

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	
Chapter Subject	Page Revision Date	
Utilization Review	1-11-2008	

CHAPTER VI
UTILIZATION REVIEWS

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	i
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

CHAPTER VI TABLE OF CONTENTS

	<u>Page</u>
Utilization Reviews	1
Introduction	1
Compliance Reviews	1
Fraudulent Claims	2
Provider Fraud	2
Recipient Fraud	3
Referrals to the Client Medical Management (CMM) Program	3
Utilization Review of the Provider for Consumer-Direction (EDCD) Waiver Services	4
Contents of Review	5
Required Documentation	6
Required Documentation for Individual Records for Agency-Directed Personal/Respite Care	6
Required Documentation for Individual Records for Adult Day Health Care (ADHC)	8
Required Documentation for Individual Records for Personal Emergency Response Systems (PERS) and Medication Monitoring	9
Required Documentation for Consumer-Directed (CD) Option	9
Annual Level-of-Care Reviews	11
Medical Records and Record Retention	11
Provider Participation Standards	11
Financial Review and Verification	12
Personal/Respite Care Services (Agency-Directed Option)	12
Adult Day Health Care (ADHC) Services	13
PERS	13
Consumer-Directed (CD) Option	13

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	ii
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

Exit Conference	13
Reimbursement Requirements	14
General	14
Personal/Respite Care (Agency-Directed Option)	14
Respite Care	15
Adult Day Health Care (ADHC)	16
Personal Emergency Response System (PERS) and Medication Monitoring Unit	17
Personal Care (Consumer-Directed Option)	18
Provider Sanctions (Adverse Actions)	18
Provider Appeal Process: Denial of Reimbursement	19
Client Appeals	20

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	1
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

CHAPTER VI UTILIZATION REVIEWS

INTRODUCTION

Under the provisions of federal regulations, the Virginia 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. Title 42 Code of Federal Regulations, Parts 455 and 456, mandates these reviews. The Department of Medical Assistance Services (DMAS) periodic utilization reviews 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. Under the Participation Agreement with DMAS (see Chapter II), the provider also agrees to give access to records and facilities to DMAS representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization reviews and control requirement procedures conducted by DMAS or its designee.

COMPLIANCE REVIEWS

DMAS staff from the Division of Program Integrity or a DMAS-designated contractor also routinely conduct reviews to ensure that the services provided to Medicaid individuals are medically necessary and appropriate and are provided by the appropriate provider. Providers and individuals in care 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.

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 of medical and other recipient and provider records as necessary.

DMAS may use a random sample of paid claims for the audit period to calculate any overpayments. Overpayments may also be calculated based upon review of all claims submitted during a specified time period. Reviews may also be conducted when providers are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

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

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	2
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

provision of poor quality services or as a result of any of the above problems, 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.

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

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	3
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

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

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT (CMM) 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

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	4
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

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.

UTILIZATION REVIEW OF THE PROVIDER FOR ELDERLY OR DISABLED WITH CONSUMER-DIRECTION (EDCD) WAIVER SERVICES

The purpose of a utilization review 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.

DMAS analysts 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 Service Plan, 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 EDCD 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.

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	5
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

CONTENTS OF REVIEW

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 a population in need of nursing facility level of care. Information used by DMAS to make this assessment includes DMAS desk review of the documentation submitted by the provider, as well as on-site review of the provider's files and interviews with staff and with individuals on visits to homes and via 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 target population. The provider has a responsibility to be aware of the criteria for this program and to evaluate accordingly, on an ongoing basis, individuals' appropriateness for services. The provider must discontinue services, using the procedures outlined in Chapter IV, for any individual whose condition does not meet the target population criteria.
2. Services rendered meet the individual's identified needs and are 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 service plan must be revised in accordance with any substantial change in the individual's condition, and the individual's record must contain documentation of any such change. This also includes the provider's responsibility to identify and make referrals for any other services which the individual requires to remain in the home setting (e.g., durable medical equipment and supplies, skilled nursing visits, etc.).
3. The provider documentation must support all services billed to DMAS.
4. Services are of a quality that meets the health and safety needs and the rights of the individual. Quality of care is best assured through an emphasis on communication and respect between the individual and the assistant, and between the individual and the provider who is responsible for the oversight of the plan. Some of the elements included in quality of care are:
 - Consistency of care;
 - Continuity of care;
 - Adherence to the Service Plan; and
 - Health, safety, and welfare needs of the individual.

DMAS will review the provider's performance in all the program goal areas to determine the provider's ability to achieve high quality of care and conform to DMAS 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

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	6
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

assess the quality of care and continued appropriateness of services. DMAS will evaluate the individual's condition, satisfaction with the service, and appropriateness of the current Service Plan. If the Service Plan is found to be inadequate, DMAS may change the hours or level of care.

REQUIRED DOCUMENTATION

Required Documentation for Individual Records for Agency-Directed Personal/Respite Care

The provider shall maintain a record for each individual. These records must be separated from those of other services, such as companion services or home health. 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 following information may be reviewed during the review process:

- The Virginia Uniform Assessment Instrument (UAI); the Preadmission Screening Authorization signed by all members of the Preadmission Screening (PAS) Team (DMAS-96); the Screening Team Plan of Care (DMAS-97 or DMAS-300 for Respite Care Services); the MI/MR Level I Supplement for EDCD Applicants (DMAS-101A for all individuals with a diagnosis of MI or MR) and the Assessment of Active Treatment Needs for Individuals with MI or MR who Request Services Under the EDCD Waiver (DMAS 101B), if applicable; all provider Service Plans (DMAS-97A/B); Supervision Request Form (DMAS-100); and all DMAS-122s;
- The initial assessment, documented on the Community-Based Care Individual Assessment Report (DMAS-99) by the RN supervisory nurse completed on or before the start of care. This must be filed in the individual's record two weeks from the date of the visit. (See Chapter IV for the content of the initial assessment.) Only the DMAS-99 can be used for nursing assessments. The Comprehensive Adult Nursing Assessment form or OASIS form is not acceptable;
- The provider staff's personnel files must verify that the minimum qualifications outlined in Chapter II are met;
- All RN supervisory notes (DMAS-99) completed and on file within two weeks of the date of the supervisory visit. Nursing notes must be in the individual's record within two weeks of the last supervisory visit made to the individual. Any supervisory visit not documented and present in the individual's record will be considered as not having been made;
- Nursing notes must reflect all significant contacts with the individual. It must be documented that the RN has made a supervisory visit (with the attendant present at least every other visit) in the individual's home;
- The frequency of the RN supervisory visit must be conducted within the determined time that was agreed upon by the individual and/or caregiver and documented by the RN on

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	7
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

the DMAS-99. For more information on the frequency of this visit, see Chapter IV, SUPERVISION OF PERSONAL CARE ATTENDANTS: AGENCY-DIRECTED MODEL. If the individual has a cognitive impairment as defined in Chapter IV, the frequency of the supervisory visit is at least every 30 days. The frequency of the RN Supervisory visits must be determined timeframe, and not a range. The individual or family/caregiver must be in agreement;

- The RN 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 attendant working with the individual. The RN supervisor's notes must also clearly document that he or she has discussed with the individual or family member the appropriateness and adequacy of service. Individual satisfaction with the services should be documented as well as all requirements for RN supervisor and documentation found in Chapters II and IV of this manual;
- All provider contacts with the individual, family members, health professionals, the pre-authorization contractor, DMAS, etc. All notes must be filed in the individual's records within two weeks. Correction fluid or any other form of deleting information must not be used to make corrections to the file. Any corrections made to the individual's record must be initialed and dated;
- Provider Attendant Record (DMAS-90) of services rendered and the individual's responses. The DMAS-90 must be thoroughly completed. The DMAS-90 must document the care given and the times of arrival to and departure from the individual's home each day the attendant renders service. The attendant and the individual must sign the records weekly. 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. The attendants' weekly comments should note significant physical, social, and emotional aspects of the individual's life that week. The DMAS-90 is the document that DMAS accepts as proof that services were rendered. The DMAS-90 forms must be in the individual's record within two (2) weeks; and
- If the individual receives skilled respite services, a separate file must contain the forms, records, and necessary documents addressing respite services and authorization. These 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 Service Plan (DMAS-300), only if respite is the sole service the individual is receiving.
 - The RN supervisor's documentation using the DMAS-99.

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	8
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

- A physician's order for skilled services using the CMS-485. The order must specify the skilled services that the LPN will render.

Required Documentation for Individual Records for Adult Day Health Care (ADHC)

The following information may be reviewed during the review process:

- The ADHC daily records (DMAS-302) must be thoroughly completed. The records must document the care given and the times of arrival and departure from the center each day. The records must be signed weekly by an ADHC professional. The staff's weekly comments should note significant physical, social, and emotional aspects of the individual's life during that period. The weekly comment section must be completed unless that information is contained elsewhere in the individual's record. The individual's family must be sent a copy of the weekly records;
- The professional staff's 30-day progress notes should describe the individual's medical/functional status, note any change in social support status, indicate any other services received by the individual (to include personal or respite care services also under the EDCD Waiver), and reference a review of any rehabilitative therapy 30-day progress notes received;
- The original UAI, DMAS-96, DMAS-97, DMAS-101A (for all individuals with a diagnosis of MI/MR), DMAS-101B if applicable, and DMAS-301 must be in the individual's record. The current and prior DMAS-122s and DMAS-302s must also be in the individual's record;
- The professional staff's personnel files must verify that all staff meet the minimum qualifications outlined in Chapter II;
- The initial interdisciplinary Service Plan (DMAS-301), all subsequent three-month interdisciplinary evaluations, and any changes to the Service Plan must be in the individual's record. The three-month interdisciplinary evaluation should indicate the reason for any change in the individual's Service Plan and state whether ADHC continues to be an appropriate long-term care service;
- All provider contacts with the individual, family members, health professionals, DMAS, the preauthorization contractor, etc. involved in the individual's health care delivery. All notes must be filed in the individual's records within two weeks. Correction fluid or similar materials must not be used to make corrections to the file. Any corrections made to the individual's record must be initialed and dated; and
- A copy of the individual's living will and durable power of attorney (if applicable).

During the visit, DMAS may interview individuals in the provider's place of business/facility to evaluate the individual's condition, satisfaction with the service, and the appropriateness of the current service plan. The ADHC Center may be requested by the analyst to have the individual's

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	9
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

primary caregiver available for this interview. In all cases, the primary caregiver is encouraged to participate in the DMAS review of the individual's care.

DMAS staff will visit or talk to at least one individual to review the appropriateness, quality, and level of care received. If the plan is found to be inappropriate, the analysts may change hours, level of care, or discontinue services. The analysts will evaluate the individual's condition, satisfaction with the service, and appropriateness of the current service plan.

Required Documentation for Individual Records for Personal Emergency Response Systems (PERS) and Medication Monitoring

The PERS provider must maintain a data record for each PERS individual at no additional cost to DMAS. The record shall contain the following and may be reviewed during the process:

- Delivery and installation date of the PERS and medication monitor;
- Enrollee/caregiver signature verifying receipt of the PERS, and medication monitor device, if applicable;
- Verification by a test that the PERS device, and medication monitoring if applicable, is operational, monthly or more frequently as needed;
- Updated and current individual responder and contact information, as provided by the individual or the individual's caregiver;
- Physician's order for the medication monitoring unit;
- If the individual has a medication monitoring unit, the individual must also have documentation for a PERS device; and
- A case record documenting individual system utilization and individual or responder contacts/communications.

Required Documentation for Consumer-Directed (CD) Option

The CD SF shall maintain a record for each individual. These records must be separated from those of other services, such as companion or home health services. DMAS staff shall review these records periodically. At a minimum, these records shall contain:

- The Virginia Uniform Assessment Instrument (UAI); the Nursing Home Preadmission Screening Authorization signed by all members of the Screening Committee (DMAS-96); the Screening Team Plan of Care (DMAS-97); MI/MR Level I Supplement for EDCD Waiver (DMAS-101A); MI/MR Level II Supplement for EDCD Waiver (DMAS-101B); the Questionnaire used to Assess a Person's Ability to Independently Manage Personal Attendants (DMAS-95 Addendum); all CD Service Facilitator Service Plans (DMAS-97A/B); and all Patient Information Forms (DMAS-122s). The current and prior DMAS-122s, for at least the last six months of services must be in the individual's record;

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	10
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

- The initial assessment by the CD SF completed prior to or on the date services are initiated and filed in the provider record within five working days from the date of the visit. (See Chapter IV for the content of the initial assessment.) The example standardized form may be used to document the initial visit;
- CD SF notes must be in the individual's record within two weeks of the last supervisory visit made to the individual. Any visit not documented and present in the individual's record will be considered as not having been made. CD SF notes must reflect all significant contacts with the individual and document that the CD SF has made a supervisory visit in the individual's home at least every 30-90 days following the CD SF's initial comprehensive visit. The CD SF's initial comprehensive visit in the individual's home must also be documented. The CD SF's documentation must include the observations of the individual made during the visits. The CD SF's notes must also clearly document that he or she has discussed with the individual or caregiver the appropriateness and adequacy of service. Individual satisfaction with the services should be documented, as well as all requirements for CD SF's and documentation found in Chapter II of this manual;
- All CD SF notes regarding contacts made between the CD SF's visits. This includes the documentation of contacts with individuals or support systems when services cannot be delivered. Other contacts may be with the family, the physician, DMAS, the pre-authorization contractor, or other professionals. All notes must be filed in the individual's file within five working days of the contact. Correction fluid or similar product must not be used to make corrections to the file;
- A copy of all Community-Based Care Individual Assessment Reports (DMAS-99);
- All correspondence between the provider, the individual, DMAS, and the pre-authorization contractor;
- Contracts signed by the individual which document the individual's choice of consumer-directed personal care services, choice of the CD SF, and acknowledgment of rights, risks, and responsibilities associated with the program;
- Outline and Checklist for Consumer-Directed Individual Comprehensive Training. This form must be completed with signatures and dates, and performed prior to the hire date of the personal assistant;
- The CD SF's personnel file must verify that the CD SF meets the minimum qualifications outlined in Chapter II of this manual; and
- Documentation to support billing of any services conducted by the CD SF.

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	11
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

ANNUAL LEVEL-OF-CARE REVIEWS

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.

Agencies will be required to submit documentation to DMAS each year to show the individual's functional status and medical/nursing needs using the Level-of-Care Review Instrument (DMAS-99C), which is found at <http://www.dmas.virginia.gov/downloads/forms/DMAS-99C.dot> and will be reviewed by a DMAS analyst. DMAS will send the agency a letter each year indicating when that agency'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 SF.

If it is found that an individual no longer meets the level of care, DMAS will terminate services in accordance to 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 without notifying the pre-authorization contractor of the change in level of care and the need for discontinuation of services.

MEDICAL RECORDS AND RECORD RETENTION

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 records 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 EDCD Waiver services must be retained for five years from the date of service and not less than five 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. All EDCD Waiver medical record entries must be fully signed and dated (month, day, and year), including the title (professional designation) of the author.

PROVIDER PARTICIPATION STANDARDS

During the on-site review, the DMAS analysts 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. The analysts will need to see all RN licenses and

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	12
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

certificates of all aides who have provided personal care services, as well 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. The provider is responsible for ensuring that all staff of the provider agency met the minimum requirements and qualifications at the start of the employment. During this review, the 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 the analysts 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.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services which have been provided in accordance with DMAS policy and which are covered under the EDCD Waiver. The DMAS analyst will also ensure that the appropriate patient pay amounts, if any, have been applied. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and retraction of payment may be necessary. DMAS will send a letter of the review findings to the provider; attached to the letter will be a billing spreadsheet listing any incorrect billings found at the time of the review, and the corrective action the provider needs to take.

The provider should not make billing adjustments without the coordination of the DMAS analyst; otherwise the provider may have the adjustments repeated through the QMR process. If the QMR results in an overpayment of funds that are due to DMAS, the Fiscal Division at DMAS will be contacted by the Waiver Services Unit and will coordinate repayment for the inappropriate payments. If the provider requests a reconsideration or an appeal of the overpayment decision from the QMR, the provider must notify the Fiscal Division of the reconsideration or Appeal request.

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 pending 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.

Personal/Respite Care Services (Agency-Directed Option)

The Provider Attendant Records (DMAS-90) must support the number of hours billed to DMAS. Only DMAS-90s will be used by DMAS to verify services delivered and billed to DMAS. No other documentation (e.g., time sheets) will be used for verification of services. If services billed

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	13
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

to and paid by DMAS are not documented on the DMAS-90, DMAS will require the provider to refund Medicaid. (See Chapter V for billing procedures.)

For skilled respite care services, the Skilled Respite Record (DMAS-90A) must support the number of hours billed to DMAS. For respite performed by a personal care attendant, the DMAS-90 must be used for documentation that services were rendered.

Adult Day Health Care (ADHC) Services

The ADHC Center's daily records on the Adult Day Health Care Daily Log (DMAS-302) must support the number of units billed to DMAS. Only DMAS-302s will be used by DMAS to verify services delivered and billed to DMAS. No other documentation (e.g., time sheets) will be used for verification of services. If services billed to and paid by DMAS are not documented on the DMAS-302, DMAS will require the provider to reimburse Medicaid. (See Chapter V for billing procedures.)

PERS

Billing for PERS must be supported by documentation regarding the installation of and training required to use the required device. 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 on behalf of the individual.

Consumer-Directed (CD) Option

Documentation must support the number of visits billed to DMAS for services conducted by the CD SF. CD SF notes must document that the CD SF has made a supervisory/routine visit in the individual's home within 30 days following the CD SF's initial comprehensive visit and another 30 days (60 days from the initial comprehensive visit). The CD SF's initial comprehensive visit in the individual's home must also be documented. Any visit not documented and present in the individual's record will be considered as not having been made. If services billed to and paid by DMAS are not documented, DMAS will require the provider to refund Medicaid. (See Chapter V for billing procedures.)

EXIT CONFERENCE

Following the analyst's review of the records and home visits, the analyst will meet with the appropriate provider staff to discuss general findings from the reviews. The provider may include any staff the provider would like to attend, but must provide appropriate staff (as requested by the analyst) for this meeting. The Exit Conference is a courtesy meeting by DMAS. If the staff determines that a face-to-face conference is not possible or not able to occur, the provider will be notified in person or by other means. The Exit Conference may be conducted face-to-face or by telephone.

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	14
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

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 changes in Service Plan, 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 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 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 overpayments and technical assistance.

During the review process, the 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 might result in the termination of the provider contract.

REIMBURSEMENT REQUIREMENTS

EDCD Waiver services that fail to meet DMAS criteria are not reimbursable. The following non-reimbursable items apply to all services and include all of the following, but are not limited to:

General

- PAS Team authorization not obtained prior to initiation of services and not available at DMAS' requests;
- Request for pre-authorization not submitted by the provider;
- Patient pay indicated on DMAS-122, but not indicated on CMS-1500 and paid by DMAS;
- The individual resides in a nursing facility, an intermediate facility for the mentally retarded, a hospital, an assisted living facility licensed by DSS, or an adult foster care provider approved by DSS;
- Duplicate hours or units billed; or
- Services began and billed prior to the physicians signature and date on the DMAS-96.

Personal/Respite Care (Agency-Directed Option)

Additional non-reimbursable items for Personal Care include all of the following, but are not limited to:

- RN, LPN, and Personal Care Attendant not meeting the minimum requirements set forth in Chapter II of this manual, and therefore not qualified to provide services;

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	15
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

- No initial RN supervisory visit on or before the initiation of services;
- RN supervisory visit late – explanation not documented;
- RN supervisory visit is made outside of the guidelines established within the Service Plan for individuals (e.g., beyond 30 days for individuals with a severe cognitive impairment) and the established frequency of RN supervisory visits documented, and therefore a late RN supervisory visit;
- Provider Attendant Record (DMAS-90) does not contain the signature of the attendant and caregiver/individual – the reason for the absence of these signature(s) is not thoroughly documented on the DMAS-90;
- The DMAS-90 does not contain the dates and arrival and departure time for each day of service;
- Pre-authorization not obtained from the pre-authorization contractor;
- Inappropriate use of authorized hours not following the Service Plan or providing services that are not allowed and/or covered within this waiver or under the guidelines of the Nurse Practice Act and licensure;
- No documentation of services provided to support billing to DMAS;
- Evidence that a criminal history check was obtained within the allotted time frame by DMAS;
- Amount provider billed DMAS exceeded the amount of services authorized or verified;
- The provider over-billed DMAS;
- The DMAS-99 was not completed, signed, and in the individual’s record with the allotted time frame set by DMAS;
- A personal care attendant rendering skilled nursing services that are not allowed or the allowed services are without RN supervision and delegation; or
- Insufficient documentation to support services billed.

Respite Care

Additional non-reimbursable items for Respite Care include all of the following, but are not limited to:

- Personal Care Attendant or LPN not qualified to provide services;

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	16
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

- LPN providing respite care when the individual does not have a skilled need;
- RN Supervisor visit late – explanation not documented;
- Record does not contain physician’s order for skilled respite services and/or updated order every six months;
- Skilled Respite Record does not contain signatures, dates, and appropriate information for skilled services;
- Personal care attendant performing skilled respite duties;
- The provider over-billed DMAS; or
- Rendered inappropriately – not for the relief of the primary caregiver.

Adult Day Health Care (ADHC)

Additional non-reimbursable items for Adult Day Health Care services include all of the following, but are not limited to:

- The ADHC Center does not have a current DSS license;
- The ADHC Center does not employ or subcontract with a RN who is licensed to practice in Virginia;
- The RN is not present at the ADHC a minimum of one day (eight hours) each month;
- Personal attendant is not qualified to provide services;
- DMAS-302 (Daily Log) does not contain the arrival/departure times for each day of service and does not show services were rendered;
- 30-day progress note missing;
- DMAS-302 is not signed or co-signed on a weekly basis by a professional staff member, including notes and staff comments regarding welfare of individual;
- DMAS-302 does not support the number of units billed to DMAS;
- Interdisciplinary staff meetings, to reassess each Medicaid participant and evaluate the adequacy of the Service Plan, are not being held at least every three months;
- The provider over-billed DMAS;
- ADHC professional staff do not meet minimum staff qualifications; or

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	17
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

- Individual's record does not have the Initial Interdisciplinary Service Plan (DMAS-301) on record along with all subsequent three-month interdisciplinary evaluations.

Personal Emergency Response System (PERS) and Medication Monitoring Unit

Additional non-reimbursable items for PERS and medication monitoring units include all of the following, but are not limited to:

- The provider does not meet the qualifications of a PERS provider as specified in Chapter II of this manual;
- Individual does not meet criteria for PERS;
- The individual is under the age of 14;
- The individual is not alone for significant parts of the day or has a regular caregiver;
- The individual does not require extensive routine supervision;
- Someone else other than the individual is in the home and is competent and continuously available to call for help in an emergency;
- The individual's caregiver has a business in the home and PERS was provided when the individual was not evaluated as being dependent in orientation and behavior;
- The PERS provider fails to document and furnish the Personal Care, Respite, or Adult Day Health Care provider(s) of the individual a report for each emergency signal that results in action being taken on behalf of the individual. This excludes test signals or other signals made in error;
- The individual has a Medication Monitoring Unit, but does not have a PERS device;
- The individual has a Medication Monitoring Unit, but there is not a current physician's order for the service;
- The provider over-billed DMAS;
- Provider did not have a data record that contains the delivery and installation date of the PERS unit(s);
- Individual/caregiver's signature not recorded to verify receipt of the unit;

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	18
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

- The verification test was not conducted at a minimum frequency of once per month;
- A case record documenting the individual's utilization and contacts/communication was not in the record or up-to-date; or
- The individual has a Medication Monitor without a PERS unit..

Personal Care (Consumer-Directed Option)

Additional non-reimbursable items include the following, but are not limited to:

- No initial comprehensive visit made by the CD SF prior to the initiation of personal attendant services;
- No re-evaluation completed every 6 months;
- CD SF does not meet the qualification criteria;
- No documentation of two visits within the 60 days of the initial comprehensive visit;
- Documentation does not support services billed to DMAS;
- The provider over-billed DMAS;
- Consumer training not conducted and correctly documented within seven days of the Initial Comprehensive visit; or
- Provider billed for a comprehensive visit when a re-assessment visit was to be billed.

PROVIDER SANCTIONS (ADVERSE ACTIONS)

The DMAS analyst will notify the provider of any overpayments or denials of reimbursement. An overpayment of reimbursement means that the provider will have to refund reimbursement that was paid inappropriately. A disallowance means that the provider will be prevented from billing for services, which were not in accordance with DMAS policy.

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 a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate pursuant to § 32.1-313.1 of the *Code of Virginia*. Repayment and interest will not apply pending appeal. The DMAS Fiscal Division will coordinate the collection of any payments due to DMAS.

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	19
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

PROVIDER APPEAL PROCESS: DENIAL OF REIMBURSEMENT

Payment to providers of EDCD Waiver services may be retracted or denied when the provider has failed to comply with the established federal and state regulations or policy.

The following procedures will be available to all non-state operated providers when DMAS takes adverse actions that afford appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the overpayment and/or denial to the attention of the appropriate Agency Division that issued the adverse action at the following address:

(Insert appropriate Agency 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, the provider may appeal the reconsideration decision. A provider may appeal where a service has already been provided by filing a written notice for a first-level appeal with the DMAS Appeals Division within 30 days of the receipt of the adverse decision. The notice of appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Appeals Division
 Department of Medical Assistance Services
 600 East Broad Street, 11th Floor
 Richmond, VA 23219

If the provider is dissatisfied with the first-level appeal decision, the provider may file a written notice for a second-level appeal, which includes a full administrative evidentiary hearing under the Virginia Administrative Process Act (APA), *Code of Virginia*, § 2.2-4000 et seq. The notice for a second-level appeal must be filed within 30 days of receipt of the first-level appeal decision. The notice for second-level appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues being appealed. Notices of Appeal must be sent to:

Manual Title	Chapter	Page
Elderly or Disabled with Consumer Direction Waiver Services Provider Manual	VI	20
Chapter Subject	Page Revision Date	
Utilization Reviews	1-11-2008	

Appeals Division
 Department of Medical Assistance Services
 600 East Broad Street, 11th Floor
 Richmond, VA 23219

If the provider is dissatisfied with the second-level appeal decision, the provider may file an appeal with the appropriate county circuit court, in accordance with the APA and the Rules of Court.

The provider may not bill the recipient (client) for covered services that have been provided and subsequently denied by DMAS.

CLIENT APPEALS

Individuals must be informed in writing of actions taken that affect their receipt of services. Most adverse actions may be appealed by the Medicaid client or an authorized representative on behalf of the client. Adverse actions include denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed.

If an appeal is filed before the effective date of the action, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the client will be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable.

Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The client 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, at the local department of social services, or by calling (804) 371-8488.

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

The appeal request must be signed and mailed to the:

Appeals Division
 Department of Medical Assistance Services
 600 E. Broad Street, 11th floor
 Richmond, Virginia 23219
 Appeal requests may also be faxed to: (804) 371-8491