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CHAPTER VI
QUALITY MANAGEMENT REVIEW

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CHAPTER VI QUALITY MANAGEMENT REVIEW

INTRODUCTION

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

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. This chapter provides information on QMR procedures conducted by DMAS.

GENERAL REQUIREMENTS FOR QUALITY MANAGEMENT REVIEW (QMR)

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.

DMAS or its designated agent 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, or referral to the Division of Program Integrity.

DMAS or its designated agent shall conduct QMRs of waiver services provided by all providers 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 individual service plans, including individual preferences, services being delivered in accordance with the Plan for Supports and the identification of inclusion and risk. In addition to assessing the individual's ongoing need for Medicaid-funded long-term care, another purpose of the reviews is to ensure a

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waiver individual's satisfaction with services and providers, and that individual choice of services and person-centered planning are being carried out. This may involve interviews with the individual and/or the family/caregiver, as appropriate.

During the on-site review, staff will monitor the provider's compliance with overall provider participation requirements. Particular attention is given to staffing qualifications as described in Chapter II of this manual. Staff will request to see registered nurses' (RNs') and other health professionals' licenses, including those of licensed practical nurses (LPNs), Certified Nursing Assistants (CNAs), and others who have provided services. In addition, staff may request to see work references or the documentation of attempts to obtain them, documentation of any required training and/or certification, documentation of criminal background checks, if applicable, and any other staffing requirements as identified in DMAS and Department of Behavioral Health and Developmental Services (DBHDS) regulations and policies. The provider is responsible for ensuring that all staff of the provider agency meets the minimum requirements and qualifications at the start of the employment. For consumer-directed services, the employer of record (EOR) is responsible to ensure that all stated requirements are met in the hiring and employment of attendants providing consumer-directed services.

During this review, DMAS staff 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 staff may also require additional documentation to verify that the provider agency 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 that the provider has a participation agreement to provide.

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 in need of intermediate care facility for persons with mental retardation (ICF/MR) level of care and who are receiving services through the Mental Retardation/Intellectual Disability (MR/ID) or Day Support (DS) Waivers. Information used to make this assessment includes DMAS desk review of the documentation submitted by the provider, on-site review of the provider's files, interviews with staff and with individuals on visits to homes, and by responses to quality assurance survey letters. DMAS bases its 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 program's eligibility criteria. If DMAS or its designated agent determines, during the QMR or at any other time,

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that the individual receiving waiver services no longer meets cost-effectiveness or eligibility standards or criteria for waiver services as set forth in DMAS regulations, DMAS shall review and request that the individual be removed from the waiver and that alternative services be discussed with the individual.

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 visits made by the provider and communication between the provider and other provider staff. The support plan must be revised in accordance with any substantial change in the individual's status, and the individual's record must contain documentation of any such change. This also includes the provider's responsibility to identify and inform the case manager of any other services that the individual requires to remain in the community (e.g., durable medical equipment and supplies, etc.).
3. Provider documentation must support all services billed to DMAS.
4. Services must be of a quality that meets the health and safety needs and the rights of the individual. Quality of supports is best assured through an emphasis on communication and respect between the individual and provider staff, and between the individual and the provider agency representative who is responsible for the oversight of the plan. Some of the elements included in quality of supports are:
 - Consistency of supports;
 - Continuity of supports;
 - Adherence to the support plan; and
 - Consideration for the health, safety, and welfare needs of the individual.
5. The provider shall maintain a record for each individual. Forms that may be used are available on the DMAS website at www.dmas.virginia.gov or the DBHDS website at www.dbhds.virginia.gov.

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

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to be inadequate, DMAS may require a revision of the plan to meet the needs of the individual.

DMAS conducts QMRs to assure that the services provided are appropriate and comply with the policies and procedures for the provision of MR/ID and DS Waiver services. For the general requirements, DMAS uses the following procedures:

1. DMAS or its designated agent will conduct an on-site review or desk review by the provider of each service periodically.
2. The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of individuals served, types of services rendered, etc.
3. QMRs will be unannounced.
4. Providers may be asked to bring program records to a central location.
5. Upon completion of on-site activities for a QMR, DMAS staff will meet with designated staff to conduct an exit conference. The purpose of the exit conference is for DMAS to provide a general overview of the QMR findings, preliminary actions required, and recommendations that may help the provider correct problems in documentation or billing practices.
6. Following the review, a written report of the findings is sent to the provider. During the review process, staff will offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures or may refer providers to DBHDS staff for more in-depth technical assistance or training. If questions arise regarding compliance issues, staff will provide information and assistance. Any uncorrected compliance issues may result in the termination of the provider contract.
7. If a plan of correction is requested, the provider will have 30 days (unless otherwise indicated) from receipt of the QMR report to submit the plan to DMAS for approval.
8. Findings identified in the written report are subject to a request from the CSB/BHA or provider for reconsideration. The procedures for submitting a request are specified in the cover letter that accompanies the written QMR report and must be submitted within 30 days of receipt of the letter.
9. If there are findings that are related to licensing procedures, a letter stating these findings will be submitted to other agencies, as appropriate (e.g., Department of Health Professions, DBHDS).

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10. DMAS will follow up on any plans of correction that are completed to ensure that corrective procedures within the plan are implemented by the provider.
11. During an on-site review, staff will review the individual's record in the provider's/ services facilitator's (SFs) place of business/offices, paying specific attention to the Plan for Supports, supervisory notes (RN and SF), daily records, support logs or progress notes, screening packages, and any other documentation that is necessary to determine if services were rendered appropriately. Staff will also meet or talk with at least one individual or primary caregiver to determine individual satisfaction with waiver services and the provider. The provider may be asked to assist in setting up this visit. In all cases, the primary caregiver is encouraged to participate in the review of the individual's supports.

REVIEW OF MR/ID TARGETED CASE MANAGEMENT AND MR/ID & DS WAIVER SERVICES

In addition to the general QMR requirements, DMAS also reviews for specific requirements for the provision of MR/ID Targeted Case Management and MR/ID & DS Waiver Services. These requirements are: eligibility for services; that the services are based on comprehensive and ongoing assessment and person-centered planning; that services are delivered, reviewed, and modified as appropriate; that the provider is qualified; and that the services are consistent with billing limitations. Specific requirements for each area follow.

Eligibility for Services

- A. The individual meets the diagnostic criteria for MR/ID as described in Chapter IV.
- B. The individual meets functional eligibility. For individuals receiving MR/ID or DS Waiver services, the ICF/MR Level of Functioning (LOF) Survey must be in the case management record, have been completed no more than six months prior to the start of waiver services, and document that the individual meets the dependency level in two or more of the categories. This must be reviewed and completed annually and reflect the current status of the individual.
- C. There is basis for initiating 90-day MR/ID Targeted Case Management.
 1. Referral information for an individual to receive 90-day MR/ID Targeted Case Management services must be clearly documented and provide a basis for this service. This includes evidence in the case management record that: a) the individual had not previously received formal case management services; b) the individual did not have diagnostic information necessary to determine

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eligibility; c) there was reason to suspect the presence of MR/ID; and d) there was an indication of a need for ongoing active case management services.

2. Documentation must indicate that the 90-day Plan for Supports began no earlier than the date of the initial face-to-face contact with the individual and ended when the assessment information (diagnosis and need for active case management) was completed, but no later than 90 days from the start date. Billing can occur for a maximum of three months. If prior to the end of the 90 days, an individual is determined ineligible, appropriate notification of the right to appeal must be sent to the individual.
- D. There is basis for initiating MR/ID Targeted Case Management services.
1. There must be documentation of diagnostic eligibility in the record of an individual receiving MR/ID Targeted Case Management services.
 2. There must be documentation that the individual requires and receives active case management services.
 3. MR/ID Targeted Case Management services must not duplicate any other Medicaid service provided under the *Virginia State Plan for Medical Assistance* or under any waiver including the MR/ID or DS Waivers.
- E. There is basis for initiating MR/ID or DS Waiver services.
1. The case management record for an individual receiving MR/ID or DS Waiver services must indicate that the individual meets both diagnostic and functional eligibility as described above.
 2. Documentation must be evident that the individual is receiving MR/ID Targeted Case Management at the time MR/ID or DS Waiver services are initiated and during any month in which MR/ID or DS Waiver services are provided. A Plan for Supports must be available in the record.
 3. For the MR/ID Waiver, documentation must indicate that the individual meets the urgent criteria (outlined in Chapter IV, "Urgent Criteria" section) at the time of enrollment.
 4. For the DS Waiver, documentation must indicate that the individual is the next on the waiting list according to date of need.
- F. The individual continues to meet eligibility for services.

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1. It must be clearly documented in the case management record that the individual's eligibility and need for continuation of any MR/ID or DS Waiver service is reviewed at least annually.
2. To confirm continued diagnostic eligibility for MR/ID or DS Waiver services, the case management record must contain a psychological evaluation (or standardized developmental assessment for children under six years of age in the MR/ID Waiver) that reflects current psychological status. There should be documentation that an updated psychological evaluation is completed whenever the individual's functioning has undergone significant change and is no longer reflective of the past psychological evaluation. The psychological evaluation must be completed by a licensed professional with documented training in conducting psychological evaluations.
3. The case management record of individuals receiving MR/ID or DS Waiver must contain an ICF/MR LOF Survey that was administered on an annual basis by the case manager. The individual must meet the indicated dependency level in two or more of the categories on the LOF.
4. Individuals less than age 6 who receive MR/ID case management services only must have a psychological or developmental evaluation that documents that the child has MR/ID as defined by American Association on Intellectual and Developmental Disabilities (AAIDD). This documentation does not have to specifically state a diagnosis of MR/ID. However, the instrument must convey evidence of cognitive and adaptive development delay or presence of a syndrome typically associated with MR/ID. The evaluation must reflect the individual's current status and have been completed prior to service initiation.

Comprehensive and Ongoing Assessment and Planning

A. An Individual Support Plan is completed and reviewed.

1. The case management record must include an Individual Support Plan that organizes the services and supports that are provided to the individual. The four essential components of an Individual Support Plan include:
 - a) The Essential Information (including risk assessment) and Personal Profile;
 - b) The individual's vision for a good life (formerly called primary goals) and desired outcomes (including risk mitigation);
 - c) A Plan for Supports for each MR/ID & DS Waiver community service requested and received by the individual (including MR/ID Targeted Case Management and all MR/ID & DS Waiver services), which outline the

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activities planned to assist in meeting the individual's needs and in attaining the individual's desired outcomes; and

d) A documentation of agreement (may be a signature page) by those participating in the development and implementation of the Individual Support Plan.

2. There must be evidence that the Individual Support Plan is reviewed by the case manager and updated annually and whenever changes or service modifications occur.

B. There is comprehensive and current assessment information.

1. There must be a Personal Profile in the case management record, completed by the team, no earlier than one year prior to start date of services and updated annually. The Personal Profile summarizes the individual's vision of a good life, their talents and contributions, and "what's working/what's not working" in the following life areas:

- Home
- Community and interests
- Relationships
- Work and alternates to work
- Learning and other pursuits
- Money
- Transportation and travel
- Health and safety

2. Additionally, the case manager maintains the Essential Information, updated at least annually and as needed, which includes:

- Contact information
- Emergency contacts/representation
- Psychological or developmental evaluation
- Current Level of Functioning Survey (for those on MR/ID or DS Waivers)
- Support Coordination and provider contacts
- Communication and sensory supports
- Health, medications and physicals
- Summary of social/developmental/behavioral/family history/previous interventions and outcomes
- Summary of employment and educational background
- Exceptional support needs/risk assessment
- Ability to access services and supports

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- Legal, financial and advocacy issues
3. There should be medical information in the case management record for any individual receiving MR/ID or DS Waiver services. Individuals receiving MR/ID or DS Waiver services must have a medical examination completed no earlier than 12 months prior to the start of waiver services. Documentation should indicate that additional evaluations occur whenever indicated. Medical examinations of children should follow the schedule of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) administered by DMAS.
 4. The case management record for an individual receiving MR/ID or DS Waiver services should contain the Virginia SIS™ (completed triennially) and an annual risk assessment (Section IV of the Virginia SIS) completed no more than 12 months prior to the start date of waiver services). Due to the phase-in, those individuals for whom a SIS has not been completed will continue to have DBHDS-approved functional assessments in the record. After July 2012, all individuals will have a Virginia SIS completed every three years or more frequently if the individual has undergone significant changes.
 5. The above assessment information must be provided to the services providers to be available to use to develop the Plan for Supports.
- C. The individual and others, as appropriate, are involved in the planning process.
1. Documentation must indicate that the individual (or legal guardian, when appropriate) provided consent to exchange information with other agencies. The case management record of an individual must contain a signed copy of this form, completed prior to the initiation of MR/ID or DS Waiver services.
 2. Documentation must indicate that the individual (or legal guardian, when appropriate) was given the choice between institutional care and MR/ID or DS Waiver services, as appropriate. The case management record must contain a copy of the form entitled “Documentation of Recipient Choice between Institutional Care or Home- and Community-Based Services” (DMAS 459-C). This form is required at the initiation of any waiver services and should be maintained in the individual’s case management record.
 3. Documentation must be in the case management record that the individual has been presented with all feasible alternatives of available agency and consumer-directed services for which he or she is eligible under the MR/ID or DS Waiver (this is done on the Recipient Choice form).

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4. Documentation must indicate that the individual (or legal guardian) was informed of all MR/ID or DS Waiver providers in the community and had the option of choosing from among qualified providers. It must be clear that the choice of providers was offered no more than six months prior to the initiation of any waiver services, whenever new services were added, when changes occur in providers, or when requests are made by the individual. The individual's record must contain a copy of the form entitled, "Virginia Home- and Community-Based Waiver Choice of Providers" (DMAS-460).
 5. Documentation must indicate that the individual (or legal guardian or family) was involved in the development of the Individual Support Plan. The team should meet within 30 calendar days of DBHDS verification of an available slot to discuss the individual's needs, existing supports, and agency-directed and consumer-directed service options for developing the Individual Support Plan. At a minimum, the individual's (and family/caregiver, as appropriate) input and satisfaction with the plan should be documented by signature(s) on the Plan for Supports in addition to the case manager's signature.
 6. Documentation must indicate that the individual (or legal guardian) was informed of any changes in services, provided the opportunity for input, and agreed to the changes before they were implemented. Documentation of this involvement should accompany any changes to the Individual Support Plan.
 7. For any termination or decrease of MR/ID Targeted Case Management, MR/ID or DS Waiver service, the case management record must contain written notification to the individual of the pending action and the right to appeal. See the appeal section in this chapter for specific requirements.
- D. The case manager receives and reviews each Plan for Supports.
1. Each Plan for Supports must be completed prior to the initiation of services and must designate supports based on current information, reflective of the individual's desires, input, and other assessment information and agreed to by the team.
 2. Each Plan for Supports must clearly describe the activities of the individual and staff. These support instructions are related to the measurable support activities detailed in the Plan for Supports, as appropriate for the individual and congruent with the type and amount of service units on the Individual Service Authorization Request (ISAR). The Plan for Supports must justify service components such as day support intensity levels, safety supports, periodic supports, etc.

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3. Each Plan for Supports must include activities and supports that are meaningful and address the individual's desired outcomes. Each Plan for Supports must satisfy the specific Medicaid criteria and service limitations for each service as described in Chapter IV.
 4. The general schedule of supports must be consistent with the service units on the ISAR for that service.
 5. When a 60-day assessment period is utilized for residential support, personal assistance (agency-directed), day support, prevocational services, or supported employment services, there must be evidence that the individual is new to the program/provider and a preliminary Plan for Supports and general schedule of supports are included in the record. Documentation must confirm attendance and provide specific information as described in the Plan for Supports support activities. There must be an annual Plan for Supports, based upon the assessment information, developed prior to the last day of the assessment period.
- E. Documentation of all planned services. The Plan of Care Summary is completed annually by the case manager and updated as needed. It must list all current MR/ID or DS Waiver and non-waiver services.

Services are Delivered, Reviewed, and Modified as Needed

- A. Services occur as planned or are adjusted to accommodate the individual's needs and requests.
1. There must be ongoing documentation in the record of each service provider regarding the services to the individual and available for review by the case manager, DBHDS, DMAS, and the individual or family or both, in accordance with applicable policies and regulations. Documentation can include case notes, various modes of measurable data collection, attendance records, notes regarding significant incidents, monthly summaries, and progress notes/support logs.
 2. The record must document a minimum of one case management face-to-face contact with the individual within each 90-day period with a 10-day grace period. There must be evidence that the case manager assessed the individual's satisfaction with services (through observation and interviews with the individual and significant others), determined any unmet needs, evaluated the individual's status, and assisted with adjustments in the services and supports as appropriate. Missed face-to-face contacts with no documented reason, particularly patterns of missed contacts, may result in the entire quarter being disallowed for reimbursement.

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3. Each service provider's records (including case management) must contain documentation that corresponds to the Plan for Supports support activities and indicates that services have been provided according to the plan. While this data may take many forms, it should be appropriate to the individual's supports and demonstrate that his or her desired outcomes are being addressed.
- B. Services are reviewed at least quarterly.
1. There must be documentation that the case manager reviewed on a quarterly basis all services provided (including MR/ID Targeted Case Management services). A 30-day grace period to complete the person-centered (quarterly) review of the Individual Support Plan will be permitted. However, the original person-centered review due dates remain unaffected by the date the review is completed.
 2. There must be evidence that person-centered reviews for the MR/ID or DS Waiver services are completed no more than 10 days following the end of each quarter as determined by the effective start date of Individual Support Plan. However, the original person-centered review due dates remain unaffected by the date the review is completed.
 3. The person-centered review for each service, including case management, will be reviewed to determine if it addresses a) the results of the services; b) any significant events; c) the individual's and, when appropriate, the family's/caregiver's satisfaction with the services and other input; and d) changes in the goals or strategies when they are ineffective or upon the individual's request.
- C. A comprehensive review of each service occurs annually.
1. The case management record will be reviewed to determine if the annual review includes a combination of record review, observation of service delivery, and interviews with the individual and family to determine if the services provided are effective and match the individual's needs and desired outcomes.
 2. All providers must be invited to the meeting and participate in the development of the new Individual Support Plan annually (no longer than 365 days – 366 days in a leap year – between Individual Support Plan effective dates). There is no grace period.

Provider Qualifications

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

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- A. It is the responsibility of the service provider to maintain documentation, readily available for review, which verifies the provider's staff qualifications.
- B. Provider qualifications and expectations are outlined in Chapters II and IV of this manual.

Services Delivered are Consistent with Service Limits

- A. Services must be authorized or preauthorized as appropriate.
 - 1. All MR/ID Waiver providers must have a current DMAS Participation Agreement that lists all services for which the provider is eligible to provide and bill.
 - 2. MR/ID Waiver services require authorization by DBHDS prior to initiation in order for the provider to be eligible for reimbursement. Consumer-directed (CD) services facilitation does not require authorization prior to service initiation.
 - 3. Terminations of single waiver services are indicated on ISARs submitted to DBHDS. Terminations of all waiver services must be reflected on a completed DMAS-225. See subsection C of this section for more information.
- B. There must be documentation that services were provided in accordance with the service plan and as billed.
 - 1. Billing for MR/ID Targeted Case Management services must be supported by a minimum of one direct or individual-related contact, activity, or communication and must be documented each month relevant to the Individual Support Plan during any month for which a claim for MR/ID Targeted Case Management is submitted. Written work and travel time are excluded. Billing for 90-day MR/ID Targeted Case Management may only occur for a maximum of three months.
 - 2. Billing for day support, prevocational, and supported employment-group model services must be supported by attendance documentation that verifies individual participation in the service in accordance with the Plan for Supports. The billing should indicate a total number of hours that is equal to or greater than the number of hours/units billed each day in a month. The documentation must include, at a minimum, the date services were rendered, the number of hours/units provided, the activities to support the type of service delivered, and a transportation log (or similar document) as needed to verify that billing for non-program related transportation does not exceed 25 percent of total time billed that day.

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3. Billing for waiver supported employment individual placement services must be supported by documentation of actual interventions or collateral contacts by the provider, not for the amount of time the individual is in the supported employment situation. A log or similar document which shows the date, hours, and type of service rendered, in accordance with the Plan for Supports must be maintained.
4. Billing for residential support services:
 - a) In-home services are billed for actual service hours. Documentation must include dates, times, and services that were provided in accordance with the Plan for Supports. When unavoidable circumstances occur so that a provider is at an individual's home at the designated time, but cannot provide services for the entire period scheduled, billing is allowed for the entire number of hours scheduled that day, as long as some portion of the Plan for Supports is implemented. It is expected that this will occur rarely, and there will be detailed documentation of the date, original schedule, time services were actually provided, and specific circumstances which prevented provision of all of the scheduled services. If this occurs on a regular basis over a 90-day period, the case manager should determine the reasons, and a new Plan for Supports with fewer hours or a change in schedule must be developed.
 - b) Congregate residential support services are typically reimbursed based on an average daily amount of hours, which is established for each individual by multiplying the total hours scheduled per week by 4.3 and dividing the result by 30. When using the average daily amount of hours, there must be verification that some portion of the approved Plan for Supports scheduled service was provided that day. Documentation of activities may be maintained by the provider in a daily format and should demonstrate that the individual is regularly receiving services as scheduled. If the hours actually provided are consistently less than the average daily amount over a 90-day period, a revised ISAR should be submitted. No more than 30 days per month (28 days in February; 29 days in leap year) may be billed when using the average daily amount of hours. If the provider of residential support chooses to be reimbursed on an hourly basis, documentation must include the dates and times of actual service delivery in accordance with the Plan for Supports.
5. Billing for therapeutic consultation, crisis stabilization, skilled nursing, and agency-directed respite, personal assistance, or companion services must be supported by documentation of the dates and times of actual service delivery. The format used for documentation of service hours should be reviewed by DBHDS staff prior to use to ensure that all required components are present.

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6. Billing for consumer-directed services is supported by employee time sheets that are signed by the individual (or employer of record) and employee.
7. Billing for environmental modifications and assistive technology must be supported by bills from contractors, rehabilitation engineers (if required), and equipment purchase receipts.
8. Billing for personal emergency response systems (PERS) must be supported by documentation regarding the installation of and training required to use the required device(s). Monthly billing for the ongoing monitoring services must be supported by documentation of at least monthly testing of the PERS device as well as documentation of each emergency signal which results in action being taken of behalf of the individual.
9. Billing for transition services must be supported by item purchase receipts with a description of the item(s) included.
10. It is not permissible to automatically bill each month at the maximum amount authorized. For all services, if the amount billed for a given service in the month audited does not correspond to documented hours/units of services delivered, the entire quarter is audited. If that quarter's billing does not correspond to service delivery records, subsequent quarters may be audited.
11. All billing errors identified by DMAS staff are reported to the provider for correction and are followed-up by DMAS. Billing errors identified during a formal review are included in the report to the provider.
12. All billing must be supported by the required documentation as outlined throughout this manual. As a result of reviews conducted by DMAS, areas of non-compliance will be cited in the written report of findings. A plan of correction may be requested when review issues cited are pervasive, repetitive, or of a serious nature. The following is a non-inclusive list of circumstances that may result in a request for a plan of correction or referral to the DMAS Division of Program Integrity when identified during reviews:
 - a) Absence of a current Plan for Supports;
 - b) Services not delivered as described in the Plan for Supports;
 - c) Services rendered to an ineligible individual: if psychological assessment (or developmental assessment for children under age 6) and/or LOF do not reflect eligibility for MR/ID Targeted Case Management, MR/ID Waiver or DS Waiver;

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- d) Case management face-to-face contacts that are not completed in a timely manner (every 90 days with a 10-day grace period);
 - e) Any periods of services billed for which there is an absence of or inadequate documentation to support that the services were rendered (amounts, type, absence of data, assessment information, etc.);
 - f) Any periods of service billed during which the staff were not certified, qualified, or properly trained, the provider had not fulfilled the terms of the Participation Agreement, and/or the required license/certification/approval had been revoked;
 - g) Any identified billing errors, such as inaccuracies in service amounts, incorrect or absent deductions of patient-pay amount, incorrect dates of service, duplication of services, etc.;
 - h) There is no documentation reflecting the need for a service or for that level of service, (e.g., high intensity day support, safety supports); and
 - i) Absence in the case manager's record of a current LOF or a LOF that does not meet the requirements for eligibility.
13. The provider must meet all other criteria and documentation requirements found elsewhere in this manual, as well as in applicable regulations and laws.
- C. If the individual has a patient-pay amount, a provider shall use the electronic patient pay process that became effective March 1, 2009. Local departments of social services (LDSS) will enter data regarding an individual's patient pay amount obligation in to the Medicaid Management Information System (MMIS) at the time action is taken on a case either as a result of an application for long-term care services, redetermination of eligibility, or reported change in an individual's situation. These types of occurrences will cause the LDSS to initiate data entry of patient pay into the MMIS.

Verification of an individual's patient pay obligation will be available through the web-based ARS system and telephone-based MediCall system. The provider designated to collect the patient pay obligation must periodically monitor the ARS/MediCall systems for Medicaid LTC individuals in order to determine the appropriate amount of patient pay to collect and notify providers, as appropriate.

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DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website to enroll for access to this system is <http://virginia.fhsc.com>. The MediCall voice response system will provide the same 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. Information regarding how to access these systems is included in Chapter 1 of each provider manual.

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

For communication of information other than patient pay, the Medicaid LTC Communication Form (DMAS-225) will be used by the case manager to report changes in an individual's situation. This form is available on the DMAS website and is used to provide information on a new address, a different case management agency, income, interruption in MR/ID or DS Waiver services for more than 30 days, discharge from all MR/ID or DS Waiver services, or death. The case manager must forward the DMAS-225 to notify DSS when such changes occur. The case manager should document communications

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

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

E. Designated MR/ID or DS Waiver services are not used when available from the primary source.

1. The individual's case manager must document before the onset of service delivery that these services are not available through the Department of Rehabilitative Services (DRS) or special education funding (as through the Individuals with Disabilities Education Act or IDEA for individuals under 22 years.

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

Annual Level of Care Reviews

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

Case managers will be required to submit documentation to DBHDS each year to verify that the individual continues to meet eligibility using the LOF Survey; this documentation will be reviewed by DBHDS staff.

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

REQUIRED DOCUMENTATION

Documentation shall be maintained in accordance with applicable statutes and policies. Waiver services that fail to meet DMAS criteria are not reimbursable. Reimbursement is not permitted in the following situations (not an all-inclusive list):

- Prior-authorization not obtained prior to initiation of services and not available at DMAS' requests;

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- Request for preauthorization not submitted by the provider;
- Patient pay requirement for the individual, but not indicated on CMS-1500 and paid by DMAS;
- The provider does not meet the qualification criteria;
- The provider staff's personnel files fail to verify that the minimum qualifications outlined in Chapter II are met;
- The individual resides in a nursing facility (NF), an ICF/MR, or a hospital; or
- Duplicate hours or units are billed.

Business and Professional Records

Providers must maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the business. An example of documents in this area is human resources documentation. These policies apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia.

Individual Records

1. The CSB/BHA shall maintain for each MR/ID Waiver individual the following documentation for review by DBHDS and DMAS staff for a period not less than six years from the individual's last date of service (for minors, not less than five years from the date they turn 18) or as provided by applicable State laws, whichever period is longer:
 - a. The comprehensive assessment and Individual Support Plans;
 - b. All Plans of Support from every provider;
 - c. All supporting documentation related to any change in the Individual Support Plan; and
 - d. All related communication with the providers, individual, consultants, DBHDS, DMAS, DSS, DRS, or other related parties.
2. The service providers must maintain the following documentation for review by DBHDS and DMAS staff for a period not less than six years from the individual's

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last date of service (for minors, not less than five years from the date they turn 18) or as provided by applicable State laws, whichever period is longer:

- a. All assessments, reassessments, and Plans for Supports;
 - b. All attendance logs, if applicable, documenting the date services were rendered and the amount and type of services;
 - c. Appropriate data, progress notes, or support logs reflecting the individual's status and, as appropriate, progress or lack of progress toward the desired outcomes on the Plan for Supports; and
 - d. Any other documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.
3. The provider must recognize the confidentiality of individual record information and provide safeguards against loss, destruction, or unauthorized use. The individual's written consent is required for the release of information not authorized by law. All information pertaining to an individual must be included in the individual's record.
 4. Records of waiver services individuals must be retained for six years from the date of service and not less than six 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 or her medical records must be retained not less than five years after the individual turns 18.
 5. All provider contacts with the individual, family members, health professionals, the preauthorization contractor, DMAS, etc. are filed in the individual's records promptly.
 6. All waiver services record entries and other documentation must be signed with the first initial and last name of the author and dated (month, day, and year). If checklists or similar data collection forms are "initialed," the provider must ensure that there is a current and accurate "crosswalk" of the authors' initials to the names in the record.
 7. Correction fluid or other forms of deleting information must not be used to make corrections to the individual's record. When an error is made during documentation, a single line must be drawn through the erroneous information; the revision must be initialed by the person making the revision. If an error in a

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note is corrected at a later time, the person must draw a single line through the error and initial and date the error. The individual must be referenced on each page of the record by his or her full name or Medicaid number.

8. Documentation must be clear and legible.

COMPLIANCE REVIEWS

DMAS staff or a DMAS-designated contractor also routinely conduct reviews to ensure that the services provided to Medicaid individuals are medically necessary, are appropriate, and are provided by a qualified provider. Medically necessary services are those services that are covered under the State Plan or home and community-based waiver and that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the individual's functioning. Providers and individuals receiving services 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.

To ensure a thorough and fair review, DMAS staff or a DMAS contractor review all cases using available resources, including appropriate consultants, and make on-site reviews or perform desk audits of medical and other individual and provider records as necessary.

DMAS or a DMAS-designated contractor will review a sample of paid claims for the audit period. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

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 concerns, Medicaid may restrict or terminate the provider's participation in the Program.

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.

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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 Division
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 East Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

The Recipient Audit Unit of DMAS investigates allegations about fraud or abuse by individuals. 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

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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 State, 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 Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

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 for detailed information 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:

Supervisor, Recipient Monitoring Unit
Program Integrity Division
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

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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.

Electronic Notification of Appeal Rights

When an individual applies for services available under MR/ID Community Medicaid Services (Targeted Case Management (TCM) and MR/ID Waiver), the case manager will provide the individual with information about the right to appeal. When initial MR/ID or DS Waiver services are authorized or whenever services for an individual already receiving MR/ID or DS Waiver services are increased, decreased, denied or terminated via an ISAR, a notification letter will automatically be generated through the VAMMIS and sent to the provider and individual. The individual's letter indicates the approved, decreased, terminated or denied services and limits and includes the right to appeal if services have been terminated, suspended, reduced, or denied.

Case Manager/Provider Responsibilities in Notification of Appeal Rights

In the cases below, because a notification letter is not generated by VAMMIS or the action will occur prior to VAMMIS electronic notification, the case manager is responsible for notifying the individual in writing of the following actions and the right to appeal these actions:

1. An individual's request for a Medicaid-covered service (such as MR/ID Waiver, ICF/MR, or TCM) is denied or offered at a decreased level. This does not mean that a particular provider cannot provide the service, it means that a particular service is determined by the CSB/BHA not to be needed for a particular individual;
2. A request for an increase in hours or units or a request for additional services is denied by the CSB/BHA;
3. When the CSB/BHA is requesting a decrease or termination of services and 10 business days advance notice is required (as described below);
4. TCM services are terminated;
5. Individual meets MR/ID Waiver criteria, but is not enrolled in MR/ID Waiver, and his or her name is placed on the urgent or non-urgent waiting list;

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6. Individual is suspended from any service (see Chapter IV for exceptions); and
7. Individual's name is moved from the urgent waiting list to the non-urgent waiting list.

The contents of the notification letter must include:

1. What action the case manager or provider intends to take;
2. The reason(s) for the intended action;
3. The specific regulations that support, or the change in federal or state law that requires the action;
4. An explanation of the individual's right to request a hearing;
5. An explanation of the circumstances under which Medicaid is continued if a hearing is requested;
6. An explanation of the requirement for the individual to reimburse DMAS if the case manager's/provider's action is upheld, if the individual continued to receive a Medicaid covered service;
7. The effective date of the action; and
8. The right to representation.

Advance Notification

Unless otherwise specified, written notification must be mailed by the case manager to the individual or authorized representative/guardian at least 10 business days prior to the date of action when a provider reduces or terminates one or all Medicaid-covered service(s).

Exceptions to the 10 Business Day Advance Notice Requirement

Written notice is required in the following cases, but advance notice is not. These include:

1. When the case manager has factual information confirming the death of an individual;

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2. When an individual or guardian provides a written request indicating that:
 - a. He or she no longer wishes services; OR
 - b. He or she gives information that requires termination or reduction and indicates an understanding of the action required by supplying this information;
3. The individual has been admitted to an institution and is ineligible for further services, including a regular admission to an ICF/MR, NF, or rehabilitation hospital, or has been incarcerated;
4. Individual loses financial eligibility for Medicaid;
5. The individual's whereabouts are unknown, and he cannot be located for the provision of services;
6. The CSB/BHA establishes the fact that the individual has been accepted for Medicaid services by another state, Territory, or Commonwealth;
7. The individual's physician prescribes a change in the level of care;
8. The health and safety of the individual or others are endangered (if appropriate, the case manager or provider must immediately notify the local DSS Adult Protective Services or Child Protective Services, as well as DBHDS Offices of Human Rights and Licensing, as required); or
9. When the individual's request for admission into a Medicaid-covered service or when the individual's request for an increase in a Medicaid covered service is denied or not acted upon promptly (90 days or 45 days respectively) for any reason.

All notification letters generated by the CSB/BHA must be filed in the case management record.

Provider Discontinues Services

In non-emergency situations in which a participating provider intends to discontinue services to an individual, the provider shall give the individual or family/caregiver and case manager 10 business days advance written notification. The letter shall provide the reasons the provider is discontinuing services and the effective date. The individual is not eligible for appeal rights in this situation and may pursue obtaining services from another provider.

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In an emergency situation in which the health and safety of the individual or provider personnel is endangered, the 10 business day advance written notification period shall not be required, however, the case manager must be notified prior to discontinuing services.