provider, on-site reviews of the provider's files, interviews with staff and with individuals during visits to their homes or place of residence, and by responses to quality assurance survey letters.

DMAS analysts will base an assessment of the provider on a comprehensive evaluation of the provider's overall performance in relation to the following

program goals:

1. Individuals served by the provider meet the waiver program's eligibility criteria. If DMAS determines, during the QMR or at any other time, that the individual receiving waiver services no longer meets eligibility standards or criteria for waiver enrollment and services as set forth in DMAS regulations, the provider shall notify level of care staff within the DMAS Division of Aging and Disability Services (LOCreview@dmas.virginia.gov), and request that the provider discuss alternative services with the individual. The provider has a responsibility to be aware of the criteria for the waiver program and to evaluate, on an ongoing basis, the individual's appropriateness for waiver services.

2. Services rendered must meet the individual's identified needs and be within the program's guidelines. The provider is responsible for continuously assessing the individual's needs through home visits made by the provider and communication between the provider, services facilitator, provider staff, the waiver individual and/or primary caregiver. The provider must be notified of any substantial change in the individual's status, the individual's record must contain documentation of any such change, and additional orders must be obtained from the physician, if appropriate. This also includes the provider's responsibility to identify and make referrals for any other services that the individual requires to remain in the community (e.g., durable medical equipment and supplies, skilled nursing visits, etc.).

3. Provider documentation must support all services billed.

4. Services must be delivered by qualified individuals and providers as required and in accordance with the plan of care.

5. Services must be of a quality that meets the health, safety and welfare needs and the rights of the individual. Quality of care is best assured through an emphasis on communication and respect between the individual and provider staff, and between the individual and the

providers who are responsible for the oversight of the plan of care. Some of the elements included in quality of care are:

Consistency of care;

Continuity of care;

Adherence to the person-centered plan of care; and

Consideration for the health, safety, and welfare needs of the individual.

6. The provider shall maintain a record for each individual. Forms that may be used are available on the Medicaid Web Portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/

DMAS analysts will review the provider's performance in all outcome areas to determine the provider's ability to achieve high quality of care and conform to DMAS regulations and policies. The DMAS analysts are responsible for providing feedback to the provider regarding those areas that need improvement. DMAS analysts will work with the individual to evaluate the individual's status, satisfaction with the service, and appropriateness of the current Plan of Care (POC). If the POC is found to be inadequate, DMAS analysts may require a revision of the plan to meet the needs of the individual.

Exit Conference (CCC Plus Waiver)

Following the DMAS analyst's or its contractors on-site review of the medical records and home visits, the DMAS analyst will meet during the exit conference with the appropriate provider staff to discuss general findings from the review. The provider may include any staff the provider would like to attend the exit conference, but must provide appropriate staff (as requested by the analyst) for this meeting. The Exit Conference is a courtesy meeting offered by DMAS. If the DMAS analysts determine that a face-to-face conference is not possible or not able to occur, the provider will be informed. The Exit Conference may be conducted face-to-face or by telephone, if necessary.

During the exit conference, the provider will be informed of the number of records

reviewed, number of participants interviewed, general recommendations regarding level-of-care issues, general recommendations regarding the changes in Plan of Care documentation, and any pertinent information regarding documentation, service verification issues, quality of care, or provision of services. The provider is expected to use the findings of the QMR review to comply with regulations, policies, and procedures in the future. Records that have been reviewed shall not be altered to meet the compliance issues. The DMAS analyst will send a letter to the provider verifying that the review was conducted. This letter will also describe the findings of the review or will give an update as to the status of the review. This letter will also include a list of any citations and technical assistance.

During the QMR review process, the DMAS analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and assistance. Any uncorrected compliance issues may result in the termination of the provider contract.

ANNUAL LEVEL-OF-CARE REVIEWS (CCC Plus Waiver)

The federal regulations under which waiver services are made available mandates that every individual receiving services be reviewed each year to assure he or she continues to meet level-of-care criteria for the waiver's targeted population.

Providers will be required to submit documentation each year for review to DMAS at: LOCreview@dmas.virginia.gov, to demonstrate the individual's functional status and medical/nursing needs using the Level-of-Care Review Instrument. DMAS LOC review analysts will send the provider a letter each year indicating when the provider's level-of-care review is due and what documentation is required. For all agency-directed personal/respite care services, the level-of-care review must be completed by an RN. For all CD personal/respite care services, the level-of-care review must be completed by a CD Services Facilitator.

If it is found that an individual no longer meets the waiver level of care, DMAS will terminate services in accordance with the procedures detailed in Chapter IV of this manual.

DMAS CAN REQUIRE REPAYMENT OF OVERPAID MONEY IF PROVIDERS CONTINUE TO SERVE INDIVIDUALS WHO DO NOT MEET THE LEVEL OF CARE WITHOUT NOTIFYING THE SERVICE AUTHORIZATION CONTRACTOR OF THE CHANGE IN LEVEL OF CARE

AND THE NEED FOR DISCONTINUATION OF SERVICES.

Medical Records and Record Retention (CCC Plus Waiver)

The provider must recognize the confidentiality of individual 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 individual's written consent is required for the release of information not authorized by law. Current individual medical record documentation and those of discharged individuals must be completed promptly. All clinical information pertaining to an individual must be centralized in the individual's clinical/medical record.

Records of CCC Plus Waiver services must be retained for six years from the last date of service and not less than six (6) years after the date of discharge. The provider must maintain medical records on all individuals 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. If the individual is under 18 years of age, his/her medical records must be retained not less than seven (7) years after the individual reaches age 18. All CCC Plus Waiver medical record entries must be fully signed and dated (month, day, and year), including the title (professional designation) of the author.

Financial Review and Verification (CCC Plus Waiver)

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 of reimbursement.

DMAS or its contractors who conduct financial provider audits will coordinate with providers for any repayment for inappropriate reimbursement.

Section 32.1-325.1 of the *Code of Virginia* requires that DMAS collect identified overpayments. Repayment must be made upon demand unless a repayment is agreed to by DMAS. Unless a lump sum cash payment is made, interest will be added to the declining balance at the statutory rate pursuant to § 32.1-313 of the *Code of Virginia*. Repayment and interest will not apply for appeals that are in a pending status.

Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates to the satisfaction of DMAS a financial hardship warranting extended repayment terms.

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 himself 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 and adhering to applicable state and federal regulations 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 or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, 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:

Supervisor, Provider Review Unit

Program Integrity Section

Division of Cost Settlement and Audit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

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:

Director, Medicaid Fraud Control Unit

Office of the Attorney General

900 E. Main Street, 5th Floor

Richmond, Virginia 23219

Recipient Fraud

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. 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.

If it is determined that benefits to which the individual was not entitled were approved, 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.

Referrals should be made to:

Supervisor, Recipient Audit Unit

Program Integrity Section

Division of Cost Settlement and Audit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) PROGRAM (CCC Plus Waiver)

DMAS providers may refer Medicaid individuals suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of DMAS. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program.

See the “Exhibits” section at the end of Chapter I of this manual for detailed information

and forms on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate individuals on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, fax, or in writing. A toll-free HELPLINE is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: 1-804-786-6548

CMM HELPLINE: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Refer to the end of Chapter I of this manual for the CMM Exhibits section.

Appendix B: Update Control Log

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Appendix D (CCC Plus Waiver)

Updated: 1/23/2020

INTRODUCTION

Service authorization is the process to review specific service requests for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization and some may begin prior to requesting authorization.

Purpose of Service Authorization

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

General Information Regarding Service Authorization

Submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests.

DMAS or its service authorization contractor will approve, pend, reject, or deny all service requests. Requests that are denied for not meeting the level of care criteria are automatically sent to medical staff for a higher level review. When a final disposition is reached the individual and the provider are notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice sent by DMAS will identify the individual's right to appeal the decision, in accordance with 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 370. The provider and individual have the right to appeal adverse decisions to the Department.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) PROGRAM

Individual's Transitioning into CCC Plus Program

Individuals who meet the benefit plan criteria are enrolled in the CCC Plus program. The CCC Plus MCO Health Plan honors the existing service authorization contractor's authorization and will automatically authorize services for a period of 30 days or until the service authorization end date whichever comes first. The continuity of care period applies to providers that are in and out of network with the MCO.

Individuals Transitioning from CCC Plus Program back to Medicaid Fee-for-Service (FFS)

Should an individual transition from CCC Plus back to Medicaid FFS, the provider must submit a request to the service authorization contractor and must indicate that the request is for a CCC Plus member who was disenrolled from an MCO into FFS. This will ensure honoring the (CCC Plus MCOs) approval of services for up to 60 days for the continuity of care period and waiving timeliness requirements. The service authorization contractor will honor the CCC Plus authorization up to the last approved date but no more than 60 calendar days from the date the CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the service authorization contractor will apply medical necessity/service criteria.

Review Process for Requests Submitted to the Service Authorization Contractor After the Continuity of Care Period:

A. The dates of service within the continuity of care period will be honored for the 60 day timeframe;
B. For dates of service beyond the continuity of care period, timeliness will be waived and the request will be reviewed for level of care necessity; all applicable criteria will be applied on the first day after the end of the continuity of care period; and
C. For CCC Plus Waiver services, level of care cap hours will be approved the day after the end of the continuity of care period up to the date of the request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the request.

The best way to obtain the most current and accurate eligibility information is for providers to complete their monthly Medicaid eligibility checks at the *beginning* of the month. This will provide information for individuals who may be in transition to and from CCC Plus at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the service authorization contractor's service authorization but the individual's CCC Plus eligibility has been retro-voided, continuity of care days will not be approved by the CCC Plus health plan. The service authorization contractor will re-open the original service authorization for the same provider upon notification by the provider.

CCC Plus Exceptions

The following exceptions apply to continuity of care upon return to FFS Medicaid:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the service authorization contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days.

The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)

- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once an individual is FFS, only Medicaid approved services will be honored for the continuity of care.
- If an individual transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the service authorization contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

Note: DMAS has published multiple Medicaid Bulletins and Provider Manuals that may be referred to for detailed CCC Plus information as posted on the Medicaid Web Portal located at this link: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/.

For additional information regarding the CCC Plus program, click on the DMAS website located at this link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

MEDICAID EXPANSION

On January 1, 2019, Medicaid expansion became effective. The new eligibility rules provide quality, low-cost health care coverage to eligible adults.

The Expansion Aid Categories:

100, 101, 102, 103, 106 and 108 (Incarcerated Adults Medical/Surgery inpatient services only)

The Medicaid Expansion Benefit Plan includes the following services:

- Doctor, hospital and emergency room services
- Prescription drugs
- Laboratory and x-ray
- Maternity and newborn care
- Behavioral health services including addiction and recovery treatment
- Rehabilitative and habilitative services including physical, occupational, and speech therapies and equipment
- Family planning
- Transportation to appointments
- Home Health
- DME and supplies
- Long Term Support Services (LTSS) to include Nursing Facility, PACE and Home and Community Based Service
- Preventive and wellness
- Chronic disease management
- Premium assistance for the purchase of employer-sponsored health insurance coverage, if cost effective
- Referrals for job training, education and job placement

Communication

Provider manuals are located on the DMAS Medicaid Web Portal and the service authorization contractor's websites. The service authorization contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to http://dmas.kepro.com. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Waiver* tab.

The service authorization contractor provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Bulletin to the DMAS Medicaid Web Portal. Changes identified in Medicaid Bulletin are incorporated within the manual.

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination. DMAS will not reimburse providers for dates of

service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's medical record and are subject to review during post payment and Quality Management Review (QMR).

SERVICE AUTHORIZATION FOR WAIVER SERVICES:

CCC Plus Waiver Services

A Screening for Long-Term Services and Supports (LTSS) is a requirement for all individuals requesting enrollment into the CCC Plus Waiver. For information regarding Screening for LTSS see the *Screening for Medicaid Funded Long-Term Services and Support* provider manual.

The individual will need to be determined eligible for CCC Plus Waiver services by the LTSS Screening Team and be Medicaid eligible to receive CCC Plus Waiver services.

The available services in the CCC Plus Waiver are: adult day health care, assistive technology, environmental modifications, personal care services, private duty nursing, personal emergency response system (PERS), respite care services, skilled respite care services, service facilitation and transition services.

Depending on the service authorization entity, processes may vary slightly for requesting services. Please reference the chart at the end of this appendix for detailed instructions (Exhibits Section).

Private Duty Nursing Services

CCC Plus waiver referrals for private duty nursing (PDN) are received at DMAS for individuals enrolled in FFS. The screening process for enrollment and clinical criteria for PDN service is described in Chapter IV of this manual.

Upon meeting clinical criteria and Medicaid financial eligibility, DMAS' Health Care Coordinator (HCC) enrolls the FFS/Medallion individual in the waiver. The DMAS HCC

collaborates with the Discharge Planner/Screening entities to secure a PDN agency. Once PDN is secured, the HCC coordinates the start of care and informs the provider of the number of hours needed per week for PDN. The HCC authorizes PDN for individuals 21 years of age or over based on the findings of the assessment of the PDN Adult Referral Form (DMAS 108). Skilled respite services for waiver individuals are for the unpaid primary caregiver and may be authorized when requested. The need for additional services for FFS individuals are determined during home visits and phone contacts between the HCC and provider agency.

Once DMAS enrolls the individual in the level of care (LOC) A and authorizes PDN as appropriate, the service authorization contractor may begin receiving requests for other CCC Plus waiver services. Since most individuals enrolled in PDN have many needs related to DME, providers may contact the service authorization contractor for DME and medical supply needs which are covered under Medicaid's State Plan Option.

NOTE: Refer to the chart at the end of this Appendix for services that require service authorization through KEPRO.

Submitting Requests for Service Authorization

Fee–for-service authorization reviews will be performed by DMAS' service authorization contractor, Keystone Peer Review Organization (KEPRO). All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests submitted. Service authorization requests must be submitted electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo).

Providers must submit requests for new admissions within ten business days of the start of care date in order for request to be timely and to avoid any gaps in service. If a provider is late submitting the request, the service authorization contractor will review the request and make a determination based on the date it was received. The days/units that are not submitted timely are denied, and appeal rights provided.

For continuation of services, if the individual continues to need waiver services, the provider

must submit a request justifying the need for the continuance of service. If the request is not received prior to the end date of the current authorized period, providers may have a denial for dates of service up to the date the request was received.

Retrospective review will be performed when a provider is notified of an individual's retroactive eligibility for Virginia Medicaid coverage. It is the provider's responsibility to obtain a service authorization prior to billing DMAS. Providers must request a service authorization for retrospective review as soon as they are aware of the individual's Medicaid eligibility determination.

**Note: Information submitted for service authorization must be documented in the medical record at the time of request. The request for service authorization must be appropriate to adequately meet the individual's needs. Any person who knowingly submits information containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

How to Register for Atrezzo

Provider registration is required to use Atrezzo Connect. The registration process for providers happens immediately on-line. To register, go to http://dmas.kepro.com, and click on "*Register*" to be prompted through the registration process. Newly registering providers will need their 10-digit Atypical Provider Identification (API) or National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount. If you are a new provider who has not received a remittance advice from DMAS, please contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com to receive a registration code which will allow you to register for KEPRO's Atrezzo Connect Portal. Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, then the *General* tab.

Submitting through Atrezzo puts the request in the reviewer queue immediately. Service authorization checklists and/or questionnaires may be accessed on KEPRO's website to assist the provider in assuring specific information is included with each request. Providers may access this information by going to http://dmas.kepro.com.

Already Registered with Atrezzo but Need Help Submitting Requests

It is imperative that providers currently registered use the portal for submitting all requests. For waiver providers, this includes admissions, discharges, continuation of care, change in hours, transfers, responding to pend requests, and all other transactions.

Registered Atrezzo providers do not need to register again. If a provider is successfully registered, but need assistance submitting requests through the portal, contact KEPRO at 1-888-827-2884 or atrezzoissues@kepro.com.

If a provider has registered for Atrezzo, and forgot their password, please contact the provider's administrator to reset the password or utilize the 'forgot password' link and respond to the security question to regain access. If additional assistance is needed by the administrator contact KEPRO at 1-888-827-2884 or www.atrezzoissues@kepro.com.

If the person with administrative rights is no longer with the organization, contact KEPRO at 1-888-827-2884 or www.atrezzoissues@kepro.com to have a new administrator set up.

When contacting KEPRO please leave caller's full name, area code and phone number and the best time to be contacted.

Additional Information for Ease of Electronic Submission

In order to make electronic submission easier for the providers, KEPRO and DMAS have completed the following:

1. Rules Driven Authorization (RDA) – These are a set of clinical criterion questions that will automatically populate in a questionnaire when requesting certain services or with specific diagnostic codes. The provider must respond to the questions found on the questionnaire on the Atrezzo Portal. The responses given by the provider must reflect what is documented in the individuals medical record. If the responses match the criterion for the specific service or diagnosis, the case will bypass a reviewer and be approved, and automatically batch for transmission to MMIS. If the responses do not match the specific criterion, the case will go to a reviewer's queue which will

follow the normal review process. If criteria are not met, then the request will go to the physician's queue and a physician will review the case and make a final determination.

2. Attestations – All providers will attest electronically that information submitted to KEPRO is within the individuals documented record. If upon audit, the required documents are not in the record, and the provider attested that they were present; retractions may be warranted as well as a referral to the Medicaid Fraud Control Unit within the Office of the Attorney General.
3. Questionnaires – for waiver providers, KEPRO and DMAS have reconfigured the questionnaires so they are shorter, require less information, take less time to complete and are more user friendly

Processing Requests at KEPRO:

KEPRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached, KEPRO notifies the provider. The individual and provider will receive a letter from DMAS regarding the status of the authorization request through the MMIS letter generation process.

When there is insufficient information to make a final determination of medical necessity, KEPRO will pend the request back to the provider and request additional information. The response includes specific timeframes for the additional information to be sent to KEPRO. When the information is not received within the timeframe requested by KEPRO, the information that was provided during the initial request will be automatically sent to a physician for review and a final determination will be made. In the absence of clinical information, the request will be submitted to the KEPRO supervisor for review and final determination. Providers and individuals are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

Providers are given one opportunity to respond to a pended case. Providers must respond electronically utilizing KEPRO's provider portal Atrezzo Connect (also known as Atrezzo). If the provider chooses to submit information prior to the pended due date, the case will be reviewed after the pended information is received. Once a case is reviewed and a decision has been rendered any additional information submitted after that timeframe will not be considered as part of the initial request.

Review Criteria to be used:

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan and is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve functional disability. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice. [42CFR441.302 (c) (1)] [12VAC30-60-300]

HOW TO DETERMINE IF SERVICES REQUIRE SERVICE AUTHORIZATION

In order to determine if services need to be authorized, providers may go to the DMAS website: http://dmasva.dmas.virginia.gov and look to the right of the page and click on the section that says Procedure Fee Files which will then bring you to this: http://www.dmas.virginia.gov/Content_pgs/pr-ffs_new.aspx. You will see a page entitled DMAS Procedure Fee Files. The information provided there will help you determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

The provider must determine whether to use the CSV or the TXT format. The CSV is a comma separated value and the TXT is a text format. Either version provides the same information.

The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. The Procedure Fee File will indicate when a code requires a service authorization as it will contain a numeric valueas one of the following:

00-No PA is required

01-Always needs a PA

02-Only needs PA if service limits are exceeded

03-Always need PA, with per frequency.

To determine whether a service is covered by DMAS access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides special coverage and/or payment information. A Procedure Flag of “999” indicates that a service is non-covered by DMAS.