MCQA-QUALITY ASSURANCE GENERAL GUIDANCE LETTER 22-001

Date: November 29, 2022

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Subject: Document Submissions for Case Management and Financial Reviews

PURPOSE: This letter is intended to clarify the documentation expectations required to comply with the Division of Health Care Financing and Policy (DHCFP) administrative review of Home and Community Based Services (HCBS) Waiver and State Plan recipients. The following is informational only and does not supersede any MSM, Waiver or State Plan policies.

AUTHORITIES:

- Home and Community Based State Plan Option Adult Day Health Care and Habilitation Services (Effective 10/01/2019)
- Home and Community Based Services Waiver for the Frail Elderly (Effective 12/01/2020)
- Home and Community Based Services Waiver for Persons with Physical Disabilities (Effective 12/01/2020)
- Home and Community Based Services Waiver for Individuals with Intellectual Disabilities (Effective 10/2018)
- MSM Chapter 1800 Home and Community Based State Plan Option Adult Day Health Care and Habilitation Services (Effective 03/01/2020)
- MSM Chapter 2100 Home and Community Based Waiver for Individuals with Intellectual Disabilities (Effective 02/01/2021)
- MSM Chapter 2200 Home and Community Based Waiver for the Frail Elderly (Effective 07/01/2022)
- MSM Chapter 2300 Home and Community Based Waiver for Persons with Physical Disabilities (Effective 07/01/2022)
- MSM Chapter 3300 Program Integrity
- Appendix K: Emergency Preparedness and Response and COVID-19 Addendum (Issued 04/15/2020 and 01/19/2021

Please note: the release or disclosure of recipient personal health information to the DHCFP is permitted by the Health Insurance Portability and Accountability Act (HIPAA), specifically the provisions located at 45 CFR Part 164.506. This section allows for disclosures of personal health information, without recipient authorization, to carry out treatment, payment or health care operations. Compliance and fiscal audits are oversight activities and are included under the definition of health care operations.

APPLICATION: DHCFP conducts periodic reviews of services provided to waiver and state plan recipients wherein Medicaid providers are required to cooperate with DHCFP's review process. The following outlines expectations of documentation needed to complete a review, timeframes to submit requested documentation, rebuttal process (*as applicable*) and follow up regarding findings.

Eligibility/Person Centered Plan Review (Case Management/Service Coordinator/Health Care Coordinator)

Annually, an Entrance Memo is released by DHCFP Quality Assurance (QA) two months prior to the start of the waiver or state plan review year. The memo outlines the total number of reviews needed to complete the review year and includes selected recipients for the first two months of the review year. The reviews are conducted monthly and cover a one year look back timeframe. A one year look back timeframe for a recipient selected for an August 2022, for example, would need documentation submitted covering any portion of August 01, 2021 – July 31, 2022. Every month, a memo will be released from QA identifying selected recipients for the current and upcoming month.

The results from this independent review are submitted monthly to policy and operation's units. Operations is allotted 30 days to submit rebuttals on citations due to misinterpretation of policy, QA oversight of information submitted timely or due to a limitation within the system that can be documented and noted as being addressed. Monthly meetings are held with policy and operations to address any review components that fall below compliance in an effort to determine appropriate next steps with trainings or potential gaps in policy. Annually, a report summarizing the review year's compliance percentages is created and submitted to DHCFP Administration for submission to Centers for Medicare & Medicaid Services (CMS), as well as, uploaded to the DHCFP intranet.

Frail Elderly (PT48/57/59)/Persons with Physical Disabilities (PT58) Waivers

The following documentation is required to be submitted by the *second Tuesday of each month* for the selected month's recipients:

- Level of Care
- Social Health Assessment
- Case Management Notes
- Verification of Monthly or Quarterly Contacts
- Signed Plans of Care (POCs)
- Signed Statements of Choice (SOCs) **NMO-3580**
- Signed Provider Service Plans
- Signed Forms of Acknowledgment (Including recipient rights and preventative health care) **NMO-7075**
- Designated Representative Attestation/Legally Responsible Individual (LRI) forms, when applicable
- Recipient Summary (Including ID number, demographics, and waiver active date)
- Any additional documentation that will assist the reviewer(s) in validating the required components.

See FE PD Checklist

Individuals with Intellectual and Developmental Disabilities (PT38) Waiver

The following documentation is required to be submitted by the *third Thursday of each month* for the selected month's recipients:

- Person Centered Plan (PCP) packets
  - Desired Outcomes
  - Level of Care (LOC)
  - PCP meeting sign in sheet
  - Personal Profile
  - Risk and Support Screener
  - Rights Assessment
  - Health Status Highlights
  - Annual Social Assessment
  - Support Plan signed by both recipient and provider
  - Habilitation Plans

- Signed Statement of Choice (SOC) **NMO-3580**
- Designated Representative/Guardianship/Legally Responsible Individual (LRI) forms, if applicable
- PCP Service Authorization of Contract Hours
- Supported Living Arrangement (SLA) Service Agreement/Contract JDT Authorization/Contract
- Jobs & Day Training (JDT) Authorization/Contract
- Documentation of monthly contacts
- Documentation of quarterly PCP reviews
- Documentation of quarterly face-to-face visits
- Any additional documentation that will assist the reviewer(s) in validating the required components.

See ID Checklist

Adult Day Health Care and Habilitation (PT39/55) State Plan

The following documentation is required to be submitted by the *fourth Wednesday of each month* for the selected month's recipients:

- Comprehensive Social Health Assessment (needs-based determination)
- Signed Provider Service Plans
- Proof of diagnosis of TBI/ABI
- Signed DHCFP Plans of Care (POC)
- Signed Statements of Choice (SOCs) **NMO-3580**
- Designated Representative Attestation/LRI forms, when applicable
- Signed document indicating received information/contact list for reporting critical incidences **NMO-7075**
- Verification recipient contacted within thirty (30) days prior to the end of the authorization period
- Copy of dated referral (if approved within the last year)
- Verification recipient contacted within seven (7) working days of referral date.
- Any additional documentation that will assist the reviewer(s) in validating the required components.

See PT 39_55 Checklist

If a recipient's file documentation will be difficult to locate and submit within the allowed timeframes, DHCFP QA will accept individual extension requests and approve these on a case-by-case basis, allowing up to fifteen (15) additional days if approved. The extension needs to be requested per recipient and within one week of the above referenced program specific due dates.

Waiver and State Plan Provider Claim Review (Financial Review)

Bi-Annually, DHCFP Quality Assurance (QA) conducts randomized reviews of all claims submitted within a specific month of a one year look back review period. Financial reviews are only conducted on services provided to FE/PD waiver recipients and State Plan recipients. Requests are sent directly to providers identifying their individual recipients and the recipient's randomly selected month of review. The first request allows for ten (10) business days to submit the needed verification documents to support billed claims. If no verifications are received, a second request is then sent via certified mail allowing for five (5) business days to submit the verifications. **Note: it is each individual provider's responsibility to ensure their addresses are kept current with DHCFP Provider Enrollment.*

If discrepancies are noted within the independent review or a provider has failed to comply with QA's request to submit the needed verifications, a referral will be sent to the DHCFP Surveillance Utilization Review (SUR) unit. The SUR unit conducts an internal review and will then either issue education or recoupment letters directly to the providers. Annually, a report summarizing the review year's compliance percentages is created and submitted to DHCFP Administration for submission to CMS, as well as, uploaded to the DHCFP intranet.

Frail Elderly (PT48/57/59)/Persons with Physical Disabilities (PT58) Waivers

- Signed Activities of Daily Living (ADL) logs, if applicable
- Signed timesheets or invoices of waiver services rendered and billed
- Electronic Visit Verification (EVV) back up verifications for errors within the logs
- Any additional documentation that supports the services rendered for the times specified.

See FE PD Financial First Request Example
See FE PD Financial Second Request Example

Adult Day Health Care and Habilitation (PT39/55) State Plan

- Signed nursing/daily logs that document the health component of the services rendered
- Signed attendance logs (or signature page if applicable)
- Any additional documentation that supports the services rendered for the times specified.

See PT 39_55 Financial First Request Example
See PT 39_55 Financial Second Request Example