Provider Manual Title: All Manuals
Chapter I: General Information

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CHAPTER I

GENERAL INFORMATION

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INTRODUCTION

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

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

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

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

PROGRAM BACKGROUND

In 1965, Congress established Medicaid under Title XIX of the Social Security Act (Public Law 89-97), creating a federal-state program that provides federal financial assistance to states to furnish health care coverage to eligible individuals. Medicaid is jointly funded by the federal government and the states and is administered by each state within federal requirements. The program provides coverage for certain low-income individuals and families, including children, pregnant women, adults, older adults, and individuals with disabilities. Today, Medicaid is a key source of health coverage for millions of Americans and provides access to a broad range of medical and behavioral health services.

Medicaid is jointly funded by the federal government and the states. Federal funding is provided to states through a matching formula that takes into account each state's per capita income, with the federal share generally higher in states with lower per capita income. Within broad federal requirements, states have flexibility to design and administer their Medicaid programs, including determining covered services, eligibility pathways, and how services are delivered.

Virginia established its Medicaid program in 1966, and the Virginia Department of

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Medical Assistance Services (DMAS) is responsible for administering the program. Virginia Medicaid provides health coverage and access to medical and behavioral health services for eligible Virginians through a statewide network of providers and delivery systems. DMAS administers the program in accordance with federal and state requirements while working with health plans, providers, and other partners to deliver services to Medicaid members across the Commonwealth.

While the Virginia Medicaid Program is administered by DMAS, eligibility determinations are performed through a combination of local and centralized processes. Local departments of social services, operating through an interagency agreement with the Virginia Department of Social Services (DSS), process Medicaid applications and renewals and provide ongoing case maintenance. Cover Virginia, the state's centralized Medicaid call center, accepts and processes applications and renewals, providing an additional pathway for individuals to access and maintain Medicaid coverage.

Historically, Medicaid eligibility was tied to an individual's "categorical" eligibility for one of two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). Federal legislation enacted in the late 1980s significantly expanded and modified Medicaid eligibility requirements. As a result of these changes, certain additional low-income populations may qualify for Medicaid based on their household income in relation to the Federal Poverty Guidelines. The Federal Poverty Guidelines are updated annually and published in the *Federal Register*. The updated guidelines take effect upon publication.

In 2018, the Virginia General Assembly adopted Medicaid expansion, an option made available to states under the Affordable Care Act (ACA) to extend Medicaid coverage to additional low-income adults. Following approval from the Centers for Medicare and Medicaid Services (CMS), Virginia began enrolling eligible adults in the Medicaid expansion coverage group on January 1, 2019.

Medicaid is a means-tested program, meaning applicants must meet established financial eligibility requirements. Income and, when applicable, other resources must fall within the financial limits established for the applicable Medicaid eligibility group. Financial standards vary by population group, including children and pregnant women, the Modified Adjusted Gross Income (MAGI) adult group, and individuals who are aged, blind, or disabled.

For detailed information about Medicaid eligibility groups and applicable financial requirements, refer to Chapter III of this manual.

GENERAL SCOPE OF THE PROGRAM

The Medical Assistance Program (Medicaid) is designed to assist eligible members

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in obtaining medical care within the guidelines of specified state and federal laws and regulations. Medicaid provides access to a wide range of medically necessary and appropriate services or procedures for eligible members.

Covered Services

A detailed list of covered service codes is available to providers in the procedure fee file and CPT search page, which is located at https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/. This website and search function provides detailed information about a full list of health care procedure codes with information about rates, service authorization requirements, covered/non-covered designation, and more. Please refer to the Frequently Asked Questions located on the DMAS website at https://www.dmas.virginia.gov/media/4489/procedure-fee-file-cpt-search-function-information-faq.pdf for an explanation of the characters in each field of the procedure fee file. The fee file is updated three times per week.

If members have questions about covered/non-covered services, please direct them to the Member Handbooks that are available on the DMAS website at https://coverva.dmas.virginia.gov/members/member-handbooks/.

General Exclusions

Payment cannot be made under the Medicaid Program for non-covered items and services, and Virginia Medicaid will not reimburse providers for these services. Providers must contact the participating MCO or use the procedure fee file and CPT search page to determine whether a code is covered. Prior to rendering the service, the provider must advise the member they will be billed for non-covered services, and the member must consent. The member consent must be in writing, dated, and signed in order to be valid.

The provider may not bill the member for missed or broken appointments, which include transportation services arranged by the member who is not at the pickup point or declines to get into the vehicle when the provider arrives.

MANAGED CARE

Coverage for the majority of Medicaid enrolled individuals is provided through the DMAS managed care program. DMAS contracts with managed care organizations (MCOs) that all offer full coverage statewide. Through the MCOs, the managed care program provides access to services that help keep people healthy as well as services that focus on improving health outcomes. The MCOs also provide care coordination services to all enrolled members. For more information, please visit https://dmas.virginia.gov/for-providers/cardinal-care-providers/.

Enrollment in managed care is mandatory for most members. Individuals newly enrolled in Medicaid receive coverage through the DMAS fee-for-service program (for approximately 15-45 days) until they are enrolled in managed care. Additionally,

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some Medicaid services for managed care enrolled individuals are covered through fee-for-service; these are referred to as managed care carved-out services.

Once enrolled in managed care, members have up to 90 days to request a change in their MCO for any reason. Members also have the ability to change MCOs during the annual open enrollment period. Open enrollment dates vary by geographic region, and are as follows:

1. Roanoke/Allegheny and Southwest Regions: December 19 through February 28.
2. Tidewater Region: February 19 through April 30.
3. Central Region: April 19 through June 30.
4. Northern Virginia Region: June 19 through August 31.
5. Charlottesville/Western Halifax Regions: August 19 through October 31.

Managed Care Enrollment Broker

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

Cardinal Care Virginia Managed Care Program

DMAS has a mobile app for enrollment for the Virginia Managed Care program. The app is available to download in the Apple App Store and Google Play for both iPhone and Android users.

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

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

MCO Provider Reimbursement

In accordance with 42 CFR 438.602, to be reimbursed for services provided to individuals enrolled in managed care, providers must enroll and maintain enrollment with DMAS, as described in Chapter 2. Providers must also contract with the MCO and adhere to their respective contract(s) with the MCO. MCOs are

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prohibited from paying any network providers who are not enrolled with DMAS. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals.

MCOs also have the option to pay out-of-network, "non-par" providers. In the absence of an agreement between the MCO and the non-par provider, the MCO must pay non-par providers at the prevailing DMAS rate in existence on the date of service. This reimbursement is considered payment in full to the non-par provider. For more information, please contact the individual's MCO directly.

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

The MCOs must provide all the services covered by Medicaid, at least within an equal amount, duration, and scope as Medicaid, except for certain "carved-out services." "Carved-out" means that the member remains enrolled in the MCO plan but the carved-out services are covered and reimbursed by DMAS, not the MCO, within DMAS program guidelines. **DMAS will NOT provide reimbursement for services provided to MCO enrolled members EXCEPT for those services carved-out specifically from the MCO contracts.** Members must present their Medicaid plastic ID cards when receiving carved-out services.

Eligibility and MCO Enrollment Verification

Providers must verify the individual's eligibility and managed care enrollment before services are provided. Managed care members will have an MCO-specific identification card and a Medicaid card, and must present the cards at the time of service. Managed care providers must adhere to their contract with the MCO regarding referrals, prior authorization, and billing requirements. Service authorization from the member's MCO is required for any out-of-network services, *except for emergency and family planning services.* The provider is responsible for ensuring that proper referrals and service authorizations are obtained. If the MCO denies authorization for a service, the member may exercise the right to appeal to the MCO. Members can also appeal to DMAS after first exhausting the MCO's appeal process. A provider may bill a member only when the provider has provided advanced written notice to the member, prior to rendering services that their MCO/Medicaid will not pay for the service, and the member has consented. The notice must also state that, should the individual decide to accept services that have been denied payment by the MCO/Medicaid, the provider is accepting the member as a private pay patient, not as a Medicaid patient, and the services being provided are the financial responsibility of the patient. Failure to confirm Medicaid eligibility

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and MCO coverage can result in a denial of payment and the member cannot be billed.

Continuity of Care

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

- In the absence of a written agreement stating otherwise, the member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO which are rendered after the MCO enrollment effective date. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the member's MCO shall continue to reimburse for authorized services without interruption until the MCO completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider.

- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the fee-for-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider.

- If the prior authorized service is an inpatient stay, the claim should be handled as follows:
  - If the provider contracts with the MCO under a per diem payment methodology, the financial responsibility shall be allocated between the member's current MCO and either DMAS or the new MCO. In the absence of a written agreement otherwise, the member's current MCO and DMAS or the new MCO shall each pay for the period during which the member is enrolled with the entity.
  - If the provider contracts with the MCO under a diagnosis related group (DRG) payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge, including any outlier charges.

- If services have been authorized using a provider who is out of network, the member's MCO may elect to reauthorize (but not deny) those services using an in-network provider. In the absence of an agreement with the out-of-network provider, the MCO must require out-of-network providers to coordinate with the MCO for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the

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MCO's network. The MCO must reimburse out-of-network providers at the fee-for-service rate in effect on the date of service. For CCC Plus Waiver and home health services, the rate must include the Northern Virginia differential.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS) PLAN

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

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

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services or non-emergency medical transportation. Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit. Please consult the procedure fee file to determine whether a service is covered for an individual who is covered by FAMIS.

If members have questions about covered/non-covered services in FAMIS, please direct them to the Member Handbooks that are available on the DMAS website at https://coverva.dmas.virginia.gov/members/member-handbooks/.

SOURCES OF INFORMATION FOR FEE-FOR-SERVICE PROVIDERS

Providers may obtain information about Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice from one of two DMAS systems: an online automated response system, or Medicall (a telephone-based automated voice response system). Providers enrolled with an MCO will need to contact their contracted MCO for claims status, payment status, service limits, service authorization status and remittance advices.

Automated Response System (ARS)

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-four-hour-a-day, seven-day-a-week online access to current member eligibility information, service limits, claim status, service authorizations, and

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provider payment history. This web-enabled tool allows providers to access current information quickly and conveniently.

The ARS can be accessed through the provider portal. Please visit the portal for information on registration and use of the ARS.

Medicall Automated Voice Response System

Toll-free numbers are available 24 hours per day, seven days a week, to obtain current member eligibility information, service limits, claim status, service authorizations, and provider payment history. The numbers are: 1-800-772-9996 or 1-800-884-9730.

HELPLINE

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

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

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

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

Do not use the HELPLINE numbers for member eligibility verification and eligibility questions. Members needing eligibility related information should be directed to CoverVA, the statewide member call center at 855-242-8282, their local departments of social services, or the member online eligibility portal, CommonHelp. CoverVA should be provided as the first resource. CoverVA can assist with submitting new applications and renewals, eligibility related questions, and member services to include sending new Medicaid ID cards, providing enrollment details, and submitting reported changes. Providers should not contact CoverVA or the local departments of social services with member eligibility questions.

If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down). The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to members.

PROVIDER MANUAL UPDATES

This manual is designed to accommodate new pages as further interpretations of

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the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by DMAS as needed.

NOTICE OF PROVIDER RESPONSIBILITY

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

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CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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Provider Manual Title: CCC Plus Waiver Revision Date: 11/5/2026
Chapter II: Provider Participation Requirements

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PROVIDER ENROLLMENT

A participating provider is a person or organization who has a current, signed participation agreement with DMAS.

Effective April 4, 2022, all newly enrolling providers seeking to participate with Medicaid managed care or fee-for-service (FFS) must be screened and enrolled with DMAS.

DMAS's online provider enrollment process may be accessed through the Provider Enrollment link located on the DMAS Medicaid Enterprise System (MES) Provider Resources site at https://vamedicaid.dmas.virginia.gov/provider.

1. As a part of the enrollment process, providers must complete a Participation Agreement applicable to their provider type. In the case of a group practice, hospital, or other agency or institution, the authorized agent of the provider institution must sign the agreement. For group practice, hospital, or other agency or institution, DMAS must receive prior written ratification of the identity of any designated authorized representative and the fact that a principal-agent relationship exists.

2. A National Provider Identifier (NPI) number must be obtained from the National Plan and Provider Enumeration System (NPPES) and provided with the enrollment application. An enrolled provider's NPI is used by MES to manage provider information across functions. For example, this number must be used on all claims submitted to DMAS.

Provider NPIs may be disclosed to other Covered Healthcare Entities pursuant to Centers for Medicaid and Medicare Services (CMS) regulations requiring the disclosure of NPIs as a part of HIPAA-compliant standard transactions. (Please reference the Healthcare Information Portability and Accountability Act (HIPAA) of 1996.)

3. Providers must have an active license from the relevant state licensing authority and provide proof of licensure during the enrollment process.

4. The provider must be successfully screened according to the requirements detailed in the next section (titled "Provider Screening Requirements").

5. Providers may be denied enrollment for any of the following reasons:
   - failing to submit any of the requested information;
   - conviction of a felony;
   - conviction of health care fraud;
   - if there are past licensure actions or actions related to privileges, enrollments, educational tenure, board certifications, authorizations, participation in health care programs, malpractice actions, liability actions, or other actions or information indicating that the individual may pose a risk to the health, safety or welfare of Medicaid members.

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Providers who are located in another state but within 50 miles of the Virginia border may be permitted to enroll if all other qualifications are met. If a provider is outside of the 50-mile border of Virginia and considered an out of state provider, then a claim or supporting documentation is required to necessitate their enrollment.

6. Providers will be notified of the enrollment decision by email notice or letter mailed to the address entered in the provider enrollment portal. For denied applications, information about filing an appeal is included in the notice or letter.

7. The enrollment effective date will begin the 1st day of the month in which the application is received, unless a retroactive effective date is approved for documented extenuating circumstances.

If you have any questions regarding the enrollment process, please email Provider Enrollment Services at VAMedicaidProviderEnrollment@gainwelltechnologies.com or phone toll free 1-888-829-5373 or local 1-804-270-5105.

PARTICIPATION IN MANAGED CARE AND FEE FOR SERVICE (FFS)

Any provider of services must be enrolled with DMAS prior to billing for services rendered to eligible individuals, including individuals enrolled in either FFS or Medicaid managed care.

Most individuals who are eligible for Medicaid or Family Access to Medical Insurance Security (FAMIS) benefits are enrolled with one of the Department of Medical Assistance Services' (DMAS') contracted Managed Care Organizations (MCOs) and receive services from the MCO's network of providers. All participating providers must confirm the individual's MCO enrollment status prior to rendering services. The MCO may require a referral, service authorization or other action prior to the start of services. All providers are responsible for adhering to state and federal requirements, their MCO provider contract(s) (as applicable), and the applicable DMAS provider manual. For providers to participate with one of DMAS' contracted MCOs, they must also become a participating provider in the MCO's network.

Please visit the DMAS website at https://vamedicaid.dmas.virginia.gov/provider for more information on participation with the Medicaid FFS and managed care programs

Carved-Out Services

Regardless of an individual's MCO enrollment, some services are "carved-out" of the managed care program and are paid directly by DMAS using FFS methodology. Providers must follow the FFS rules in these instances.

Individuals who receive services under one of the three 1915(c) Developmental Disabilities Home and Community-Based Services (HCBS) Waivers, including the

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Building Independence, Community Living, and Family and Individual Supports Waivers, are enrolled in managed care for their non-waiver services (e.g., acute, behavioral health, pharmacy, and non-waiver transportation services). The individual's waiver services benefits are carved-out and managed directly by DMAS.

PROVIDER SCREENING REQUIREMENTS

The 21st Century Cures Act (Cures Act)114 P.P.255 requires all states to screen Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organizations (MCOs) upon enrollment. An abbreviated screening is also performed on a monthly basis for any provider who participates with the Virginia Medicaid Program. The full screening is conducted at the time of revalidation, and providers are required to revalidate at least every five (5) years.

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

Limited Risk Screening Requirements

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

Moderate Risk Screening Requirements

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

High Risk Screening Requirements

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

Application Fees

Institutional providers may be required to pay a federally-required fee at the time of application for enrollment, re-enrollment or reactivation, and when adding new locations. If a provider is required to pay an application fee, it will be outlined in the provider enrollment application and/or revalidation notice.

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

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

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

Out-of-State Provider Screening

Prior to enrollment in DMAS, providers with a primary servicing address located outside of the Virginia border must have a site visit conducted by either their state’s Medicaid program or by CMS due to their provider risk-level. Pursuant to 42 CFR 455 Subpart E, an application will be pended for proof of this information if it is received by DMAS prior to the completion of the site visit.

Revalidation Requirements

All participating providers are required to revalidate at least every five (5) years. Providers are notified in writing of their revalidation due date and of any new or revised provider screening requirements. (Providers will indicate their preferred mode of notification, i.e., email or USPS, at the time of enrollment.) DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements if a provider is enrolled as a Medicare provider at the time of revalidation.

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ORDERING, REFERRING, AND PRESCRIBING (ORP) PROVIDERS

42 CFR 455.410(b) states that state Medicaid agencies must require all ordering, or referring, and prescribing physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ORP providers to enroll to meet new program integrity requirements designed to ensure that all orders, prescriptions or referrals for items or services for Medicaid members originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. There is one exception: the provider enrollment requirements do not apply to physicians who order or refer services for a Medicaid member in a risk-based managed care plan.

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

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

PARTICIPATION REQUIREMENTS

Providers approved for participation in the Virginia Medicaid Program must perform the following activities, as well as any other activities specified by DMAS:

- Immediately notify Provider Enrollment Services in writing of any change in the information that the provider previously submitted to DMAS.
- Ensure freedom of choice to individuals who are eligible for medical assistance under the Virginia Medicaid Program (eligible individuals) in seeking waiver services or medical care from any institution, pharmacy, provider, or practitioner qualified to perform the required service(s) and participating in the Virginia Medicaid Program at the time the service was performed.
- Ensure the eligible individual's freedom to reject supports, medical care and treatment.
- Provide services and supplies to eligible individuals in the same mode of delivery and of the same quality and as provided to the general public.
- Charge DMAS for the provision of services and supplies to eligible individuals in amounts not to exceed the provider's usual and customary charges to the general public.

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- The provider shall submit all other available third-party payment sources prior to submitting a claim to DMAS or the MCO, as applicable. Notwithstanding this, the Provider shall not request, pursue (e.g., assignment of rights by member or member's representative) or accept payment for medical services from any tortfeasors or their carrier arising from a bodily injury claim (for example, motor vehicle, or homeowner's insurance).

- The provider and its vendors must submit claims for medically necessary, Medicaid-covered services to DMAS or the MCO, as applicable, provided that the member has supplied information to verify the member's Medicaid enrollment at least 21 days before the claim submission deadline. A provider that does not comply with this requirement agrees not to bill the member for such services or assert any contractual assignments, benefits, rights to reimbursement, or statutory liens against the member.

- Accept assignment of Medicare benefits for eligible individuals.

- Use DMAS-designated billing forms to submit claims.

- Maintain and retain business and professional records sufficient to fully and accurately document the nature, scope, and details of the health care services provided. In general, such records must be retained for a period of not less than six years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.

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

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

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

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PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

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

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

All providers are required to take the following three steps to meet Federal and Virginia Medicaid program integrity requirements:

- Screen all new and existing employees and contractors to determine whether any of them have been excluded from participation in Medicaid or Medicare. (Go to https://oig.hhs.gov/exclusions/)

- Search the Health and Human Services Office of the Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs.

- Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS
Attn: Program Integrity/Exclusions 600 E. Broad St, Suite 1300
Richmond, VA 23219
-or-
E-mailed to: providerexclusions@dmas.virginia.gov

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

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

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Medicaid providers are responsible for making provisions for individuals with disabilities in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

REQUIREMENTS OF THE CIVIL RIGHTS ACT OF 1964

All providers of care and suppliers of services under contract with DMAS must comply with the requirements of Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the basis of race, color, religion, sex, or national origin.

UTILIZATION OF INSURANCE BENEFITS

Virginia Medicaid is a "payer of last resort" program. Benefits available under Medicaid shall be reduced to the extent that they are available through other federal, State, or local programs; coverage provided under federal or State law; other insurance; or third-party liability.

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

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

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

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

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- Liability Insurance for Accidental Injuries - DMAS will seek repayment from any settlements or judgments in favor of eligible individuals who receive medical care as the result of the negligence of another. DMAS should be notified promptly if an eligible individual is treated as the result of an accident so action can be initiated to establish a lien as set forth in the Code of Virginia §8.01-66.9. In liability cases, providers may choose to bill the third-party carrier or file a lien in lieu of billing DMAS.

In the case of an accident in which there is a possibility of third-party liability or if the eligible individual reports a third-party responsibility (other than those cited on his Medical Assistance Identification Card), and whether or not Medicaid is billed by the provider for rendered services related to the accident, the physician is requested to forward the DMAS-1000 to the attention of the Third-Party Liability Casualty Unit, Department of Medical Assistance Services, 600 East Broad Street, Richmond, Virginia 23219. The form can also be sent electronically to TPLcasualty@dmas.virginia.gov

DOCUMENTATION REQUIREMENTS

The Virginia Medicaid Program provider participation agreement requires that medical records fully disclose the extent of services provided to all Medicaid members. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the service is rendered and the description of the services rendered must be clear. All documentation must be signed (name and title) and dated (month, day, year) on the date of service delivery.

ELECTRONIC SIGNATURES

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

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

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

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

An original written signature is still required on provider enrollment forms and for medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records.

TERMINATION OF PROVIDER PARTICIPATION

The provider participation agreement is time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to DMAS 30 days prior to the termination's effective date. The written notification should be sent to the following address:

DMAS Provider Enrollment Services
PO Box 26803
Richmond, Virginia 23261-6803

DMAS may terminate a provider's participation agreement. DMAS must provide written notification 30 days prior to the termination's effective date. Such action precludes further payment by DMAS for services provided to customers after the date specified in the termination notice.

Pursuant to §32.1-325 (D) of the Code of Virginia, the DMAS Director of Medical Assistance Services is authorized to:

Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

Appeals of Provider Termination or Enrollment Denial: A provider has the right to appeal in any case in which a Virginia Medicaid Program provider agreement or contract is terminated or denied pursuant to Virginia Code §32.1-325(D). The provider may appeal the decision in accordance with the Administrative Process Act (Code of Virginia §2.2-4000 et seq.) and the Provider Appeals regulations (12 VAC 30-20-500 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division within 15 calendar days of the receipt of the notice of termination or denial.

APPEALS OF ADVERSE ACTIONS

There are two types of appeals – client and provider. In a client appeal, the patient, their

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parent or guardian, or an authorized representative has the right to appeal for services not yet rendered. Please refer to Chapter III for more details on the client appeal process. In a provider appeal, a provider or its authorized representative has the right to appeal.

An appeal is an independent review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. For provider appeals, an adverse action can be:

1. Any negative action on payment for a service the provider has already given to the patient. A negative action can be: (a) a termination, suspension, reduction, or denial of authorization; (b) a claim denial; or (c) an audit determination.
2. Denial or termination of enrollment as a DMAS participating provider.

Appeals are processed in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*., Code of Virginia § 32.1-325.1, and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

PROVIDER APPEALS: NON-STATE-OPERATED PROVIDERS

The following procedures apply to all providers not operated by the Commonwealth.

Before the Appeal: Reconsideration Requirements

If an MCO, Acentra, or DentaQuest took the adverse action, the provider must exhaust the reconsideration process with that contractor **before** the provider can appeal with DMAS. DMAS will dismiss appeal requests made before the final reconsideration. If the reconsideration is final, the notification letter will state so and include instructions on how to request an appeal with DMAS.

If DMAS took the adverse action, the provider must request reconsideration if the action involves a DMAS claim under the Enhanced Ambulatory Patient Grouping (EAPG) payment methodology or a ClaimCheck denial. The deadline to request reconsideration for these claims is 30 days from when the provider received written notice of the adverse action. The provider must include all supporting documentation with the reconsideration request.

Address the EAPG or ClaimCheck reconsideration request to the Program Operations Division at the following address:

Program Operations Division
Department of Medical Assistance Services
600 East Broad Street, Richmond, Virginia 23219

The Program Operations Division will review the reconsideration request and provide a written response.

If the reconsideration partially or completely upholds the adverse action, or reconsideration is not required, the provider may request an informal appeal with the DMAS Appeals Division.

Stages of Provider Appeals

There are two stages of provider appeals: informal and formal.

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For informal appeals, an informal appeals agent conducts an impartial review of the adverse action and issues the informal appeal decision. An informal appeal decision must be issued before a provider can request a formal appeal.

For formal appeals, a hearing officer is selected from a list maintained by the Supreme Court of Virginia. The hearing officer sends a recommended decision to the Agency Director, who then issues the final agency decision.

Appeal Requests

How to Request an Appeal

Effective November 5, 2026, all providers must request appeals through the Appeals Division's online portal, the Appeals Information Management System ("AIMS"). Providers must have an AIMS account to request an appeal.

Provider registration requests must be reviewed before the account is created. As a result, providers will not have an AIMS account immediately after registering. Providers are encouraged to register for AIMS even if they do not need to file an appeal.

Providers can register for and access AIMS at www.dmas.virginia.gov/appeals.

Exception to the Portal Filing Requirement

Providers who are unable to file an appeal request through AIMS can request an exception. The request must have a subject of "Exception Request for Portal Filing." For emails, this must be in the subject line. For delivered requests, this must be underneath the address block on the cover letter. The request must be filed prior to the appeal request deadline.

Exceptions will be granted for good cause shown. Examples of good cause include:

1. The infrastructure necessary to support electronic submission is not available in the provider's geographic region;
2. The disability of all members of a provider's staff prevents their use of AIMS; or
3. The provider cannot transmit documents through AIMS due to unusual or unavoidable circumstances.

Providers can request an exception using any of the following methods:

1. Email the exception request to appeals@dmas.virginia.gov.
2. Mail or bring the exception request to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

If the DMAS Appeals Division grants an exception to the portal filing requirement, the provider must file an appeal request through email, postal mail, or hand delivery, prior to the appeal request deadline. See 12VAC30-20-520 for more information.

Multiple Appeal Requests

Providers must submit a new appeal request for each appealable notice received.

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Filing Date

A provider's appeal request is filed when it completes transmittal to AIMS.

If the DMAS Appeals Division grants an exception to the portal filing requirement, the provider's appeal request is filed when it is date-stamped by the DMAS Appeals Division. See 12VAC30-20-520 for more information.

The Department of Medical Assistance Services' normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern Time. If a provider submits documents or correspondence to the DMAS Appeals Division after 5:00 p.m., DMAS will date stamp the document or correspondence on the next day the Department is officially open. If a provider sends a document to the DMAS Appeals Division after 5:00 p.m. on the deadline date, it is untimely.

Communication Options

Providers must upload all documents, correspondence, and other items to AIMS. The Appeals Division will not accept items a provider sends through any other method unless the Appeals Division granted the provider's request for an exception from the portal filing requirement.

The Appeals Division will send all documents and correspondence through AIMS. The Appeals Division will send an email notification to the provider's point of contact when an item is ready to review in AIMS. The Appeals Division will not directly email electronic copies of documents or correspondence to the provider's point of contact; for security reasons, the email will only contain a link to log in to AIMS to review the documents. The Appeals Division presumes the point of contact receives all items when the Appeals Division sends the email notification to the point of contact.

For technical assistance with AIMS, contact AIMS Help at aimshelp@dmas.virginia.gov or 804-486-2865.

If the Appeals Division grants an exception to the portal filing requirement, the Appeals Division will send all documents and correspondence to the postal mail address listed in the provider's exception request. The provider may transmit items through email, mail, or hand delivery. See 12VAC30-20-520 for more information on filing documents after an exception request is granted.

Administrative Dismissals

Informal Appeals

The Appeals Division will administratively dismiss an informal appeal if:

- A provider fails to request an informal appeal before the applicable deadline.
- DMAS requests proof that an individual or entity is authorized to pursue the appeal and the provider does not return the required paperwork by the deadline.

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- A provider has not exhausted the DMAS or contractor's reconsideration, review, or internal appeal process, if the process is required before filing a DMAS informal appeal.

An administrative dismissal is an informal appeal decision dismissing the informal appeal without any further proceedings. If a provider's informal appeal results in an administrative dismissal, the provider will have the right to appeal the dismissal.

Formal Appeals

The Appeals Division cannot administratively dismiss formal appeals.

Appeal Request Timeframes

Informal Appeals

The informal appeal request timeframe begins when a provider receives notice of the adverse action. The appeal request deadline depends on the type of appeal the provider requests.

The deadline to request an appeal of a DMAS provider agreement termination is **15 calendar days**.

The deadline to request an appeal of adjustments to a cost report is **90 calendar days**.

The deadline is **30 calendar days** for:

- Any payment-related action that does not involve adjustments to a cost report.
- Any other adverse action not stated above.

Formal Appeals

Any provider appealing a DMAS informal appeal decision must file a formal appeal request with the DMAS Appeals Division. The formal appeal request must identify the informal case(s) that are being appealed. The deadline is **30 calendar days** from the provider's receipt of the DMAS informal appeal decision. Failure to file a formal appeal request within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal.

Circuit Court Appeals

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

Repayment

Virginia Code § 32.1-325.1 requires DMAS to collect identified overpayments. Repayment must be made upon demand unless DMAS agrees to a repayment schedule. If a provider does not repay DMAS in a lump sum cash payment, DMAS will add interest on the declining balance at the statutory rate, pursuant to Va. Code § 32.1-313.1. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates a financial hardship warranting extended repayment terms. The provider must demonstrate the hardship to the satisfaction of DMAS.

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DMAS and associated contractors (e.g. MCOs) cannot collect repayment or apply interest during the administrative appeal.

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

PROVIDER APPEALS: STATE-OPERATED PROVIDERS

The following procedures apply to all Medicaid-enrolled providers operated by DMAS.

Reconsideration

A state-operated provider has the right to request a reconsideration of any issue that the State Plan allows a non-state operated provider to appeal. This is the sole procedure available to state-operated providers.

The reconsideration process has three steps:

1. An informal review by the Division Director.
2. A review by the DMAS Agency Director.
3. A Secretarial review.

1. Informal Review

For Step One, the state-operated provider must submit written information specifying the nature of the dispute and the relief sought to the appropriate DMAS Division Director. DMAS must receive this request within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute.

If a provider seeks a reimbursement adjustment, the written information must include the nature of the adjustment, the amount of the adjustment, and the reason(s) for seeking the adjustment. Upon request by either party, DMAS may arrange an informal meeting to discuss a resolution.

The Division Director or a designee will review the information and request additional information if necessary. The designee will then recommend to the Division Director whether relief is appropriate under applicable laws and regulations. The Division Director shall consider any recommendation of the designee and render a decision.

2. Agency Director Review

Step Two permits a state-operated provider to request the DMAS Agency Director review the Division Director's decision. The state-operated provider must request the Agency Director's review within 30 days after receipt of the Division Director's decision. The DMAS Agency Director may appoint a designee to review the Division Director's decision. The DMAS Agency Director has the authority to take whatever measures the Agency Director deems appropriate to resolve the dispute.

3. Secretarial Review

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Step Three occurs when the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider. Step Three permits the provider to request the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. The state-operated provider must request referral for Secretarial review within 30 days after receipt of the DMAS Agency Director's Decision. Any determination by such Secretary or Secretaries is final.

AREAS OF SERVICE – CCC+ WAIVER

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

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

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

PERSON-CENTEREDNESS

As a core tenet of Home and Community-Based Services, all providers of CCC Plus Waiver services must engage with the waiver individual with a person-centered approach. Person-centered planning is a requirement of HCBS, but good person-centered thinking and planning allows all parties involved to reach the person's vision for their preferred life with optimal outcomes including independence, good health, and quality of life. Person-centered plans help create a system where waiver individuals can live their lives by making informed choices, having full control, and accessing the array of quality services.

The National Center of Advancing Person-Centered Practices and Systems (NCAPPS) defines the following terms that focus on the individual first and foremost:

- Person-Centered Thinking: the means for a person to live a life that they and the people who care about them have good reason to value.
- Person-Centered Planning: a way to assist people who need HCBS and supports to construct and describe what they want and need to bring purpose to life.
- Person-Centered Practice: the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals.

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In developing a person-centered plan, providers must work with the individual to document ***what is important to*** and ***what is important for*** the individual. What is important to an individual are the relationships, personal control, the individual's routines and pace of life; the places, activities, and experiences that the individual wants or likes to do or to have; and the physical things that are important to the individual. What is important for the individual may include social rules, the individual's contributions and role in the community; their health status; diet and exercise; and topics of safety.
developing the person-centered plan, providers should, at a minimum, adhere to the following requirements:

- Let the individual, even if a minor, lead the discussion to the extent possible. The individual can have a representative to participate, as needed and to the extent defined by the individual, in the process; however, the individual's opinions and voice should be considered first and foremost in the process. In addition to their representative, the individual has the right to have other people involved at their choosing in the planning process, such as family members, friends, or neighbors;
- Provide information and supports on all available services in the waiver, other Medicaid and non-Medicaid services and supports that may be available, and additional assistance so that the individual is able to direct the process to the extent possible and enabled to make informed choices and decisions;
- Is performed timely and at a time and place of the individual's choosing;
- Reflects the individual's strengths and preferences plus individually identified goals and desired outcomes;
- Reflects cultural considerations of the individual and conducted using plain language and in a way that is accessible to the waiver individual, which would include the provider's use of interpretation services if the individual has a limited English proficiency (use of a family member to translate or interpret is not acceptable);
- Identifies risk factors and includes measures in place to minimize them;
- Discuss possible areas of conflict, disagreement, or conflict of interest during the process that includes written documentation wherever the individual, individual's representative, or provider disagree so that objections are noted; and
- Record alternative services, supports, and settings that were discussed and considered with the individual but were not selected.

The person-centered planning process must be reviewed on an annual basis and may be updated more frequently as needed. The person-centered plan is meant to be a document that empowers individuals to build the life they want at that particular moment in their life; all individuals change as they get older and have new experiences and outlooks on life, and just as the aspirations and goals of those who do not have a disability change over time, so too should it be expected that the person-centered plans of waiver individuals show changes in preferences, goals, and outcomes.

The person-centered plan must be agreed to by the individual and signed by the individual. If the individual is a minor, the individual's representative must also sign. If the individual does not agree to the plan due to a reasonable objection, such as the provider has not documented the individual's preferred services, supports, or caregivers or that the individual feels their personal wants and goals have not been addressed due

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to provider or other external interference, then the plan is not person-centered and must be adjusted. If the reason for the individual's objection is one where the provider and other individuals in the planning meeting have raised and documented their concerns that the individual's preferences are likely to lead to health, safety, and welfare issues or are entirely unrealistic, then those in the meeting should work with the individual to develop a more reasonable plan that addresses ways to reduce the possibility of those issues and provides a more realistic path towards achieving the individual's dreams and goals.
person-centered plans must ensure freedom of and respect for choice to individuals. This includes the individual's right to choose from nursing facility, PACE or HCBS care as well as identification of the individual's choice of pharmacy, practitioner, or other provider qualified and enrolled in Medicaid to provide the services identified and selected. Person-centered plans should document the individual's goals.

INDIVIDUAL CHOICE OF PROVIDER

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

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

DIRECT MARKETING

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

CRIMINAL BACKGROUND CHECKS

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

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

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

Providers must keep proof that an original criminal record check from the Central Criminal Records Exchange and a search of the VDSS Child Protective Services (CPS) Central Registry, as applicable, was requested and conducted for each staff member hired.

PARTICIPATING AGENCY-DIRECTED PERSONAL/RESPITE CARE PROVIDER

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

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

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

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

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PROVIDER PARTICIPATION STANDARDS FOR AGENCY-DIRECTED PERSONAL/RESPITE CARE SERVICES

In addition to the above, to be enrolled as a Medicaid personal/respite care provider and maintain provider status, an agency must meet the following special participation conditions:

Staffing Requirements for Personal Care and Respite Care Services

1. Registered Nurse (RN)

   The provider must employ (or subcontract) and directly supervise a registered nurse (RN) who will provide ongoing supervision of all personal care aides and licensed practical nurses (LPN). The RN must possess the following qualifications:

   - A license to practice in the Commonwealth of Virginia;
   - At least one (1) year of related clinical experience as a RN or a LPN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility.
   - A satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the RN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adults or children is acceptable.
   - The RN must submit to a criminal record check obtained through the Virginia State Police. If the individual receiving services is a minor, the RN must also submit to a search of the VDSS Child Protective (CPS) Central Registry. The provider must not hire any RN with findings of barrier crimes identified in 32.1-162.9:1 of the *Code of Virginia* or founded complaints in the CPS Central Registry.

     Documentation of license, clinical experience, references, and evidence of a criminal background record check and central registry search if applicable must be maintained in the RN's personnel file for review by DMAS staff or its contractors.

2. Personal Care Aide

   - Each personal care aide hired by the provider must be evaluated by the provider to ensure compliance with qualifications as required by DMAS. Basic qualifications for personal care aides include:
   - Physical ability to do the work;
   - 18 years or older;

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- Ability to read and write in English to the degree necessary to perform the expected tasks and possess basic math skills;
- Ability to create and maintain required documentation
- Have the required skills to perform the services;
- Have a valid social security number; and
- Special training in the needs of the elderly and individuals with disabilities through the completion of a minimum 40-hour training program consistent with DMAS requirements. The provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements.

DMAS requirements may be met in one of four ways:

1. Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration containing a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as a personal care aide. A copy of the state certificate must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the agency must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons and that the aide meets one of the other two DMAS requirements.

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

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

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

   Goals of Personal Care, Prevention of Skin Breakdown, Physical and Biological Aspects of Aging, Physical and Emotional Needs of Older Adults,

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Orientation to Types of Physical Disabilities, Personal Care and Rehabilitative Services, Body Mechanics, home management, Safety and Accident Prevention in the Home, Accident Prevention, Typical Hazards in the Home, Policies and Procedures Regarding Accidents or Injuries, Food, Nutrition, and Meal Preparation, Importance of Nutrition to the Individual, General Concept of Planning Meals, Special Considerations in Preparation of Special Diets, Food Purchasing and Preparation, Care of the Home and Personal Belongings, and Documentation Requirements for Medicaid Individuals.

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

Regardless of the method of training received, documentation must be present indicating the training was received prior to assigning an aide to provide services for an individual. Based on continuing evaluations of the aide's performance and the individual individual's needs, the RN Supervisor shall identify any significant gaps in the aide's ability to function competently and shall provide the necessary training.

In addition to the initial training requirements for personal care aides, each aide must have a minimum of 12 hours of training annually. The year is based on the aide's hire date. This training is provided by the provider agency and must be related to the performance of personal care services. Documentation of this training must be kept in the employee's personnel files, including a description of the training, the date performed, the length of time taken, and a signature with title of the administrator of the training confirming that the aide satisfactorily completed the training.

The provider should verify all information on the employment application prior to hiring a personal care aide. The aide must have a satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults and children. If the aide has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable. If possible, obtain references from the educational facility, vocational school, or institution where the aide's training was received. Documentation of the date of the reference check, the individual contacted and his or her relationship to the aide (friend, co-worker, supervisor), and the content of the reference check must be maintained in the employee's personnel record. These qualifications must be documented and maintained in the provider personnel files for review by DMAS staff or its contractors.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The personal care aide must submit to a search of the VDSS

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Child Protective Services (CPS) Central Registry if the individual receiving services is a minor child. **The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the *Code of Virginia* or has a founded complaint confirmed by the CPS Central Registry.**

The provider must have documentation proving that a criminal background check and CPS Central Registry check if applicable was requested and obtained. This documentation must be made available to DMAS staff or its contractors, upon request.

Payment may be made for services rendered by family members or caregivers living under the same roof as the individual receiving waiver services only when there is written, objective documentation as to why no other aide or provider is able to render services to that individual. The family member or caregiver providing personal care services to the individual must meet the same requirements as other aides. This documentation is not required for a legally responsible individual (natural, adoptive, or foster parent; stepparent; or legal guardian of a minor under the age of 18 or a spouse).

It is extremely important that the minimum qualifications be met by each personal care aide to ensure the health, safety, and welfare of each individual enrolled in the CCC Plus Waiver.

No aide may work more than 16 hours in a day, starting at 12AM and ending at 11:59PM, providing Medicaid-reimbursed personal care and/or respite services.

3. Licensed Practical Nurse (LPN)

Each LPN hired by the provider must be evaluated by the provider to ensure compliance with qualifications as required by DMAS. Basic qualifications for LPNs include:

- The LPN must be able to practice in the Commonwealth of Virginia;
- Have at least one (1) year of related clinical experience as a LPN. Clinical experience may include work in an acute care hospital, public health clinic, home health agency, rehabilitation hospital, or nursing facility.
- A satisfactory work history as evidenced by two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the LPN has worked for a single employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is acceptable.

Providers are responsible for complying with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and crimes against minors obtained through the Virginia State Police. The LPN must submit to a search of the VDSS Child

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Protective Services (CPS) Central Registry if the individual receiving services is a minor child. **The provider shall not hire any persons who have been convicted of barrier crimes as defined in § 32.1-162.9:1 of the *Code of Virginia* or has a founded complaint confirmed by the CPS Central Registry.**

The provider must have documentation proving that a criminal background check and CPS Central Registry check, if applicable, was obtained. This documentation must be made available to DMAS staff or its contractors, upon request.

If possible, obtain references from the educational facility, vocational school, or institution where the LPN received training. Documentation of the date of the reference check, the individual contacted and their relationship to the LPN (friend, co-worker, supervisor), and the content of the reference must be maintained in the employee's record.

Documentation of all staff credentials must be maintained in the provider's personnel files for review by DMAS staff or its contractors.

PARTICIPATING QUALIFICATIONS FOR PRIVATE DUTY NURSING/SKILLED RESPITE PROVIDERS

A participating Private Duty Nursing (PDN)/skilled respite care provider is an institution, facility, agency, partnership, corporation, or association that meets the standards and requirements set forth by the Department of Medical Assistance Services (DMAS) and has a current, signed Participation Agreement with DMAS. The duties and responsibilities of the provider are the same for both services. Each service requires a separate Participation Agreement and provider identification (ID) number. A provider may, however, choose to offer only one of the two services.

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

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

- Accreditation Commission for Health Care, Inc. Certification (ACHC)
- Centers for Medicare and Medicaid Services (CMS) Certification
- Community Health Accreditation Program Certification (CHAP)

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- Joint Commission on Accreditation for Health Care Organizations (JCAHO)
- Virginia Department of Health (VDH) Home Care Organization (HCO) License

NURSING QUALIFICATIONS FOR PRIVATE DUTY NURSING SERVICES

RN Supervisors

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

Private Duty Nurse – RN or LPN

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

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

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

- Have completed a provider training program related to the care and technology needs of the assigned waiver individual; and
- Have a completed TB test and current CPR certification.

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

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

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

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

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

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

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

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

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

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

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waiver.

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

The provider must have documentation proving that a criminal background check and CPS Central Registry check, if applicable, was requested and obtained. This documentation must be made available to DMAS staff or its contractors, upon request. The actual background check results must not be maintained in the record but should be securely disposed.

PARTICIPATION STANDADS FOR ADULT DAY HEALTH CARE (ADHC)

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

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

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

Each ADHC Center participating with Medicaid is responsible for adhering to the VDSS Adult Day Center standards. The DMAS special participation conditions included here are

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standards imposed in addition to VDSS standards, which must be met to perform Medicaid ADHC services.

HCBS SETTINGS COMPLIANCE

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

- The setting must be integrated in and supports full access to the greater community. This includes opportunities to engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
    - Rules and practices that facilitate community access should be established. When providing HCBS, individuals should not be isolated from those who do not have disabilities. Providers must ensure that practices do not create an environment that is institutional in nature. This includes the ability to come and go from settings (with appropriate supports) and provider support to individuals who express a desire to participate in the community by providing opportunities for new experiences.

- The setting must ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
    - People in HCBS have the right to be treated with respect and dignity in all facets of life. This includes respecting people’s likes and dislikes, treating them in a way that makes them feel respected and heard, and assisting people with supports in a compassionate manner that preserves their privacy and dignity. Examples of providing services with dignity include, but are not limited to:
        - Addressing individuals by their preferred name and not nicknames that are not preferred or calling the individual by endearments such as baby, sweetie, or honey;
        - Wearing typical clothing while providing supports such that the greater community is unable to distinguish that an individual is receiving paid supports (vs. scrubs, uninforms, or clothing items with provider agency logos);
        - Providing individuals with discreet and appropriate storage areas for personal items such as incontinence supplies and personal care items;
        - Knocking on a bathroom door and getting permission for entry before entering (unless there is an emergency);
        - Maintaining a setting that is free from institutional traits and signage such as conspicuously posted memos/training for staff, staff sign in/out logs, reminders and notices for staff, and any important information pertaining to the protected health information (PHI) and

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personally identifiable information(PII) of an individual in the setting;
- Utilizing person-first language in verbal and written documentation and refraining from language that would be demeaning to an individual using HCBS services. Examples of outdated and demeaning language may include mental retardation, client, consumer, wheelchair bound, etc. Dignified language would include person with a disability, individual, a person's name, person who uses a wheelchair.

- The setting must optimize, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
  - People retain the ability to make choices about how they spend their time in any given setting and have opportunities to participate in age-appropriate activities. Providers must engage with the individual and the team using person-centered thinking to ensure that:
    - Individuals are supported in life-informed "real" choices and autonomy;
    - Individuals are offered actual experiences on which they can base future choices;
    - Plans are created with the appropriate balance between autonomy and safety.

- Individuals' personal preferences are made a priority. When there is a difference of opinion with an individual (or, if the individual is unable to make decisions for his/herself, a parent or guardian) or provider preference (unless for a documented health and safety), there should be open dialog in order to come to an agreement
  - Individuals are supported and inspired to work towards their goals, dreams, and priorities;
  - Individuals' choices regarding services and supports, and who provides them are facilitated. If an individual wishes to change their services or support, they can do so without fear of retaliation or coercion by the current service or support provider, including family members;
  - Individuals' choices to decline activities or supports are respected. This includes staying home rather than attending ADHC. Individuals should be informed about potential risks or natural consequences of their choices, and this should be documented and re-evaluated with the individual on a regular basis;
  - All providers should be providing individualized services in accordance with the Person-Centered Service Plan.

- Individuals control their day-to-day lives the same way other community members do. This includes control over planning their own daily schedules and activities and choosing when and what they eat. This includes the ability to choose not to participate in scheduled activities. Individuals have freedom and support to control

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their own schedules and activities and have access to food at any time.

- The setting is physically accessible to the individual. Providers must provide adaptations for physical accessibility for those who need supports to move about the setting. All common areas must be accessible to the individuals in the setting. This includes all areas that would be used in typical daily activities including general spaces, kitchens, dining rooms, pantry/food storage, bathrooms, and any office area within the ADHC. Adaptations for physical accessibility may include, but are not limited to:
    - Grab bars;
    - Seats in the bathroom;
    - Ramps for wheelchairs;
    - Viable exits for emergencies;
    - Accessible appliances to individuals; and
    - Tables and chairs at a convenient height and location so that individuals can access and use the furniture comfortably.

- The setting must facilitate individual choice regarding services and supports, and who provides them.

- Use the information and resources provided to critically evaluate each setting's compliance with these standards and to develop strategies to ensure individual's rights are supported and achieved.

- The setting must develop a Home and Community Based Services Rights Policy. This policy must be inclusive of the following:
    - A specific outline of the rights afforded to people receiving HCBS services (including a value on community and personal interests);
    - A person-centered planning policy;
    - All documentation, including a disclosure form, about the HCBS Settings Rule, Person Centered Planning, and the rights of each individual are in a significant and understandable manner and are provided to the individual or designated representative for review and signature upon admission and annually thereafter (with a copy provided to the individual/family/caregiver after signature); and
    - Agency policy and appropriate documentation that new employees, contractors, students, and volunteers are trained in HCBS rights upon orientation and annually thereafter.

Prior to ADHC enrollment, providers must complete a HCBS Provider Self Assessment. The provider can get access to the assessment, additional information, reference materials, and further instructions by accessing the HCBS Toolkit at https://dmas.virginia.gov/for-members/benefits-and-services/waivers/home-and-community-based-services-toolkit/ Interested Adult Day Centers interested in meeting

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compliance with the Settings Rule to be enrolled as an ADHC should review only the ADHC portions of the toolkit. Once completed, the Adult Day Center may email the completed HCBS Provider Self Assessment to hcbscomments@dmas.virginia.gov for review and compliance verification by DMAS staff. Once the ADHC is determined compliant, they will receive a DMAS Compliance Letter. The ADHC will send a copy of the letter to DMAS Provider Enrollment Services Unit when applying for the NPI number.

Individual Staff Requirements

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

“Staff” is defined as professional and aide staff.

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

Adult Day Health Care (ADHC) Minimum Staffing Requirements

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

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

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

Volunteers shall be included in the staff-individual ratio only when they meet the qualifications and training requirements of paid staff, and, for each volunteer, there shall be at least one paid employee also included in the staff- individual ratio.

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

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

These staff include the:

Director - Responsible for the overall management of the ADHC Center’s programs and employees. This individual is the provider contact person for the service authorization contractor and is responsible for participation agreements and receiving and responding

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to communication from DMAS. The Director is responsible for ensuring the initial development of the Plan of Care (DMAS-301) for individuals;

Activities Director – Responsible for directing the recreational and social activities of the ADHC recipients.

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

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

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

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

All staff must be 18 years of age or older.

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

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supervision of the task.

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

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

Minimum Qualifications of Adult Day Health Care Staff

Personal Care Aide

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

- Ability to read and write in English to the degree necessary to perform the expected tasks;

- Physically able to do the work; and

- Special training in the needs of the elderly and individuals with disabilities through the completion of a minimum 40-hour training program consistent with DMAS requirements. The provider must obtain documentation that the aide has satisfactorily completed a training program consistent with DMAS requirements.

DMAS requirements may be met in one of the following ways:

- Registration as a Certified Nurse Aide: The Virginia Board of Nursing maintains a registry for Certified Nurse Aides. Each aide who is registered with the Board of Nursing will have a certificate of registration, which contains a registration number and an expiration date. Any aide who has such a certificate meets the DMAS standard for participation as an ADHC Aide. A copy of the state certification must be maintained in the aide's personnel record. If the certification has expired and the aide has not renewed the certification, the provider must contact the Board of Nursing to ensure that the aide's certification was not revoked for disciplinary reasons. DMAS does not require Board of Nursing Nurse Aide Certification in order to perform ADHC aide services; it is merely one type of certification that meets DMAS requirements.

- Graduation from an Approved Educational Curriculum: The Board of Nursing has

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

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

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

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

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

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

    - Completion of the most current National Adult Day Services Association curriculum. (Information for this curriculum can be accessed by mailing a request in writing to the address below or by checking their website at:
      The National Adult Day Services Association
      11350 Random Hills Road, Suite 800
      Fairfax, VA 22030 Email: info@nadsa.org
      memberservices@nadsa.org Phone: 1-877-745-1440

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

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

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

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

Registered Nurse (RN)

The RN must:

- Be registered and currently licensed to practice nursing in the Commonwealth of Virginia;
- Have one year of related clinical experience as an RN. Clinical experience may include work in an acute care hospital, rehabilitation hospital, public health clinic, home health agency, or nursing facility; and
- The RN must have a satisfactory work history as evidenced by documentation of two (2) satisfactory reference checks from prior job experience, including no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children, recorded in the nurse's personnel file. If the RN has worked for a single

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employer, one (1) satisfactory reference from a prior job experience and one (1) personal reference both with no evidence of abuse, neglect, or exploitation of an incapacitated or older adult is be acceptable.

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

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

Director

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

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

Activities Director

The Activities Director must have a minimum of 48 semester hours or 72 quarter hours of post-secondary education from an accredited college or university with a degree in recreational therapy, occupational therapy, or a related field such as art, music, or physical education; and one year of related experience, which may include work in an acute care hospital, rehabilitation hospital or nursing home, or have completed a course of study including the prescribed internship in occupation, physical, or recreational therapy or music, dance, art therapy or physical education.

PROVIDER PARTICIPATION STANDARDS FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) AND MEDICATION MONITORING SYSTEMS

A participating Personal Emergency Response System (PERS) and Medication Monitoring provider is a certified home health or personal care agency, a Durable Medical Equipment (DME) provider, or a PERS manufacturer that has the ability to provide PERS equipment, direct services (i.e., installation, equipment maintenance, and service calls), and PERS monitoring. The PERS provider must meet the standards and requirements

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set forth by DMAS, and have a current, signed Participation Agreement with DMAS. All PERS providers must enroll as DME providers in order to provide this service to Medicaid individual and to receive reimbursement from Medicaid. Enrollment as a DME provider does not obligate the PERS provider to provide any other DME services. The agency designated in the Participation Agreement must directly provide the services and bill DMAS for Medicaid reimbursement.

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

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

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

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

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

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

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

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

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

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

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

PARTICIPATION SERVICES FACILITATION (SF) PROVIDER

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

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

PROVIDER PARTICIPATION STANDARDS FOR SERVICES FACILITATION

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

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CD Services Facilitator (SF) Requirements

SFs employed after January 11, 2016 shall have at least two references from prior job experience in direct care of the elderly or individuals with disabilities with no evidence of abuse, neglect, or exploitation of incapacitated or older adults or children. If the SF has only worked for one employer, the SF must have a reference from the prior employer and an appropriate personal reference with no evidence of abuse, neglect, or exploitation. The SF must be 18 years of age or older. The SF must possess a minimum of two years of satisfactory direct care experience supporting individuals with disabilities or older adults.

All SFs shall complete required training and competency assessments with a score of 80% prior to working as a SF and must complete the competency assessments within every five years thereafter. Satisfactory competency assessment results shall be kept in the service facilitator's record. The training and competency assessment can be accessed through the DMAS website.

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

Knowledge of:

- Types of functional limitations and health problems that may occur in older adults or individuals with disabilities, as well as strategies to reduce limitations and health problems;

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

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

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

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

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

- Interviewing techniques;

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- The waiver individual's right to make decisions about, direct the provision of, and control his or her services, including hiring, training, managing, approving work shifts, and firing a personal care aide;

- The principles of human behavior and interpersonal relationships; and

- General principles of record documentation.

Skills in:

- Negotiating with individuals and service providers;

- Assessing, supporting observing, recording, and reporting behaviors;

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

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

Ability to:

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

- Demonstrate a positive regard for individuals and their families;

- Be persistent and remain objective;

- Work independently, performing position duties under general supervision;

- Communicate effectively both orally and in writing; and
- Develop a rapport and communicate with individuals from diverse cultural backgrounds.

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

If the services facilitator is not an RN, then the services facilitator shall inform the primary

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health care provider for the individual who is enrolled in the waiver that services are being provided within 30 days from the start of such services and request consultation with the primary health care provider, as needed. This shall be done after the services facilitator secures written permission from the individual to contact the primary health care provider. The documentation of this written permission to contact the primary health care provider shall be retained in the individual's medical record. All contacts with the primary health care provider shall be documented in the individual's medical record.

Services Facilitation providers cannot be spouses, parents (natural, step-parent, adoptive parent, foster parent, legal guardian), or any family member living under the same roof as the individual requesting services.

CONSUMER DIRECTED (CD) PERSONAL CARE ATTENDANT REQUIREMENTS

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

Basic qualifications for personal care attendants include:

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

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Payment may be made for services rendered by family members or caregivers living under the same roof as the individual receiving waiver services only when there is written, objective documentation as to why no other attendant is able to provide services for the individual. The family member or caregiver providing personal care services must meet the same requirements as other personal care attendants. This documentation is not required for a legally responsible individual (natural, adoptive, or foster parent; stepparent; or legal guardian of a minor under the age of 18 or a spouse).

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

No personal care attendant may work more than 16 hours in a day, starting at 12AM and ending at 11:59PM, providing Medicaid-reimbursed personal care and/or respite services.

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

ASSISTIVE TECHNOLOGY (AT) and ENVIRONMENTAL MODIFICATION (EM) PROVIDER QUALIFICATIONS

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

Providers of AT and EM services cannot be spouses, parents (natural, step-parent, adoptive parent, foster parent, legal guardian), or any family member living under the same roof as the individual requesting services.

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

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

ANNUAL LEVEL OF CARE REVIEWS

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

If during an annual level of care review, it is determined that an individual who is using consumer-directed services no longer meets the established criteria for waiver services, the SF must inform the individual and EOR. It is the responsibility of the individual and EOR to ensure that the personal care attendants are made aware that the individual no

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longer meets the level of care criteria to be eligible for CCC Plus waiver services. Payment to attendants on behalf of individuals who no longer meet criteria for waiver services will not continue and any additional payments will be the responsibility of the individual/EOR. The notification from the SF must be made in writing to the individual/EOR within 10 days (plus 3 days for mailing) of receipt of official notification by DMAS.

INDIVIDUAL RIGHTS AND RESPONSIBILITIES

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

The statement of individual rights must include the following:

- The provider's responsibility to notify the individual in writing of any action taken which affects the individual's services;
- The provider's responsibility to render services according to acceptable standards of care;
- The provider's procedures for patient pay collection;
- The individual's obligation for patient pay, if applicable;
- The provider's responsibility to make a good faith effort to provide care according to the scheduled Plan of Care and to notify the individual when unable to provide care;
- The provider must inform the individual of his or her responsibility to have some planned back-up for times when the provider is unable to secure coverage and to identify which staff the individual should contact regarding schedule changes;
- The provider's responsibility to treat the individual with respect, to respond to any questions or concerns about the care rendered, and to routinely check with the individual about his or her satisfaction with the services being rendered;
- Offer the individual choice of provider agencies and waiver services;
- The individual responsibility to notify the appropriate provider staff whenever the individual's schedule changes or assigned staff fail to appear for work; and
- The individual's responsibility to treat provider staff with respect and to

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communicate problems immediately to the appropriate provider staff.

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

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

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

DMAS
Office of Community Living 600 East Broad Street, Suite 1300
Richmond, VA 23219

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

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CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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Chapter IV: Covered Services and Limitations

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INTRODUCTION

The Commonwealth of Virginia offers the following home- and- community- based waivers under the Medical Assistance Program:

Commonwealth Coordinated Care (CCC Plus) Waiver;
Family and Individual Supports (FIS) Waiver;
Building Independence (BI); and
Community Living (CL) Waiver

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

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

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

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) WAIVER

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

Individuals authorized for the CCC Plus Waiver are considered to be “at risk” of nursing facility placement within the next 30 days without the services in the waiver. All waiver individuals must use at least one standalone service no less frequently than every 30 days to receive the necessary care to prevent nursing facility admission. Standalone services are personal care (agency and consumer-directed), respite (agency and

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consumer-directed) or skilled respite (agency directed), ADHC, and PDN. Individuals can choose to receive a single standalone service only or in conjunction with other waiver services. PERS, including medication monitoring, AT, EM, transition services, and Services Facilitation without the use of consumer-directed personal care and/or respite are not standalone services and are not sufficient. Individuals who use any of these services must also receive at least one standalone service no less than once every 30 days to maintain ongoing eligibility in the waiver.

The LTSS Screening Team (Community or Hospital screeners) must determine if the individual is eligible for CCC Plus Waiver services. DMAS or its service authorization (srv auth) contractor must authorize all waiver services in order for any provider, including consumer-directed attendants, to be reimbursed. Individuals may be authorized to receive services based on the documented need for the service(s) and the individual's choice of services and providers. For individuals participating in the Cardinal Care managed care program, the chosen Managed Care Organization (MCO) will provide service auth functions.

SCREENING PROCEDURES FOR CCC PLUS WAIVER SERVICES

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

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

1. Who meet the nursing facility criteria as outlined in the Medicaid Long Term Services and Supports (LTSS) Screening Manual;
2. Who are eligible for Medicaid;
3. For whom an appropriate, cost-effective Plan of Care can be established, including a viable back-up plan;
4. Who are not residents of nursing facilities (licensed by the Virginia Department of Health), or assisted living facilities (licensed by DSS) that serve 5 or more individuals;

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5. When there are no other or insufficient community resources to meet the individuals' needs; and
6. Whose health, safety, and welfare in the home environment can be ensured.

CCC Plus Waiver services must be the critical services that enable the individual to remain at home rather than the imminent risk of being placed in a nursing facility within 30 days.

AUTHORIZATION FOR MEDICAID PAYMENT OF CCC PLUS WAIVER SERVICES

Screening by the LTSS Screening Team and authorization of CCC Plus Waiver services by the service authorization contractor is mandatory before Medicaid will reimburse for CCC Plus Waiver services.

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

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

DETERMINATION OF MEDICAID ELIGIBILITY

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

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

MEDICAID APPLICATION PENDING

DMAS cannot reimburse for CCC Plus Waiver services unless:

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

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

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

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

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

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

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

No correspondence or invoices should be included with the enrollment or services requests other than the required forms and documentation as specified in Appendix D of this manual, and the Service Authorization Contractor's website. The srv auth contractor will ensure that level of care criteria and the appropriateness of CCC Plus Waiver services have been met. Any enrollment or service authorization request which is incomplete or submitted incorrectly will be pended by the srv auth contractor, and the provider/SF will be notified. The information must be submitted within the timeframe given on the request for additional information notice or the request may be rejected, denied, or partially approved.

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

LONG TERM CARE COMMUNICATION FORM (DMAS-225)

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

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

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

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

- An individual dies - include the date of death;
- An individual is discharged or discontinued from services - The date of discharge or discontinuation should be the last date services were rendered for that individual. This includes when the individual is discharged from one provider agency/SF and admitted to another; is admitted to a nursing facility or inpatient rehabilitation hospital (even for one day); or transfers from the CCC Plus waiver to another HCBS waiver or PACE; or
- Any other circumstances that cause services to cease or become interrupted for more than thirty (30) consecutive calendar days. Refer to the *Medicaid LTSS Screening* Provider Manual for more information on requirements for updated and new screenings.

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

PATIENT PAY AMOUNT

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

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

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

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

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

Providers must send in the Medicaid LTC Communication form (DMAS-225) on a timely basis so that the LDSS can update patient pay in the VACMS/MMIS before new claims are processed. Providers should follow up with the LDSS if patient pay has not been

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updated in 30 days and escalate it to a supervisor if patient pay has not been updated in 45 days. Providers should contact the DMAS Provider HELPLINE if patient pay has not been updated in 60 days.

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

Agency providers need to document how the actual patient pay amount was obtained. The Fiscal/Employer Agent (F/EA) is responsible for ensuring the patient pay amount is withheld from CD reimbursement.

Patient Pay Collection for Consumer Direction (CD)

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

Patient Pay when Respite Care is the Sole Service

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

NURSING FACILITY OR INPATIENT REHABILITATION HOSPITAL ADMISSION

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

HOSPITALIZATION OF INDIVIDUALS

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

If the individual or family member requests an increase in personal care hours following a hospitalization, the RN/SF must make a post-hospitalization visit to the individual's home and assess the need for the increase. The srv auth contractor will not approve an increase in hours until the individual is discharged home and the RN/SF has made the post hospital assessment visit.

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

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

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

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

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

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Response to Referral: All Services

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

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

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

Response to Inappropriate Referral for Services

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

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

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

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

PERSONAL CARE SERVICES: AGENCY AND CONSUMER DIRECTED

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Personal care services means a range of active, hands-on support services necessary to enable the individual to remain at or return home rather than enter a nursing facility or Long Stay Hospital and which includes assistance with activities of daily living (ADLs) instrumental activities of daily living (IADLs), access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition. Children and adults may receive personal care services under the waiver. Children may also receive personal care through EPSDT; review the EPSDT provider manual for more information.

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

Agency-Directed Model

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

Initial Assessment Visit

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

- Discuss the individual's support needs, preferences and review of the screening documents from the LTSS Screening Team;
- Assessment and completion of the Community-Based Care Individual Assessment Report (DMAS-99);
- The RN will identify, with the individual or family/caregiver, all individual needs to be addressed in the Plan of Care (DMAS 97-A/B) and develop a safe, appropriate Plan of Care that will meet the identified needs of the individual.
- The RN will review the Plan of Care with the individual and/or the individual's family and the aide (if present), to ensure that there is complete understanding of the

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services that will be provided.

- The DMAS-97A/B must be completed with the individual's name, 12-digit Medicaid number, provider name and identification number, ADL composite score, RN signature and title, individual's signature and start-of-care date. (This is the date that the nurse performs the initial assessment for CCC+ waiver services, and this date should also be the one used on the DMAS-225).

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

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

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

Follow-up Visit

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

RN Supervisory Visits

The RN Supervisor must conduct home visits for the purpose of assessing the LPN Supervisor's performance as well as to assess the on-going needs of the individual and services received. The RN Supervisor must identify any gaps in the LPN's supervisor's ability to function competently and shall provide training as appropriate. The RN

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Supervisor must also conduct a reassessment of the individual's needs and evaluate the plan of care to ensure the services meets the individual's on-going needs. This visit must be conducted every 90 calendar days and documented in the individual's records.

RN/LPN Supervisory Visits

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

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

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

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

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

Consumer-Directed (CD) Model

Individuals choosing to receive services through the CD model may do so by choosing a SF to provide the training and guidance needed to be an employer. Services Facilitation without the use of consumer-directed personal care or respite shall not be the sole waiver service received. As the employer, the individual is responsible for hiring, training, supervising, and firing attendants. The individual may choose to designate a person to serve as the employer on his/her behalf. The individual or the chosen designee is the Employer of Record (EOR). If the individual is under 18 years of age or if it is documented that the individual is disoriented/confused, the parent or another responsible adult must serve as the EOR. The EOR is someone who is regularly and intimately aware of the individual's needs and is available to provide supervision and training to the attendant. A person serving as the EOR cannot be the paid caregiver, attendant, or SF. An EOR can

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only serve on behalf of one individual. The only exception to this is that EORs can serve on behalf of multiple individuals only if the individuals reside at the same address.

Individuals have the right to choose, hire, and employ an attendant whom they know has been convicted of a crime that is not prohibited in the applicable sections of the Code of Virginia (32.1-162.9:1), as may be amended from time to time. When doing so, individuals and family members/caregivers must understand this decision and that the consequences thereof are their sole responsibility. The Individual/Employer Acceptance of Responsibility for Employment form must be completed and submitted to the F/EA.

All CD services must be authorized by the srv auth contractor and require the services of a SF. Specific duties of the individual or EOR, as the employer of the CD personal care attendant, include checking references, determining that the employee meets basic qualifications, submitting required hiring documentation to the fiscal employer agent (F/EA), training, supervising performance, and submitting work shifts to the F/EA on a consistent and timely basis. CD attendants are not eligible for Worker's Compensation.

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

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

Consumer (Individual) Training (S5109): The SF, using the Employer of Record Manual must provide the individual/EOR with face-to-face training on the responsibilities as an employer within seven days of the completion of the comprehensive visit (SFs may complete the comprehensive visit and individual training in the same day, if appropriate). The SF must ensure that the EOR is competent to perform their responsibilities as an employer prior to the training. To document the appropriateness of the EOR, the SF must complete the DMAS-95 Addendum for members choosing to be the EOR or the DMAS-95B (Consumer Direction Services Management Questionnaire) when someone else is designated to be the EOR. To assure that the training content for Employee Management Training meets the acceptable requirements, the SF must use the DMAS CD EOR Manual found on the DMAS website at www.dmas.virginia.gov and instruct the EOR on

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how to access it. The SF must also follow the checklist outlined in the Consumer-Directed Individual Comprehensive Training Form (DMAS-488). This is an outline of the subjects that DMAS requires the SF to cover during the training. The SF must check each subject on the form after it has been covered and obtain the required signatures and dates. This form must be maintained in the individual's record and be available for review by DMAS staff or DMAS contracted entity. The SF will ensure that the individual/EOR understands his/her rights and responsibilities in the program and signs all of the Participation Agreements including the DMAS-486 and DMAS-489. These forms must be signed before the individual can begin employing an attendant in the program, and a copy of these forms must be kept in the individual's file. The SF should also provide assistance in filling out employer forms in the Employer of Record Welcome Packet that is received from the F/EA.

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

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

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

Routine On-site Visits (99509): After the comprehensive visit, it is recommended but not required that the SF conduct two in-home routine visits within 60 calendar days of the comprehensive visit (once every 30 calendar days), to monitor the individual/EOR's ability to hire and maintain attendants, to monitor the individual's Plan of Care and assess both the quality and appropriateness of the services being provided.

After the first two routine in-home visits, a face-to-face meeting with the individual must be conducted at least every 90 days. If the frequency of the visits needed is 30 or 60 days, there must be written justification of the medical needs in the individuals 's record that supports visits to occur at a frequency less than 90 days. The SF must review the individual's status, make any needed adjustments to the plan of care, and provide any necessary information to the individual and record all significant contacts in the individual's record.

During visits with the individual, the SF must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate and document the adequacy and appropriateness of the CD services with regard to the individual's current functioning and cognitive status, medical and social needs, and the established Plan of Care on the

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DMAS-99. The individual's satisfaction with the type and amount of service must be discussed. The SF must determine if the Plan of Care continues to meet the individual's needs and document the review of the plan. If it does not, then a new DMAS-97 A/B must be developed and if a change in the amount of hours is needed, the SF must submit the request to the srv auth contractor for review. For hours over the LOC maximum, supporting documentation must be submitted with the service authorization request and the requested hours are not approved retroactive.

The SF must also review copies of the work shifts and attendant documentation at least quarterly to ensure that the hours of service provided are consistent with the Plan of Care. Work shifts may be viewed on the F/EA web portal. If discrepancies are identified in the work shifts in relation to the plan of care, the SF must contact the individual or EOR to resolve discrepancies. If there are consistent discrepancies in the work shifts, or the attendant is regularly not performing identified activities in the Plan of Care, and training has been offered to the individual/EOR, the SF must meet with the individual/EOR to determine if CD services remain appropriate (i.e., that the individual or EOR can manage the services).

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

- Whether CD services are adequate to meet the individual's needs and whether changes to the Plan of Care need to be made;
- Any suspected abuse, neglect, or exploitation and to whom it was reported. This must be reported to the Virginia Department of Social Services; Adult Protective Services (APS) or Child Protective services (CPS), as appropriate;
- Any critical incidents and to whom it was reported (if it was not reported, the SF must submit the report immediately after conclusion of the visit);
- Hospitalization or change in medical condition, functioning, cognitive status, or social support;
- The individual's or family's /caregiver's (as appropriate) satisfaction with services;
- The presence or absence of the EOR and attendant in the home during the visit;
- Any change in who is employed as the attendant. The F/EA cannot pay for any services until a completed packet is received for each employee;
- Dates of and reasons for any service lapses (hospitalization admission, attendant not available, etc.); and
- In addition to the information that must be documented in the SF's routine visit summary, there are several areas (such as bowel/bladder programs, range of motion

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exercises, catheter and wound care, etc.) that, when they are part of an individual's Plan of Care due to physician's orders, require monitoring by the individual's primary health care professional or a RN and special documentation by the SF of their ongoing completion and the personal care attendant's qualifications to perform these tasks. See this chapter for additional information about the delegation of skilled services.

- A signature from the waiver individual or primary caregiver on the DMAS-99 on the date of the visit. If the individual is a minor, documented as disoriented/confused, or otherwise unable to sign, the primary caregiver or EOR, as identified on the DMAS-99, must sign on behalf of the waiver individual. The paid attendant is not permitted to sign as the individual or primary caregiver unless the aide is also the LRI parent of the minor waiver individual.

Reassessment Visit (**T1028)**: At least every six months for personal care or when respite is the sole service, the SF must meet with the individual in person to conduct a reassessment of the individual's current functional and social support status and a complete summary of all services reviewed. Documentation of the reassessment visit must include a complete review of the individual's needs and available supports, both paid and unpaid, and a review of the Plan of Care in addition to all topics during the Routine Visit. The reassessment visit must be documented on a DMAS-99. If a Routine Visit and Reassessment Visit are scheduled within 30 days of each other, the SF shall only perform a Reassessment Visit and not the Routine Visit.

On-going Monitoring Activities: The SF is responsible for counseling an individual/EOR regarding the responsibilities as an employer; requesting from the srv auth contractor any changes of the individual's Plan of Care as needed; consulting with the individual/EOR or family member/caregiver as needed; and discussing with the individual the need for additional community based services. The SF must be available by telephone to individuals receiving CD services during normal business hours, have voice mail capability, and return phone calls within one business day. The SF is not responsible for supervision of personal care attendants and has no authority in hiring/firing attendants. The EOR is solely responsible for attendant supervision.

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

Management Training (**S5116):** This face-to-face training is provided by the SF upon the request of the individual/EOR to address program rules. This training provided to EOR is to assist in understanding employer-related activities. Management training is not intended to be needed on-going. Should the EOR need management training consistently, the SF must reassess to determine if the individual is appropriate to serve as the EOR. Management training provided must be documented in the individual's record to include the questions asked by the EOR, either with a copy of the email sent by the EOR or notes of any calls or voicemails, including date, time, and phone number, left

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by the EOR. Documentation of the information and answers provided by SF must also be included in the record. Management training must not be used to train the attendant.

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

Verification of Work Hours and Tasks: The SF shall review attendant hours worked and tasks completed as part of the routine and reassessment visits to ensure that the hours of service provided are consistent with the Plan of Care. Attendant hours and documented tasks may be viewed on the F/EA web portal.

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

Visit Requirements: Due to the complex needs of the individual and the need of the SF to evaluate the surroundings and holistic needs of the individual, all Services Facilitation visits are required to be conducted face-to-face with the individual. Telephonic and/or virtual visits are not permitted. If the SF is unable to conduct the routine or reassessment visit within required timeframes, it shall be documented in the waiver individual's record with the reason for the delay. Such visits shall be conducted within 15 calendar days of the waiver individual's first availability.

Consumer Directed (CD) Services and Fiscal/Employer Agent (F/EA) Functions
The F/EA performs payroll activities on behalf of the EOR. This allows the individual to use waiver funds to hire and pay attendants. DMAS contracts with the F/EA to ensure that payment to the attendant is based on the approved service authorization which documents the number of hours and services and work shifts approved by the EOR. Time worked by attendants is paid based on 15 minute units. The F/EA keeps payment records and follows all tax rules on the EOR's behalf.

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

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Service Units and Limitations

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

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

Exception Criteria

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

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

1. Documentation of dependencies in all of the following activities of daily living: bathing, dressing, transferring, toileting, and eating/feeding, as defined by the current admission screening criteria. (Verification submitted to the srv auth contractor and documented on the questionnaire); OR
2. Documentation of dependencies in both Behavior and Orientation as defined by the current admission screening criteria. (Verification submitted to the srv auth contractor and documented on the questionnaire); OR
3. Documentation from the LDSS that the individual currently has an open case with either Adult Protective Services (APS) or Child Protective Services (CPS) (as described in subdivisions (1) and (2) of this subdivision) and is in need of additional services above the 56 hour per week cap. Documentation can be in the form of a phone log contact or any other documentation provided. (Submitted to the srv auth contractor via attestation.)

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

When submitting attestation information, upon post payment review and/or Quality Management Review (QMR), should documentation regarding proof of attestation submitted to the srv auth contractor is absent in the clinical record, the provider's

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reimbursement may be subject to retraction and/or a referral to the Medicaid Fraud Control Unit (MFCU) initiated.

Allowable Activities

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

Aides/attendants are permitted to work up to 16 hours per day, starting at 12AM and ending at 11:59PM. Aides/attendants must be awake during the entire shift while performing personal care or respite services.

The allowable activities for personal care services include the following:

1. Assistance with activities of daily living (ADLs) such as: bathing or showering, toileting, dressing, transferring, etc.;

2. Assistance with monitoring health status and physical condition;

3. Assistance with self–administration of medication (not to include in any way determining the dosage of medication or the direct administration of medication) and other medical needs;

4. Assistance with preparation and eating of meals, cleaning dishes and eating areas related to the individual's meal (preparation of only the individual's meal is allowed);

5. Assistance with instrumental activities of daily living (IADLs) related to the care needs of the individual such as participant focused housekeeping activities including bed making, dusting, vacuuming, laundry, and grocery shopping, etc., when specified in the individual's Plan of Care and essential to the individual's health or welfare. These activities are limited to those areas that are affected by the individual's direct use and not expected to be performed by the primary caregiver;

6. General support to assure the safety of the individual;

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

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

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

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

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

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

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

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

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

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

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

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

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

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other family member is available or able;

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

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

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

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

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

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

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

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

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DELEGATION OF SKILLED SERVICES

Personal care and respite services shall not include either practical or professional nursing services as defined in the Nurse Practice Act with the exception of skilled nursing tasks that may be delegated pursuant to the *Virginia Administrative Code 18VAC90-19-420 et seq*. The delegating RN is responsible for identifying and assessing if the personal care aide/attendant is capable of performing the skilled nursing activity.

If the RN delegates this activity to an aide/attendant, the provider/SF must maintain the following documentation:

- The name of the RN, a copy of the RN's current license, and license number, and qualifications as stated in Chapter II of this manual;
- A description of the assessment conducted by the RN that includes the clinical status and stability of the individual's condition;
- The specific tasks that are to be delegated to the aide/attendant;
- A description of the instruction given to the aide/attendant, and confirmation by the RN that the aide/attendant has been witnessed successfully giving the care;
- Review notes by the RN demonstrating the delegated activity is monitored and supervised by the RN at least every 90 calendar days, or more often if determined appropriate; and
- A current physician's order for the service(s). A new physician's order must be obtained every six (6) months or more frequently if changes in the individual's condition occur.

If a skilled task cannot be delegated, the provider should inform the individual to contact his or her physician about the possibility of a referral for home health services to determine if the activity can be performed through those services.

Exemption of Nurse Delegation Requirements

For CD services, the *Code of Virginia § 54.1-3001(12)* states: "any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks" is exempted from the Nurse Practice Act and nurse delegation requirements.

Key requirements for the exemption from nurse delegation requirements:

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- Applies to consumer-directed services only
- Applies to tasks that are “typically” self-performed
- The individual receiving service must be capable of directing the attendant in the appropriate performance of the task
- The individual must live in a private residence
- The individual must be unable to perform the tasks due to a disability

DEVELOPMENT OF THE PLAN OF CARE (DMAS-97A/B): AGENCY- AND CONSUMER-DIRECTED PERSONAL CARE

The DMAS-97A/B Plan of Care must be completed by the provider/SF at the time of initial evaluation for all individuals. The LTSS Screening indicates to the provider/SF the general needs of the individual. The provider/SF should allocate time for the four service categories (which include specific personal/respite care tasks) listed on the DMAS-97A/B. The RN/SF’s assessment should note any special considerations for service provision and the support available to the individual. Time must be allocated for each tasks on the Plan of Care. The time is based on discussion with the individual; common knowledge of such activities; and professional experience of how long each activity takes for an individual, taking into consideration the unique circumstances of the individual. . Each service category must be totaled if time has been allotted to that category (ADLs, Special Maintenance, Supervision, and IADLs).

Each individual is assigned a level of care based on his/her composite ADL score as calculated on the DMAS-97A/B. The composite ADL score is the sum of a rating of the ADL categories. These categories are bathing, dressing, transfers, ambulation, eating, and continence. The provider/SF must assign a rating for each ADL category that best describes the individual based on the RN/SF’s assessment and observation at the time of the initial home evaluation and subsequent reassessments. Once the individual’s composite score is derived, a level of care is designated for that individual as a Level A, B, or C. The designation of a level of care determines the **maximum** number of hours per week of personal care services that the individual may have allocated to his/her Plan of Care prior to service authorization. Each level of care category has a **maximum** amount of hours that may be initiated without authorization for that level. The LOC, corresponding composite scores, and **maximum** hours are as follows:

LOC A
(score 0-6)
Maximum Hours prior to service authorization - 25 per week

LOC B
(score 7-12)
Maximum Hours prior to service authorization - 30 per week

LOC C
(score 9+ wounds, tube feedings, etc.)

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Maximum Hours prior to service authorization - 35 per week

Prior to designating the level of care, the provider/SF must develop the Plan of Care to reflect the needs of the individual and not necessarily the **maximum amount** of service that the individual is able to have based on the level of care. This **maximum** is based on a seven-day-per-week Plan of Care.

Since the level of care may not reflect the medical needs of the individual based on diagnosis, recent history or the individual's personality or environment, the guidelines may not fully capture the range of needs and support that the provider may encounter. It is only in very unusual circumstances that a Plan of Care would contain more than two (2) hours per day for housekeeping and meal preparation (combined). These unusual circumstances must be clearly documented on the DMAS-99 or DMAS-97A/B. The provider is expected to use professional judgment to determine the amount of service needed by the individual. Documentation must support the amount of hours included in the Plan of Care.

The hours requested on the DMAS-97A/B must be the actual time it takes aide/attendant to assist the individual to perform the tasks for the individual. Although the provider/SF may use the **maximum** allowed for the level of care, it is expected that individuals will not routinely require **maximum amounts** of care.

The level of care maximum composite score may not always reflect the range of needs and supports that the individual may need. Service authorization requests must include documentation to support the hours needed.

A copy of the current Plan of Care(s) (DMAS 97 A/B) must be kept in the individual's home. The aide/attendant should be instructed to use the provider Plan of Care as a guide for daily service provision.

The aide/attendant must chart tasks performed that are not included in the individual's Plan of Care if the individual has a need for the task to be done. The aide/attendant must note why this task was performed. If the need for this task continues to exist, it is then the responsibility of the RN/LPN/SF to determine whether there is a need for the task to be included on the Plan of Care on an ongoing basis and make the appropriate changes. Likewise, if the aide/attendant does not perform a task that is included in the Plan of Care, the aide/attendant must note the reason why the task was not performed. If a pattern exists where the aide/attendant is not performing the task, the provider must update the Plan of Care.

Level of Care A - The individual's score is 6 or less on the ADL composite rating. Individuals in Level of Care (LOC) A are the most functionally capable group and, therefore, should usually require the least amount of services (anywhere from 7.5 to 17.5 hours per week). The **maximum amount** of time per week that an individual in LOC A may be provided services has been established at 25 hours per week prior to service authorization. This **maximum** is based on a seven-day-per-week Plan of Care with an

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average daily need for ADL care of two (2) hours/day and housekeeping of one and one half (1.5) hours per day, when the individual lives alone. Within the level of care, the amount of time required to perform ADL/IADL and housekeeping tasks will vary.

The following guidelines are intended to assist the provider/SF to determine the appropriate allocations of ADL/IADL time for individuals within LOC A.

1. Minimal Needs – Individual is the least dependent, often borderline in meeting the criteria for nursing facility care (ADL score 2-3). The individual may require prompting rather than hands-on assistance, may use mechanical help more than human help with a need for standby assistance:

   Suggested time allocated for ADLs - .75 - 1 hour/day
   Suggested time for Housekeeping - 1 - 1.5 hours/day

2. Average Needs - Individual has somewhat more need for hands-on help, standby assistance, and are somewhat more dependent (ADL score 3-4):

   Suggested time allocated for ADLs - 1 - 1.5 hours/day
   Suggested time for Housekeeping - 1 - 1.5 hours/day

3. Heavy Needs - Individual will require some help in all areas of ADL care although they will usually be mobile and can probably eat without assistance (ADL score 4-6):

   Suggested time allocated for ADLs - 1.5 - 2 hours/day
   Suggested time for Housekeeping - 1 - 1.5 hours/day

Level of Care B - The individual's score is between 7-12 on the ADL composite rating. Typically, these individuals will require an average of 15 to 28 hours of service per week. The **maximum amount** of time per week that an individual in LOC B may be provided prior to service authorization is 30 hours per week, with an average daily need for ADL care of 2.5 hours/day and housekeeping of 1.75 hours per day, when the individual lives alone. This **maximum** is based on a seven-day-per-week Plan of Care.

The following guidelines are intended to assist the provider/SF to determine the appropriate allocations of ADL/IADL time for individuals within LOC B. Within this level of care, the amount of time required to perform ADL/IADL and housekeeping will vary. Individuals in LOC B probably require between the heavy time allocated in LOC A and an average amount of time for housekeeping tasks.

1. Minimal Needs - Individual may require assistance to ambulate, but are still able to perform some tasks for themselves (ADL score 7-8):

   Suggested time allocated for ADLs - 1.5 - 2 hours/day
   Suggested time for Housekeeping - 1 - 1.75 hours/day

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2. Average Needs -Individual may require assistance with most ADLs, including transferring, ambulating, eating, and toileting, (ADL score 9-10):

   Suggested time allocated for ADLs - 2 - 2.5 hours/day
   Suggested time for Housekeeping - 1 - 1.75 hours/day

3. Heavy Needs - Individual will require the maximum amount of help in all areas of ADL care. They will usually be bed-confined and, therefore, may actually take less time to render services than the individual who performs some self-care but requires assistance (ADL score 11-12):

   Suggested time allocated for ADLs - 1.5 - 2.5 hours/day
   Suggested time for Housekeeping - 1 - 1.75 hours/day

Level of Care C - The individual's score is 9 or more on the ADL composite rating. Individuals in LOC C are the least functionally capable group and must have skilled medical/nursing needs. Examples of skilled needs are wound care requiring the intervention or observation of a licensed nurse or MD, tube feedings, intravenous infusions, etc. Note: These needs merely qualify an individual to be rated as LOC C. These individuals will probably require an average of from 20 to 30 hours per week. The maximum amount of time per week that an individual in LOC C may be provided prior to service authorization has been established at 35 hours per week, with an average daily need for ADL care of three (3) hours per day and IADL/housekeeping of two (2) hours per day, when the individual lives alone.

The following guidelines are intended to assist the provider/SF with determining the appropriate allocations of ADL/IADL time for individuals within LOC C. Within this level of care, the amount of time required to perform ADL/IADL and housekeeping tasks may vary.

1. Minimal Needs - Individuals may have the **maximum** in-home support and minimal special maintenance needs. Some of the individuals in this minimum range of needs within LOC C will actually be quite dependent, but may be cared for quickly merely because they do not participate in their own care:

   Suggested time allocated for ADLs - 1.5 - 2 hours/day
   Suggested time for Housekeeping - 1 - 2 hours/day

2. Average Needs - Individuals will generally require more ADL time to prevent skin breakdown by frequent turning, may require wound care, feedings completed by the family, etc., and have only moderate support to assist with this care:

   Suggested time allocated for ADLs - 2 - 3 hours/day
   Suggested time for Housekeeping - 1 - 2 hours/day

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3. Heavy Needs – May be individuals living with complex medical needs or their condition provides constant barriers to performance of ADLs without human help and at risk for rapid deterioration if daily supports are not in place.

   Suggested time allocated for ADLs - 2 - 3 hours/day
   Suggested time for Housekeeping - 1 - 2 hours/day

The **maximum amount** of care established for all levels of care were not established with regard to the need for supervision as a personal care task. Additional time can be added to the Plan of Care beyond the **maximum amount** of time for that individual's level of care, but requires authorization from the srv auth contractor before it can be initiated. The time allocated on the Plan of Care for ADLs, IADLs, Special Maintenance and Supervision shall not be inflated to provide extra personal care time. Selecting a LOC is not necessary for a respite Plan of Care.

Supervision

Personal care services allow for individualized hands on care that is based on the needs of the participant. While individuals may not always require constant ADL supports, there may be a need for the individual to have services authorized during times when they cannot safely be left alone.

Supervision is an allowable activity within the personal care Plan of Care when the purpose is to supervise or monitor those individuals who require and have a documented need for the physical presence of the aide/attendant to ensure their safety during times when no other support system is available. The inclusion of supervision in the Plan of Care is appropriate only in the following situations:

- The individual cannot be left alone **at any time** due to mental or severe physical incapacitation;
- The individual is unable to call for help in case of an emergency and there are no competent adults in the home who are capable of dialing 911 in the event of an emergency; and
- When supervision is deemed necessary to ensure the health, safety, or welfare of the individual.

When members demonstrate a support need that is intermittent in nature, supervision must be considered as an option to provide coverage for participants who are not safe or have health risks that require immediate attention when the member is left alone.

Supervision will not be authorized for family members to sleep either during the day or during the night unless the individual is dependent in orientation and behavior pattern (documented on the DMAS-99) and cannot be left alone at any time due to documented

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safety issues or wandering risk. Supervision cannot be considered necessary because the individual's family or provider is generally concerned about leaving the individual alone or would prefer to have someone with the individual. There must be a clear and present danger to the health, safety, or welfare of the individual as a result of being left unsupervised.

Supervision as a component of personal care must be authorized prior to being rendered and cannot be authorized retroactively. The effective date of authorization for supervision hours will be no earlier than the date of receipt by the srv auth contractor, with the exception of provider transfers, as detailed later in this chapter. In no case shall more than eight hours (8) per day of Supervision as a component of personal care be authorized.

In every case in which the provider/SF has identified the need for supervision to be included in the individual's Plan of Care, the following documentation requirements must be met:

- The RN Supervisor/SF must complete a DMAS-100 (Request for Supervision Form).
- The DMAS-100 form must include:
  - the reason supervision is needed,
  - the amount of supervision needed,
  - the schedules of all adult residents in the home and formal and informal caregivers, and
  - must identify who will provide supervision in the absence of the personal care aide. Supervision cannot be authorized prior to the signature/date of completion of this document.

Supervision time must not include time allotted for ADL, Special Maintenance, or IADL care. The supervision component of the Plan of Care does not include assistance needed for ADL's, Special Maintenance or IADL's. Time for these components must be included in the appropriate section of the Plan of Care. Supervision is not intended as additional time to perform these tasks.

If the individual's primary caregiver has a business or works in the home, supervision will be considered if the individual is documented as being dependent in orientation and behavior pattern on the UAI and/or documented on the DMAS-99. Supervision may be needed when the primary caregiver is working in the home and is unable to provide the required supervision because of work requirements.

The amount of supervision time in the Plan of Care must be no more than is necessary to prevent physical deterioration or injury to the individual and ensure health, safety, and welfare needs are met.

If the individual requires more supervision and time beyond that which is provided through the personal care time allowed for ADLs, Special Maintenance, Supervision and IADLs,

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the individual must have a support system that is willing and able to provide the additional assistance/supervision. Individuals who have supervision time in the Plan of Care must have documentation that someone is with them 24 hours a day.

If supervision is being requested while the caregiver works, the provider/SF may be asked to submit a note from the caregiver's employer to the srv auth contractor verifying the work schedule.

Personal Emergency Response Systems (PERS) may be an appropriate service for an individual who does not meet all of the requirements for supervision. An individual may not have supervision and PERS simultaneously.

Special Maintenance

Special maintenance is a covered service within the Plan of Care when an individual has an identified need for skilled care that may be performed by an aide/attendant as specified above under Allowable Activities. These tasks may include vital signs and recording of findings, assistance with medications, bowel program, ROM and wound care.

Personal Care Services to More than One Individual in the Same Household

There may be instances in which two or more individuals residing in the same household receives personal care through the same agency or SF. When this occurs, tasks such as meal preparation, cleaning rooms, laundry, and shopping considered as Instrumental Activities of Daily Living (IADL) must be provided for both individuals simultaneously. Each individual will need a Plan of Care with separate ADL hours and shared IADL hours. Should the individuals choose to have separate agencies or separate SF providers, these hours are not shared.

Annual Plan of Care

The provider/SF must either complete a new Plan of Care at least annually or document on the current Plan of Care (DMAS 97A/B) annually that the Plan of Care was reviewed, then date and sign that no changes are necessary. Copies of all Plans of Care must be maintained in the individual's record.

Changes to the Plan of Care

The provider/SF is responsible for making modifications to the Plan of Care as needed to ensure that the aide/attendant and individual/EOR or family/caregiver are aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the individual. Any time there is a need to change the number of hours for an individual, the provider/SF must develop a new Plan of Care. The most recent Plan of Care must always be in the individual's home and available for the aide/attendant to review.

The provider/SF is permitted to develop a Plan of Care and subsequently make changes

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to the Plan of Care without prior approval from the srv auth contractor as long as the individual's amount of service does not exceed the **maximum amount** established for that individual's level of care and as long as supervision is not being added as a new service. For changes within the LOC maximum, the provider/SF must submit to the srv auth contractor the change of hours for billing purposes, within the timelines established for submission. Reimbursement for the full amount of services included in the Plan of Care may be denied when the individual's Plan of Care is inflated beyond the actual, documented needs of the individual.

Any hours beyond the maximum for the individual's level of care must be authorized by the DMAS srv auth contractor. DMAS will not reimburse retroactively for hours over the LOC maximum which were provided prior to the date the request was submitted to the srv auth contractor, with the exception of provider transfers, as outlined later in this chapter.

Changes of hours must be submitted to the srv auth contractor. If the hours on the new Plan of Care exceed the individual's current level of care on the DMAS-97A/B, the provider/SF must submit to the srv auth contractor information from the new Plan of Care reflecting the revised hours and updated composite ADL score reflecting the level of care. The srv auth contractor may request Plans of Care, or any supporting documentation at any time. Providers/SFs are required to submit changes in hours when they occur.

The provider/SF must follow the procedures to request a revised service authorization whenever a change in the individual's condition (physical, mental, or social) indicates that:

- The individual requires supervision to be added to the Plan of Care even if the individual's hours will be within the level-of-care category; or

- An increase or decrease in the Plan of Care is needed regardless of whether it is within or outside of the amount allowed according to the level of care, in order to assure appropriate reimbursement for services.

When multiple providers/SF are working with the individual and a change to the Plan of Care is required all providers/SF involved shall consult to coordinate the changes to the Plan of Care. An individual can have only one SF, but there could be one or more agency providers. This applies to changes upon admission of a new individual or after services have been initiated. This communication must be documented in each provider/SF's individual record.

See Appendix D of this manual for information regarding submittal of service authorization requests.

The srv auth contractor will transmit authorizations or denials into the MMIS. Once the entry has been made, the provider/SF and individual will receive a computer-generated letter notifying them of the decision and providing appeal rights if a partial approval or denial is issued. Individuals have the right to appeal any adverse action taken by the srv

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auth contractor. A copy of this letter must be maintained in the individual's record. If a denial is issued, the provider/SF will also be notified via fax by the srv auth contractor.

Personal Care Split-Shift Service Delivery (Agency and Consumer-Directed)

There are situations in which the individual may benefit from services offered during two distinct shifts during the day (i.e., morning and evening). For example, an individual may need assistance with ADLs in the morning and additional ADL assistance in the evening. A split shift is indicated when there are at least two hours between each shift. When a split shift is desired, the provider/SF must complete two Plans of Care, labeled AM and PM, to indicate each shift of services. The total number of hours on morning and afternoon Plans of Care combined cannot exceed the number of hours allowed for the individual's level of care without prior approval from the srv auth contractor.

For agency-directed services, when a split-shift service is provided and a different aide is working on each shift, the RN/LPN Supervisor must alternate the supervisory visit between both shifts in order to provide supervision to each aide. If weekend or night service is the only time when the services are provided (example: 11:00 p.m. until 7:00 a.m.), the RN/LPN must make a supervisory visit at least every other visit during the time the aide is working. If the individual is also receiving services during the day hours, and the aide that is providing the weekend or night services is different than the weekday aide, the RN/LPN can make the supervisory visit during the weekday and discuss the other shifts with the individual and/or family/caregiver.

Legally Responsible Individuals (LRI) and The Personal Care Plan of Care

A legally responsible individual (natural, adoptive, or foster parent; stepparent; or legal guardian of a minor under the age of 18 or a spouse) of the waiver individual may provide personal care when there are extraordinary care circumstances. Parents who are an aide/attendant to an adult child are not considered LRI.

When an LRI is hired as an aide/attendant, they must adhere to the same requirements as other Medicaid providers. LRIs may be reimbursed up to 40 hours per week per minor child in providing personal care services. LRIs will not be reimbursed to provide IADL or supervision supports.

The provider must complete a Plan of Care when there is a LRI as a paid caregiver. If the individual requires more than 40 hours of personal care in a week, then the provider must develop multiple Plans of Care: one for the LRI and one for the remaining hours needed that will be performed by another aide/attendant The Plans of Care must be developed similarly to the section above "Personal Care Split-Shift Service Delivery."

<u>Extraordinary Care</u>

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LRIs may be reimbursed for personal care that is considered “extraordinary” in nature. Personal care may only be used to meet the extraordinary needs of the participant under the age of 18 due to their disability. Extraordinary care are those needs that are above and beyond what an individual of the same age may need. For individuals under 18, the LRI must meet the needs of the individual, including the need for assistance and supervision typically required for children at various stages of growth and development.

The RN supervisor or SF must document the extraordinary care needs on the DMAS -99 and LRI Plan of Care, including:

- The types of ADL tasks requiring support;
- The time to complete each task each day—a checkmark for the task is not acceptable;
- Evidence that the task is not typical care based on the age and development of the individual;
- Special Maintenance activities can be considered for LRI reimbursement if the needs are extraordinary (and where a current physician’s order is included when required).
- As with other aides/attendants, skilled nursing services are not permissible activities.

Tasks that are not extraordinary care cannot be approved to be provided by an LRI. The Extraordinary Care Guide (Appendix E) is to be used by the SF/nurse supervisor to determine extraordinary needs. This document outlines guidelines for providing extraordinary care based on the individual’s age and specific needs. As plans of care are person-centered, it is possible for activities not identified as extraordinary care to be justified though additional documentation. Generalized statements such as “safety concerns” or standardized written notes from providers that simply states the individual receives a type of therapy or has a specific diagnosis are not sufficient justification; the reasoning must include specific, age-appropriate, personalized explanations why the task is extraordinary. This justification must be written by the provider and submitted to the service authorization entity for review.

Scheduled Services Not Provided

The personal care aide/attendant is responsible for following the current Plan of Care (DMAS-97A/B). If the aide/attendant does not work the total number of hours during a scheduled day, as it is listed on the DMAS-97A/B, the aide/attendant may use the unused hours on another day within that same week only if:

1. The individual/EOR and/or primary caregiver requests that the unused time be used on another day of that week; and

2. The reason for the hours to be carried over to another day is for extraordinary circumstances that cannot be accommodated by the Plan of Care, and the leftover time is needed to meet the needs of the individual. For Agency Directed care, the

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need must be documented by the aide on the Provider Aide Record (DMAS-90) and by the RN/LPN in the individual's record. The reason cannot be to allow the aide/attendant to make up the unused hours of the week; and

3. The total amount of hours worked during the week does not exceed the number of authorized hours for the week as noted on the DMAS-97A/B.

Inability Of An Aide To Provide Services And Substitution Of Aides- Agency-Directed (AD) Model If a provider cannot supply an aide to render authorized services, the provider may either obtain a substitute aide from another provider, if the lapse in coverage is expected to be less than two weeks in duration, or may transfer the individual's services to another provider. If the provider obtains a substitute aide from another agency, the two providers are responsible for negotiating the financial arrangements of paying the substitute aide.

When a substitute aide is secured from another provider, the following requirements apply:

- The authorized provider is responsible for providing supervision for the substitute aide;

- Only the authorized provider may bill DMAS for services rendered by the substitute aide;

- The authorized provider must ensure that all DMAS requirements continue to be met; and

- The agency providing the substitute aide must send to the provider having individual care responsibility a copy of the aide's daily records signed by the individual and the substitute aide. All documentation of services rendered by the substitute aide must be in the individual's record. The documentation of the substitute aide's qualifications must also be obtained and recorded in the personnel files of the responsible provider.

Substitute aides obtained from other providers should be used only in cases where no other arrangements can be made for personal care services coverage and should be used on a temporary basis. If a substitute aide is needed for more than two weeks, the case must be transferred to another provider that has the aide capability to serve the individual(s).

If no other provider can supply an aide, the provider shall notify the individual or family and explain the possible availability of CD services or ADHC. Service authorization is required in those cases in which the services are transferred to another provider, to CD services, or ADHC.

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Some waiver individuals take turns staying with different relatives throughout the year in different parts of the state. Rather than transferring a case back and forth, one primary provider (which could be an ADHC or a personal care provider) may contract with a provider in another city or county to provide services. In that event, the same procedure should be followed for obtaining a substitute aide.

Respite Care

Respite services are unskilled services (AD or CD) or skilled services (AD) of a nurse. Respite can be performed either in the home and community of the individual by a personal care aide or at a licensed Children's Residential Facility for children with a developmental disability where multiple staff may provide care during the individual's stay. Respite is for the relief of the **unpaid primary caregiver** due to the physical burden and emotional stress of providing support and care to the waiver individual. If an LRI chooses to be a paid aide/attendant for personal care, respite is not an allowable service. The maximum amount of all types of respite care services that an individual may receive is **480 hours** in a state fiscal year (SFY, July 1 – June 30). Respite may be the sole service received by the individual or in conjunction with other CCC Plus Waiver services.

For AD respite care, the provider agency is responsible for tracking the number of hours used. If the individual is using both AD and CD respite services, the SF and the provider agency must coordinate the tracking of the respite care hours used. Respite care must be authorized by the srv auth contractor before being rendered. If more than 480 hours per state fiscal year are provided, DMAS will only pay for the first 480 hours that are billed.

Individuals who exhaust their respite hours prior to the end of the SFY must be informed that no additional hours will be authorized. In these cases, they must wait until the state fiscal year has expired. The provider/SF must ensure that the individual continues to meet the criteria, as stated above, to receive respite services.

An initial Plan of Care (DMAS-97A/B) must be developed by the provider/SF and updated annually or as needs arise.

Skilled Respite Care (Agency-Directed Only)

Providers may be reimbursed for respite services provided by a LPN or an RN with a current, active license and able to practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the individual's skilled needs. DMAS will reimburse for LPN respite care for those individuals who require the skilled level of care and who meet the criteria below.

<u>The circumstances that warrant provision of skilled respite care by a LPN or RN are</u>:

- The individual receiving care has a need for routine skilled care that cannot be provided by unlicensed personnel [i.e., individual requiring nasogastric or

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gastrostomy feedings, injections, wound care etc. that is not or cannot be delegated or provided in accordance with the *Code of Virginia § 54.1-3001(12)*];

- No other individual in the individual's support system is able to provide the skilled component of the individual's care during the caregiver's absence;

- The individual is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver; and

- A physician's orders for services is obtained for the skilled care, prior to the service begin date and updated every six months. The DMAS-300 or CMS-485 may be used for this purpose.

Under respite care services, a LPN can perform selected nursing procedures under the direction and supervision of a RN. Such selected procedures may include:

- Administration of medications;

- Care of tracheotomies, feeding tubes, etc.; and

- Wound care requiring sterile technique.

When a nurse is required, the nurse must also provide services normally provided by an aide and shall document the tasks performed on the Skilled Respite Record (DMAS-90A). These records are to be kept in the individual's respite record. For skilled respite services, the nurse's skills and knowledge necessary to provide the services must be documented.

If the individual receives skilled respite services, a separate record or a separate section of the individual's record must contain the forms and necessary documents addressing respite services and authorization.

These respite forms include:

- Skilled Respite Record (DMAS-90A) signed and dated by the nurse and the individual or family/caregiver. It must contain weekly notes on the individual's care and status;

- Respite Care Needs Assessment and Plan of Care (DMAS-300) or CMS-485, if respite is the sole service the individual is receiving;

- The RN Supervisor's documentation using the DMAS-99; and

- A physician's order/CMS-485/DMAS-300 for skilled services. The order must specify the skilled services the nurse will render.

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Supervision of Respite: Agency-Directed (AD) Model

The respite care agency shall employ or contract with and directly supervise a RN/LPN who will provide ongoing supervision of respite care aides. A RN shall provide supervision to all direct care LPNs.

When respite care services are received on a routine basis, the minimum acceptable frequency of the required RN/LPN supervisor's visits shall not exceed every 90 calendar days, based on the initial assessment. If an individual is also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN supervisory visits. However, the RN supervisor shall document supervision of respite care separately from the personal care documentation. For this purpose, the same individual record may be used with a separate section for respite care documentation.

When respite care services are not received on a routine basis but are episodic in nature, a RN/LPN supervisor shall not be required to conduct a supervisory visit within a specified number of days. Instead, a RN/LPN supervisor shall conduct the home supervisory visit with the aide/LPN on or before the start of care and make a second home supervisory visit during the second respite care visit.

When respite/skilled respite services are offered in conjunction with personal care, the supervisory visit conducted for personal care may serve as the supervisory visit for respite. The RN/LPN must document on the DMAS-99 whether respite is being used and the reason why. The RN/LPN supervisor must document on the DMAS-99 that the supervisory visit is for both personal care and respite care. This documentation may be kept in one record but must be maintained with a separate section for respite services documentation. The supervisor must document supervision of respite services separately. If a separate record is used for both personal care and respite care, the DMAS-99 must be in each record. When the supervisory visit is for both personal care and respite, the DMAS-99 form must be used. A copy of the DMAS-99 may be filed in the respite record or section of the chart; however, the original document must be available in the personal care record or section.

When respite care services are received through a licensed Children's Residential Facility, the RN/LPN supervisor should review the Plan of Care prior to each utilization of respite care services. If the individual's status or health condition have changed, the RN/LPN supervisor must update the Plan of Care as necessary with the family/caregiver. The RN/LPN supervisor shall conduct the supervisory visits with the individual and family/caregiver at the Children's Residential Facility. The RN/LPN supervisor will not be required to perform the visit in the home of the individual.

Supervision of Respite: Consumer-Directed (CD) Model

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When respite care services are received on a routine basis, the minimum acceptable frequency of the required routine visits shall not exceed every 90 calendar days, based on the initial assessment. If an individual is also receiving personal care services, the respite care routine visit may coincide with the personal care routine. However, the SF shall document review of respite care separately from the personal care documentation. For this purpose, the same individual record may be used with a separate section for respite care documentation.

When respite is the sole service, a face to face visit with the individual must be conducted every six months, or upon the usage of 240 hours of respite, whichever comes first to ensure appropriateness of services (including reassessments at least every 6- months).

AGENCY-DIRECTED MODEL OF PERSONAL CARE AND RESPITE SERVICES

Required Documentation for Individual Records for Personal and Respite Care

The provider shall maintain a record for each individual. These records must be separated from those of other services, such as home health services. If an individual receives personal care and respite care services, one record may be maintained, but separate sections must be reserved for the documentation of the two services.
The individual record must include the following documentation:

- If the individual is newly enrolled in the waiver, the LTSS Screening Packet which includes: Uniform Assessment Instrument (UAI); the Screening Authorization signed by all members of the LTSS Screening Team (DMAS-96); the Individual Choice Form (DMAS-97 or DMAS-300 for only Respite Care services);

- All provider Plans of Care (DMAS-97A/B); Supervision Request Form (DMAS-100), if applicable; Community Based Care Individual Assessment Report (DMAS 99); Aide Records (DMAS-90) and all LTC Communication Forms (DMAS-225);

- The initial assessment by the RN must be completed on or before the start of care by the aide. This must be filed in the individual's record within two (2) weeks from the date of the visit. Only the DMAS-99 can be used for nursing assessments. The Comprehensive Adult Nursing Assessment form, or OASIS form, is not acceptable;

- All RN/LPN Supervisor notes must be completed and filed within two weeks of the supervisory visit. Any supervisory visit not documented and present in the individual's record will be considered as not having been made;

- The frequency of the RN/LPN Supervisor visit must be conducted within the timeframe that was agreed upon by the individual and/or caregiver and documented by the RN on the DMAS-99;

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- The aide must be present during the RN/LPN Supervisor's visit at least every other visit. If the aide is always present during the Supervisory visit, then every other month the RN/LPN must arrange to speak with the individual/family privately to assess the family and individual's satisfaction with services. If it is not possible to arrange a private conversation with the individual and/or family, the RN/LPN must make a telephone call to the family or individual during non-personal care hours. This telephone conversation must be documented in the individual's record. This gives the family or the individual, or both, the ability to address any concerns or issues without the presence of the aide;

- The RN/LPN Supervisor's documentation, using the DMAS-99, must include the observations of the individual made during the visits as well as any instruction, supervision, or counseling provided to the aide working with the individual. The RN/LPN Supervisor's notes must also clearly document that he/she has discussed with the individual or family member the appropriateness and adequacy of service. Individual/family/caregiver satisfaction with the services must be documented;

- The RN/LPN Supervisor summary must note:

    - Any change in the previously documented individual's medical condition, functional status, and social support. The RN/LPN Supervisor is expected to know the nursing facility criteria and to apply the criteria when assessing whether the individual continues to meet nursing facility criteria to receive personal/respite care services. If the RN/LPN Supervisor determines that the individual does not meet criteria for personal/respite care services, the RN Supervisor must contact DMAS for a level of care review and to discuss discontinuation;

    - Whether the Plan of Care is adequate to meet the individual's needs or if changes need to be made;

    - Dates of any lapse of services and why (e.g., hospitalization, nursing facility or inpatient rehab hospital admission and discharge dates, aide not available, etc.);

    - The presence or absence of the aide in the home during the visit; and

    - Any other services received by the individual;

- All provider contacts with the individual, family members/caregivers, health professionals, formal and informal service providers, the srv auth contractor, DMAS, etc., must be documented. All notes must be filed in the individual's records within two (2) weeks from the date of the contact;

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- All DMAS-99 and DMAS 97-A/B forms, signed and fully dated by the RN/LPN;

- All personal care/respite aides' records (DMAS-90);

- Personal/respite services must have an individualized Plan of Care that reflects the results of an assessment completed prior to or on the date services are initiated (and subsequent reassessments annually and as needed) and includes the activities that will be provided during the personal/respite care period and the approximate hours that will be allowed for each activity. The Provider Agency Plan of Care Form (DMAS-97A/B) must be used for this purpose;

  The provider must copy the questionnaire and any information entered by direct data entry that is submitted electronically via the srv auth contractor's portal system; and

- During visits to the waiver individual's home, the RN/LPN supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal and/or respite care services with regard to the waiver individual's current functioning status and medical and social needs. The aide's/LPN's record shall be reviewed and the waiver individual's or family's/caregiver's, or both, satisfaction with the type and amount of services discussed and documented.

The provider is responsible for documenting the monitoring of the ongoing provision of services to each Medicaid individual. This monitoring documentation includes:

- The quality of care provided by the aide, LPN (when utilized) and the RN;

- The functional and medical needs of the individual and any modification necessary to the Plan of Care due to a change in these needs; and

- The individual's need for support in addition to care provided by personal/respite care aide. This includes an overall assessment of the individual's health, safety and welfare in the home with personal/respite care.

Aide Required Documentation: Agency-Directed (AD) Model

The aide is responsible for following the Plan of Care, notifying the RN/LPN Supervisor of any change in condition, support, or problem that arises and documenting the performance of duties on the DMAS-90.

The DMAS-90 must be completed on the day the service was delivered. The DMAS-90 is designed to contain one calendar week of service provision. Agencies may not, in any way, make changes to the DMAS-90. If the same aide renders personal care and respite care services to the individual, a separate DMAS-90 must be used for the different services, even if the two services are rendered on the same day.

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Documentation on the DMAS-90 must include:

- the specific services delivered to the waiver individual by the aide. If the aide does not perform a task that is documented on the Plan of Care, the aide must include a note explaining why the task was not performed. Likewise, if an allowable task was performed but is not documented on the approved Plan of Care, the aide must include a note with the reason why it was performed;
- the personal care/respite aide's actual daily arrival and departure times. The personal care agency must also document any instances when services are not provided with a comment why;
- the aide's weekly comments or observations about the waiver individual, including the individual's physical and emotional condition, daily activities, and responses to services rendered;
- any other information appropriate and relevant to the waiver individual's care and need for services;
- Signatures: the personal care aide's and individual's or responsible caregiver's weekly signatures, including the date, to verify that personal care services have been rendered during that week as documented in the record. An employee of the provider cannot sign for the individual unless he/she is a family/caregiver of the individual. This family member, including LRI, cannot be the same family member who is providing the service. In instances where the individual is unable to sign and there is no family member or other legal representative to do so, the reason for the absence of this signature must be thoroughly documented on the DMAS-90. If the individual is unable to sign his/her signature on the DMAS-90, the individual may initial or make an "X". The RN Supervisor must document on the DMAS 99 that the "individual is unable to sign the DMAS-90". If the individual is documented as disoriented or confused, the individual should not sign the DMAS-90;
- documentation on the DMAS-90 must be in the English language; and
- signatures, times and dates shall not be placed on the personal care aide record prior to the last date that the services are actually delivered. The aide record sheets must be in the individual's record within two (2) weeks.

Corrections to any form in the record must be made by drawing a line through the incorrect entry, then re-enter and initial and date the correct information. Correction fluid ("white-out") must never be used for correction in medical records. Copies of all documents are subject to review by state and federal Medicaid staff or representatives.

A periodic review of the DMAS-90 must be done prior to filing it in the individual's record to ensure that the RN Supervisor is aware of any changes in the individual's needs or any changes in the Plan of Care, which may be indicated by the aide's documentation on the DMAS-90. An accurately signed and dated DMAS-90 is the only authorized documentation of services provided for which DMAS will reimburse. DMAS will not accept employee payroll time sheets in place of the DMAS-90.

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When respite care services are performed in a licensed Children's Residential Facility, the start and end times of each aide providing care to the minor waiver individual shall not be required on the DMAS-90. Instead, the start and end times of the waiver individual's stay at the facility must be documented. Each aide that provides care to the waiver individual may attach individual notes to the DMAS-90 with a corresponding signature.

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Electronic Visit Verification (EVV)

Personal care agencies are required to have a HIPAA compliant EVV system that records and contains the same elements as the DMAS-90 and permits the system to verify the location from which the services are provided and the individual for whom the services are provided.

The EVV shall: 1.) Ensure daily back-up for all data collected; 2.) Protect data securely and reliably; 3.) Demonstrate a disaster recovery mechanism allowing for use within twelve hours of disruption to services (subject to exceptional circumstances such as war and other disasters of national scope); and 4.) Be capable of producing reports of all services and supports rendered, the individual's identity, the start and end time of the provision of services and supports and the date/s of service in summary fashion that constitute documentation of service that is fully compliant with regulation.

The EVV system, at a minimum, must be able to capture the following required data elements:

1. Type of service performed (personal care or respite);
2. Individual receiving the service;
3. Date of the service;
4. Location of the service delivery (beginning and ending);
5. Individual providing the service; and
6. Time the service begins and ends.

Each personal care aide and individual/family receiving services will have a unique personal identification number or a biometric identification system. The personal care aide shall not be able to enter or modify the time and date. The unique identification system shall constitute the necessary electronic signatures for services. No additional electronic or "wet" signatures shall be required.

Adjustments may be allowed when necessary to EVV shifts. Adjustments must be made by an RN, supervisor, agency owner, or other designee who has the authority to make independent verification. Personal care aides are not permitted to adjust their own shifts nor those of other personal care aides. Each manual entry and/or adjustment must include documentation as to why manual entry was performed and why the visit was not electronically verified at the time of service. If there is an ongoing need to perform a manual entry for an individual's shifts, it must be documented on the DMAS-99 with the explanation, such as no cell phone service, GPS, or landline to verify location.

Claims submitted for reimbursement must not exceed the actual time worked based on the EVV data. Agency staff authorized to make edits must not edit clock-in and clock-out times to match the aide's scheduled start and end times.

Electronic Visit Verification (EVV) and DMAS-90

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EVV systems that are used in place of the DMAS-90 must contain the same elements and must be consistent with the DMAS-90 requirements starting on page 40. Personal care agencies must verify that their EVV system matches all of the same fields as located on the DMAS-90, including the ability to make notes. Additional tasks or fields not present on the DMAS-90 must not be listed or made available as tasks to mark as completed.

The aide must adhere to the DMAS-97A/B Plan of Care when rendering services and completing a work shift. EVV systems must not systematically require task completion in order for the aide to complete the end of the shift. The aide must only document tasks that were actually completed. When the Plan of Care includes a task that the aide did not perform during his/her shift, the EVV system must allow the aide to proceed with leaving the task unchecked. As with a paper DMAS-90, the aide must note why tasks listed in the Plan of Care were not performed via EVV.

If the EVV system does not capture or have all of the same fields available to complete, the electronic version does not meet DMAS standards, and the paper DMAS-90 form is required for each service delivery and must be kept in the individual's file.

Attendant Responsibilities/Required Documentation: Consumer-Directed (CD) Model

Documentation must clearly indicate the dates and times of CD personal care services delivery (i.e., shifts submitted to the F/EA contractor).

CD attendants should submit their work shifts upon the conclusion of their shift. Shifts must be submitted and approved by the EOR no later than 30 days after the shift in order to be reimbursed.

At the end of each shift, the attendant must document the tasks they completed. The tasks completed should match those identified on the plan of care. Any tasks that were needed and completed must be documented.

DMAS is required to comply with the 21st Century Cures Act on the use of EVV. All CD attendants are required to use EVV unless they have a confirmed live-in status with the F/EA. Services Facilitators are required to support this initiative in order to ensure the continued viability of the consumer-directed model and should review the attendant's method of submission when reviewing work shifts. If a CD attendant is found not to be using EVV, it is the responsibility of the SF to discuss with the EOR why the attendant is not using EVV and remedy the situation. If there is a documented history of non-compliance with EVV, DMAS has the authority to terminate the individual's enrollment in consumer-direction.

Required Services Facilitation Documentation

The SF must maintain records for each individual served. These records must be separated from those of any other services that may be provided by the SF. All

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documentation must be filed in the individual's record within two (2) weeks from the date of the visit/contact.

The individual medical record must include the following:

- If the individual is newly enrolled in the waiver, the LTSS Screening Packet which includes: the Uniform Assessment Instrument (UAI); the Pre-Admission Screening Authorization signed by all members of the LTSS Screening Team (DMAS-96); the Individual Choice Form (DMAS-97 or DMAS-300 for Respite Care services, as applicable);
- All provider Plans of Care (DMAS-97A/B); Supervision Request Form (DMAS-100), if applicable; Community Based Care Individual Assessment Report (DMAS 99) with signatures from the SF and individual, EOR, or other authorized representative on the date of the visit;

- All copies of the Plans of Care (DMAS-97 A/B), the results of the SF's initial comprehensive home visit (or initial reassessment visit) completed on or before the attendant's start of care date (and subsequent reassessment visits, as needed) on the DMAS-99. Only the DMAS-99 may be used for assessments/reassessments. The start date on the Plan of Care and DMAS-225 will be thedate of the first assessment performed by the SF for CCC+ waiver services for the individual;

- The SF must copy the questionnaire and any information entered by direct data entry that is submitted electronically via the srv auth contractor's portal system;

- All DMAS-225 forms;

- All correspondence and SF notes recorded and dated documenting contacts with the individual/EOR and family/caregiver, DMAS, and the srv auth contractor,;

- Records of contacts made with physicians, formal and informal service providers, and all professionals concerning the individual;

- All management training, including copies of emails or notes of calls received from the EOR that necessitated the management training visit, provided to the individual/EOR, including the individual's or EOR's accuracy of the attendant's work shifts or documentation;

- All documents signed by the individual or the family/caregiver that acknowledge the responsibilities for receipt of the services with the date of the visit;

- If tasks are performed requiring nurse delegation, the RN's documentation of training, supervising, and all other related information and documentation must be maintained by the service facilitation provider.

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- All DMAS-99 forms. Documentation must include the observations of the individual made during the visits. The notes must also clearly document that he/she has discussed with the individual or family the appropriateness and adequacy of services.

- **The SF's assessment and reassessment documentation must note:**

    - Any change in the previously documented individual's medical condition, functional status, and social support, which may require modifications to the Plan of Care. The SF is expected to know the nursing facility criteria and to apply the criteria when assessing whether the individual continues to meet nursing facility criteria to receive CCC Plus waiver services. If the SF determines that the individual does not meet criteria for personal/respite care services, the SF must contact DMAS for a level of care review and to discuss discontinuation of services;

    - A review of the Plan of Care with the individual/EOR and family/caregiver (as appropriate) to determine if it is adequate to meet the individual's needs or if changes need to be made;

    - Dates of any lapse of services and why (e.g., hospitalization, nursing facility or inpatient rehab hospital admission and discharge dates, aide not available, etc.);

    - The presence or absence of the attendant in the home during the visit. The individual/EOR and family/caregiver satisfaction with the services must be documented; and

    - Any other services received by the individual.

All criteria and documentation requirements must be met for the entire time the service is provided in order to be reimbursed under the CCC Plus Waiver. The SF will not be reimbursed for services unless the individual is authorized for waiver services by the srv auth contractor.

TRANSPORTATION

Transportation is available to CCC Plus waiver members; however, is not a service available under the CCC Plus waiver. Transportation to providers of Medicaid services may be arranged through the DMAS transportation broker or through the appropriate Medicare and Medicaid Plan. There are times that the aide/attendant or nurse may accompany the waiver individual to medical appointments or to other activities in the community. In no case will DMAS pay through the CCC Plus Waiver for mileage or other

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costs associated with transportation. The individual and/or aide/attendant assume all risks and responsibilities associated with transportation.

Transportation: Agency-Directed (AD) Services

Aides or nurses (for skilled respite services) may accompany the waiver individual to medical appointments, dialysis or community activities based on the following criteria:

- The agency will not be reimbursed for time beyond the already approved Plan of Care hours, or for vacations or overnight trips;
- The aide/nurse is essential for the safe transport of the individual (to assist in transfers, ambulation, behavior management, etc.);
- No other individual is available and physically able to accompany the individual;
- The total time required by the aide/nurse for the day, including the time required to accompany the individual, does not cause the individual's weekly authorized hours to be exceeded. If, due to events beyond the provider's control, the number of hours is exceeded, the provider shall contact the srv auth contractor the next business day with the actual hours used for authorization of hours exceeded in the previous day's visit. The record must document why the hours were exceeded or the additional time may be deducted from another day as long as this does not jeopardize the individual's health and safety. The RN/LPN Supervisor must be notified in advance of the appointment, and must document (with the date) this approval in the RN notes in the individual's record;
- When the aide/nurse is required to accompany the individual based on the above criteria, DMAS will pay the agency for the time the aide/nurse is accompanying the individual to such appointments. This must be documented on the aide's/nurse's record; and
- DMAS will not pay the provider when the individual is accompanied by the aide to the hospital or essential medical appointments when the individual is being transported by ambulance.

Transportation: Consumer-Directed (CD) Services

As the attendant is the employee of the individual receiving CD services, any arrangements for transportation not paid for by the Medicaid program are between the attendant and the individual. This includes transportation necessary to implement the CD services Plan of Care (for example, to permit community access and activities). It is permissible for the attendant to transport the individual in the attendant's, the individual's, or the caregiver's vehicle with prior consent from the vehicle owner.

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It is the responsibility of the individual or family member/caregiver to determine that the attendant has a valid Virginia driver's license, is registered in the Commonwealth of Virginia, and has vehicle insurance. Proof of the insurance coverage shall be received and shall cover the following.

The vehicle insurance shall cover the insured and/or the other person:

- Against loss from any liability imposed by law for damages;
- Against damages for care and loss of services, because of bodily injury to or death of any person;
- Against injury to or destruction of property caused by accident and arising out of the ownership, use, or operation of such motor vehicle or motor vehicles within the Commonwealth of Virginia, any other state in the United States, or Canada;
- Subject to a limit exclusive of interest and costs, with respect to each motor vehicle of $25,000 because of bodily injury to or death of one person in any one accident and, subject to the limit for one person, to a limit of $50,000 because of bodily injury to or death of two or more persons in any one accident; and
- Subject to a limit of $20,000 because of injury to or destruction of property of others in any one accident.

The total time required by the attendant for the day, including the time required to drive the individual, cannot exceed the individual's authorized weekly hours. If the total time required exceeds daily hours, additional time may be deducted from another day as long as this does not jeopardize the individual's health and safety, or the SF may submit a request within one business day to the srv auth contractor for a temporary increase in hours to provide reimbursement for the extra time in that day.

DMAS will not pay the attendant when the individual is accompanied by the attendant to the hospital or essential medical appointments when the individual is being transported by ambulance.

ADULT DAY HEALTH CARE (ADHC) SERVICES – AGENCY-DIRECTED (AD) ONLY

Service Definition

Adult day health care (ADHC) means long term maintenance or supportive services offered by a DMAS-enrolled community-based adult day program, licensed by the Virginia Department of Social Services (DSS) as an Adult Day Center (ADC). ADHC provides a

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variety of health, therapeutic, and social services designed to meet the specialized needs of waiver individuals.

ADHC may be the sole service received by the individual or in conjunction with other CCC Plus Waiver services. A multi-disciplinary approach to developing, implementing, and evaluating each individual's POC is essential to ensuring quality ADHC services.

Services Units and Limitations

The services offered by the ADHC Center must be designed to meet the needs of the individual. The range of services provided by the ADHC Center to each individual may vary to some degree and there must be a minimum range of services available to every individual attending ADHC through the CCC Plus waiver to include nursing, rehabilitation services coordination, nutrition, transportation coordination, social services, recreation, and socialization services.

DMAS will reimburse a per-diem fee to a DMAS-enrolled ADHC provider who has received authorization from the srv auth contractor for the claim dates of service. This is considered payment in full for all services rendered to that individual as a part of the individual's approved ADHC Plan of Care. A day is defined as attendance at the ADHC Center for six hours or more.

ADHC services shall not be provided, for the purpose of Medicaid reimbursement, to individuals who reside in NFs, ICFs/IID, hospitals, assisted living facilities that are licensed by VDSS that serve five (5) or more individuals, or group homes which are licensed by DBHDS.

ADHC services may take the place of personal care services either completely or for several days a week if it is determined that this would meet the needs of the individual. ADHC augments the social support system available to the individual by providing some assistance with activities of daily living. An individual may attend ADHC during the day and also receive personal care services in the morning or evening, or both, as appropriate to meet the identified needs.

Staff Responsibilities

Aide Responsibilities: The aide must provide assistance with ADLs (e.g., ambulating, transferring, toileting, eating or feeding, bathing, dressing), supervision of the individual, and assistance with the management of the individual's Plan of Care.

Nursing Responsibilities: These services include periodic evaluation, at least every 90 calendar days, of the nursing needs of each individual; provision of the indicated nursing care and treatment; responsibility for monitoring, recording, and administering prescribed medications; supervising the individual in self-administered medication; or general supervision of provider staff, who are certified through the Board of Nursing, in medication management and administering medications. Nursing functions also include the support

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of families in their home care efforts through education and counseling, and helping families identify and appropriately utilize health care resources.

Rehabilitation Services Coordination Responsibilities: These services are designed to ensure the individual receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include the coordination and implementation of physical therapy, occupational therapy, and speech therapy. The ADHC Center may arrange for individual rehabilitation treatment with an outpatient facility or independent rehabilitation provider. The coordination and implementation responsibilities of the ADHC Center include:

- A referral for an evaluation by the appropriate rehabilitative discipline when necessary;
- If the ADHC chooses to offer rehabilitation on-site, then the provision of rehabilitation therapy in the ADHC Center by an independent rehabilitation provider may be offered, if the individual chooses to receive this service during ADHC service hours. Reimbursement for rehabilitation services are not part of the reimbursement fee for ADHC; and
- Coordination of any rehabilitative treatment plan into the individual's overall Plan of Care to include arrangement for transportation from the ADHC to the rehabilitation provider if necessary, and implementation by ADHC staff (designated by the Coordinator) of activities typically considered part of a home program prescribed by the therapist in conjunction with ongoing therapy.

Transportation Responsibilities: Every DMAS-approved ADHC Center must provide transportation when needed in emergency situations for any Medicaid individual to his or her home (e.g., the primary caregiver has an accident and cannot transport the individual home). Any ADHC Center which is able to provide individuals with transportation routinely to and from the center can be reimbursed by DMAS based on a per-trip fee (to and from the individual's residence). Refer to Chapter V for more billing information.

Nutrition Responsibilities: The ADHC Center must provide at least one meal per day, which supplies one-third of the daily nutritional requirements established by the U.S. Department of Agriculture. Special diets and counseling must be provided as necessary.

ADHC Coordination: The ADHC Coordinator, designated by the ADHC Director, must coordinate the implementation of the Plan of Care, make updates to the Plan of Care, record 30-day progress notes, and review the individual's daily log each week (when the log is completed by a program aide). The designation of a professional staff member as the ADHC Coordinator is intended to promote the maintenance of the individual's physical and mental health by coordinating services and providing assistance with any personal or social problems. This may be accomplished by individual or group discussion of problems, coordination with family, home, and other community agencies, counseling and

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referral to available community resources. In cases where the individual only receives ADHC and PERS, the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.

Recreation and Social Activities Responsibilities: The ADHC Center must provide planned recreational and social activities suited to the needs of the individuals and designed to ensure community integration, encourage physical exercise, prevent deterioration, and stimulate social interaction.

A multi-disciplinary approach to developing, implementing, and evaluating each individual's Plan of Care is essential to quality ADHC services.

Skilled Services and ADHC

An ADHC Center may choose to admit individuals who have skilled needs. Centers that do not employ professional nursing staff on site shall not be permitted to admit waiver individuals who require skilled nursing care to their centers. Examples of skilled nursing care may include: (i) tube feedings; (ii) Foley catheter irrigations; (iii) sterile dressing changing, or; (iv) any other procedures which require sterile technique. The ADHC shall not permit aide employees to perform such procedures unless it is performed in accordance with the Virginia Administrative Code 18VAC90-19-240 through 18VAC90-19-280, *Delegation of Nursing Tasks and Procedures*.

Re-Evaluation of the Adult Day Health Care (ADHC) Individual

The ADHC Center professional staff will continually assess the adequacy of ADHC services for each individual and shall meet and document changes in the individual's condition and Plan of Care at least every three months (this does not mean every 90 days). ADHC services may be authorized for up to seven (7) days of service based on the individual's needs and the center's availability. Any time the number of days an individual attends ADHC changes, the Plan of Care must be modified. The ADHC Coordinator must contact the srv auth contractor to request authorization for the change. The most recent Plan of Care must always be in the individual's record.

Whenever the professional staff determines that ADHC services, either alone or in combination with other community resources, are no longer appropriate for an individual, the ADHC Center will contact the srv auth contractor for authorization to conduct a re-evaluation of the individual's needs to ensure that the individual is receiving services which meet his/her needs and ensure the individual's continued health and safety in the community in a cost-effective health care setting.

DMAS will conduct annual level of care reviews of each individual according to established procedures described in Chapter VI of this manual.

ADHC Provider Individual Experience Survey

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The individual experience survey is intended to determine an individual's experience in the setting where ADHC services are provided and to ensure their experience is consistent that of a home and community based setting. This requirement is for those members receiving ADHC services only.
The contractor shall require that all providers of CCC Plus Waiver ADHC services maintain compliance with the provisions of the CMS HCBS rule as detailed in the provider agreement.
As part of the annual assessment and plan of care review, the managed care organization's care coordinator or another entity as approved by the department shall conduct, an Individual Experience Survey in order to ensure that the member's services and supports are provided in a manner that comports with the setting provisions of the HCBS regulations in 42 CFR § 441.301(c) (4)-(5).

Each member receiving Medicaid ADHC services must receive an annual individual survey to determine their experience with their services and awareness of HCBS rights and requirements.

Conducting the Survey
The Individual Experience Survey must be conducted in person. The survey must include the member and also may include a family member or representative, as appropriate. ADHC services staff may participate as requested by the member and his/her family member/representative.

Inability to Provide ADHC Services

The provider is responsible for providing reliable, continuous care to any individual receiving Medicaid ADHC services for the number of hours per day or days per week as outlined on the Plan of Care. Any time the provider is unable to furnish ADHC services as determined in the Plan of Care, the individual or family/caregivers, as appropriate, must be notified immediately, to initiate other care arrangements for these individuals. Documentation of the contact must be recorded in the individual record. An ADHC provider may either sub-contract with another ADHC provider or may transfer the individual to another ADHC if they cannot provide the number of days per week as written in the Plan of Care.

The provider must explore with the individual, prior to the start of services, the individual's back-up plan or ability to go without service (in the event the provider cannot provide ADHC services). Back-up support can be provided by an informal network of family, friends or neighbors who can be called on as needed as long as this ensures the individual's needs are met.

The center may discharge waiver individuals from the center's services but not from the waiver. Written notice of discharge shall be provided, with the specific reason or reasons for discharge from the ADHC, at least 10 calendar days prior to the effective date of the

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discharge. In cases when the individual's or any other person's safety may be in jeopardy, the 10-calendar day notice shall not apply.

ADHC Provider Documentation Requirements

The ADHC Center shall maintain all records of each ADHC individual. These records shall be reviewed periodically by the DMAS staff or its designated agent who is authorized by DMAS to review these records.

At a minimum, the ADHC records shall contain, but shall not necessarily be limited to:

- If the individual is newly enrolled in the waiver the LTSS Screening packet which includes: the Uniform Assessment Instrument (UAI), the Screening Authorization (DMAS-96), and the Screening Team Plan of Care (DMAS-97);

- The Interdisciplinary Plan of Care (DMAS-301) developed in collaboration with the waiver individual or family/caregiver, or both as may be appropriate, by the center's director, RN, and therapist, as may be appropriate, and any other relevant ADHC staff or individual's support persons;

- Documentation of interdisciplinary staff meetings that shall be held at least every three (3) months to reassess each waiver individual and evaluate the adequacy of the POC and make any necessary revisions. The initial ADHC POC can be used for documentation of interdisciplinary staff meetings and to make up to three (3) updates to the Plan of Care as long as the individual's status has not significantly changed. A new Plan of Care must be developed whenever re-evaluation indicates a need for significant changes to the Plan of Care;

- At a minimum, 30-day goal oriented progress notes recorded by the designated ADHC care coordinator. If a waiver individual's condition and treatment POC changes more often, progress notes shall be written more frequently than every 30 days;

  Progress notes must:

  1. Describe the individual's medical and functional status;

  2. Note contacts made to or from the primary caregiver;

  3. Indicate any change in social supports;

  4. Indicate any other services received by the individual; and

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5. Reference a review of the 30-day rehabilitative progress report and updated Plan of Care, if appropriate.

   Note: DMAS does not require a form for recording the progress notes. However, the DMAS-99 form may be used for this purpose. At a minimum, the functional status section of the DMAS-99 form must be completed every 30 days by the RN or ADHC Coordinator;

- The ADHC Center must obtain, or should document efforts to obtain, a rehabilitative progress report and updated treatment plan from any professional discipline involved in the individual's care every 30 days (e.g., physical therapy, speech therapy, occupational therapy, etc.);

- Daily logs of service provided (DMAS-302) - The daily log must contain the specific services delivered by ADHC Center staff. The log must also contain the actual arrival and departure time of the individual and a weekly signature by either the director, activities director, RN, social worker, or therapist employed by the center. The daily log must be completed on a daily basis, not before or after the date of service delivery. At least once a week, a staff member must chart significant comments regarding care given to the individual. If the staff member writing comments is different from the staff signing the weekly record, that staff member shall sign the weekly comments. A copy of this record shall be given weekly to the individual or family/caregiver and maintained in the individual-specific medical record;

- All contacts shall be documented in the individual's medical record, including correspondence, made to and from the individual, with family/caregivers, physicians, DMAS, the srv auth contractor, formal and informal service providers, and all other professionals related to the waiver individual's Medicaid services or medical care; and

- All Plans of Care.

The provider must use the approved DMAS forms or exact duplicates, where indicated.

Initiation of ADHC Services

Upon receipt of the referral and no later than the individual's fifth (5th) visit to the ADHC Center, the Plan of Care must be developed based on the needs identified by the ADHC professional staff's evaluation of the individual's need for nursing, transportation coordination, nutrition, social services, rehabilitation services coordination, PERS, recreation services, and socialization.

The staff will meet to develop a Plan of Care for that individual, using the ADHC Interdisciplinary Plan of Care (DMAS-301) to document the goals and objectives for each

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of the major areas of individual needs. The DMAS-301 must include the individual's name and Medicaid number, the ADHC provider identification number, signatures of the interdisciplinary team members present, the date services actually began, and the content of the Plan of Care. The DMAS-301 must also address all medications the individual takes, not just those received at the center.

If, the ADHC Center evaluates the individual's needs and determines a change is needed to the number of days or hours the individual attends the ADHC, the ADHC Center must contact the srv auth contractor to request a change in authorization and at any other time the number of days an individual attends ADHC changes.

If ADHC is the individual's sole CCC Plus Waiver service, the provider must notify the eligibility worker at LDSS and DMAS Level of Care (LOCERI) staff of this decision immediately and provide DMAS with the documentation supporting its decision. If DMAS agrees that the provider should not start services, DMAS will send a letter of notification to the individual informing him/her of this decision and provide appeal rights.

The individual will have 30 calendar days to appeal the DMAS decision. Copies of the DMAS letter to the individual will be sent to the provider.

If DMAS disagrees with the provider's decision not to initiate care, DMAS will contact the provider in writing and inform them that services can be initiated.

If the ADHC determines that they should not initiate services and the individual is receiving at least one other CCC Plus Waiver (not PERS), the ADHC must send a letter of notification to the individual informing them of the decision not to provide services and provide appeal rights.

Monitoring the Individual's Condition and Changes to the Plan of Care for ADHC Services

The ADHC provider must assess the individual's functional, cognitive, and health status and record as necessary any changes to his/her condition in the 30-day progress notes and quarterly on the DMAS-301. The provider must know the DMAS criteria for ADHC services and take action to modify the Plan of Care as needed to ensure that the days and type of care and services are appropriate to meet the current needs of the individual.

If the ADHC determines the individual is no longer appropriate for attendance at the center, the provider may discharge the individual from their center, but not from the waiver. It is the responsibility of the provider to notify DMAS for a level of care review and to discuss discontinuation of services when the provider believes the individual no longer meets criteria for the waiver. Only DMAS may terminate the individual from the waiver. he provider has discharged the individual from its services, the provider must also send the Medicaid LTC Communication Form (DMAS-225) with the last date of service to DMAS. The DMAS-225 must also be sent to the LDSS to notify them of the

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individual's discharge from the provider's services. The discharge request must be made to the srv auth contractor.

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ADHC: Change in Services

Increase in Days of Service

The srv auth contractor must authorize any increase in days of service, either at the time of enrollment or afterward. The ADHC Center must contact the srv auth contractor as described in Appendix D of this manual and provide the following information:

- The reason the increase in days of service is needed; and
- The effective date of the increase.

(Note: If the individual receives personal care under the CCC Plus Waiver, the ADHC Center must have the provider information for the personal care provider/SF and must know how personal care services will be affected by the increase in the days of service.)

If the increase is denied, the srv auth contractor will indicate that the increase was denied and the reason for the denial. The srv auth contractor will send this copy to the ADHC. Once the decision has been made, the provider and individual will receive a notice with the decision and appeal rights if a denial is issued. Individuals have the right to appeal any adverse action taken by the srv auth contractor. A copy of this letter must be maintained in the individual's record. The srv auth contractor will not retroactively approve increases.

Decrease in Days of Service (ADHC-Initiated Decrease)

- The ADHC Center will send the individual a letter giving the reason for the decrease, the effective date of the decrease, the individual's Medicaid number, and the individual's right to appeal.
- The decrease request must be submitted to the srv auth contractor, as described in Appendix D, who will process the change requests.
- Once the change request is processed, the provider and individual will receive a computer-generated letter verifying that the change was made.

It is not necessary for the ADHC to send the srv auth contractor the revised Plan of Care or supporting documentation unless this information is requested. The Plans of Care and the Community-Based Care Authorization Forms must be maintained in the individual's record. The Plans of Care and documentation-of-service delivery must be consistent with the information communicated to the srv auth contractor.

PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

Service Definition

Personal Emergency Response System (PERS) is an electronic device that shall be capable of being activated by a remote wireless device and enables individuals to secure

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help in an emergency. PERS electronically monitors individual's safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through a two-way voice communication system that dials a 24-hour response or monitoring center upon activation via the individual's telephone system or other two way voice communication system. When appropriate, PERS may also include medication monitoring devices.

DMAS will only reimburse services as defined in the service description, documented in the individual's approved Plan of Care, and that are within the scope of practice of the providers performing the service.

Criteria

PERS services are limited to those individuals, ages 14 and older, who live alone, are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency. The individual must be alert and cognitively able to operate the device appropriately. Medication monitoring services are also available in PERS with a physician order. PERS, including medication monitoring, shall not be the sole waiver service received and can only be authorized in conjunction with at least one other authorized standalone waiver service.

Service Units and Limitations

There is a one-time reimbursement for installation of the unit(s) per provider, which shall include installation, account activation, individual and family/caregiver instruction, and removal of equipment when it is no longer needed. The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line or other two way voice communication system within seven (7) days of the request unless there is appropriate documentation of why this time frame could not be met. If the PERS provider requests or requires the individual to self-install the device, the PERS provider shall not bill DMAS for installation costs. The provider must furnish all supplies necessary to ensure that the system is working properly. A unit of service for PERS monitoring is a one-month rental price and for nursing services for the purpose of refilling the medication monitoring device is one-half hour.

In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a registered nurse, a licensed practical nurse, or a licensed pharmacist. The units can be refilled every 14 days.

Additional PERS Requirements

The PERS installation shall include local seize line circuitry, which guarantees the unit to have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

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A PERS provider must maintain all installed PERS equipment in proper working order and have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

Standards for PERS Equipment

All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The console shall be waterproof; shall automatically transmit to the response center a low-battery alert signal prior to the battery losing power; be able to be worn by the individual; and have the capacity to be automatically reset by the response center after each activation in order to allow subsequent signals to be transmitted without requiring a manual reset by the individual or family/caregiver.

A PERS provider shall furnish education, data, and ongoing assistance to DMAS and/or the srv auth contractor to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and instruct the individual, family/caregiver, and responders in the use of the PERS service.

The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices, or medication monitoring unit while the original equipment is being repaired.

The emergency response activator must be activated, either by breath, touch, or by some other means, and must be usable by persons who have visual or hearing impairments or a physical disability. The emergency response console must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24 hours and automatically transmit a low-battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the individual resetting the system in the event it cannot get its signal accepted at the response center.

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

<u>The monitoring agency's equipment must include the following</u>:

- A primary receiver and a back-up receiver, which must be independent and interchangeable;

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

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

Provider Documentation Requirements

1. The PERS Request Form (DMAS-100A) or the current DMAS approved electronic request, to be completed by the provider/SF may serve as the PERS Plan of Care provided it adequately documents the need for the service, the type of device to be installed, and description of ongoing services, including training regarding the use of the PERS. Information from this form must be submitted to the srv auth contractor for authorization to occur, maintained in the individual's record, and updated at least annually for reauthorization and whenever a change in needs arise;

2. A PERS provider must maintain a data record for each individual utilizing PERS at no additional cost to DMAS or the individual. The record shall document all of the following:

   - Delivery date and installation date of the PERS;
   - Individual/caregiver signature verifying receipt of PERS device;
   - At a minimum monthly testing to verify that the PERS device is operational;
   - Updated and current individual responder and contact information, as provided by the individual, or the individual's care provider; and

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- A case log documenting individual system utilization and individual, family/caregiver, provider, SF, or responder contacts/communications;

3. The PERS provider shall document and furnish, within 30 days of the action taken, a written report to the agency provider/SF, or in cases where the individual only receives ADHC services, to the ADHC provider, for each emergency signal, which results in action taken on behalf of the individual. This information must be maintained in the individual's record at the PERS provider. This shall exclude test signals or activations made in error.

4. The PERS provider must retain a copy of the most recent DMAS-100A in the individual records.

5. The PERS provider must obtain and keep on file a copy of the most recently completed DMAS-225 for the individual. The provider must document efforts to obtain a copy of the DMAS-225 until it is received from the personal care, respite care, SF or ADHC provider.

PRIVATE DUTY NURSING (PDN)

Service Definition

PDN means in-home nursing services provided for individuals enrolled in the CCC Plus waiver with a serious medical condition and/or complex health care need. The individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse. PDN services may include consultation and training for the primary caregiver or other providers of care.

PDN is offered to individuals (21 years of age or older) who would otherwise require a specialized care nursing facility placement and supplemented care rendered by a primary caregiver; PDN may be used:

1. To provide supports in the individual's home setting;
2. To accompany the individual to medical appointments; or
3. To facilitate community integration (church, theater, etc.).

PDN may be the sole service received by the individual or in conjunction with other CCC Plus Waiver services. Services such as personal care and skilled respite care may not be performed at the same time or duplicate any other service received.

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PDN services are authorized by DMAS or its contractors and rendered according to a plan of care (CMS-485) certified by a physician as medically necessary to enable the individual to remain at home rather than in a hospital or nursing facility. PDN may be provided to individuals living in the community who have been authorized to receive certain HCBS as an alternative to receiving services in an institutional setting. PDN includes specific treatments, procedures and individual/primary caregiver training/education related to the developed and certified plan of care goals. PDN services will also meet the medical needs and ensure the health, safety and welfare of the individual while residing in the community.

PRIVATE DUTY NURSING (PDN) CRITERIA

Private Duty Nursing (PDN) may be authorized for adults 21 and older through the CCC Plus waiver for individuals who are chronically ill or have a significant disability, needing a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability. Those under the age of 21 must receive PDN through the EPSDT benefit.

To qualify for PDN, the *PDN Adult Referral Form (DMAS-108)* must be completed and the individual must be determined to meet Category A- be dependent on a ventilator, or Category B-must meet all eight (8) specialized care criteria for complex tracheostomy care:

Category A:
Individual dependent on mechanical ventilator; or

Category B:
Individuals who have a complex tracheostomy as defined by:

- Tracheostomy with the potential for weaning off of it, or documentation of attempts to wean with subsequent inability to wean;
- Nebulizer treatments ordered at least four times a day or nebulizer treatments followed by chest physiotherapy provided by a nurse or respiratory therapist at least four times a day;
- Pulse oximetry monitoring at least every shift due to unstable oxygen saturation levels;
- Respiratory assessment and documentation every shift by a licensed respiratory therapist or nurse;
- Have a physician’s order for oxygen therapy with documented usage;
- Receives tracheostomy care at least daily;

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- Has a physician's order for tracheostomy suctioning; and

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- Deemed at risk to require subsequent mechanical ventilation.

PDN is generally provided in the waiver individual's primary residence, as determined on initial enrollment into the waiver.

For individuals receiving PDN services through FFS Medicaid, DMAS will monitor the individual's status and provision of nursing services by telephone contact with the provider as needed and review required documentation routinely submitted by the provider. DMAS will perform annual Level of Care (LOC) assessments in the individual's home. For individuals enrolled with a MCO, these functions will be performed by a care coordinator.

PDN hours are based on the assessed skilled needs of the individual. These hours may be authorized up to a maximum of 112 hours per week, per the DMAS-108.

Primary Caregiver Responsibilities

It is the responsibility of the primary caregiver to assure and provide all care when the private duty nurse is not available. Documentation in the medical record must state the name and phone number of the trained primary caregiver. This trained primary caregiver shall also have a back-up system (i.e.: caregiver) available in emergency situations. Due to the complex medical care needed for individuals receiving PDN services, they may not be left alone at any time.

When an individual approved for PDN services also receives personal care, the primary caregiver is responsible for providing all of the skilled nursing needs. The aide/attendant may only provide the individual with personal care services and cannot be left alone with the individual at any time. If the aide/attendant for personal care is a LRI, the LRI aide/attendant must not perform the skilled nursing needs during any time billed for personal care. The LRI primary caregiver may also not perform paid personal care while the PDN nurse is providing services.

The trained primary caregiver and a back-up caregiver name and phone number must be documented in the medical record of the individual. The back-up caregiver shall accept responsibility for the oversight and direct care of the individual in case of an emergency, and ensure the health, safety and welfare of the individual when the primary caregiver is ill, incapacitated, or unavailable for any reason. The back-up caregiver will do so without Medicaid compensation and shall be trained in the skilled technologies required by the individual.

When care for enrolled individuals is interrupted due to their primary caregiver's emergency unavailability and an adequate back-up system is not available, hospitalization or placement in a specialized nursing facility shall occur as a temporary last resort alternative.

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PRIVATE DUTY NURSING AGENCY RESPONSE TO REFERRAL

Individuals choosing to receive PDN services must do so by choosing a PDN provider enrolled with DMAS to provide the services. Once the agency has accepted the PDN referral, the RN supervisor must make the initial home assessment visit on or before the actual initial start of services date.

Providers shall not begin PDN services until the LTSS Screening packet is received from the screening team or DMAS, and DMAS has approved PDN services. It is the provider's responsibility to review and ensure the receipt of a complete and accurate LTSS Screening packet.

The first date of PDN services cannot be before the physician signature date on the DMAS-96 and must be on the same date as the DMAS PDN service effective date as identified on the Skilled Private Duty Nursing Authorization.

DMAS will coordinate with the chosen nursing provider to assist with a smooth transition to PDN services. The PDN provider shall make available any documentation requested by DMAS as part of the required assessments and home visits.

The RN or LPN providing PDN services will do so according to the nursing services ordered by the physician, in accordance with all Medicaid regulations, policies and provider policies.

DMAS PDN INITIAL REVIEW

DMAS will work with the screening entities, the physician, the individual/primary caregiver and providers to assure a safe and smooth transition to HCBS. In conjunction with the referral assessment for eligibility criteria, the DMAS review shall include:

1. Verification that the primary caregiver's training needs have been met to ensure the safety of the individual while living in the community;

2. Verification that the discharge planner has included the delivery of medical equipment to the home;

3. Verification that the PDN provider initial assessment home visit has been performed and completed by the RN supervisor; and

4. Verification of the DMAS authorized first date of PDN services.

DMAS will perform an initial assessment within 14 business days of PDN service initiation. The purpose of this assessment is to assure services are rendered according to the physician orders and the assessed needs of the individual. This assessment will include all documentation submitted to DMAS and the required documentation available in the

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home. DMAS will assure the individual is living in a safe environment, verifies the primary caregiver/back-up caregiver and ensure choice of services and providers.

PRIVATE DUTY NURSING SERVICES VISIT REQUIREMENTS

At a minimum, supporting documentation in the form of physician's orders on the CMS-485, PCA plans of care (97A/B), daily PDN nurses notes and Supervisory Monthly Summary (DMAS-103) forms must clearly describe the following:

- The type of skilled procedures to be performed by the skilled private duty nurse and the type of personal care services being performed;
- The complexity of steps needed to complete each procedure;
- The extent to which the skilled private duty nurse is called upon to use nursing knowledge and expertise to make an assessment, follow-up with a physician, or adjust orders/plans of care; and
- Documentation of all care provided by the skilled private duty nurse.

INITIAL PDN ASSESSMENT VISIT

The initial PDN assessment visit is performed by the provider RN Supervisor before the start of PDN or any other waiver services. This visit serves as the admission visit of the individual and involves an assessment of all of the health care needs, social and psychological needs, and additional service needs found as a result of this visit. The provider RN supervisor must also ask and document any signals or alerts the individual uses in the event of an emergency or when the individual is under duress. This visit must occur in the individual's home and be documented on the Provider RN Home Assessment (DMAS-116). A copy of the assessment (DMAS-116) must be sent to DMAS within two (2) business days of the initial visit.

The Physician's Home Health Certification and Plan of Care – CMS- 485 (with or without MD signature) must also be sent to DMAS within two (2) business days of the initial visit. The CMS-485 must include the specific number of nursing hours needed per day (i.e. not a range of hours). The provider must submit a service authorization request for the number of hours the agency is able to adequately staff. Once the assessment and CMS-485 is received and reviewed by DMAS, the authorization will be completed. DMAS will work with the individual/primary caregiver to identify additional nursing agencies to cover the remaining PDN hours the agency is unable to staff; for individuals enrolled with a MCO, this function will be performed by a care coordinator. Medicaid reimbursement cannot be made until the provider receives service authorization from DMAS. Failure of the provider to ensure timely submission of the required assessments may result in retraction of all PDN payments for the period of time of the delinquency.

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An initial assessment visit must also be made when an individual is re-enrolled after discharge from services or is a transfer from another provider or another payer source.

PDN services are documented on Skilled Nursing Notes for dates rendered in accordance with the physician orders.

Monthly Supervisory Visits

The RN Supervisory Visit must be performed every 30 days to provide oversight for PDN services offered to the individual in the home. These visits include:

1. An assessment of the individual based on their skilled needs;
2. Review of the home medical record;
3. A determination that health care needs are met in the home;
4. Documentation of the individual's satisfaction and choice of services;
5. Documentation of satisfaction of service plan meeting their personal goals;
6. A review of the CMS-485 to ensure physician orders are accurate, current and being followed; and
7. An assessment of personal care services when provided by the PDN provider agency.

The Monthly Supervisory Visit (DMAS-103) must be submitted to DMAS within 5 days following the end of the month in which the visit is due.

These visits are documented on the PDN Supervisory Monthly Summary Visit (DMAS-103). At least every other month, the supervisory visit shall be made in the primary residence of the individual. The individual receiving PDN services must be present during every supervisory monthly visit.

The home medical record shall be easy to find, organized and legible. The provider shall assure the information in the home record is current. The agency may purge the home record but must assure at least two weeks of data remain in the home record.

PHYSICIAN SUPERVISION/CERTIFICATION AND RECERTIFICATION FOR THE PLAN OF CARE

Individuals receiving PDN services must be under the care of a licensed physician authorized to practice in the Commonwealth of Virginia.

The following documentation is required:

- A written physician's certification statement, which may be documented on the CMS-485 Plan of Care, in the form of physician orders, must be in the individual's medical record in the PDN provider's office and at the individual's home. Provider agencies that elect not to use the CMS-485 may develop their own form that must contain all of the elements and requirements as set forth in regulation and in this

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manual for the CMS-485. The statement of certification of medical necessity must be found on the form and must include:

- Physician certification statement of the individual's need for PDN care;
- Identification of primary care physician who has agreed to manage the medical care of the individual;
- Order must include the identification of the type, scope, amount, duration and frequency of services;
- Name and current address, home and cell phone numbers of the individual;
- Individual's date of birth, Medicaid ID number, PDN start of care date as well as the 60 day certification period;
- Choice of services made by the individual;
- Personal goals of the individual;
- A plan and certification for furnishing services to the individual which is reviewed, updated and signed by the physician every 60 days;
- The diagnosis of the individual which is directly associated with the services ordered and ICD code;
- A list of current medications, treatments, allergies and equipment ordered;
- Measurable goals for care/services;
- Both the dated RN and Physician signatures; and
- Current signed CMS-485 to be kept in the individual's home.

All new or modified orders must be signed and dated by the physician and kept with the current CMS-485. These orders must be included on the next CMS-485, if appropriate.

Verbal orders may be received by a registered nurse. When a verbal order is taken by a LPN, the agency provider RN Supervisor must assure the accuracy of the order and its inclusion in the next CMS-485. All verbal orders must be signed and dated by the physician, per medical standards of practice (typically within 3 days).

To assure all of the care needs of the individual are met, the most recent CMS-485 must be kept in the individual's home and easily accessible at all times. This CMS-485 will assist the nurse in cases of emergencies, substitution or when there is more than one nurse providing care.

Orders for Skilled Care (CMS-485, Block 21)

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Discipline and Treatments orders must include the following information for these specific technologies:

BIPAP/ CPAP/ Ventilators
- Machine or Vent model
- Current MD ordered Vent settings
- Orders for Vent use, i.e.- time to be used, weaning schedule (if ordered)

Tracheostomy
- Trach manufacturer, size, and back up trach size
- With cuff use - Please specify when cuff is to be inflated (with vent use, with sleep only, while eating, etc.). Inflate with air or water and amount
- Trach Care to include:
  Frequency of change and LOCATION if not done at home
  Specific ostomy site care and frequency per day
  Inner cannula care or change, if applicable
  Trach suction catheter size and frequency

Oxygen
- Should be ordered as a medication to include: dose/amount, time to be used (PRN/with sleep/continuous), route

Pulse Oximeter
- Include high/low limits and orders in response to exceeding those limits
- Frequency of use

Nutrition
- Specify PO, enteral feeding or TPN
- Include specific PO diet, i.e. consistency and indicate if thickener is required for liquids
- Enteral feeding should specify formula name, amount, frequency and delivery method
- Gastrostomy site care, frequency of care, tube size, and changing schedule must be ordered

Catheter Care
- Foley, size, change frequency, irrigation if ordered
- Straight catheter, size, scheduled or PRN, irrigation if ordered

Wound Care
- Site, type, specific treatment orders, measurements of wound if applicable
- Include name and phone number of any agency that provides RN skilled wound care visits

Infusion Therapy

- Type of infusion fluids
- IV site, care orders

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- Dosage and daily time schedule for giving the infusion
- Include name and phone number of any agency that provides infusion therapy visits

RN SUPERVISOR RESPONSIBLITIES

Using a person-centered planning team approach to nursing services, the provider RN supervisor shall:

- Ensure choice of services is made by the individual, legally authorized guardian, or responsible party if a minor;
- Ensure personal goals of the individual are respected;
- Conduct the initial evaluation visit to initiate PDN services in the primary residence;
- Regularly evaluate the individual's status and nursing needs and notify DMAS if the individual no longer meets the LOC criteria for the waiver;
- Complete the CMS-485 every 60 days and as necessary for revisions. The new CMS-485 must be sent to DMAS at the beginning of each new certification period;
- Perform monthly skilled nursing assessment, every 30 days, using the *Monthly Supervisory Visit (DMAS-103)* (the monthly nursing assessment cannot be made by the nurse providing care in the home);
- Coordinate services;
    - Inform the physician, DMAS and other personnel of changes in the individual's condition and needs;
    - Contact DMAS if an individual does not meet PDN criteria;
    - Educate the individual/primary caregiver in meeting nursing and related goals;
    - Supervise and educate other personnel involved in the individual's care;
- Ensure all nurses have a *PDN Skills Checklist (DMAS-259) form* completed by the RN supervisor *prior* to assignment to an individual; review with each nurse all skills listed on the DMAS-259 and have the nurse demonstrate or explain in detail how they would perform each task. Nurses may not complete the DMAS-259 form on themselves. PDN staff may not complete this form on their nursing peers;
- Ensure availability of a supervising RN for 24 hours per day to address concerns that may arise with PDN individuals;
- Notify DMAS of any major problem or changes in an individual's family/social situation or primary residence;

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- Ensure nurse supervisors do not work as a private duty nurse on cases they supervise;
- Ensure that all nurses and caregivers are aware that timesheets must be accurate with arrival and departure time of the nurse and that falsifying timesheets is fraudulent; and
- Ensure that respite documentation is kept separate from regular nursing documentation and labeled as respite.

TWO AGENCIES PROVIDING PRIVATE DUTY NURSING

When two agency providers share an individual's care, the agencies must coordinate the services between each other. Weekly communication between agencies in shared cases is encouraged regarding PDN hours, billing, and health, safety or welfare issues.

Both providers shall:

- Maintain an individual's medical record with all required documentation;
- Maintain CMS-485 and medication sheets;
- Send all verbal orders to the co-sharing agency;
- Track the annual respite hours being used;
- Perform monthly supervisory visits every 30 days; and.
- Maintain weekly communication between agencies in shared cases is encouraged regarding PDN hours, billing, and health, safety or welfare issues.

CONGREGATE PDN

Congregate PDN is skilled nursing simultaneously provided to three or fewer waiver individuals who reside in the same primary residence.

Congregate PDN may be authorized in conjunction with PDN in instances when individuals must be out of the home for part of the authorized PDN hours.

Only one nurse shall be authorized to care for no more than two waiver individuals receiving congregate nursing. When three individuals share a home, nursing ratios shall be determined by DMAS or its designated agent, based on the care needs of all of the individuals who are living together.

DMAS ONGOING REVIEW

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For FFS individuals, DMAS will monitor the individual's status and the provision of nursing services by telephone contact with the provider, review provider Supervisor Monthly Visit Notes, review skilled nursing notes, as needed, and will perform the annual DMAS visits.

Annual eligibility assessment visits, performed by DMAS for all individuals receiving PDN services, shall include, but are not limited to:

- Reviewing the most recent CMS-485 for appropriateness of the level, amount, type, and quality of services provided;
- Monitoring the cost-effectiveness of the individual's care in the community;
- Reviewing the last three months of Supervisory Monthly Summary notes (DMAS 103);
- Discussing customer satisfaction and choice;
- Assessing that health, safety and welfare needs are being identified and met by the provider; and,
- Reviewing skilled nurse’s notes.

PRIVATE DUTY NURSING SERVICE UNITS AND LIMITATIONS

Adults are eligible for a maximum of 112 hours per week of PDN hours due to complex care needs and must be ventilator dependent or meet complex tracheostomy criteria on the Private Duty Nursing Adult Referral form (DMAS-108).

The following are service units and limitations:

- PDN is billed in hourly units.
- A day is defined as 24 hours which begins at 12:00 AM and ends at 11:59 PM.
- A week is defined as Sunday through Saturday for the purpose of authorization.
- Payment is available for allowable activities which are authorized and provided by qualified providers and in accordance with an approved CMS-485.
- Nurses shall not transport individuals receiving PDN. Medicaid will not reimburse for transportation to school, or other localities as these are the primary caregiver’s responsibility.
- In no instances are PDN services to be provided for the convenience of other family members living in the individual’s home.

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- PDN services cannot be provided simultaneously with respite care or personal care.

- PDN services shall not be billed to include time the individual is receiving hospital emergency room care or during emergency transport of the individual to such facilities and/or hospitalization. The RN or LPN shall not transport the waiver individual to such facilities.

DECREASE OR INCREASE IN PDN HOURS

DMAS or its designated agent shall have the final authority to approve or deny a requested change to an individual's PDN hours. Any request for an increase to an individual's PDN hours shall be authorized by DMAS or its contractors and accompanied by adequate documentation justifying the increase.

The provider may request a decrease in the amount of authorized PDN hours if the revised PDN hours are appropriate and based on the needs of the individual. The provider agency shall work with DMAS staff for coordination and final approval of any decrease in service delivery. A revised PDN authorization shall be completed by DMAS for final authorization and forwarded to the provider agency.

When the RN Supervisor determines that a decrease/increase in hours of service is warranted, he or she will contact the DMAS Health Care Coordinator (HCC) assigned to the individual immediately. DMAS will work with the RN Supervisor to re- evaluate the needs of the individual based on the assessed information from the provider.

A PDN authorization will be provided by DMAS to the nursing agency and will include the number of PDN hours to be provided per week and the effective date the change will occur.

The provider shall be responsible for documenting the physician's verbal orders and for inclusion of the changes on the recertification POC (CMS-485) in accordance with the DMAS PDN Authorization form. The provider agency's RN supervisor, who is responsible for supervising the individual's care, shall use a person-centered approach in discussing the change in PDN hours with the individual and individual's representative to include documentation in the individual's record. The DMAS or its service authorization (SA) contractor shall notify in writing the individual or individual representative of the change. Reimbursement will not occur without authorization from DMAS staff. The provider must ensure tasks performed meet the current needs of the individual.

If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the individual's right to appeal the adverse decision, in accordance with *42 CFR §200 et seq*. and *12VAC30-120-1780 et seq*. The provider also has the right to appeal adverse decisions to DMAS.

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Regardless of the type of change (increase/decrease of hours/services), DMAS will send a letter to the individual/primary caregiver with the change in hours, the effective date of the change, and include appeal rights. Appeal rights can be found at the end of this chapter. A copy of this letter must be filed in the individual's record at the agency.

PDN DOCUMENTATION REQUIREMENTS

Provider Required Documentation - Office Records

The provider shall maintain all records of each individual receiving PDN services. These records shall be separated from those of non-HCBS, such as companion or home health services. These records shall be reviewed periodically by personnel who are authorized by DMAS.

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At a minimum, these records shall contain:

1. All assessments and plans of care, all PDN and all LTC Communication forms (DMAS-225), all medical orders-verbal orders as well as the CMS-485 authorizing PDN, and the age appropriate PDN Adult Referral form (DMAS-108);

2. The physician's certification for services (CMS-485) obtained prior to the service start date and updated every sixty (60) days;

3. The initial assessment (DMAS-116) completed in the home by a registered nurse;

4. The Monthly Supervisory Visit (DMAS-103) completed every 30 days;

- RN supervisor's notes documented and dated during significant contacts with the case and during supervisory visits to the individual's home;
- Include AM and PM behind time notation, such as "in" and "out" time of visits; include printed name and initials and title when documenting; assure time sheets and nursing notes are completed daily, at the end of each shift, and copies or originals are left in the individual's home record;
- When the supervisory visit is missed, documentation must include the reason and the make-up assessment must occur within five (5) days. When there is an interruption in services such as hospitalization, the post hospital RN supervisory visit may serve as the supervisory visit and following visits will resume accordingly;

5. The PDN note must include, but is not limited to, all PDN care provided, as ordered, on the CMS-485, assistance with activities of daily living, administration of medications and any other medical needs and the monitoring of the individual's health status and physical condition. When there are health, safety and welfare concerns, documentation must indicate supervisory and DMAS notification and the appropriate Adult Protective Services/Child Protective Services referrals. The PDN notes must be signed and dated by the nurse providing the care;

6. All correspondence with the individual, DMAS, and the designated SA contractor;

7. Reassessments made during the provision of services;

8. Contacts made with family, physicians, formal and informal service providers, and all professionals involved in the individual's Medicaid services or medical care;

9. The name and phone number of a back-up caregiver who will provide the alternate care usually provided by the trained primary caregiver, in the event of an emergency;

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10. Comments or observations recorded about the individual. The nurse's comments shall include, but not be limited to, observation of the individual's physical and emotional condition, daily activities, and the individual's response to services rendered; and

11. To assure all services are rendered, the signatures of the individual or primary caregiver and the private duty nurse must be documented once each shift when PDN and Respite care is completed. Signatures, times, and dates shall not be placed on the notes prior to the delivery of service for that day. An employee of the provider shall not sign for the individual or caregiver. Documentation verified by signature of the individual or primary caregiver must include arrival and departure time of the nurse.

Provider Required Documentation – Home Records

Documentation in the home record shall be kept in the home at all times. Documentation should be kept in a binder which is kept organized and in a designated place in the home. Caregivers should know the location of the nursing binder.

This home record/binder shall include all of the following:

1. Current CMS-485
2. Medication Administration Records (MAR)
3. Two (2) weeks of nursing shift notes
4. Additional physicians orders received during the certification period
5. Treatment records
6. Nursing assessments and documentation
7. Emergency contact information
8. DNR orders (if applicable)

Nursing documentation must be completed during the shift in which the PDN care is provided. Information documented after the shift is provided must be identified as a "late entry".

HIPAA law shall be observed regarding all documentation and medical records. All nursing documentation must be maintained in the home record.

ENVIRONMENTAL MODIFICATIONS

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Service Definition

Environmental Modifications (EM) are physical adaptations to the individual's primary residence, and/or primary vehicle used by the individual, which provide direct medical or remedial benefit to the individual. These adaptations are necessary to ensure the health, welfare, and safety of the individual, or directly enable the individual to function with greater independence in the home. Without these adaptations, the individual would require institutionalization. The purpose of Environmental Modifications is to modify, not make general improvements to the home. Environmental Modifications are for pre-existing structures.

Criteria

The EM services are available to individuals in the CCC Plus waiver. Individuals who qualify for these services must have a demonstrated need for equipment or modifications of a remedial nature or medical benefit offered in an individual's primary residence, or primary vehicle used by the individual, community activity setting, or day program to specifically improve the individual's personal functioning and is medically necessary. These physical adaptations shall be necessary to ensure the health, welfare and safety of the individual. EM shall not be the sole waiver service received and can only be authorized in conjunction with at least one other authorized standalone waiver service.

Medically necessary includes those services or specialized medical equipment or supplies that are not covered for reimbursement under the State Plan for Medical Assistance that are reasonable, proper, and necessary for the treatment of an illness, injury or deficit.

Allowable Activities

- Physical adaptations to the individual's primary residence necessary to ensure an individual's health, safety and welfare; or
- Physical adaptations to the individual's primary residence that enable an individual to live in a non-institutional setting and to function with greater independence that do not increase the square footage of the primary place of residence; or
- Modifications to the primary vehicle being used by the waiver individual. This service does not include the purchase or lease of vehicles or general repair of vehicles. Repairs of modifications that have been reimbursed by DMAS shall be covered.

<u>Examples of Environmental Modifications</u>

Such modifications may include, but be limited to the following:

- Installation of non-portable wheelchair ramps and grab-bars at the primary residence;

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- Widening of doorways and other adaptations to accommodate wheelchairs;
- Modification of bathroom facilities to accommodate wheelchairs (not strictly for cosmetic purposes);
- Installation of specialized electrical and plumbing systems required to accommodate the medical equipment and supplies which are necessary for the individual's welfare; and
- Modifications may include a generator for individuals who are dependent on mechanical ventilation for 24-hours a day and when the generator is used to support the medical equipment and supplies necessary for the individual's welfare.

Collaboration

The provider and the waiver individual may collaborate with multiple providers in order to complete a modification, for example:

1. A Physical Therapist, Speech Therapist or Occupational Therapist may be accessed to evaluate the needs for environmental modifications; and/or

2. A Rehabilitation Engineer or Rehabilitation Specialist may be used to evaluate the individual's needs and subsequently act as Project Manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. Alternatively, the Rehabilitation Engineer may actually design and personally complete the modification.

For example, a Rehabilitation Engineer might be required if:

- The Environmental Modification involves combinations of systems which are not designed to go together; or

- The structural modification requires a Project Manager to assure that design and functionality meet ADA accessibility guidelines.

3. A building contractor may design and complete the structural modification;

4. A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the building contractor or Rehabilitation Engineer; or

5. A durable medical equipment (DME) provider enrolled with DMAS may be used to bill for modifications.

Collaborative funding is allowed for Medicaid covered services; however, due to the Federal rules, the provider would need to break down the parts. For example, if an individual needs a wheelchair van lift, the provider needs to determine the cost for the floor of the van, the cost for the ties, and the cost for the lift. For the parts funded with Medicaid dollars, the provider must accept payment as payment in full. The provider will

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need to delineate which parts are Medicaid funded and which are private pay or another funding source, e.g., DARS, Assistive Loan Fund Authority, church or other private funding, etc.

Service Units and Service Limitations

a. EM shall be available for a maximum Medicaid-funded amount of $5,000 per household per SFY (State Fiscal Year – July 1 to June 30).

b. Costs for EM cannot be carried over from one plan of care year to the next. Each item shall be service authorized by the DMAS Srv Auth contractor for each SFY year. Unexpended portions of this maximum amount shall not be accumulated across one or more years to be expended in a later year.

c. When two or more individuals receiving waiver services live in the same home, the EM shall be shared to the extent consistent with the type of requested modification.

d. Only the actual cost of material and labor is reimbursed. There shall be no additional markup. Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered non-covered.

e. EM shall be carried out in the most cost effective manner possible to achieve the goal required for the individual's health, safety, and welfare.

f. All services shall be provided in the individual's primary residence in accordance with applicable state or local building codes and appropriate permits or building inspections, which shall be provided to the DMAS designated Srv Auth contractor.

g. Proposed modifications that are to be made to rental properties must have prior written approval of the property's owner. Modifications to rental properties shall only be valid if it is an independently operated rental facility with no direct or indirect ties to any other Medicaid service provider.

h. Modifications may be made to a vehicle if it is the primary vehicle used by the waiver individual. This service shall not include the purchase of, or the general repair of, vehicles (repairs of modifications which have been reimbursed by DMAS shall be covered).

i. Under the *State Plan for Medical Assistance*, Physical, Occupational, and Speech Therapy services must be authorized through the DMAS Srv Auth Contractor if more than five (5) visits have been provided to the individual. Visits are individual-specific, not provider-specific.

j. The EM provider shall ensure that all work and products are delivered, installed and in good working order prior to seeking reimbursement from DMAS. The date of service on this provider's claim shall be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced during the approval dates.

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k. The service authorization shall not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) shall be submitted to the DMAS designated Srv Auth contractor for revision to the previously issued service authorization and shall include justification and supporting documentation of medical needs.

l. A copy of the provider's cost estimate for labor and materials for an environmental modification must be submitted to the service authorization contractor.

Service Exclusions

- Environmental Modifications cannot take place at any site owned and operated by a residential program.
- Environmental Modifications are to modify, not furnish, new additions to a home.
- Environmental Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. The EM service does not include those adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit to the individual. Such non-covered items include, but shall not be limited to: carpeting, roof repair, central air conditioning, general maintenance and repairs to a home, additions or maintenance of decks, maintenance/replacement addition of sidewalks, driveways, carports, turning a shed, attic, basement, or garage into a habitable space, or adaptations which only increase the total square footage of the home, etc.
- Environmental Modifications shall not be covered by Medicaid for general leisure, or diversion items, or those items that are recreational in nature or those items that may be used as an outlet for behavioral supports. Such non-covered items include, but shall not be limited to, swing sets, playhouses, climbing walls, trampolines, hot tubs, elevators, fences, pools, basketball or other courts, protective matting or ground cover, sporting equipment or exercise equipment, such as special bicycles or tricycles, etc.
- DMAS does not repurchase items paid for with waiver funds unless those items have specific timeframes of usefulness (i.e., quarterly maintenance on lifts). Additional repairs are considered on an individual basis.
- Providers that supply environmental modifications for an individual may not perform assessment/consultation, design or inspect environmental modification for that individual.
- There shall be no duplication of EM services within the same plan of care year or EM services within the same primary residence, such as multiple wheelchair ramps or previous modifications to the same room.
- EM shall not include the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source.

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- Excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), and the Rehabilitation Act (20 USC§ § 794). This service shall not cover modifications where payment can be made through the Fair Housing Act (42 USC § 3601 et seq.) or the Virginia Fair Housing Law (§ 36-96.1 et seq. of the Code of Virginia).

- Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under Environmental Modifications. DME and Supplies information can be found on the DMAS Web Portal by accessing the *DME Provider Manual, Appendix B* at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.
- DMAS shall not reimburse for any environmental modifications previously completed prior to service authorization.

EM Provider Documentation Requirements

1. Supporting documentation must demonstrate the medical need for the service, the process to obtain the service (contacts with potential contractors of service, costs, etc.), and the timeframe during which the service is to be provided. This includes a separate written notation of the evaluation, design, labor, and supplies or materials (or both). The supporting documentation and plan of care must include documentation of the reason that a Rehabilitation Engineer is needed, if one is to be involved;

2. Documentation of the date services are rendered and the amount of services and supplies;

3. Any other relevant information regarding the modification;

4. Documentation of the completion of the modification and written receipt and satisfaction of the individual/primary caregiver with the service provided;

5. Instructions are to be provided to the individual/primary caregiver regarding warranty coverage, repairs, maintenance and complaint resolution;

6. The EM provider will ensure that all work and products are delivered, installed and in good working order prior to the end of the plan of care year and prior to billing DMAS;

7. The date of service on the provider claim must be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced during the service authorization approval dates; and

8. The service authorization will not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) must be

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submitted to the DMAS designated Service Authorization Contractor for revision and must include justification and supporting documentation of medical needs.

ASSISTIVE TECHNOLOGY

Service Definition

Assistive Technology (AT) services are specialized medical equipment and supplies, including those devices, controls, or appliances, that are medically necessary to enable individuals to increase their ability to perform ADLs or IADLs or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment medically necessary for the proper functioning of such items. AT devices are expected to be portable.

Medically necessary includes those services or specialized medical equipment or supplies that are not covered for reimbursement under the *State Plan for Medical Assistance* that are reasonable, proper, and necessary for the treatment of an illness, injury or deficit.

Criteria

In order to be eligible for these services, the individual must have a demonstrated need for AT equipment for remedial or direct medical benefit primarily in the individual's primary residence to specifically serve to improve the individual's personal functioning. Ancillary supplies and equipment necessary for the proper functioning of the item may also be included. AT shall not be the sole waiver service received and can only be authorized in conjunction with at least one other authorized standalone waiver service.

Collaboration

An independent, evaluation shall be obtained from qualified professionals who are knowledgeable of the recommended item for each AT request prior to approval by the Srv Auth contractor. All evaluations must be signed by the qualified professional. The professional evaluation includes the trial period of time for the individual to use the device and documentation of any follow up training provided for the recommended items. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists. A prescription alone shall not meet the standard of an evaluation.

Examples of Assistive Technology Devices (not a comprehensive list)	Professional Evaluation Required

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Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Computer/software or Communication Device	Speech Language Pathologist or Occupational Therapist
Orthotics, such as braces for hands, arms, feet, legs, etc.	Physical Therapist, Physician or Orthotist
Writing Orthotics	Occupational Therapist or Speech Language Pathologist
Support Chairs	Physical Therapist or Occupational Therapist
Specialized Toilets	Occupational Therapist or Physical Therapist
Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist, or Occupational Therapist; depending on the device or equipment
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist, Psychologist, or Behavioral Consultant

Items such as furniture shall not be approved if they are of general utility and are not of direct medical benefit.

The AT provider's quote must be compatible with the evaluation completed by the qualified professional.

The provider and the waiver individual may collaborate with multiple providers in order to complete a request for AT, for example:

1. A Physical Therapist, Speech Therapist or Occupational Therapist may be accessed to evaluate the needs for AT; and/or

2. A Rehabilitation Engineer or Rehabilitation Specialist may be used to evaluate the individual's AT needs. The Rehabilitation Engineer may actually design and personally complete the AT, if needed.

For example, a Rehabilitation Engineer might be required if:

- The AT involves combinations of systems (which may include EM), which are not designed to go together; or
- An existing AT device must be modified or a specialized AT device must be designed and fabricated.

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Collaborative funding is allowed for Medicaid covered services; however, due to the Federal rules, the provider would need to break down the parts. For the parts funded with Medicaid dollars, the provider must accept payment as payment in full. The provider will need to delineate which parts are Medicaid funded and which are private pay or another funding source, e.g., DARS, Assistive Loan Fund Authority, church or other private funding, etc.

Service Units and Service Limitations

- The service unit is always one, for the total cost of all AT requested for a specific timeframe. The service unit is the total cost of the item and any supplies, or hourly Rehabilitation Engineering costs.

- The maximum Medicaid-funded expenditure per individual for all AT covered procedure codes combined shall be $5,000 per individual per SFY (State Fiscal Year – July 1 to June 30). Unexpended portions of the maximum amount shall not be carried over from one SFY to the next.

- AT shall be covered in the least expensive, most cost-effective manner. An AT provider's written cost estimate for labor and materials for AT must be submitted to the Srv Auth contractor. AT shall be provided primarily in the individual's home or community setting.

- Each item shall be authorized by the Srv Auth contractor prior to providing the service and cannot be authorized retroactively. The service authorization will not be modified to accommodate delays in product deliveries. In such situations, new service authorizations must be sought by the provider.

- Computer software purchased for an individual must be owned by the individual and accessible by the individual/caregiver to make changes, download updates, etc.

- All products must be delivered, demonstrated, installed and in working order prior to submitting any claim to Medicaid. The date of service on the claim must be within the service authorization approval dates, which may be prior to the delivery date as long as the initiation of services commenced during the approved dates.

- When two or more individuals receiving waiver services live in the same home, the AT shall be shared to the extent practicable consistent with the type of AT.

  Under the *State Plan for Medical Assistance*, Physical, Occupational, and Speech Therapy services must be authorized through the DMAS Srv Auth Contractor if more than five (5) visits have been provided to the individual. Visits are individual-specific, not provider-specific.

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- AT shall not be available to waiver individuals younger than 21 years of age. AT for these individuals shall be accessed through the EPSDT benefit.

Service Exclusions

- AT is not covered for purposes of convenience for the caregiver or for restraint of the waiver individual, or for recreation, leisure, diversional purposes, or for an outlet for behavioral supports, or for educational purposes. Such items include, but are not limited to, swing sets, playhouses, bowling balls, tricycles/bicycles, trampolines, television sets, video equipment/games, computer games, playing cards, printers, scanners, musical, educational, vocational software or hardware, sporting equipment, exercise equipment, etc. are not covered.

- Providers that supply AT for the individual may not perform the professional evaluation or write specifications for that individual.

- AT equipment and supplies shall not be rented but shall be purchased through an AT provider.

- DMAS does not repurchase items paid for with AT funds unless those items have specific timeframes or usefulness (i.e. computer - 5 years).

- DMAS does not pay for duplicate items such as software and later updates to original purchases. This is considered carry over from one year to the next.

- Only the actual cost of material and labor is reimbursed. There shall be no additional markup. Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered non-covered.

- Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under Assistive Technology. DME and Supplies information can be found on the DMAS Web Portal by accessing the *DME Provider Manual, Appendix B.* at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

- Excluded shall be items that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), and the Rehabilitation Act (20 USC§ § 794).

Provider Documentation Requirements

The document requirements are as follows:

1. The evaluation must be completed by the independent professional consultant;

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Supporting documentation, which includes the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the timeframe during which the service is to be provided. This includes separate notations of design, labor, supplies, and materials. The supporting documentation must include the reason that a Rehabilitation Engineer or Certified Rehabilitation Specialist is needed, if one is to be involved. A Rehabilitation Engineer or Certified Rehabilitation Specialist may be involved if a need for such expertise is documented;

2. Written documentation regarding the process and results of ensuring that the item is not covered by the *State Plan for Medical Assistance* as Durable Medical Equipment and Supplies and that it is not available from a DME provider when purchased elsewhere;

3. Documentation of the date services are rendered and the amount of service needed; other relevant information regarding the device or modification;

4. Documentation of the individual/caregiver's receipt of and satisfaction with the AT provided as well as any training provided to the individual/primary caregiver on the usage of the AT;

5. The date of service on the claim must be within the service authorization approval dates, which may be prior to the delivery date as long as services commence during the approved dates;

6. The AT provider is required to deliver and ensure the individual is trained to use the equipment prior to the end of the plan of care year and provide instructions regarding any warranty, repairs, complaints, or servicing that may be needed;

7. The AT provider will ensure that all work and products are delivered, installed and in good working order prior to the end of the plan of care year and prior to billing DMAS;

8. Any request for a change in cost (either an increase or a decrease) requires justification and supporting documentation of medical need and authorization by the SA contractor; and

9. The AT provider must receive a copy of the professional evaluation in order to purchase the items recommended by the professional**.** If a change is necessary, then the provider must notify the assessor to ensure the changed items meet the individual's needs.

TRANSITION SERVICES

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Service Definition

Transition Services are a means of providing for set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Individuals may receive Transition Services for up to nine (9) months through the CCC Plus waiver. Individuals who leave a qualified institution prior to enrolling in CCC Plus waiver but demonstrate a need for Transition Services have 30 days to apply for the service post transition.

Transition Services shall be service authorized for nine (9) months. If the waiver individual chooses consumer directed services, the DMAS designated fiscal employer agent (F/EA) shall manage the reimbursement for the transition services. If the waiver individual chooses agency directed services, the health plan shall manage the reimbursement to the agency or provider for the transition services.

All individuals using the CCC Plus waiver must have the transition services included on a person-centered transition service plan prior to seeking service authorization from the health plan.

Criteria

Transition services are furnished only to the extent that:

- they are reasonable and necessary as determined through the transition service plan development process,
- they are clearly identified in the transition service plan,
- the person is unable to meet such expenses, and
- the goods/services cannot be obtained from another source.

This service does not include services or items that are covered under other waiver services, or state plan options, or by other providers. Transition Services shall not be the sole waiver service received and can only be authorized in conjunction with at least one other authorized standalone waiver service.

Service Units and Service Limitations

Services are available for one transition per waiver individual per lifetime limit and must be expended within nine (9) months from the date of authorization. The funds shall not be available to the individual after that period of time.

The total cost of these services shall not exceed $5,000 per person per lifetime limit, coverage of transition costs to residents of Nursing Facilities, Long Stay Hospitals,

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ICFs/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities), PRTFs (Psychiatric Residential Treatment Facilities) or IMDs (Institute for Mental Disease) who are Medicaid participants and are able to return to the community after at least 90 consecutive days in a qualifying institution.

Transition Services may be requested within 30 days after a transition. If not requested within that timeframe, the individual will not be considered for transition services.

The provider shall work closely with the individual to assure that all costs are reasonable and necessary for transitioning from the institution to the home-and-community-based setting.

Allowable costs include, but are not limited to:

- Security deposits that are required to obtain a lease on an house, condo, apartment or other residence; Essential household furnishings and appliances required to occupy and use a community domicile, for example furniture, window coverings, food preparation items, and bed/bath linens;
- Connection or set-up fees or deposits for utility or services access, such as telephone, electricity, heating and water;
- Services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy;
- Moving expenses;
- Needed clothing items; and
- Fees to obtain a copy of a birth certificate, photo identification card, or driver's license.

Non-allowable costs include, but are not limited to:

- Re-occurring charges such as monthly rental or mortgage expenses;
- Food;
- Regular utility charges;
- Household items that are intended for decoration, diversional or recreational purposes; and
- Services or items that are covered under other waiver services such as chore, homemaker, environmental modifications and adaptations, or specialized supplies and equipment.

DISCONTINUANCE OR CHANGE IN SERVICES BY THE PROVIDER

Advance Notice required for Personal Care/Respite/SF/ADHC/PERS/PDN

There are various financial, social, and health factors that might cause a provider to discontinue, increase, or decrease services to a Medicaid individual. The provider must make adjustments to services as indicated by any change in the individual's needs or

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situation. The provider must give the individual or family ten (10) calendar days written notification plus three days for mailing of any decision to discontinue or to change the amount of services received (unless the individual requests a date which is less than ten (10) calendar days and the provider documents the individual's request).

The provider may discontinue services if the individual fails to pay the required patient pay amount that is due. If services are discontinued by the provider, this notice must **not** contain appeal rights since the individual has not been terminated from Medicaid services.

Decrease in Hours

If the RN Supervisor/SF has determined that a decrease in hours of service is warranted, the RN Supervisor/SF must discuss the decrease in hours with the individual or family during a home visit and document the visit and conversation in the individual's record. If there is to be a decrease in hours, the provider must develop a new Plan of Care and notify the individual, the caregiver, and submit a request for the decrease in hours to the srv auth contractor. The provider/SF must state in writing the specific reasons for the decrease, the new number of hours to be provided per week, and the effective date of the decrease in hours. The provider/SF must give the individual a copy of the new DMAS-97A/B. The srv auth contractor must also receive the new DMAS-97A/B,

If the individual requests a decrease in hours by telephone, the RN Supervisor/SF is not required to make an extra visit to the individual's home. The provider/SF will send a letter confirming the individual's request, the new number of hours, the new DMAS-97 A/B, and the effective date of the change. The new DMAS-97 A/B must be signed by the individual at the next visit.

If the individual disagrees with the decrease or the new Plan of Care, the effective date of the decrease shall be ten (10) calendar days from the notification date. The provider must develop the Plan of Care based on the assessment, but request from the srv auth contractor the actual number of hours that the individual/caregiver wants. The request to the srv auth contractor must clearly state that the individual/caregiver does not agree with the decrease. The srv auth contractor will review all of the information submitted. If unable to authorize what the individual/caregiver requests, the srv auth contractor will process the change request as a partial denial, and appeal rights will be offered in the letter automatically generated through the MMIS system.

The individual may file an appeal with DMAS, in accordance with *12 VAC 30-110-100*.

Increase in Hours

The provider/SF is able to establish the amount of service in the Plan of Care, which is appropriate to meet the individual's needs as long as the maximum number of hours per week for that individual's level of care is not exceeded. (Under no circumstances can the

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individual receive more hours of care than his or her level of care allows without prior approval from the srv auth contractor).

The provider/SF must send a request to the srv auth contractor to authorize the increase if a change in the individual's condition indicates that either (i) supervision needs to be added to the Plan of Care or (ii) the individual's level of care has changed and an increase to the Plan of Care is needed for more than the amount allowed according to the individual's current level of care. This contact must be documented in the individual's record with the date and time of the call, to whom the RN Supervisor/SF spoke with, the requested information, and the outcome of the call. The updated DMAS-97 A/B and any other documentation necessary to justify the need for and use of hours may be requested by the srv auth contractor.

The srv auth contractor will transmit authorizations or denials to the MMIS. Once the entry has been made, the provider/SF and individual will receive a computer-generated letter notifying them of the decision and providing appeal rights if a denial or partial approval is issued. Individuals have the right to appeal any adverse action taken by the srv auth contractor. A copy of this letter must be maintained in the individual's record.

Transfer of Cases

When a SF or Personal Care Agency chooses to end services or when an individual chooses to change providers for a service, the prior SF/agency must supply the new SF/agency provider with a copy of the last Plan of Care, a copy of the discharge 225, and a copy of the screening (if available). The new provider should request this documentation from the prior SF/agency provider to assist the new provider in developing an appropriate Plan of Care for the individual.

For a transfer admission, the new provider/SF must submit a request to the srv auth contractor and complete the required questionnaire. The information from the DMAS-97A/B or DMAS-301, the DMAS-99 and the DMAS-100 (if the Plan of Care includes supervision time) will be needed when completing the questionnaire. **The new provider must complete a new assessment and Plan of Care for authorization of services.** If the previous provider/SF has not discharged the individual through the srv auth contractor, the new provider/SF must answer the questions on the questionnaire regarding transfers using the information found on the discharge DMAS-225, or a transferring letter from the previous provider indicating the last billable date of service.

NOTE: If there has been a lapse in time between services, the provider is responsible for ensuring that the screening is still valid, as specified in the Medicaid Long Term Services and Supports (LTSS) Screening Provider Manual.

If the individual's previous Plan of Care included supervision or was for hours over the individual's level of care and the new (receiving) provider/SF has evaluated and found that these same hours are needed and criteria are met for the supervision or hours over the level of care, the new provider must verify that these hours were previously approved.

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In transfer situations, supervision and hours over the LOC cap may be approved to the start of care date when the request is submitted within 10 business days of the start of care. Supervision and hours over the LOC maximum will only be authorized by the service authorization contractor when the new provider/SF provide documentation showing criteria are met and with appropriate documentation/justification for the hours included in the plan of care.

If the new provider/SF's Plan of Care is a decrease in hours from what the individual was previously receiving, the provider/SF must send the individual a decrease notification letter. These decreased hours may be implemented if the individual is in agreement with the new hours and Plan of Care. If the individual disagrees with the decrease and the new Plan of Care, the effective date of the decrease shall be ten (10) calendar days from the notification date. The provider must develop the plan of care based on the assessment, but request from the srv auth contractor the actual number of hours that the individual/caregiver wants. The request to the srv auth contractor must clearly state that the individual/caregiver does not agree with the decrease. The srv auth contractor will review all of the information submitted. If unable to authorize what the individual/caregiver requests, the srv auth contractor will process the change request as a partial denial, and appeal rights will be offered in the letter automatically generated through the MMIS system.

The individual may file an appeal with DMAS, in accordance with *12 VAC 30-110-100*.

Disenrollment from Consumer-Directed Services

There may be instances in which a waiver individual must be disenrolled from consumer-directed services, either voluntarily or involuntarily. The following situations may be cause to remove an individual from consumer-directed services:

- It is determined that the waiver individual cannot complete the duties of the EOR and no one else is able to assume this role;

- The waiver individual has demands of their attendant outside of the scope of personal care services; medication or skilled nursing needs; or is seeking assistance for medical or behavioral conditions that cannot be met via CD services;

- The waiver individual, or EOR, as appropriate, is consistently unable to retain or manage the attendant as may be demonstrated by, but not necessarily limited to, a pattern of serious discrepancies with the attendant's work shift entries or non-compliance with CD requirements, including but not limited to, non-compliance with Electronic Visit Verification, inappropriate documentation of tasks performed, or non-compliance with timely submission of work shifts.

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Under these circumstances, the Services Facilitator must offer agency-directed services to the waiver individual and provide the individual the freedom of choice to select the personal care agency.

In situations where the attendant's work shift entry discrepancies are known, the services facilitator must assist the waiver individual's transfer to agency-directed services by doing the following:

1. Verify that training has been provided to the waiver individual or EOR;

2. Document in the waiver individual's record the conditions creating the necessity for the individual's disenrollment and actions taken by the services facilitator;

3. Discuss with the waiver individual and/or EOR, as appropriate, the option of agency-directed services and the actions needed to arrange for such services as well as offer the individual the choice of potential agency providers;

4. Provide written notice to the waiver individual of the right to appeal such involuntary termination of consumer direction. The written notices must give at least 10 calendar days plus 3 for mailing prior to the effective date of this termination. In cases when the individual's or provider personnel's health, safety, or welfare may be in jeopardy, the 10 day notice does not apply.

PDN Transfer

The PDN provider must transfer an individual's care to another PDN agency whenever the provider is no longer able to sufficiently staff the individual's case or the individual requests a transfer to another provider of their choice.

- The transferring skilled PDN provider is instructed to contact DMAS to inform them of the need to transfer the individual, the provider chosen to accept the transfer and the effective date of the transfer.

- The transferring skilled PDN provider must send to the accepting skilled PDN provider and DMAS:

    1. The last date of service to be rendered by the transferring provider and the reason for the transfer;

    2. A copy of the current POC/CMS-485;

    3. The individual's waiver PDN Needs Assessment or the LTSS Screening packet including the DMAS 96, 97, UAI, and DMAS-108 with the individual's PDN admission date to the waiver;

    4. The most recent Waiver PDN Monthly Supervisory Visit (DMAS-103) form; and

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5. The DMAS-225 communication form sent to DMAS and DSS.

Note: The accepting provider is responsible for ensuring the above information is received and seeking approval from DMAS prior to the initiation of services. Once services start, the accepting provider must send to DMAS the RN Initial Home Assessment form (DMAS-116) and a copy of their initial POC/CMS-485.

Advance Notice Not Required

CCC Plus waiver services may be discontinued without prior notice, if the provider's staff or SF is in immediate danger, or the individual requests immediate discontinuation of services, or the provider does not have staff available to render services and is unable to secure a substitute aide or transfer services. However, the provider/SF must send a letter to the individual indicating that the discontinuation of waiver services and the effective date. A copy of this letter must go to the local department of social services, and Adult Protective Services, if applicable. The discharge request must be submitted to the srv auth contractor. A copy must also be kept in the individual's record.

If the provider does not have staff, the provider must attempt to transfer services to another provider agency. If the individual has adequate back-up support and requests that the provider not transfer the services, the individual must be informed of progress or lack of progress and alternatives. This must be documented in the individual's record. The provider must inform the individual that, if services are not received for 30 consecutive days, continued waiver eligibility will be affected.

Transitioning to Developmental Disability (DD) Waiver for Individuals under Managed Care

When a managed care enrolled member is transitioning from the CCC Plus Waiver to a DD Waiver, DD waiver enrollment, service authorizations, and services cannot begin earlier than the first day of the month after the month in which the CCC Plus Waiver service authorization ended. For example, if an individual is enrolled in the CCC Plus Waiver and is assigned a DD Waiver slot on December 10th, the earliest that any DD Waiver services may be authorized to begin is January 1st. The CCC Plus Waiver service authorization will automatically end based on the effective date of the DD Waiver enrollment.

For individuals transitioning from the CCC Plus Waiver to a Community Living (CL) or Family and Individual Supports (FIS) Waiver, the same number of personal care hours authorized by the MCO for an individual enrolled in the CCC Plus Waiver will be honored for 30 days. To ensure a seamless transition and mitigate service interruption, providers should follow the continuity of care service authorization process as follows:

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1. The SF/agency should expect contact from the Support Coordinator for the individual's DD Waiver services. The SF/agency should make sure the waiver individual has consented to allow an exchange of information with the Support Coordinator.
2. The SF/agency uploads the most recent Plan of Care (DMAS-97A/B) into WaMS. In the justification box in WaMS, the SF/agency will enter "continuity of care service authorization request". If the Support Coordinator finds the hours on the Plan of Care do not match those authorized by the MCO, the SF/agency must submit a revised Plan of Care that reflects the hours authorized by the MCO.
3. The Services Facilitator/Agency provider completes and submits to the Department of Behavioral Health and Disability Services (DBHDS) all required assessments and documentation for CL or FIS Waiver service authorization of personal care services by the 20th of the month that the continuity of care service authorization is in effect. Any delay on the part of the provider shall result in the service authorization start date being the date the request was submitted.
4. For consumer-directed services, the Services Facilitator must submit the Fiscal Agent Request Form to Consumer Direct Care Network and initiate the change in Fiscal/Employer Agent, if applicable, and the change from CCC Plus Waiver services to DD Waiver services.

For questions regarding this procedure, contact the Division of High Needs Supports at DDwaiver@dmas.virginia.gov.

CRITICAL INCIDENTS

A critical incident is any incident that threatens or impacts the well-being of a waiver individual. Critical incidents include, but are not limited to, the following:

- Medication Errors;
- Severe Injury;
- Falls;
- Theft;
- Suspected Mental or Physical Abuse, Neglect, or Exploitation; and
- Death.

It is the responsibility of all providers, including aides and attendants, to report all suspected critical incidents as soon as possible. For individuals in managed care, critical incident reports must be sent to the appropriate MCO using the MCO's preferred method. For incidents involving fee-for-service individuals, reports must be sent directly in an encrypted email to DMAS at FFS.CCCPSupport@dmas.virginia.gov. When reporting a critical incident provide as much information as possible to include the individual's name; Medicaid ID; date, time, and location of the critical incident and when it was first discovered; contact information of the individual, provider, and any witnesses who may also be able to give information; and a description of the incident. If the incident involves

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abuse, neglect, or exploitation, APS or CPS must also be notified; see “Suspected Abuse or Neglect” for more information.

All providers are required to report critical incidents upon first knowledge of the incident.

INDIVIDUAL HEALTH, WELFARE AND SAFETY ISSUES

If the provider/SF becomes aware that the services being provided and the individual’s current support system may not adequately provide for the individual’s safety, the provider/SF must immediately determine whether the individual’s current status represents a potential risk or an actual threat to his or her health, welfare or safety.

A potential risk is identified as deterioration in either the individual’s condition or environment, or both, which, in the absence of additional support, could result in harm or injury to the individual.

An actual threat is the presence of harm or injury to the individual which can be attributed to the individual’s deterioration and lack of adequate support (e.g., the individual becomes anemic, malnourished, or dehydrated due to the inability to obtain food and water; the individual develops decubitus due to lying in urine or feces, etc.).

To determine whether an actual threat may exist, the provider should consider the following:

1. Is the individual capable of calling for help when needed?
2. Is there a support system available for the individual to call?
3. Can conditions be arranged for the individual to care for basic needs when the support system is absent?
4. Is the individual medically at risk when left alone?
5. Has some harm or injury to the individual been reported?
6. Does the individual express fear or concern for his/her welfare?

If answers to any of the above listed concerns indicate a potential risk, the provider/SF is required as a mandated reporter by State Law to report to Adult Protective Services (APS)/Child Protective Services (CPS) at first suspicion.

When reviewing service authorization requests, when a real threat to the individual’s health, safety, and/or welfare exists, the srv auth contractor will attempt to assess whether additional services can be obtained to maintain the individual in a home environment. If continued maintenance in the home is not possible, the contractor will initiate procedures to terminate services and advise the provider/SF or the individual that nursing facility

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services should be considered. The provider/SF shall report the situation to APS/CPS. For the provider's/SF's protection, a letter from the provider must follow up a telephone call to APS/CPS. Waiver services may be discontinued if a safe Plan of Care cannot be developed.

SUSPECTED ABUSE OR NEGLECT

If the provider suspects that a CCC Plus Waiver individual is being abused, neglected, or exploited, or is at risk for abuse, neglect or exploitation, Virginia law (*§§ 63.2-1606 and 63.2-1509 Code of Virginia*) mandates that the party having knowledge or suspicion of the abuse, neglect, and/or exploitation, immediately make a report to either the LDSS where the individual resides or to the toll-free, 24-hour hotlines:

APS: 1-888-83 ADULT (1-888-832-3858)
CPS: 1-800-552-7096 (out of state); 804-786-8536 (in- state).

Local departments of social services are responsible for the investigation of alleged adult abuse, neglect, and exploitation and alleged child abuse and neglect. Contact with the local departments may be made anonymously, but the provider record must note the alleged abuse, neglect, or exploitation and state that the appropriate report has been made. The provider/SF must also report the suspicions to DMAS.

RELATION TO OTHER MEDICAID-FUNDED HOME CARE SERVICES

Home Health

Home health services are provided by a certified home health agency on a part-time or intermittent basis to an individual in their place of residence. An individual's place of residence does not include a hospital or nursing facility. Home health services are intended to provide skilled intervention with an emphasis on individual/caregiver teaching. For additional information and covered home health services, refer to the Department of Medical Assistance Services Home Health Provider Manual, which can be found on the Medicaid web portal located at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

Hospice Care

Hospice is an autonomous, centrally administered, medically-directed program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill individual and the family.

It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic challenges, which are experienced during the final stages of illness and during bereavement. The goal is to maintain the individual at home for as long as possible while providing the best care available to the individual thereby avoiding institutionalization. For

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additional information and covered hospice services, refer to the Department of Medical Assistance Services Hospice Provider Manual found on the Medicaid web portal located at: https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library.

Simultaneous Provision of CCC Plus Waiver Services and Hospice Services

The following information is applicable regardless of whether the hospice receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Hospice enrollment does not limit the waiver services an individual may receive. Waiver services must be authorized by the srv auth contractor. The waiver services provider/SF is required to coordinate services with the hospice provider for those individuals also enrolled in a hospice benefit.

REFUSAL OF SERVICES BY THE INDIVIDUAL

Individuals have the right to refuse services. This refusal must be documented in the individual record. If all services for the day are refused, the aide must contact the provider agency, leave the home and document the early departure time. If services are refused frequently, a reduction in care hours may be warranted (see “Decrease in Hours” in this chapter). This refusal must be documented by the provider in the individual’s record and an evaluation should be conducted, and the service-authorization contractor staff should be contacted, if appropriate.

The provider may not bill Medicaid for the individual for any time services are scheduled, but the aide/attendant is not able to provide care (e.g., the aide arrives and the individual is not home).

CHANGE OF RESIDENCE

If an individual’s residence changes, the provider must record this change in the individual’s record and notify the LDSS immediately and in writing (using the DMAS-225).

INDIVIDUALS WITH COMMUNICABLE DISEASES

Current information regarding the transmission of Acquired Immune Deficiency Syndrome (AIDS) and other similar communicable diseases indicates that these diseases are not transmitted through casual contact, and isolation techniques or procedures are not required for providing care to these individuals in their homes.

Certain routine hygienic precautions designed to prevent the spread of all communicable diseases, including bloodborne infections, should be taken by all providers when rendering care to any individual, regardless of his/her known medical condition. These precautions should include care in handling sharp objects such as needles, the wearing of disposable gloves when one could become exposed to blood or other body fluids, and scrupulous hand washing before and after caring for each individual.

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Providers are prohibited from discriminating against individuals who have been diagnosed as having Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) and other communicable diseases.

INDIVIDUALS WITH MENTAL ILLNESS, INTELLECTUAL DISABILITIES, DEVELOPMENTAL DISABILITIES, OR RELATED CONDITIONS APPROVED FOR SERVICES

Federal waiver programs are designed to serve a specific targeted population. The CCC Plus Waiver can only serve individuals who are at risk of nursing facility placement and meet eligibility requirements for the waiver. Individuals who qualify for the CCC Plus waiver may also be on waiting lists for other waivers. Refer to the DMAS web site for more information on waivers for individuals with developmental or intellectual disabilities.

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CHAPTER III

MEMBER ELIGIBILITY

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Chapter III: Member Eligibility

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DETERMINING ELIGIBILITY

The Department of Medical Assistance Services (DMAS) administers Virginia's medical assistance programs: Medicaid and the state's Children's Health Insurance Program (CHIP), called Family Access to Medical Insurance Security (FAMIS). Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at https://coverva.dmas.virginia.gov/. DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") A member's eligibility must be reviewed when a change in the member's circumstances occurs. All members are subject to a periodic renewal (redetermination) of eligibility annually, with the following exceptions:

- Effective January 1, 2027, individuals enrolled in the Medicaid Expansion coverage group must renew coverage every six months.
    - American Indian Tribal members who are enrolled in Expansion are not subject to the six-month requirement and must complete the renewal process annually.
- Pregnant members have continuous eligibility through the end of their postpartum period, which is 12 months postpartum, with the exception of FAMIS Prenatal members, whose postpartum coverage period ends 60 days postpartum.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet. Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. The FAMIS programs—FAMIS for Children, FAMIS MOMS and FAMIS Prenatal Coverage for pregnant women—offer coverage similar to Medicaid but have higher income limits.

Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients

- Aged, blind or disabled (ABD) recipients of Supplemental Security Income

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(SSI) and certain former SSI recipients with “protected” status.

- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older, blind, or disabled and/or who are eligible for or enrolled in Medicare.

- Low-Income Families with Children (LIFC; a coverage group for parents with a dependent child under age 18 years in the home who meet certain income limits and other eligibility criteria).

- Pregnant women, and postpartum women through the end of the 12-month postpartum period (Medicaid and FAMIS MOMS).

- Pregnant women otherwise eligible for full-benefit coverage through Medicaid or FAMIS MOMS but for their immigration status, through the FAMIS Prenatal Coverage program. FAMIS Prenatal Coverage members are eligible for the duration of the pregnancy and through the end of the month in which the 60th postpartum day falls.

- Newborns up to age one year born to individuals enrolled in Medicaid, FAMIS, or FAMIS MOMS at the time of birth.

- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.

- Children under age 19 years (Children’s Medicaid, FAMIS)

- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare (Medicaid Expansion Adults).

- Individuals under age 21 in institutional care.

- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) — women and men who were certified through the Breast and Cervical Cancer Early Detection Program.

- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care.

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

- Qualified Medicare Beneficiaries (QMBs) with income less than or equal to

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100% of the FPL. This group is eligible for Medicaid coverage of Medicare premiums, deductibles, and coinsurance only.

- Special Low-Income Medicare Beneficiaries (SLMB) with income over 100% and less than or equal to 120% of the FPL. This group is eligible for Medicaid coverage of Medicare Part B premiums only.

- Qualified Individuals (QI) with income over 120% but less than or equal to 135% of the FPL. This group is eligible for Medicaid coverage of the Medicare Part B premiums only.

- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of Medicare Part A premiums only.

- Plan First – Individuals with income up to 200% of FPL who are not covered for full Medicaid benefits. Coverage is limited to family planning services only. Applicants must opt in to be evaluated for Plan First coverage if they do not qualify for full Medicaid coverage.

Medically Needy Covered Groups and Spenddown

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

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18
- Individuals under age 21 in institutional care, under supervision of the Department of Juvenile Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

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

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

Eligible Noncitizens and Emergency Medicaid Services

To be eligible for full Medicaid or FAMIS benefits, an individual must be a resident of Virginia and a U.S. citizen, or a noncitizen qualified for full benefits. Included in this definition are lawfully residing immigrants who are pregnant or within the first 12 months postpartum and lawfully residing immigrant children under the age of 19. In addition, the FAMIS Prenatal Coverage program offers prenatal coverage, through 60 days postpartum, for uninsured pregnant women up to 200% FPL who do not meet immigration status criteria but are otherwise eligible for Medicaid or FAMIS MOMS.

Individuals who do not qualify for full Medicaid benefits due to their Immigration status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage.

Individuals may apply for Emergency Services Medicaid through the same application processes used to apply for Medicaid.

For more information, please see the Emergency Medicaid Services Supplement that is attached to the Physician-Practitioner, Hospital, and Transportation Manuals.

Medicaid Eligibility for Institutionalized Individuals

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

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

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual’s eligibility in one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person.

A married institutionalized individual's spouse at home is referred to as the

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community spouse. The community spouse is able to retain a specified amount of resources to continue to meet maintenance needs in the community. Some of the institutionalized spouse's monthly income may also be allocated to the community spouse if certain criteria are met. At the time of application for Medicaid, the LDSS completes a resource assessment, producing a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be allocated to the community spouse). An institutionalized spouse with a community spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

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

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS)

FAMIS Children

FAMIS is Virginia's Title XXI Children's Health Insurance Program (CHIP) and is a comprehensive health insurance program for children from birth through age 18 who are not covered under other creditable health insurance and whose income is over the Medicaid income limit but no more than 200% of the FPL.

When children are initially enrolled in FAMIS they will have brief coverage in fee-for-service (FFS), with a Medicaid look-alike benefit package, before transitioning to a managed care organization (MCO). Once in managed care, FAMIS children are eligible for benefits similar to those covered for children under the State Plan for Medical Assistance, with some exceptions.

FAMIS MOMS

The FAMIS MOMS program covers uninsured pregnant women whose income is over the Medicaid income limit but no more than 200% of the FPL. This coverage extends through 12 months postpartum. FAMIS MOMS provides the same benefits to pregnant women as Medicaid, including dental services.

FAMIS Prenatal Coverage

Effective July 1, 2021, prenatal coverage is available through the FAMIS Prenatal Coverage program for uninsured pregnant women who meet all other eligibility criteria for Medicaid and FAMIS MOMS but do not meet immigration status rules. FAMIS Prenatal Coverage is available through the end of the calendar month in which the 60th postpartum day falls.

12-MONTHS CONTINUOUS ELIGIBILITY FOR CHILDREN

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It is mandatory for states to provide 12 months of continuous eligibility (CE) for children under age 19 in Medicaid and CHIP (FAMIS), with limited exceptions. CE means the child remains enrolled for a protected 12-month period, during which their coverage cannot be reduced or terminated regardless of changes in circumstance. Changes in circumstance that do not impact eligibility until the end of the child's CE period include, but are not limited to, an increase in household income, loss of Supplemental Security Income (SSI), or a FAMIS-enrolled child obtaining other qualifying health coverage.

Exceptions to the CE requirement are listed below:

- The child turns age 19. Coverage under a children's eligibility group will end at the end of the month in which the individual turns 19. The individual will be evaluated for ongoing coverage as an adult and enrolled if eligible.
- The child moves out of Virginia. Coverage ends at the end of the month in which the child ceases to be a Virginia resident.
- The child or their representative requests termination of the child's coverage.
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child/child's representative.
- Death of the enrolled child.

Medicaid-enrolled children may not be moved into FAMIS during the 12-month continuous eligibility period as this is a reduction of coverage. FAMIS-enrolled children may be moved into Medicaid during a CE period but must be given a new 12-month CE period beginning when the change occurs.

MEMBER ELIGIBILITY CARD

A white plastic eligibility card with the Cardinal Care logo on front is issued to members enrolled in either Medicaid, FAMIS, or Plan First coverage to present to participating providers. A sample of an eligibility card is included under "Exhibits" at the end of this chapter.

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

Most individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral and authorization from the MCO. These members will have an MCO card from their assigned MCO provider with the Cardinal Care logo in

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addition to the Medicaid/FAMIS Cardinal Care logo card. Both cards should be presented to the provider when requesting services or medications. The verification response will advise if the member has restrictions such as a contracted MCO enrollment, or a primary payer.

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

Name of Eligible Person

An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Check the name against another proof of identification if there is any question that the card does not belong to the member. Cards with “Do Not Use” or other non-names should not be accepted.

Member's Eligibility Number

The **member's** complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or moves into another case, or has a break in eligibility, they keep the same number and the same card. This number serves as a “key” in verifying current eligibility status.

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

Bank Identifier

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

Date of Birth

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

Card #

The sequential number of the member’s card is given. If a card is lost or stolen and

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another is issued, the prior card will be de-activated.

VERIFICATION OF MEMBER ELIGIBILITY

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. Possession of a card does not mean the holder is currently eligible for benefits. .

Program/Benefit Package Information

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

Limited Benefit Programs for Which Members Receive Eligibility Cards

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

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

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

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

Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a Plan First identification card. This group's Medicaid verification provides the message, "limited benefits

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only." See the Plan First Manual for more information.

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

Special Indicator Code (formerly Copayment Code – Copayments are no longer charged for Medicaid and FAMIS eligible members)

The Special Indicator Code indicates eligibility for certain additional services. These codes are:

Code	Message
A	Under 21.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care
C	All Other Members

Insurance Information

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

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

Only insurance information for active policies during the period for which eligibility is

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requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to their LDSS eligibility worker to correct the data so bills will be processed correctly.

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

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

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

MANAGED CARE PROGRAMS

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

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

- Cardinal Care: https://dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/
- Program of All-Inclusive Care for the Elderly (PACE) https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care

MEMBER WITHOUT AN ELIGIBILITY CARD

A member who seeks services should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the

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card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

ASSISTANCE TO PATIENTS POSSIBLY ELIGIBLE FOR BENEFITS

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover Virginia Call Center at 1-855-242-8282 to complete an application for Medicaid. In most cases, a member's eligibility begins the first of the month in which the individual applies for coverage; however, Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility.

Retroactive Coverage

Effective January 1, 2027, an individual may request an evaluation for retroactive coverage of medical expenses that were incurred prior to the month of application.

- Individuals eligible for Medicaid Expansion may be evaluated for retroactive coverage one month prior to the month of application.
- Individuals eligible for all other Medicaid coverage groups may be evaluated for retroactive coverage up to two months prior to the month of application.
- FAMIS retroactive coverage is limited to children for whom an application is submitted within the two months following the month of birth.

Once a patient is found eligible, providers shall bill Medicaid for covered services, and upon receipt of payment from Medicaid, must reimburse the patient for anyout-of-pocket expenses; Medicaid cannot reimburse members for out-of-pocket expenses.

MEDICAID APPLICATIONS – AUTHORIZED REPRESENTATIVE POLICY

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

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless the child is legally emancipated from their parents. If a child is not legally emancipated, the parent or legal guardian**, or** an authorized representative designated by the parent or legal guardian, or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age

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may apply for Medicaid on behalf of their own child.

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

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

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

An application may be filed on behalf of a deceased person by their guardian or conservator, attorney-in-fact, executor or administrator of their estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within the appropriate retroactive time periods (see section titled: Assistance to Patients Possibly Eligible for Benefits) subsequent to the month of the individual's death. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

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NON-MEDICAID PATIENT RELATIONSHIP

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

NEWBORN INFANT ELIGIBILITY

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

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

A streamlined way to report the birth of the newborn is through the Medicaid MES/FAS Web Provider Portal http://vamedicaid.dmas.virginia.gov/ under the link “E-213”. Any provider approved for access to the Portal may report the newborn’s birth. To review the newborn’s Member ID number, access the portal 30 days after submitting the E-213.

The newborn’s birth can also be reported by calling CoverVA (1-833-5CALLVA/ 833-522-5582) or by reporting to the local department of social services in the locality where the member resides.

See Chapter I for more information on eligibility verification.

MEDICAID ELIGIBILITY FOR HOSPICE SERVICES

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

GUIDELINES ON INSTITUTIONAL STATUS

Individuals Residing in an Institution for Mental Diseases (IMD)

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Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to individuals under age 65 years who are patients in an IMD, unless they are under age 22 and are receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental health conditions. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

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

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

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

Incarcerated Individuals

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

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and

- individuals held in regional and local jails, including those on work release.

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

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

Individuals released from jail under a court probation order due to a medical emergency are NOT inmates of a public institution because they are no longer incarcerated.

Once an individual is released from the correctional facility, they can receive full benefit Medicaid coverage, provided they meet all Medicaid eligibility requirements.

Juveniles

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

a. Prior to Court Disposition

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

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

b. After Court Disposition

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

   If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center.

   A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to

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Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private, must be determined. A juvenile who resides in an ineligible public residential facility is not eligible for full-benefit Medicaid. The child can be eligible for Medicaid coverage limited to inpatient hospitalization if they are admitted to a medical facility for inpatient services.

Who is Not an Inmate of a Public Institution

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

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

APPEALS OF ADVERSE ACTIONS

An appeal is a request for a review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. There are two types of appeals – a provider appeal, which may be filed by a provider or their authorized representative, and a client appeal, which may be filed by an individual or an authorized representative on the individual's behalf. The client appeals process is described below. The provider appeals process is described in Chapter II.

CLIENT APPEALS

Definitions

Administrative Dismissal – The dismissal of a client appeal on various grounds, such as lack of a signed authorized representative form, or the lack of a final adverse action from the Medicaid Managed Care Organization ("MCO"), other DMAS Contractor, or other agency acting on behalf of DMAS.

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Adverse Action – means the denial or termination of enrollment or reduction in coverage, or the partial approval, denial, reduction, suspension, or termination of a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise their right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 C.F.R. § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1. For non-members, defined as a request for review of an adverse action by DMAS, a DMAS Contractor, or another agency acting on behalf of DMAS.

2. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members enrolled in an MCO, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

3. For members receiving fee-for-service ("FFS") services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Internal Appeal – means a request to the MCO by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination. The internal appeal is the only level of appeal with the MCO and must be exhausted

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by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Representative (or Authorized Representative) - means an individual who has been authorized to represent someone who received an adverse action. The authorized representative can be anyone such as a family member, friend, neighbor, provider, etc. However, the authorization for someone to serve as a representative for an individual 18 years of age or older must be in writing and submitted to the DMAS Appeals Division to process the appeal. This includes authorization for a provider to represent a member when the services at issue have not been rendered. Written authorization can include a power of attorney, proof of guardianship, or other legal documents establishing the representation. DMAS also has an authorized representative form available on its website at: https://www.dmas.virginia.gov/appeals.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for client appeals. Any adverse action by DMAS, a DMAS Contractor, or other agency acting on behalf of DMAS or internal appeal decision rendered by the MCO may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

There are three types of client appeals, each of which is described below. The first two types, MCO and FFS, involve individuals who are enrolled in Medicaid or a Medicaid program and receiving services either through an MCO or through fee-for-service. The third type, non-member, involves individuals who are seeking to become enrolled in Medicaid or a Medicaid program.

Member Appeals (MCO)

A member, an attorney, a provider authorized to represent a member, or another authorized representative on behalf of the member have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted, or deemed exhausted (due to the failure of the MCO to adhere to the notice and timing requirements), prior to a member filing an appeal with the DMAS Appeals Division.

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

A member may request continuation of services during the MCO's internal appeal

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

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

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there, you can fill out a client appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the client appeal. The request can be submitted by:
  - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
  - Email to appeals@dmas.virginia.gov; or
  - Fax to (804) 452-5454

- By phone at (804) 371-8488 or in-person at the Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

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

Member Appeals (FFS)

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Adverse actions may be

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appealed by the Medicaid member or by an attorney, by a provider authorized to represent the member, or other authorized representative on behalf of the member. Adverse actions include terminations of enrollment, or partial approvals, denials, reductions, suspensions, and terminations of service. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

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

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at https://www.dmas.virginia.gov/appeals or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through AIMS at https://www.dmas.virginia.gov/appeals/. From there you can fill out a client appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the client appeal. The request can be submitted by:
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The Department's state fair hearing decision may be appealed to the appropriate

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Circuit Court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

NON-MEMBER APPEALS

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS, its contractors, or another agency on behalf of DMAS, takes an action that affects the non-member. Adverse actions may be appealed by the non-member, an attorney, a provider authorized to represent the member, or other authorized representative on behalf of the member. Adverse actions include denials of enrollment in the Medicaid program or denial of services that would result in enrollment in a Medicaid program. Also, failure to act within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at https://www.dmas.virginia.gov/appeals or by calling (804) 371-8488. A copy of the notice or letter about the action should be included with the appeal request. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through AIMS at https://www.dmas.virginia.gov/appeals/. From there you can fill out a client appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the client appeal. The request can be submitted by:
  - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
  - Email to appeals@dmas.virginia.gov; or
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The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

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CHAPTER V

BILLING INSTRUCTIONS

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Provider Manual Title: CCC Plus Waiver Revision Date: 12/5/2025
Chapter V: Billing Instructions

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INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program (Medicaid) for covered services provided to Medicaid-eligible individuals. The Department of Medical Assistance Services (DMAS) is the agency that oversees Medicaid in the Commonwealth of Virginia.
This chapter will address:

- **General Information** - This section contains information about DMAS' claims systems and requirements, including timely filing and the use of appropriate claims forms.

- **Billing Procedures** – This section provides instructions on completing claim forms, submitting adjustment requests, and additional payment services.

This manual chapter primarily relates to fee-for-service billing. For more information about reimbursement and claims processing instructions for an individual in a managed care organization, please contact the managed care organization (MCO) directly. Providers must be credentialed with a member's MCO in order to bill for services provided to that member.

Providers under contract with the Program of All-Inclusive Care (PACE) should contact the PACE Program for billing information. For additional details see https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care/.

FEE SCHEDULE

A fee schedule is a complete listing of fees used by Medicaid fee-for-service to pay providers for most services to include professional claims. DMAS develops the fee schedule and can be found on the DMAS website, https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/.

Managed Care Organizations (MCOs) must reimburse providers in accordance with the individual provider's contract with the MCO. There are specified services which require the MCO to pay FFS reimbursement rates or to pay providers at a certain percentage of the FFS rate. MCO rules for provider payments are explained in the Cardinal Care Managed Care Contract, Chapter 12, Provider Payment, available on the DMAS website @ Cardinal Care Managed Care.

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ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing using Electronic Data Interchange (EDI) is an efficient way to submit Medicaid claims. Providers use EDI software that enables the automated transfer of data in a specific format following specific data content rules directly to DMAS. For more information, go to https://vamedicaid.dmas.virginia.gov/edi.

The Virginia Medicaid Enterprise System (MES) is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

MES will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 5010.

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

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

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://vamedicaid.dmas.virginia.gov/edi#gsc.tab=0

The mailing address, phone number and fax number for the EDI program are:

EDI Coordinator
Virginia Medicaid Fiscal Agent
P.O. Box 26228
Richmond, Virginia 23260-6228

Phone: (866) 352-0766
Fax number: (888) 335-8460

The email for technical/web support for EDI is MESEDISupport@dmas.virginia.gov.

DIRECT DATA ENTRY (DDE)

Providers may submit Professional (CMS-1500), Institutional (UB-04) and Medicare

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Crossover claims using Direct Data Entry (DDE). Providers also may make adjustments or void previously submitted claims through DDE. DDE is provided at no cost to providers. Paper claims submissions are not allowed except when requested by DMAS.

Providers must use the Medicaid Enterprise System (MES) Provider Portal to complete DDE. The MES Provider Portal can be accessed at https://vamedicaid.dmas.virginia.gov/provider.

MEDICAID PROVIDER TAXONOMY

Providers must include a valid provider taxonomy code as part of the claims submission process for all Medicaid-covered services. Providers must select at least one taxonomy code based on the service or services rendered. Providers may validate the taxonomy that is associated with their National Provider Identifier (NPI) and practice location through the MES Provider Portal.

For information on taxonomy codes, please go to:
https://vamedicaid.dmas.virginia.gov/provider/downloads

TIMELY FILING

Federal regulations [42 CFR § 447.45(d)] require the initial submission of all Medicaid claims (including accident cases) within 12 months from the date of service. Only claims that are submitted within 12 months from the date of service are eligible for Federal financial participation. To request a waiver of timely filing requirements, providers billing electronically must submit a Claim Attachment Form (DMAS-3) with the appropriate attachments.

DMAS is not authorized to make payment on claims that are submitted late, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month in which the individual makes application for benefits. All eligibility requirements must be met within that period for retroactive eligibility to be granted. In these instances, unpaid bills for that period may be submitted to DMAS as Medicaid claims.

Delayed Eligibility - Initial denials of an individual's Medicaid eligibility application may be overturned or other actions may cause an eligibility determination to be delayed. DMAS may make payments for dates of service more than 12 months in the past when the claims are for an individual whose determination of eligibility was delayed.

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It is the provider's obligation to verify the individual's Medicaid eligibility. The individual's local department of social services will notify providers who have rendered care during a period of delayed eligibility. The notification will indicate notification of the delayed eligibility and include the Medicaid ID number, and the time span for which eligibility has been granted. The provider must submit a claim within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims - Denied claims must be submitted and processed on or before 13 months from the date of the initial claim denial where the initial claim was filed according to the timely filing requirements. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.

- Attach written documentation to justify/verify the explanation. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits).

Accident Cases - The provider may either bill DMAS or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to DMAS within 12 months from the date of the service. If the provider waits for the settlement before billing DMAS and the wait extends beyond 12 months from the date of the service, DMAS shall make no reimbursement.

Other Primary Insurance - The provider must bill other insurance as primary. However, all claims for services **must be billed to DMAS within 12 months from the date of the service.** If the provider waits for payment before billing DMAS and the wait extends beyond 12 months from the date of the service, DMAS will make no reimbursements. If payment is made from the primary insurance carrier after a payment from DMAS has been made, an adjustment or void should be filed at that time.

Other Insurance - The member can keep private health insurance and still be covered by Medicaid. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers may collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

INVOICE PROCESSING

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The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

Remittance Voucher

- **Approved** - Payment is approved or Pended. Pended claims are placed in a pended status for manual adjudication (the provider must not resubmit).
- **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- **Pend** – Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.

No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The** provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible members are automatically submitted to DMAS for processing. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as “crossovers” since the claims are automatically crossed over from Medicare to the DMAS Medicaid system for processing.

CLAIMSXTEN/CORRECT CODING INITIATIVE (CCI)

DMAS utilizes the Medicaid-specific National Correct Coding Initiative (NCCI) edits through ClaimsXten/CCI. NCCI is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit current and historic claims. Any adjustments or denial of payments from the current or historic claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimsXten/CCI edits are based on the following global claim factors: same member, same provider, and same date of service or date of service is within established pre- or post-operative period.

Procedure-To-Procedure (PTP) Edits:
CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported

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together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note**: Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

Medically-Unlikely Edits (MUE):

DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, resulting in a denial of the claim.

Modifiers:

DMAS only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of “1”or “0” in the listing of the NCCI PTP column code. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient’s medical record must contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

Reconsideration

Providers that disagree with the action taken by a NCCI or ClaimsXten edit may request a reconsideration of the process via email (claimcheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, NCCI/ClaimsXten
Division of Program Operations

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

There is a 30 calendar-day time limit form the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30 calendar-day limit will not be considered.

BILLING INSTRUCTIONS FOR SERVICES REQUIRING SERVICE AUTHORIZATION

Please refer to the “Service Authorization” Chapter.

REQUESTS FOR BILLING MATERIALS

Paper versions of the Health Insurance Claim Form CMS-1500 (02-12) and CMS-1450 (UB-04) are available from the U.S. Government Bookstore at https://bookstore.gpo.gov/.

Providers may use the paper forms only if specifically requested to do so by DMAS. DMAS does not provide CMS-1500 and CMS-1450 (UB-04) forms.

INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM

Providers typically use Direct Data Entry (DDE), however, the CMS-1500 (02-12) form must be used in those instances where DMAS has requested the use of the paper form. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12).

SPECIAL NOTE: The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

1 Locator REQUIRED Instructions Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an “X” in the OTHER box for Temporary Detention Order (TDO) or Emergency Detention Order (EDO).
1a REQUIRED Insured's I.D. Number - Enter the 12-digit Virginia Medicaid identification number for the member receiving the service.
2 REQUIRED Patient's Name - Enter the name of the member receiving the service.
3 NOT REQUIRED Patient's Birth Date
4 NOT REQUIRED Insured's Name
5 NOT REQUIRED Patient's Address
6 NOT REQUIRED Patient Relationship to Insured
7 NOT REQUIRED Insured's Address
8 NOT REQUIRED Reserved for NUCC Use
9 NOT REQUIRED Other Insured's Name

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9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	REQUIRED	Is Patient's Condition Related To: - Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.

10d Conditional Claim Codes (Designated by NUCC)
Enter “ATTACHMENT” if documents are attached to the claim form.

11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID

11c REQUIRED If applicable, Insurance Plan or Program Name
If applicable, providers that are billing for non-Medicaid MCO copays only – please insert “HMO Copay.

11d REQUIRED if applicable Is there another health benefit plan? Providers should only check Yes if there is other third party coverage.

12 NOT REQUIRED Patient’s or Authorized Person’s signature

13 NOT REQUIRED Insured or Authorized Person’s signature

14 REQUIRED if applicable Date of current illness, injury, or pregnancy. Enter date MM DD YY. Enter Qualifier 431 – Onset of current symptoms or illness.

15 NOT REQUIRED Other date

16 NOT REQUIRED Dates patient unable to work in current occupation

17 REQUIRED if applicable Name of referring physician or other source

17a REQUIRED ID number of referring physician. The qualifier ZZ may be entered if the provider taxonomy code is needed to adjudicate the claim.

17b REQUIRED ID number of the referring physician. Enter the National Provider Identifier of the referring physician.

18 NOT REQUIRED Hospitalization Dates Related to Current Services

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19 REQUIRED if applicable Additional claim information. Enter the CLIA #.

20 NOT REQUIRED Outside lab.

21 REQUIRED Diagnosis or nature of illness or injury. Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L.
Note: ICD Ind. -OPTIONAL
0=ICD-10-CM – Dates of service 10/1/15 and after

22 REQUIRED if applicable Resubmission Code – Original Reference Number. Required for adjustment and void. See the instructions for Adjustment and Void Invoices.

23 REQUIRED if applicable Service authorization (SA) Number – Enter the PA number for approved services that require a service authorization.

NOTE: The locators 24A thru 24J have been divided into open areas and a shaded line area. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. ENTER REQUIRED INFORMATION ONLY.

24a lines 1-6 open area REQUIRED Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01/01/14). DATES MUST BE WITHIN THE SAME MONTH

24a lines 1-6 red shaded REQUIRED if applicable DMAS requires the use of qualifier 'TPL'. This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is $27.08; red shaded area would be filled as TPL27.08. No spaces between qualifier and dollars. No $ symbol but the decimal between dollars and cents is required.

DMAS requires the use of the qualifier 'N4'. This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number.

NOTE: The unit of measurement qualifier code is followed by the metric decimal quantity
Unit of Measurement Qualifier Codes: F2 – International Units
GR – Gram ML – Milliliter UN – Unit
Examples of NDC quantities for various dosage forms as follows:

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- Tablets/Capsules – bill per UN
- Oral Liquids – bill per ML
- Reconstituted (or liquids) injections – bill per ML
- Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
- Creams, ointments, topical powders – bill per GR
- Inhalers – bill per GR

BILLING EXAMPLES:
TPL, NDC and UOM submitted: TPL3.50N412345678901ML1.0
NDC, UOM and TPL submitted: N412345678901ML1.0TPL3.50
NDC and UOM submitted only: N412345678901ML1.0
TPL submitted only:
TPL3.50

Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples)
All supplemental information is to be left justified.

SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed:

- If there is nothing indicated or 'NO' is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2.
- If locator 11d is checked 'YES' and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. **An EOB/documentation must be attached to the claim to verify nonpayment**.
- If locator 11d is checked 'YES' and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of $15.50. This relates to the old coordination of benefit code 3.

24b open area — REQUIRED **Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.

24c open area — REQUIRED if applicable **Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**

24d open area — REQUIRED Procedures, Services or Supplies – CPT/HCPCS – Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.

24e open area — REQUIRED **Diagnosis Code -** Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than

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	A-L in Locator 24-E or blank may be denied.
24f open area	REQUIRED **Charges -** Enter your total usual and customary charges for the procedure/services.
24g open area	REQUIRED Days or unit. Enter the number of times the procedure, service, or item was provided during the service period.
24h open area	REQUIRED if applicable. **EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services. 1. Early and Periodic, Screening, Diagnosis and Treatment Program Services 2. Family Planning Service
24I REQUIRED	NPI – this is to identify that it is an NPI that is in locator 24J
24I red shaded	REQUIRED if applicable. **ID QUALIFIER –T**he qualifier 'ZZ' is entered to identify the rendering provider taxonomy code.
24J open	REQUIRED if applicable. **Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J red shaded	REQUIRED if applicable. **Rendering provider ID#** - The qualifier 'ZZ' is entered to identify the provider taxonomy code.
25	NOT REQUIRED Federal Tax I.D. Number
26	REQUIRED Patient's Account Number – Up to FOURTEEN alpha-numeric characters are acceptable.
27	NOT REQUIRED Accept Assignment
28	REQUIRED Total Charge - Enter the total charges for the services in 24F lines 1-6
29	REQUIRED if applicable. Amount Paid – For personal care and waiver services only – enter the patient pay amount that is due from the patient. NOTE: The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED. Reserved for NUCC use.
31	REQUIRED. Signature of Physician or Supplier Including Degrees Or Credentials - The provider or agent must sign and date the invoice in this block.

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32	REQUIRED if applicable. Service Facility Location Information – Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. NOTE: For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	REQUIRED if applicable. **NPI # -** Enter the 10 digit NPI number of the service location.
32b red shaded	REQUIRED if applicable. **Other ID#:** - The qualifier of 'ZZ' is entered to identify the provider taxonomy code.
33	REQUIRED. Billing Provider Info and PH # - Enter the billing name As first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	REQUIRED **NPI –** Enter the 10 digit NPI number of the billing provider.
33b red shaded	REQUIRED if applicable. **Other Billing ID -** The qualifier 'ZZ' is entered to identify the provider taxonomy code. **NOTE: DO NOT** use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM, CMS-1500 (02-12), AS AN ADJUSTMENT INVOICE

The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.
1023 Primary Carrier has made additional payment
1024 Primary Carrier has denied payment
1025 Accommodation charge correction
1026 Patient payment amount changed

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1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting admitting, referring, prescribing, provider identification number
1053 Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only **one** claim can be adjusted on each CMS-1500 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

NOTE: ICNs can only be adjusted through the MES Provider Portal up to three years from the **date the claim was paid**. After three years, ICNs are purged from the MES and can no longer be adjusted through the system. If an ICN is purged from the system, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:
Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier 600 East Broad Street, Suite 1300
Richmond, VA 23219

INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM CMS-1500 (02-12), AS A VOID INVOICE

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (08-05), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.
1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong member eligibility number
1046 Primary carrier has paid DMAS maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Member not my patient

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1052 Miscellaneous
1060 Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the MES Provider Portal up to three years from the **date the claim was paid**. After three years, ICNs are purged from the MES and can no longer be voided through the system. If an ICN is purged from the system, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:
Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier 600 East Broad St. Suite 1300
Richmond, VA 23219

NEGATIVE BALANCE INFORMATION – Fee for Service

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, "less the negative balance" and it may also show "the negative balance to be carried forward".

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00 a check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

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INSTRUCTIONS FOR COMPLETING THE PAPER CMS-1500 (02-12) FORM FOR MEDICARE AND MEDICARE ADVANTAGE PLAN DEDUCTIBLE, COINSURANCE AND COPAY PAYMENTS FOR PROFESSIONAL SERVICES

The Direct Data Entry (DDE) Crossover Part B claim form can be located through the MES Provider Portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration with MES is required to access and use DDE within the MES Provider Portal.

Once logged on to MES, choose Provider Resources and then select Claims. Providers have the ability to create a new initial claim, as well as a claim adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to providers. Paper claim submissions should only be submitted when requested specifically by DMAS.

Purpose: A method of billing Medicare's deductible, coinsurance and copay for professional Providers typically use Direct Data Entry (DDE), however, the CMS-1500 (02-12) form must be used in those instances where DMAS has requested the use of the paper form. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12).

NOTE: Note changes in locator 11c and 24A lines 1-6 red shaded area. These changes are specific to Medicare Part B billing only.

Locator	Instructions	
1	REQUIRED	Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Custody Order (ECO).
1a	REQUIRED	Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	REQUIRED	Patient's Name - Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	REQUIRED	Is Patient's Condition Related To: - Enter an "X" in the appropriate box.

- Employment
- Auto accident
- Other Accident (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.

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10d	Conditional	Claim Codes (Designated by NUCC) Medicare/Medicare Advantage Plan EOB should be attached.
11	REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	REQUIRED	Insurance Plan or Program Name Enter the word 'CROSSOVER' **IMPORTANT: <u>DO NOT</u>** enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word 'CROSSOVER'
11d	REQUIRED If applicable	Is There Another Health Benefit Plan? If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage **other than** Medicare/Medicare Advantage Plan and Medicaid.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 – Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a red shaded	NOT REQUIRED	ID Number of referring physician. The qualifier 'ZZ' is entered if the provider taxonomy code is needed to adjudicate the claim.
17b	NOT REQUIRED	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization dates related to current services
19	NOT REQUIRED	Additional Claim Information. Enter the CLIA#
20	NOT REQUIRED	Outside Lab?
21	REQUIRED	Diagnosis or Nature of Illness or Injury. Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. NOTE: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. Note: ICD Ind. - OPTIONAL 0=ICD-10-CM – Dates of service 10//1/15 and after
22	REQUIRED if applicable.	Resubmission Code – Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment: 1023 Primary carrier has made additional payment

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1024 Primary carrier has denied payment
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting admitting, referring, prescribing provider identification number
1053 Adjustment reason is in the miscellaneous category

Enter one of the following resubmission codes for a void:
1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong member eligibility number
1046 Primary carrier has paid DMAS' maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Member is not my patient
1052 Void reason is in the miscellaneous category
1060 Other insurance is available

Original Reference Number - Enter the claim reference number/ICN of the Virginia Medicaid paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted or voided. Only one paid claim can be adjusted or voided on each CMS-1500 (02-12) claim form. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be adjusted or voided through the MES up to three years from the date the claim was paid. After three years, ICNs are purged from the MES and can no longer be adjusted or voided through the system. If an ICN is purged from the system, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to: Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St. Suite 1300
Richmond, VA 23219

23 REQUIRED if applicable. Service Authorization (SA) Number – Enter the PA number for approved services that require a service authorization. NOTE: The locators 24A thru 24J have been divided into open and shaded line areas. The

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shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. ENTER REQUIRED INFORMATION ONLY.

24 lines 1-6 open area. Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01 01 14).

24 A-H lines 1-6 red shaded. REQUIRED. DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing: A1 = Deductible (Example: A120.00) = $20.00 ded A2 = Coinsurance (Example: A240.00) = $40.00 coins A7= Copay (Example: A735.00) = $35.00 copay AB= Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = $145.10 Allowed Amount MA= Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below CM= Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable (Example CM27.08) see details below N4 = National Drug Code (NDC)+Unit of Measurement

This qualifier is to be used to show Medicare/Medicare Advantage payment. The MA qualifier of the payment by Medicare/Medicare Advantage Plan Example: Payment by Medicare/Medicare Advantage Plan is $27.08; enter MA27.08 in the red shaded area
This qualifier is to be used to show the amount paid by the insurance carrier other than Medicare/Medicare Advantage plan. The CM qualifier is to be followed by the dollar/cents amount of the payment by the other insurance. Example:
Payment by the other insurance plan is $27.08; enter
CM27.08 in the red shaded area

NOTE: No spaces are allowed between the qualifier and dollars. No $ symbol is allowed. The decimal between dollars and cents is required.

This qualifier is to be used for the National Drug Code (NDC) whenever a drug related HCPCS code is submitted in 24D to DMAS. The Unit of Measurement Qualifiers must follow the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity or unit. Do not enter a space between the unit of measurement qualifier and NDC.

.

Example: N400026064871UN1.0
Any spaces unused for the quantity should be left blank.
Unit of Measurement Qualifier Codes:
F2 – International Units GR – Gram
ML – Milliliter UN – Unit

Examples of NDC quantities for various dosage forms as follows:

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Tablets/Capsules – bill per UN
Oral Liquids – bill per ML
Reconstituted (or liquids) injections – bill per ML
Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
Creams, ointments, topical powders – bill per GR
Inhalers – bill per GR

Note: All supplemental information entered in locator 24A thru 24H is to be left justified.

Examples:
Deductible is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $20.00, Medicare/Medicare Advantage Plan Paid Amt is
$16.00, Coinsurance is $4.00.
Enter:A110.00 AB20.00 MA16.00 A24.00

Copay is $35.00, Medicare/Medicare Advantage Plan Paid Amt is $0.00
Medicare/Medicare Advantage Plan Allowed Amt is $100.00
Enter: A735.00 MA0.00 AB100.00

Medicare/Medicare Advantage Plan Paid Amt is
$10.00, Other Insurance payment is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $10.00, Coinsurance is $5.00, NDC is 12345678911, Unit of measure is 2 grams
Enter:
MA10.00 CM10.00 AB10.00 A25.00 N412345678911GR2

24b open area REQUIRED Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.

24c open area REQUIRED if applicable. Emergency Indicator - Enter either ‘Y’ for YES or leave blank. DMAS will not accept any other indicators for this locator.

24d open area REQUIRED Procedures, Services or Supplies – CPT/HCPCS – Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.

24e open area REQUIRED Diagnosis Code - Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered. Claims with values other than A-L in Locator 24-E or blank will be denied.

24f open area REQUIRED Charges - Enter the Medicare/Medicare Advantage Plan billed amount for the procedure/services. NOTE: Enter the Medicare/Medicare

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Advantage Plan Copay amount as the charged amount when billing for the Medicare/Medicare Advantage Plan Copay ONLY.

24g open area REQUIRED Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period.

24h open area REQUIRED if applicable EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services.
1 Early and Periodic, Screening, Diagnosis and Treatment Program Services
2 Family Planning Service

24i open area REQUIRED if applicable. NPI – This is to identify that it is a NPI that is in locator 24J

24i red shaded REQUIRED if applicable. Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.

24j open and red shaded REQUIRED if applicable. Rendering provider ID# - If the qualifier ‘ZZ’ was entered in 24I shaded area enter the provider taxonomy code if the NPI is entered in locator 24J open line.

25 NOT REQUIRED Federal Tax I.D. Number

26 REQUIRED Patient's Account Number – Up to FOURTEEN alpha-numeric characters are acceptable.

27 NOT REQUIRED Accept assignment

28 REQUIRED Total Charge - Enter the total charges for the services in 24F lines 1-6

29 REQUIRED If applicable, Amount Paid - For personal care and waiver services only enter the patient pay amount that is due from the patient.
NOTE: The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.

30 NOT REQUIRED Rsvd for NUCC Use

31 REQUIRED Signature of Physician or Supplier Including Degrees or Credentials – The provider or agent must sign and date the invoice in this block.

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32 REQUIRED If applicable. Service Facility Location Information Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered.
NOTE: For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.

32a open REQUIRED if applicable. NPI # - Enter the 10 digit NPI number of the service location.

32b red shaded REQUIRED if applicable. Other ID#: - entered in the provider taxonomy code if the NPI is entered in locator 32a open line.

33 REQUIRED Billing Provider Info and PH # - Enter the billing name as first line, address identify the provider that is requesting to be paid.
NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.

33a open REQUIRED NPI Enter the 10 digit NPI number of the billing provider.

33b red shaded REQUIRED if applicable. Other Billing ID – the qualifier '1D' is required with the API entered in this locator. The qualifier 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 33a open line.
NOTE: DO NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files. Mail the completed claims to:
Department of Medical Assistance Services CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC VISIT VERIFICATION (EVV)

DMAS no longer accepts paper claims (CMS-1500) or direct data entry (DDE) claims for agency directed personal care and respite services. EVV is the required means to submit claims except in one of the exceptions as listed below**.** All agency providers submitting procedure codes associated with EVV must submit electronic EDI claims in the 837-P X12 standard. Should a provider submit claims for these services on paper, or via DDE, the

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claim will deny. The following link provides access to the 837 Professional Health Care Claims and Encounter Transactions Companion Guide:
https://www.dmas.virginia.gov/files/links/1157/MES_EPS_837P_Companion Guide

Each of the following six (6) data elements must be captured for EVV:

1. The type of service(s) performed – service procedure code
2. The individual receiving the services – member's Medicaid ID
3. The date of the service
4. The location of the service delivery – This is a physical address, city, state and zip code and not geographical coordinates. Two (2) locations will be captured in the event that the beginning location is not the same as the ending location.
5. The individual providing the service – the aides first and last name, and a unique ID of the aide, which is generally an employee ID associated with the agency submitting the claim.
6. The time the service began and ended – this will be in the military format

If any of these fields are not completed or incomplete on the 837P, the claim will deny with one or more of the following edits:

1. Beginning Location Address, City, State, Zip Code must be present
2. Ending Location Address, City, State and Zip Code must be present
3. Attendant/Aides Last Name, First Name, and unique ID must be present
4. Time Service Begin – must be in valid 24hour military time format
5. Time Service Ended – must be valid 24-hour military time format and after the begin time, either later in the same day, or the next day.

EVV will not be required for services in Department of Behavioral Health and Developmental Services (DBHDS) licensed facilities, such as a group home, sponsored residential home, supervised living, supported living or similar licensed facility, the REACH Program, or in a school setting. These agency providers must use a modifier of UB in association with the agency directed service procedure code when submitting their claim.

Providers employing live-in caregivers are no longer required to submit EVV data for claims in which a live-in aide provided care. Agency providers must use the modifier UB in association with the procedure code to submit these claims. This modifier will notify DMAS that the claim is exempt from EVV requirements.

NORTHERN VIRGINIA LOCALITIES

For purposes of billing rates provided under the CCC Plus Waiver, the following are considered the Northern Virginia localities:

Alexandria City Arlington County

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Clarke County
Culpeper County
Fairfax County
Fairfax City
Falls Church City
Fauquier County
Fredericksburg City
Loudon County
Manassas City
Manassas Park City
Prince William County
Rappahannock County
Spotsylvania County
Stafford County
Warren County

RATES OF REIMBURSEMENT FOR AGENCY-DIRECTED PERSONAL CARE SERVICES

To comply with federal and state mandates, a ceiling for the cost of personal care services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to the geographic location of the member. The fee for personal care services is an hourly fee that reimburses for authorized personal care services. This fee must cover all expenses associated with the delivery of personal care services, including nursing visits. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The amount of personal care services required by each member shall be determined by the service authorization contractor. Once authorization is approved and the services are provided, the maximum number of personal care hours, which can be billed, is the amount on the provider's approved Plan of Care.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided over the course of a calendar month, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR AGENCY-DIRECTED RESPITE CARE SERVICES

To comply with federal and state mandates, a ceiling for the cost of respite care services has been calculated for regions of the state and must be applied uniformly on a statewide basis according to the geographic location of the member. The unit of service for respite care will be defined by the number of hours of service which are provided. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The reimbursement must cover all expenses associated with the delivery of respite care services.

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The amount of personal care services required by each member shall be determined by the Screening Team and the pre-authorization contractor. This authorization for units of service will establish the maximum number of units and the allowable payment for the service. The maximum amount of respite care service hours allowed in the waiver per individual per State Fiscal Year (SFY) is 480 hours.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR PRIVATE DUTY NURSING (PDN) SERVICES

To comply with federal and state mandates, a ceiling for the cost of PDN services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to the geographic location of the member. The fee for PDN services is an hourly fee that reimburses for authorized PDN services. This fee must cover all expenses associated with the delivery of PDN services, including nursing visits. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The amount of PDN services required by each member shall be determined by the service authorization contractor. Once authorization is approved and the services are provided, the maximum number of PDN, which can be billed, is the amount on the provider's approved Plan of Care. The maximum amount of PDN services hours allowed in the waiver for an individual is 112 hours per week.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided over the course of a calendar month, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR ADULT DAY HEALTH CARE (ADHC) SERVICES

To comply with federal and state mandates, a ceiling for the cost of Adult Day Health Care (ADHC) services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to geographical locality. The fee for ADHC services is a per-diem fee. A day is defined as attendance at the ADHC Center for six hours or more. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

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This fee must cover all expenses associated with the delivery of services for the time the member is attending an ADHC Center. The per-diem reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs.

If a member attends the ADHC Center for less than six hours on any given day, it is considered a half day of service. At the end of the month, the half days of service may be added and rounded to the nearest whole day of service. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

Any ADHC Center which is able to provide members with transportation routinely to and from the center can be reimbursed by DMAS based on a per-trip (to and from the member's residence) fee. This reimbursement for transportation must be service authorized by either the Screening Team or the service authorization contractor review staff. The per-trip reimbursement rate can be found on the DMAS web site at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) SERVICES

The monthly rate (one unit) includes administrative costs, time, labor and supplies associated with the installation, maintenance, and monitoring of the PERS.

The one-time installation of the unit includes installation, account activation, member and caregiver instruction, and removal of equipment.

The rates of reimbursement for PERS monitoring and installation can be found on the DMAS web site at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR MEDICATION MONITORING SERVICES

The rates of reimbursement for medication monitoring installation, monthly monitoring, and the bimonthly (twice per month) rate of reimbursement for PERS nursing visits to fill the medication monitoring unit can be found on the DMAS website at www.dmas.virginia.gov.

The one-time installation of the unit includes installation, account activation, member and caregiver instruction, and removal of equipment.

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RATES OF REIMBURSEMENT FOR SERVICES FACILITATION SERVICES

The reimbursement for service facilitation services varies according to the type of services provided to the member. The fees must cover all expenses associated with the delivery of service facilitation services, including nursing visits. The reimbursement rates are considered by the Department of Medical Assistance Services (DMAS) as payment in full for all administrative overhead and other administrative costs that the provider incurs. Service facilitation reimbursement rates can be found on the DMAS website at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR CONSUMER-DIRECTED (CD) PERSONAL CARE AND RESPITE CARE SERVICES

The reimbursement rates for consumer-directed (CD) personal care services and respite care services can be found on the DMAS web site at www.dmas.virginia.gov. CD personal care and respite care services are reimbursed in 15 minute increments.

PATIENT PAY AMOUNT AND COLLECTION

This form is used by a local Department of Social Services (DSS) and CCC Plus Waiver services provider to exchange information with respect to:

- The responsibility of an eligible member to make payment toward the cost of care;
- The admission or discharge of the member or death of the member; and
- Other information known to the provider that might involve a change in eligibility or patient pay responsibility.

The form shall be prepared by the provider to request a Medicaid number, eligibility determination, or confirmation of the patient pay amount or to notify the local DSS of changes in the member's circumstances. A new form must be prepared by the local DSS at the time of each re-determination of eligibility and whenever there is any change in the member's circumstances that results in a change in the amount of the patient pay.

DISPOSITION OF COPIES

The provider should initiate the form upon receiving a referral from the Hospital or Community Screening Team in order to notify the local DSS that he or she has admitted the member to services and provided the begin date of service. Upon determination of eligibility, the DMAS-225 form will be returned to the provider with the following information:

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- Whether the member does or does not have financial responsibility toward the cost of care;
- The amount and sources of finances; and
- The date on which the patient pay responsibility begins.

There must be a completed DMAS-225 form in the member's file prior to billing DMAS. The provider with the most authorized hours is responsible for the DMAS-225 form. The provider with the most authorized hours of service per month is considered the primary service provider (PSP). Providers involved in the member's care must coordinate the DMAS-225 activities. For CD services, the Services Facilitator must also provide a copy of the DMAS-225 form to the Fiscal Agent. If there is a change in the patient pay amount for members receiving CD services, the CD Services Facilitator must send a copy of the revised DMAS-225 to the pre-authorization contractor and the Fiscal Agent.

The patient pay amount is the member's contribution toward his or her care received in a calendar month. If the amount of services received by a member in a calendar month is equal to or less than such member's patient pay amount, only the amount for the services rendered should be collected from the member, and DMAS should not be billed for that month. If the amount of services rendered is greater than the amount of patient pay, an invoice should be submitted showing the total allowable charges and the patient pay amount. The provider will be reimbursed by DMAS for the total allowable charges less the patient pay amount. For consumer-directed services, if the amount of services rendered is greater than the amount of the patient pay, the Fiscal Agent will subtract the patient pay amount from the CD attendant's payroll. The member is responsible for paying the employee the patient pay directly.

The patient pay amount is that amount of a Medicaid member's income that must be contributed to the cost of his or her care. The amount of patient pay is determined by the DSS based on the member's income and medically related deductions. It is the responsibility of the DSS to notify the member and the provider of any change in the patient pay amount. Patient pay **estimates** are obtained by the Screening Team to inform the member of the estimated patient pay amount and should be included on the DMAS-97 form. The provider should immediately initiate a DMAS- 225 form and send it to the local DSS upon beginning services so that the DSS can notify the provider of the actual patient pay amounts. The provider should compare these actual figures against the Screening Team's estimates. If the two do not correspond, the provider should notify the member and the Fiscal Agent (if applicable) of the patient pay amount on the DMAS-225 form and bill DMAS accordingly.

Upon receipt of a referral in which a patient pay amount for services is indicated, the primary care provider (PCP) should verify that the member understands and agrees to his or her patient pay obligations. Medicaid suggests that this verification be in the form

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of a signed statement of obligation and that the patient pay amount be collected at the beginning of the month. It is the responsibility of the provider to collect the patient pay amount. For consumer-directed services, it is not the responsibility of the Service Facilitator to collect the member's patient pay amount. It is the member's responsibility to ensure the patient pay amount is given to the consumer-directed attendant to cover the amount of personal care services authorized. DMAS will not reimburse a provider for any portion of the patient pay amount.

In those instances where the patient pay responsibility usually exceeds the amount of services authorized for one provider, the provider will divide the amount of patient pay so that the statement obligation signed by the participant indicates the amount the participant will pay monthly to one provider and the amount the participant will pay monthly to a second service provider. The primary service provider must provide a copy of this statement to the secondary service.

For additional information and examples of patient pay collection when a member is receiving more than one waiver service, see Chapter IV's Patient Pay Amount section.

In the event that the member does not pay the patient pay amount in a timely manner, the provider must make a reasonable effort to notify the member/family of the situation in an effort to collect the required amount. A reasonable effort shall be defined as three written notifications to the member.

The member's failure to pay the patient pay amount may affect his or her Medicaid eligibility. Therefore, if the provider is unable to collect the patient pay amount, the provider must also notify the local DSS eligibility worker having case responsibility for the member. For consumer-directed services, if the Service Facilitator becomes aware that the member is not paying the patient pay amount to the consumer-directed attendant, the Service Facilitator must also notify the local DSS eligibility worker having case responsibility for the member. This notification must be in writing and a copy retained in the member's record by the provider. It is the responsibility of the member to pay the patient pay to the provider or, if applicable, to the consumer-directed attendant. The provider or the consumer-directed attendant, if applicable, has the right to decide whether to continue service delivery to a member who neglects to pay his or her patient pay amount. DMAS will not reimburse the provider or the consumer-directed attendant, if applicable, for the patient pay amount that is not paid by the member.

If, after a reasonable effort to collect the patient pay amount, the provider decides to discontinue services, the provider must give the member/family ten days' written notice of discontinuance of services plus three days for mailing of any decision. Such notice must include the reason for discontinuance and the effective date. A copy of this notification must be sent to the local DSS eligibility worker. A copy of all correspondence must be retained in the member's record with the provider and a copy sent to the pre-authorization contractor.

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SPECIAL NOTE: TAXONOMY

With the implementation of the National Provider Identifier (NPI), it will become necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS, and SLH. Prior to using the NPI, DMAS assigned a unique number to a provider for each of the service types performed. In regard to the NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudicated and paid based on the service type, the DMAS system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

Personal Care:
Taxonomy Code: 3747P1801X
Procedure Code (CPT): T1019
Modifier: N/A
Units: Hour

Respite Care:
Taxonomy Code: 385H00000X
Procedure Code (CPT): T1005
Modifier: N/A
Units: Hour

CD Attendant Care
Taxonomy Code: 3747P1801X
Procedure Code (CPT): S5126
Modifier: N/A
Units: Hour

CD Respite Care
Taxonomy Code: 385H00000X
Procedure Code (CPT): S5150
Modifier: N/A
Units: Hour

Private Duty Nursing
Taxonomy Code: 163WC2100X
Procedure Code (CPT): T1002 (RN) T1003 (LPN)
Modifier: N/A
Units: Hour

Private Duty Nursing Respite
Taxonomy Code: 163WC2100X

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Procedure Code (CPT): S9125
Modifier: For RN =TD For LPN = TE
Units: Hour

Congregate Nursing
Taxonomy Code: 163WC2100X
Procedure Code (CPT): T1000 (RN) T1001 (LPN)
Modifier: U1
Units: Hour

Congregate Nursing Respite
Taxonomy Code: 163WC2100X
Procedure Code (CPT): T1030 (RN) T1031 (LPN)
Modifier: For T1030 = TD For T1031 = TE
Units: Hour

Adult Day Health Care
Taxonomy Code: 261QA0600X
Procedure Code (CPT): A0120 (per trip) S5102 (per diem)
Modifier: N/A
Units: Per Trip, Per Diem

PERS
Taxonomy Code: 332B00000X
Procedure Code (CPT): S5160, S5161, S5185, H2021
Modifier: For S5160 = U1 H2021 (RN) = TD H2021 (LPN) = TE
Units: S5160=Per Visit; S5161=Month; S5185=Month; H2021 = 30 minutes

Environmental Modifications
Taxonomy Code: 332B00000X
Procedure Code (CPT): 99199, S5165
Modifier: For 99199 = U4
Units: Per Item/Request

Assistive Technology
Taxonomy Code: 332B00000X T
Procedure Code (CPT): 1999
Modifier: Maintenance
Costs Only = U5
Units: Per Item/Request

Transition Services
Taxonomy Code: N/A
Procedure Code (CPT): T2038

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Modifier: N/A
Units: Per Item/Request

Services Facilitation
Taxonomy Code: 251B00000X
Procedure Code (CPT): 99509, H2000, S5109, S5116, T1028
Modifier: N/A
Units: Per Visit

REJECTION CODES: (WHEN THE TAXONOMY IS DENIED)

EDI Remark: Medicaid Edit- Reject
N94: 1359- Billing Taxonomy Code Does Not Cross-reference to Provider Type
N94: 1392- Taxonomy Code Does Not Cross-reference to Provider Type
N288: 1393- No service Taxonomy Code on the Claim
N255: 1394- No Billing Provider Taxonomy Code on the Claim

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL/RESPITE CARE

Locator 14 Date of Current Illness, Injury, or Pregnancy
Date care began is located on the DMAS-93 form (P.A. Letter)

Locator 24D Procedures, Services, or Supplies
CPT/HCPCS - Enter the appropriate procedure code from the following list:
T1019 Personal Care
T1005 Respite care services, aide/hr.
S9125 Respite care services, LPN/hr.

Locator 24J COB (Primary Carrier Information)
3 - Billed and Paid (Use for patient pay.)

NOTE: For claims submitted on CMS-1500 (02-12) refer to locator 11D & 24A red-shaded area of previous billing instructions.

Locator 24K Reserved for Local Use
Enter the patient pay amount except for Personal Care. (For Personal Care, see instructions for Locator 29). Patient pay and primary carrier payments can be combined if applicable. EOB should be attached to claim.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine Patient Pay and TPL since this revised for allows separation.

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Locator 29 Amount Paid
Enter the patient pay amount for Personal Care only.

SPECIAL BILLING INSTRUCTIONS FOR ADULT DAY HEALTH CARE (ADHC)

The providers of ADHC must complete the CMS-1500 Claim Form. The claim form must be completed as normal with a few special billing instructions:

Locator 24D CPT/HCPCS – Enter the appropriate procedure code from the following list for the service rendered:

S5102 Adult Day Health Care Services

A0120 Adult Day Health Care Transportation

Locator 24J COB (Primary Carrier Information)

3 - Billed and Paid (Use for patient pay.)

NOTE: For claims submitted on CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area of previous billing instructions.

Locator 24K Reserved for Local Use
Enter the payment from other insurance, if applicable.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine Patient Pay and TPL since this revised form allows separation.

Locator 29 All claims submitted to DMAS on or after April 15, 2005, with a patient pay amount, must have the patient pay amount recorded in block 29 of the claim form.

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

Locator 24D <u>Procedures, Services, or Supplies</u>

CPT/HCPCS – Enter the appropriate procedure code from the following list: S5160 PERS Installation
S5161 PERS Monitoring

Locator 24K Reserved for Local Use

Enter the payment from other insurance, if applicable.

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SPECIAL BILLING INSTRUCTIONS FOR MEDICATION MONITORING

Locator 24D Procedures, Services, or Supplies
CPT/HCPCS – Enter the appropriate procedure code from the following list:
S5160 with modifier U1 Medication Monitoring unit installation
S5185 Medication Monitoring unit monthly monitoring
H2021 with modifier TD Medication Monitoring RN visit H2021 with modifier TE Medication Monitoring LPN visit

Locator 24K Reserved for Local Use

Enter the payment from other insurance, if applicable.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine patient pay and TPL since this revised from allows separation.

SPECIAL BILLING INSTRUCTIONS FOR SERVICE FACILITATION SERVICES FOR CONSUMER-DIRECTED (CD) SERVICES

Locator 24D Procedures, Services, or Supplies

It is essential that the provider submit all claims in a timely manner, preferably within 30 days of the date that the service was provided.

CPT/HCPS - Enter the appropriate procedure code from the following list.

NATIONAL CODE	MODIFIER	DESCRIPTION
H2000		Comprehensive Visit
S5109		Consumer Training
99509		Routine Visit
T1028		Reassessment Visit
S5116	U1	Management Training
99199		Criminal Record Check
99199		CPS Registry Check
S5126		Personal Care
S5150		Respite Personal Care

SPECIAL BILLING INSTRUCTIONS FOR RECEIVING SERVICES FROM MULTIPLE PROVIDERS ON THE SAME DAY

For individuals who receive the same service from two different providers on the same day, the first provider's claim is to be billed with modifier 77 on the claim. The second

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provider must submit their claim with the national code and modifier 77. Otherwise, the second provider's claim will be denied due to duplication of services from the first provider. The modifier is placed in block 24D on the CMS-1500 Claim Form.

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Provider Manual Title: CCC Plus Waiver
Revision Date: 5/16/2024
Chapter VI: Utilization Review and Quality Management Review

CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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Provider Manual Title: CCC Plus Waiver
Revision Date: 5/16/2024
Chapter VI: Utilization Review and Quality Management Review

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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. The Department of Medical Assistance Services (DMAS) or its designated contractor(s) conducts periodic utilization reviews on all programs. In addition, DMAS or its designated contractor(s) conducts compliance reviews on providers that are found to provide services that are not within the established Federal or State codes, DMAS guidelines, or by referrals and complaints from agencies or individuals.

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

FINANCIAL REVIEW AND VERIFICATION

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

COMPLIANCE REVIEWS

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

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

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

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

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

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

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself 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

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

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

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

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

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

Member Fraud

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

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

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for Medicaid for a period of twelve months beginning with the month of fraud conviction. The sanction period may only be revoked or shortened by court order.

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

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

PATIENT UTILIZATION AND MANAGEMENT SAFETY PROGRAMS (PUMS)

The DMAS contracted MCOs must have a Patient Utilization Management & Safety Program (PUMS) for MCO enrolled members which is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and care coordination program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the MCO must refer members to appropriate services based upon the member's unique situation.

Once a Member meets the placement requirements for PUMS, the MCO may limit a member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO may limit a member to providers and pharmacies that are credentialed in their network.

If the member changes MCOs while the member is enrolled in a PUMS, the receiving MCO must re-evaluate the member within thirty (30) calendar days to ensure the member meets the minimum criteria above for continued placement in the health plan's PUMS.

UTILIZATION REVIEW – GENERAL REQUIREMENTS

Utilization reviews of enrolled providers are conducted by DMAS, the designated contractor or the MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be

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selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

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

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

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider’s care. Such documentation shall fully disclose the extent of services provided in order to support provider’s claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered or within one business day from the time the services were rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

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

- If a provider lacks a full or conditional license or a provider enrollment agreement does not list each of the services provided and the locations where the provider is offering services, then during a utilization review the provider will be subject to retraction for all unlisted service and/or locations.
- Health care entities with provisional licenses shall not be reimbursed by Medicaid.
- An assessment of whether the provider is following The U.S. Department of Health and Human Services’ Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009).
- An assessment of whether the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.).
- The appropriateness of the admission to service and for the level of care, and medical or clinical necessity of the delivered service.

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- A copy of the provider's license/certification, staff licenses, and qualifications to ensure that the services were provided by appropriately qualified individuals and licensed facilities.
- Verification that the delivered services as documented are consistent with the documentation in the individual's record, invoices submitted, and specified service limitations.
- The reviewer determines that all documentation is specific to the individual and their unique treatment needs. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient services and may not be adequate recordkeeping mechanisms for these services.
- The reviewer determines whether all required aspects of treatment (as set forth in the service definitions) are being provided, and also determines whether there is any inappropriate overlap or duplication of services.
- The reviewer determines whether all required activities (as set forth in the appropriate sections of this manual and related regulations) have been performed.
- The reviewer determines whether inappropriate items have been billed.
- The reviewer determines whether the amount billed matches the documented amount of time provided to the individual.

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

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

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be noted. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting medical record documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, DMAS or its designated contractor(s) will

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contact the provider to conduct an Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the provider.

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

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

MEDICAL RECORDS AND RETENTION

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

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

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

QUALITY MANAGEMENT REVIEWS

A typical QMR encompasses the follow elements:



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Discovery: The review of documentation findings and individual interviews.

Remediation: Based on Discovery, the provision of technical assistance or provision of a corrective action plan ensure needed changes are implemented. Corrective action is taken by Provider to ensure compliance.

Improvement: The follow up activities to assure that recommended or mandated corrective
action and/or improvements to service delivery have been initiated**.**

By federal law, DMAS is the single state authority responsible for the supervision of the administration of home and community-based services waivers in the Commonwealth of Virginia and shall perform routine QMRs of waiver services and providers. QMRs are not to be confused with URs, which is a separate review, as described in this chapter.

DMAS analysts or its contractors shall conduct ongoing monitoring of provider compliance with DMAS participation standards and policies. QMR includes a review of the provision of services to ensure that services are being provided in accordance with DMAS regulations, policies and procedures. A provider's noncompliance may result in a request for a corrective action plan, provision of technical assistance, and/or referral to the Division of Program Integrity. DMAS uses the following procedures when conducting a QMR:

- DMAS or its designated agent will conduct an on-site review and/or desk review of services rendered by providers periodically.
- The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of individuals served, types of services rendered, etc.
- QMR visits may be unannounced.
- Providers may be asked to bring program records to a central location.
- During an on-site QMR, staff will review the individual's record in the provider's place of business/office, paying specific attention to the Plan of Care, supervisory notes (RN and SF), daily records, support logs or progress notes, screening documentation, and any other documentation that is necessary to determine if services were rendered appropriately. Staff may also conduct home visits to meet and talk with individuals

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and/or their family/caregiver to determine satisfaction with waiver services and the provider. The provider may be asked to assist in setting up this visit.

- During the review, staff will offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. 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 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.
- Following the QMR review, a written report of the findings is sent to the provider.
- If there are findings related to licensing procedures, a referral with these findings may be made to other agencies, as appropriate (e.g. Department of Health Professions, Department of Health).
- If a corrective action plan is requested, the provider will have 30 days (unless otherwise indicated) from receipt of the QMR report to submit the plan to DMAS or its contractor for approval. The provider may submit additional documentation that supports their corrective action plan.

DMAS or its contractor will follow up with any corrective action plans that are submitted to ensure that corrective procedures are implemented by the provider.

When the team arrives at the provider's place of business/offices, the team will request a minimum number of records per team member in order to begin the review process. The QMR review team will also request the provider to provide the rest of the records on the review list within two (2) hours of their arrival time for open records and by close of business on the arrival day for closed records.

DMAS analysts shall conduct QMRs of waiver services provided to ensure the health, safety, and welfare of the individual and individual satisfaction with services. The reviews shall focus on the Centers for Medicare and Medicaid's (CMS) assurances of health, safety and welfare, level of care determination, plan of care, and qualified providers, including individual preferences and choices, services being delivered in accordance with the plan of care and the identification of inclusion and risk. In addition to assessing the individual's ongoing need for Medicaid-funded home and community based services (HCBS), another purpose of the reviews is to ensure a waiver individual's satisfaction with waiver services and providers, and that individual choice of services and person-centered planning are being carried out. This may involve interviews with the individual and/or the family/caregiver, as appropriate.

During the on-site QMR review, DMAS analysts monitor the provider's compliance with overall provider participation requirements. Providers must maintain separate employee files for each person hired and make available to QMR staff upon request. Particular attention is given to qualifications of provider staff such as work references (or proof in the personnel file of a good faith effort to obtain such references) and documentation of criminal background checks from the Virginia State Police, as described in Chapter II of

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this manual. However, no employee shall be permitted to work in a position that involves direct contact with an individual in the waiver until an original criminal background record clearance from the Virginia State Police has been received unless such person works under the direct supervision of another employee for whom a background check check has been completed in accordance with the Code of Virginia. If the employee is hired to provide waiver services to a minor under the age of 18, the employee must also have a CPS check performed prior to initiating care to the minor with the CPS check documented in the employee's record. The employee record should contain proof that a check with the Virginia State Police, and as necessary the CPS check, has been requested and conducted within 30 days of hire; however, Virginia State Police rules state that the results of the background check should be properly destroyed and not disseminated to other parties or maintained in the employee's file. DMAS analysts will request to see health professionals' licenses, training certificates for personal care aides, etc. and required documentation that staff who have provided services meet all qualification requirements as identified in DMAS regulations and policies. The provider is responsible for ensuring that all staff of the provider meets the minimum requirements and qualifications at the start of the employment and continues to meet the requirements of the monthly LEIE list check compliance. Personal care aides hired by a personal care agency or an Adult Day Health Care Center must also receive 12 hours of training relating to their job responsibilities on an annual basis. Such record of training, including the training subject, length, and date of training, must be maintained in the employee's record. Information on required documentation in employee files can be found in Chapter II of this manual.

During the QMR, DMAS analysts will discuss with the provider's administration the provider's overall status as a Medicaid provider, any areas of concern, technical assistance needs, the plans for addressing those needs, and any recommendations that staff may have. DMAS may also require additional documentation to verify that the provider is in compliance with DMAS provider agreements and policies, including requirements for ownership of provider agencies. It is the responsibility of the provider to know and fulfill all applicable state and federal requirements relating to the services the provider is authorized to provide per a Medicaid participation agreement.

Providers are continually assessed to ensure that they conform to Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to individuals who are receiving services through the Commonwealth Coordinated Care Plus (CCC Plus) waiver. Information used to make this assessment may include desk reviews of the documentation submitted by the provider, on-site reviews of the provider's files, interviews with staff and with individuals during visits to their homes or place of residence, and by responses to quality assurance survey letters.

DMAS analysts will base an assessment of the provider on a comprehensive evaluation of the provider's overall performance in relation to the following program goals:

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1. Individuals served by the provider meet the waiver program's eligibility criteria. If DMAS determines, during the QMR or at any other time, that the individual receiving waiver services no longer meets eligibility standards or criteria for waiver enrollment and services as set forth in DMAS regulations, the provider shall notify level of care staff by emailing LOCreview@dmas.virginia.gov and request that the provider discuss alternative services with the individual. The provider has a responsibility to be aware of the criteria for the waiver program and to evaluate, on an ongoing basis, the individual's appropriateness for waiver services.

2. Services rendered must meet the individual's identified needs and be within the program's guidelines. The provider is responsible for continuously assessing the individual's needs through home visits made by the provider and communication between the provider, services facilitator, provider staff, the waiver individual and/or primary caregiver. The provider must be notified of any substantial change in the individual's status, the individual's record must contain documentation of any such change, and additional orders must be obtained from the physician, if appropriate. This also includes the provider's responsibility to identify and make referrals for any other services that the individual requires to remain in the community (e.g., durable medical equipment and supplies, skilled nursing visits, etc.).

3. Provider documentation must support all services billed. For services that utilize Electronic Visit Verification, this includes the provider being able to present the appropriate DMAS-90 or electronic equivalent for the shifts being reviewed.

4. Services must be delivered by qualified individuals and providers as required and in accordance with the plan of care. The Plan of Care must be adequate and appropriate for the individual and revised at a minimum annually, and as needed to address changing needs. Services should be received in the frequency, duration, type, scope, and amount as specified in the Plan of Care.

5. Prepare and maintain unique person-centered progress note written documentation in each individual's record about the individual's responses to services and rendered supports and of specific circumstances that prevented provision of the scheduled service or visit, should that occur. Such documentation should be written, signed, and dated on the day that the services were provided. Documentation that occurs after the date services were provided must be dated for the date the entry is recorded and the date of actual delivery of services is to be noted in the body of the note. Examples of unacceptable person-centered progress notes may include:

    - Standardized or formulaic notes;
    - Notes copied from previous service dates and simply re-dated;

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- Notes that are not signed and dated by staff who deliver the service, with the date that the services were rendered, and/or
- Notes that do not document the individual's personal opinions or observed responses to services.

6. Providers opting to use an electronic signature for documentation purposes must comply with the following:
   - The electronic signature can be clearly identified;
   - The electronic signature identifies the individual signing the document and the signature of the date;
   - The electronic signature cannot be altered once it is attached to a document;
   - The date of the signature cannot be altered once it is attached to the signature;
   - Document cannot be signed electronically by anyone other than the individual required to sign the document; and
   - Documents containing electronic signatures can be printed out upon request of the QMR analyst.

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

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

8. The provider shall maintain a record for each individual. Forms that may be used are available on the Medicaid Web Portal at: https://vamedicaid.dmas.virginia.gov/provider/forms#gsc.tab=0

DMAS analysts will review the provider's performance in all outcome areas to determine the provider's ability to achieve high quality of care and conform to DMAS regulations and policies. The DMAS analysts are responsible for providing feedback to the provider regarding those areas that need improvement. DMAS analysts will work with the individual to evaluate the individual's status, satisfaction with the service, and appropriateness of the current Plan of Care (POC). If the POC is found to be inadequate, DMAS analysts may require a revision of the plan to meet the needs of the individual.

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EXIT CONFERENCE

Following the DMAS analyst's or its contractors on-site review of the medical records and home visits, the DMAS analyst will meet during the exit conference with the appropriate provider staff to discuss general findings from the review. The provider may include any staff the provider would like to attend the exit conference but must provide appropriate staff (as requested by the analyst) for this meeting. The Exit Conference is a courtesy meeting offered by DMAS. If the DMAS analysts determine that a face-to-face conference is not possible or not able to occur, the provider will be informed. The Exit Conference may be conducted face-to-face or by telephone, if necessary.

During the exit conference, the provider will be informed of the number of records reviewed, number of participants interviewed, general recommendations regarding level-of-care issues, general recommendations regarding the changes in Plan of Care documentation, and any pertinent information regarding documentation, service verification issues, quality of care, or provision of services. The provider is expected to use the findings of the QMR review to comply with regulations, policies, and procedures in the future. Records that have been reviewed shall not be altered to meet the compliance issues. The DMAS analyst will send a letter to the provider verifying that the review was conducted. This letter will also describe the findings of the review or will give an update as to the status of the review. This letter will also include a list of any citations and technical assistance.

During the QMR review process, the DMAS analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and assistance. Any uncorrected compliance issues may result in the termination of the provider contract.

ANNUAL LEVEL-OF-CARE REVIEWS

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.

If it is found that an individual no longer meets the waiver level of care, DMAS will terminate services in accordance with the procedures detailed in Chapter IV of this manual.

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Commonwealth of Virginia
Department of Medical Assistance Services
Office of Community Living

Consumer-Directed
EMPLOYER OF RECORD MANUAL



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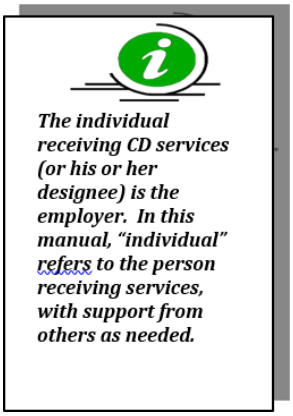
CHAPTER ONE:
INTRODUCTION

Consumer Directed (CD) services are support services that are necessary to enable an individual to remainat or return home rather than enter an institution. Services may include assistance with bathing, dressing, toileting, transferring, and nutritional support necessary for consumers to remain in their own homes or in the community. Services can also include supervision and respite services.

The decision to use consumer directed services means that the individual or someone the individual chooseswill be the employer of the attendants providing the supports and services instead of agency directed care.

This Consumer-Directed Employer of Record (EOR) Manual provides information about the responsibilities and the benefits that come with consumer- direction, including hiring, training, supervising, and, if necessary, firing attendants who will be providing CD services to the individual.



CD services are available in the following Virginia Medicaid waivers, benefit, and program:

1) Commonwealth Coordinated Care Plus (CCC Plus) waiver
2) Community Living (CL) waiver
3) Family and Individual Supports (FIS) waiver
4) EPSDT (Early and Periodic Screening, and Diagnostic and Treatment)Benefit
5) Medicaid Works Program

NOTE: Neither the Department of Medical Assistance Services (DMAS) nor the fiscal employer agent (F/EA) employs the attendant; the individual receiving CD services or their designee is the employer of record (EOR). Please review and refer to this manual often in order to carry out the responsibilities as an EOR. The table of contents will guide the employer through this EOR manual.

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TERMS TO KNOW

- **Employer of Record (EOR)** – The person who performs the function of the employer in the consumer-directed model. The EOR may be the individual receiving the services or another person designated by the individual.
- **Individual** – The person receiving Medicaid waiver services/supports.
- **Services Facilitator (SF)** – The provider that is responsible for assisting the individual/EOR with theemployer packet, hiring of an attendant, and coordination of other CD related services.
- **Fiscal/Employer Agent (F/EA)** – The DMAS or MCO Contractor who handles attendant paymentsfor CD services on behalf of the EOR.
- **Attendant** – The person hired to provide consumer directed care or supports.

BENEFITS OF CONSUMER – DIRECT SERVICES

- Increased flexibility
- Accommodation of individual needs and preferences
- Responsibility to recruit, hire, employ, train and fire attendants
- Control of employment decisions
- Increased opportunity for choice of attendant who provides services

WHO IS ELIGIBLE FOR CONSUMER-DIRECTED SERVICES?

Individuals must be Medicaid eligible to receive a Medicaid waiver service. The local departments of social services determine Medicaid eligibility. If not yet enrolled in a Medicaid program that offers CD services, the DMAS website offers information which may be helpful; the website link is: http://www.dmas.virginia.gov/#/longtermwaivers.

- ✓ CD services are available in the following waivers, benefit, or program:
- ✓ Commonwealth Coordinated Care (CCC) Plus waiver
- ✓ Community Living (CL) waiver
- ✓ Family and Individual Supports (FIS) waiver
- ✓ EPSDT (Early and Periodic Screening, and Diagnostic and Treatment) Benefit
- ✓ Medicaid Works Program

An individual may not be eligible for CD services if any of the following exists:

- ✓ It is determined that he or she cannot be the employer, and no one else is able to assume this role,
- ✓ The individual wants CD services, but cannot assure health and safety or develop an adequate back-up support plan, or
- ✓ The individual has medication or skilled nursing needs or medical/behavioral conditions that cannotbe met through CD services.

For individuals that are not eligible for CD services, agency directed supports may be available. The above will be reviewed during the LTSS screening process and periodically by the SF

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(Services Facilitator), support coordinator, care coordinator, DMAS and/or its authorized agent.

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BACK UP SUPPORT PLAN

The individual receiving CD services must have a back-up support plan in the event the CD attendant cannot come to work, so the individual is not left without someone to perform the duties the attendant would usually do. The individual may choose a family member, neighbor, friend, or paid employee willing and available to assist the individual when needed as the back-up support
plan. The individual should keep a list of names, telephone numbers, and hours that people are able to work as back-up supports.



Individuals who do not have a back-up plan are not eligible for CD services or Medicaid waivers until they have developed a back-up plan. The SF, case manager, or support coordinator may not be the back-up support for the individual.

COMMONWEALTH COORDINATED CARE (CCC) PLUS PROGRAM

Individuals enrolled in the Commonwealth Coordinated Care (CCC) Plus program are eligible to receive CD services while enrolled in the CCC Plus waiver, the EPSDT benefit, or Medicaid Works program, through their Managed Care Organization (MCO). MCOs are often referred to as health plans. Individuals will continue to work with a SF and will have the additional resource of an assigned care coordinator from the health plan to ensure that the individual's needs are met.

The role of the SF may be slightly different than described in this manual; if the EOR has questions, they should discuss them with the individual's MCO care coordinator or call the number on the back of the CCC Plus program identification card.

All individuals enrolled in the CCC Plus program receive the same level of necessary supports and services as those individuals who are not enrolled in the CCC Plus program. The CCC Plus MCO is responsible for authorizing services based on the plan of care developed by the care coordinator, the EOR, and the SF.

Each MCO contracts with a F/EA for CD services as follows:

Aetna Better Health of Virginia – Public Partnerships, LLC &
Consumer Direct Care Network (CDCN)
Anthem HealthKeepers Plus – Public Partnerships, LLC
Molina Complete Care – ACES$ Financial Management Services
Optima Health Community Care – Public Partnerships, LLC
United Healthcare – Public Partnerships, LLC
Virginia Premier Elite Plus – Consumer Direct Care Network (CDCN)

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WHICH SERVICES CAN BE CONSUMER-DIRECTED?

Companion Services are available only to CL and FIS Waiver individuals aged 18 or older. It is not available in the CCC Plus waiver, EPSDT benefit, or Medicaid Works. Companion services are defined as assisting adult individuals with housekeeping, shopping and community activities.

Personal assistance services help individuals with their activities of daily living (ADLs), such as dressing, bathing, toileting, eating, and assistance with self-administration of medication. They may also be used to support individuals with their ADLs at work and other places in their community. This service is available in the CCC Plus, CL, and FIS waivers, in Medicaid Works, and in the EPSDT benefit.

Respite services provide assistance and support to individuals that provide the unpaid primary caregiver (for example, a family member) time to do things that they need to do for themselves or other members of the family. A respite attendant assists the individual at home and in the community with tasks the family/caregiver normally helps with, giving the family/caregiver the needed time away.

NOTE: An attendant cannot provide skilled respite services. Skilled respite services means temporary skilled nursing services that MUST be performed only by a LPN or RN for the relief of the unpaid primary caregiver who normally provides the care. General respite services that do not require a LPN or RN are available in the CCC Plus, CL, and FIS waivers. Respite services are not available in EPSDT or Medicaid Works.

SERVICES EXCLUDED FROM CONSUMER- DIRECTED SERVICES

CD attendant services do not include nursing services, unless they are providing health care tasks that the individual would typically do themselves, but because of a disability, they are unable to do. The waiver individual must be able to supervise and direct their CD attendant in carrying out the tasks. Some examples may be helping the individual take some medications or placing dry dressings on wounds.

If the attendant provides any nursing services that are not directed and supervised by the individual and is not a task that would not be typically done by the individual during the time that Medicaid is paying for the service, the individual may be removed from CD services. If there are questions about what is considered a nursing service, talk to the SF. Attendants are not trained nor authorized to provide nursing services.

The individual may have skilled nursing needs and receive CD services if the skilled nursing service are provided by a non-Medicaid provider or a non-paid caregiver, are performed by the individual, or are provided through a skilled nursing or home health Medicaid benefit.

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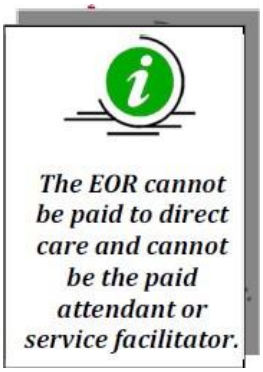
CHAPTER TWO:
CHOOSING CONSUMER-DIRECTED SERVICES

ROLE OF THE EMPLOYER OF RECORD (EOR)

For each individual receiving CD services, there must be an EOR (Employer of Record). This person is considered the employer of the attendants providing care/supports for the individual. An EOR must be atleast 18 years old. A parent or other responsible party must act as the EOR for a child under the age of
18. In many cases, the EOR is the individual receiving services. In other cases, the EOR is a person designated by the individual receiving services to act as the employer. The EOR can only serve on behalfof one individual. The only exception when an EOR can serve multiple individuals is if the individuals receiving CD services reside at the same address. The EOR is the individual who will sign employee paperwork, manage attendants, and approve shifts.

NOTE: The EOR cannot be paid to direct care, cannot be the paid attendant, andcannot be the SF.



The duties of the EOR include:

- ✓ Recruiting, interviewing, hiring, training, directing and supervising allattendants;
- ✓ Firing an attendant, if necessary;
- ✓ Making schedules and tasks to be completed by each attendant;
- ✓ Managing and evaluating the work of each attendant;
- ✓ Keeping track of the services provided by the attendant; and
- ✓ Establishing a system for signing and submitting work shift entriesto the F/EA on a timely basis.

Throughout this manual, the EOR is discussed as if he or she is the individual receiving services; however,the EOR may also be the representative of the individual

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ROLE OF SERVICE FACILITATOR (SF)

The Services Facilitator (SF) is the person who supports the individual in consumer-directing services. TheSF trains the EOR on the responsibilities of being an employer and how to manage attendants.

The role of the SF is to:

- ✓ Make sure the individual gets the services needed.
- ✓ Develop the service plan with the individual and the EOR.
- ✓ Provide the fiscal/employer agent the appropriate forms to start the process of establishing the EOR.
- ✓ Review this manual with the EOR.
- ✓ Submit requests for service authorization of CD services to the appropriate service authorizationcontractor.
- ✓ Train the EOR on the required tasks of an employer.
- ✓ Document services as required by the Department of Medical Assistance Services (DMAS).
- ✓ Assist the EOR when filling out paperwork for the Fiscal/Employer Agent.
- ✓ Conduct required routine and reassessment visits.
- ✓ Conduct the annual level of care review process.

EORs may discuss employer concerns and questions with their SF.. The member must choose the SF provider from the list of enrolled providers from DMAS or the MCO. For a list of current Virginia Medicaid enrolledServices Facilitators, visit the Virginia Medicaid Portal: **https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/searchforproviders** Members enrolled in managed care for their consumer directed services must choose a SF from the MCO network of participating providers. Contact your MCO for a list of SF providers.

The Services Facilitator **cannot** be:

- ✓ The individual receiving services;
- ✓ The individual's spouse;
- ✓ The individual's parent, if the individual is a minor; or
- ✓ The EOR.

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ROLE OF THE FISCAL EMPLOYER AGENT (F/EA)

The fiscal employer agent (F/EA) performs payroll activities on behalf of the EOR. This allows theindividual to use waiver funds to hire and pay attendants. DMAS contracts with the F/EA to ensure that payment to the attendant is based on the approved service authorization, which documents the number of hours and services and shifts approved by the EOR. The F/EA keeps payment
records and follows all tax rules on the EOR's behalf. **DMAS, the SF, and theF/EA do not employ the attendant(s); the EOR employs the attendant(s).**



The F/EA is responsible for:

- ✓ Management of enrollment packets
- ✓ Helping the EOR and attendants with the enrollment process
- ✓ Processing attendant employment and tax-related documents
- ✓ Payroll processing and issuance of paychecks to attendants every two weeks with the receipt of fully completed and signed shifts for DMAS-approved services
- ✓ Calculates, withholds, and deposits of State and Federal income tax, Medicare, SocialSecurity, and unemployment taxes for attendants to maintain tax compliance
- ✓ Completes of criminal background checks for each attendant
- ✓ File monthly, quarterly, and annual forms and tax deposits with State and Federal agencies
- ✓ Issue W-2 Statements to each attendant every January
- ✓ Provide quarterly reports to the EOR showing services used and services remaining
- ✓ Answer all questions that the EORs and attendants have about payroll and services

NOTE: Refer to Appendix A, Page 37 of this manual for the current F/EA contact information andwebsite links.

ROLE OF THE ATTENDANT

The attendant is the individualhired by the EOR who provides CD personal assistance, respite services, or companion services to the individual. The attendant provides those services that are authorized by DMAS or its designated service authorization agent.

The attendant should have the knowledge, skills and abilities to perform the functions and duties necessary to support the individual who is receiving services. Refer to Chapter Five of this manual for more informationregarding attendant requirements.

Certain individuals are prohibited from serving as the attendant. The attendant cannot be the parent if the individual being served is a minor child or the individual's spouse. Companion services shall not be providedby adult foster care providers or any other paid caregivers for an individual living under the same roof.

The attendant must successfully pass a criminal background check through the Virginia State Police and a child protective services background check if they are providing care to a minor child. Refer to Chapter Fiveof this manual for more detailed information.

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STEP PROCESS – JOB EXPECTATIONS FOR THE EOR

CHOOSING CD (CONSUMER-DIRECTED) SERVICES

The individual must be previously screened and enrolled in the CCC Plus, CL, and FIS waiver, be determinedfor a need for personal care through EPSDT, or qualify under the Medicaid Works aid category in order to choose CD services. When the individual chooses CD services or a combination of CD and Agency Directed(AD) services, they are given a list of possible services facilitators (SF). The individual chooses a services facilitator (SF) and then contacts the chosen SF directly. If the chosen SF agrees to provide services, the SFmakes a visit to the individual.

COMPREHENSIVE VISIT

The SF meets face to face with the individual and the EOR as appropriate for the comprehensive initial visitand ensures that the individual is eligible to receive CD services. The SF reviews the Individual Selection of Consumer Directed Services Form (DMAS-489) and the Service Agreement between the Individual and the CD Services Facilitation Provider Form (DMAS-486). These forms explain responsibilities of the Individual and the EOR and the SF. They must be signed and dated by the Individual/EOR and the SF beforethe individual/EOR can begin employing an attendant in the program service. Copies must be maintained by the SF, and it is also recommended that the EOR maintain copies of these forms. Copies of these two formsare in Appendix C of this manual.

During the comprehensive visit, the SF will ask questions about the service needs and preferences and will work together with the individual to develop a person centered service plan that includes the types and amounts of services to be needed. After the visit, the SF will submit a service authorization (SA) request complete with all necessary documents to the appropriate entity based on the agreed upon service plan. TheSF will contact the F/EA to request an Employer of Record enrollment packet that can be mailed to the EORin order to get the individual/EOR enrolled with the F/EA. F/EAs also provide the enrollment packet onlinefor download and completion.

COMPLETING THE VIRGINIA EMPLOYER OF RECORD ENROLLMENT PACKET

The EOR must enroll with the F/EA before services can begin. The EOR must fully complete and return allforms found in the Employer of Record Enrollment Packet. The EOR must mail or email the original completed packet to the F/EA who makes sure all employment rules are followed for payroll. When the packet has been successfully processed by the F/EA, the EOR is ready to hire an attendant.

EMPLOYER MANAGEMENT TRAINING

Within seven days of the initial comprehensive visit (or that same day), the SF must train the EOR on hiring,supervising, training, and firing attendants. The specific topics for training are documented on the ConsumerDirected Individual Comprehensive Training Form (DMAS-488). This form must be completed by the SF during the training, and signatures of the Individual/EOR and the SF must be obtained after the training.

HIRING ATTENDANTS

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The EOR selects and hires the attendant(s). The attendant(s) must fully complete the Attendant Applicationfound on the F/EA website. After receipt of the application, the F/EA will send the EOR “The Attendant

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Employment Welcome Packet" that the attendant must complete. Once the packet has been successfully processed, the attendant is considered in a "good to pay" status by the F/EA.

IMPORTANT: **The attendant will not be paid for services provided until all information is received and processed by the F/EA and a service authorization has been approved**. If the attendant begins providing services before the service authorization is approved and a problem arises such as the authorizationfor services is not approved or is approved for fewer hours than requested, the attendant will not be paid for hours that were worked beyond those that were approved. In this case, the EOR may be responsible for paying the attendant for the unauthorized hours. ***Attendants cannot be paid with Medicaid funds for any time that the individual is not eligible for Medicaid, eligible for the applicable Medicaid waiver, benefit, orprogram, and authorized by DMAS or its contracting agent to provide the CD service.***

TIME SHIFTS

The EOR must train the attendants and provide feedback as appropriate on work shift entries. Using the Electronic Visit Verification (EVV) compliant mobile app or interactive voice response (IVR) system provided by the F/EA, the attendant will submit time to be confirmed by the EOR. The EOR and the attendantwill determine the best system to enter and approve work shift entries. For assistance or questions regardingcompleting and submitting attendant time shifts, contact your F/EA or SF.

PAYROLL

The F/EA pays the attendant on behalf of the individual receiving services, less applicable taxes, patient pay deductions, and other withholdings, if appropriate. The individual receiving waiver services is responsible for paying the patient pay amount, if required, directly to the attendant. Patient pay amount is defined in more detail in Chapter Four of this manual.

SF FOLLOW-UP VISITS

- It is recommended that the SF visit the individual at least twice within 60 days of the first comprehensive meeting to monitor the CD services employment process
- The SF must visit at least semi-annually if only respite services or companion services are being provided.
- The SF must visit the individual once every 30 to 90 days if personal care services are being provided. The EOR and SF should agree upon the frequency of these visits. The SF may also visit more frequently as needed and/or requested by the individual.
- The individual or EOR may contact the SF at any time with questions.

QUARTERLY SERVICES REPORTS

The individual reviews the *Quarterly Services Report* provided by the F/EA. This is a report that provides information to the individual on the number of hours of service used, patient pay withheld, and how much each employee has been paid. This report will be sent to the EOR quarterly. Any errors noted should be immediately reported to the SF or F/EA.

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CHAPTER THREE:
DEFINING INDIVIDUAL NEEDS AND SERVICE PLANNING

THE SERVICE PLAN

Person-centered planning is based on a variety of approaches or tools to organize and guide life planning with individuals, their families, and friends. Focusing on the individual in person-centered planning ensures that the service plan moves beyond program planning and considers the whole picture of the individual's life. Furthermore, in person centered planning, it is the individual who directs the support andservice planning process, with assistance from the SF and other involved family and friends.

The service plan identifies the following:

- An individual's care or support needs andpreferences
- Tasks that the attendant will perform on a daily basis, or as neede
- The individual's personal goals,
- Amount, frequency, duration, and scope of services,
- The type of provider to furnish each service,
- Back-up support plan, and
- Formal and informal supports



The individual may need CD services at separate times of the day (e.g., some hours in the morning and some in the evening). The service plan must show what activities will be done during each time period. The individual may have two different attendants: one for the morning and one for the evening, or one attendant who works both times. Either way, the total number of hours of services provided must be documented in the service plan and authorized by the service authorization contractor.

As the employer of the attendant, the EOR **must** monitor the delivery of the service plan and must maintaina copy of the service plan in the home. Payment may only be made for services that are authorizedand documented in the service plan as provided.

SERVICE AUTHORIZATION

All CD services require service authorization by DMAS or the designated agent. Currently, KEPRO is theagent responsible for processing and authorizing Fee-for-Service service requests. The Department of Behavioral Health and Developmental Services (DBHDS) is responsible for processing and authorizing CLand FIS waiver requests. The health plans are responsible for authorizing service requests for those in managed care.

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The EOR works with the SF to obtain service authorization before services can begin. Once authorizationis completed by the service authorization contractor, services will be paid back to the approved start date of the authorization. **If the attendant begins providing services before the authorization is received, and a problem arises such as the authorization is not approved or is approved for fewer hours thanrequested, the attendant will not be paid or paid for all of the hours he or she may have worked. Inthis case, the individual may be responsible for paying the attendant for unauthorized or incorrect hours.**

Requests for changes to the service plan and authorizations must be submitted by the SF. The EOR is encouraged to contact the SF or case manager when unusual situations occur, or changes in hours and times of services may be needed.

It is also the responsibility of the SF to ensure that yearly requests for service authorization renewals arecompleted and submitted to the appropriate service authorization contractor in advance to avoid any service interruption or delays in payment to the attendant.

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CHAPTER FOUR:
RESPONSIBILITIES OF BEING AN EMPLOYER

RESPONSIBILITIES AS AN EMPLOYER OF RECORD (EOR)

When choosing CD services, as the employer, the EOR incurs all responsibilities of an employer. It is important that the EOR understand all that is required of an employer.

Eligibility: The individual receiving services must be eligible for Medicaid services and enrolled in one of Virginia's waivers, benefit, or program that allows CD services in order for the attendant to receive Medicaid payment for services rendered. Should eligibility be terminated, the EOR may be responsible for payment of services rendered during the period of ineligibility.

Service Plan: As the employer of the attendant, the EOR must agree to work with the SF to develop a service plan outlining the tasks and activities of daily living that the individual wants the attendant to perform. This plan will be written and available to the attendant to guide the supports and services that the individual wants the attendant to perform.

Back-up Plan: A back-up plan must be in place to cover unforeseen circumstances, when the attendant is not able to come to work such as an illness, or for scheduled vacations, holidays, etc. The back-up plan can be a family member, friend, neighbor, or other paid employee willing and able to assist when needed.

Documentation: The EOR should maintain a record that includes the service plan, attendant application(s), documentation of TB (Tuberculosis) testing, if required, and any other information relevantto being an EOR of CD services.

DMAS Reviews: The EOR shall agree to be available for any DMAS reviews or audits. The EOR mustprovide documentation, upon request by DMAS or health plans, for audit purposes.

AGENT (F/EA)

Enrollment Packets: These forms must be completed and returned to the F/EA for processing. It is the EOR's responsibility to ensure the packets are sent to the F/EA before the attendant begins work. The EOR must complete all necessary forms found in the Employer of Record Enrollment Packet and the attendant must complete all necessary employee information in the *Attendant Employment Welcome Packet.* Contact the SF or the F/EA for help if needed.

Taxes: The F/EA will file and withhold all of the appropriate Employer Federal and State taxes on behalfof the EOR for CD services.

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Criminal Background Checks: The F/EA will request the required criminal background records check. Ifthe criminal record check shows that the attendant has a conviction of having committed a barrier crime, or the attendant has a substantiated finding in the Child Protective Services (CPS) Central Registry (if the individual is a minor), the EOR is prohibited from hiring or continuing to employ the attendant.

EOR RESPONSIBILITIES REGARDING ATTENDANTS

Training: The EOR must train and direct the attendant in providing the authorized services described in the service plan.



Scheduling: The EOR shall establish a mutually agreeable schedule with the attendant. The hours must be worked in accordance with the individual's approved service plan and authorization. The EOR and attendant are both responsible for providing adequate notice of changes in the attendant's work schedule. The attendant should notify the EOR as soon as possible in the event of illness, emergency or other instance that prevents the attendant from coming to work or arriving late. This will give the EOR time to arrange for assistance from someone else.

Equipment/Supplies: The EOR must provide any safety equipment and supplies necessary to provide care (e.g., if blood or other bodily fluids are handled, the employer provides protective gloves.) Recommendations regarding disposable items are based on current universal precaution guidelines from the Centers for Disease Control and Prevention at: www.cdc.gov. Examples of disposable items may include non-sterile disposable medical gloves, isolation gowns, and face protection such as face shields, masks or goggles. Refer to the CDC web site listed above for more detailed information on universal precautions. There is more information on universal precautions in Chapter Six of this manual.

Note: Medicaid may pay for protective gloves in some instances such as contact with blood or other bodily fluid. Medical supplies are accessed through a Medicaid enrolled durable medical equipment and supplies provider. Ask the SF for assistance, if applicable.

RESPONSIBILITIES REGARDING ATTENDANT PAY

Shifts: Approved methods for shifts must be properly completed and signed/approved by both the EOR and the attendant after work has been completed. Hours recorded on the shifts cannot exceedthe authorized number of hours or the approved service authorization. Approved methods are provided bythe F/EA and are compliant with federal requirements of EVV. For questions and instructions on completing work shift entries with EVV, please contact your F/EA or SF for assistance.

The following requirements must be followed for proper shift submission:

- ✓ It is the responsibility of the EOR to verify the attendant's reported hours worked as well as make sure that shifts are accurate and fully completed before it is submitted. This includes

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the submission of sick leave hours.

- ✓ Shifts can be entered electronically in the F/EA's mobile application or an interactive voice response system through a telephone available from the F/EA.

- ✓ Biweekly time-entries must be signed, dated (month, day, year), and approved by both the EOR and the attendant after work has been completed. The signature can be captured electronically or verbally.

- ✓ Hours recorded on the time-entries cannot exceed the authorized number of hours on the approved service authorization.

- ✓ It is the EOR's responsibility to approve the time-entries within two business days from the end of the pay period.

- ✓ Any time-entry recorded before the end of the pay period will not be paid until the time period is completed.

- ✓ Incorrect time entries will be "denied" or "pended" and the attendant will not be paid until all issues are resolved.

IMPORTANT: The EOR must not share user names and passwords with the attendants. Doing so may allow the attendant to submit and approve shifts that have not been verified by the EOR. It is always a good idea to keep user names and passwords in a secure location to safeguard access by others. In addition, the attendant should not share user names or passwords with the EOR.

Patient Pay: The individual receiving services may have to pay a portion of the attendant's wages (the "patient pay" amount), if applicable. The individual will be notified by the local department of social services of any patient pay responsibility. The EOR agrees to make sure the individual receiving services pays the attendant the patient pay amount on a regular and timely basis. The patient pay should be paid to attendants on the pay date it was withheld from the attendant. This amount will not be included in the attendant's pay received from the F/EA.

Service Authorization: Payments made to attendants will be made only when there is a valid approved service authorization and based on the number of hours approved for the time period. Any work performed by the attendant when there is no valid service authorization will not be paid by DMAS or the F/EA. The EOR is responsible for payment of the unauthorized time including wages and applicable taxes. The EOR should work with the SF to ensure there is always a valid approved service authorization for the individual.

Medicaid Payment in Full: The EOR cannot supplement payments other than their obligation related to the patient pay as described above. Hired attendants must agree that payments made with Medicaid funds are considered payment in full. The pay rate is determined by the Virginia General Assembly and is not negotiable. Attendants may not be paid any extra amount above this rate.

Transportation: Attendants can transport individuals in their vehicles, but cannot get paid for

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both their time and transportation expenses by Medicaid. However, they may keep track of their mileage and relatedtransportation expenses and may be able to count these as deductions on their income taxes, even if they are using the short form for filing their taxes. For assistance with tax advice, attendants can contact the Internal Revenue Service (IRS) or the Virginia Department of Taxation. Be aware that vehicles used for

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transporting individuals, whether they belong to the individual or the attendant, must be currently registeredthrough the Department of Motor Vehicles (DMV) and be properly insured based on the minimal liability insurance requirements. For more information, refer to the local Virginia DMV Office or the DMV web site at: https://www.dmv.virginia.gov/#/. Neither DMAS nor the Commonwealth has any liability if injury or other harm occurs during transportation of an individual.

Important Information: The EOR must acknowledge that Medicaid payments for services will not be made to attendants if any of the following circumstances exist:

- Services not performed or time not worked;
- Lack of service authorization for time worked;
- Services when the individual is hospitalized or in a nursing facility or ICF/IID;
- Incorrect or incomplete submission of shifts;
- The attendant has been convicted of a barrier crime; or
- Services rendered when the individual is not Medicaid eligible or no longer enrolled in a waiver,the EPSDT benefit, or Medicaid Works program.

Any false or misrepresentation of time, services, individuals, and/or other information is not permitted. Ifthe EOR or the attendant approves/signs a shift that is determined to misrepresent information, the individual will lose the option of consumer-direction and will be reported to the Medicaid Fraud Control Unit. Payment of wages is from Federal and State funds. Any false claims, statements, documents, or concealment of material facts will be prosecuted under applicable Federal and State laws and may result in the loss of Medicaid coverage for the individual.

In the EOR Agreement (located on the F/EA web site) that is signed and dated by the EOR, it reads as follows**:**

I understand and acknowledge wages are from federal and state funds. Any untruthful submissionof services provided in an attempt to obtain improper payment is subject to investigation as MedicaidFraud. Medicaid Fraud is a felony and can lead to substantial penalties and/or imprisonment.

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CHAPTER FIVE:
HIRING AN ATTENDANT

This chapter covers the necessary steps for hiring an attendant, to include advertising, screening and interviewing applicants, making a decision, and conducting background checks and CPS registry, and TBtesting.

WHO CAN BE AN ATTENDANT?

The attendant is the person who provides personal care or supports for the individual. The attendant is the person hired by the EOR who provides CD personal assistance, respite services, or companion servicesto the individual.

There are several things that a person must do before he or she can be hired as

an attendant.The attendant must:

- ✓ Be 18 years of age or older;
- ✓ Have the skills to perform services as specified in the individual's service plan;
- ✓ Have basic math, reading, and writing skills;
- ✓ Have a valid Social Security number and be authorized to work in the United States;
- ✓ Submit to a criminal history background records check through the Virginia State Police, and, if theindividual being served is a minor, the Virginia Dept. of Social Services (VDSS) Child Protective Services (CPS) Central Registry;
- ✓ Demonstrate the capability to perform health maintenance activities required and that are in the service plan, or be willing to receive training in performing the activities;
- ✓ Not be a spouse of the individual receiving services or a parent or step parent of a minor child receiving the services;
- ✓ Not be the individual's Services Facilitator or Case Manager or Support Coordinator; and
- ✓ Not be the person designated as the EOR who is directing the care of the individual receivingservices.

In addition, the attendant must:

- Protect the individual's health, safety and welfare by providing authorized services in accordancewith the policies and standards of the applicable Medicaid waiver, benefit, or program.

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- Maintain all confidential information regarding the individual and respect his or her privacy.

- Understand that the attendant is employed by the EOR, not the F/EA, the Services Facilitator, theDepartment of Medical Assistance Services (DMAS), nor the MCO.

- Understand that the property of the individual receiving services, including the telephone, is notto be used by the attendant for personal use unless mutually agreed upon by both parties prior to use of the property.

- Be punctual, neatly dressed, and respectful of all family members. All instructions regarding caremust be carried out carefully.

ATTENDANT JOB DESCRIPTIONS

The EOR can develop a job description that reflects their needs, likes, and dislikes. The service plan canbe the basis for the information and duties needed to be included in the job description.

The job description should explain:

- ✓ What duties the EOR/individual needs the attendant to perform;

- ✓ The hours the attendant needs to work for the individual; and

- ✓ How the attendant will do the job.

The key to success as an employer is a specific, easy-to-understand job description for the attendant. A jobdescription is used to define the duties, manage time, and schedule the attendant. Its purpose is to provide the person who might become the attendant with a brief description of what the attendant will be doing eachday to support the individual. Be realistic about what the attendant can do to support the individual and carry out the requirements of the service plan.

The EOR may require the attendant to have additional qualifications or perform specific duties related to the individual's needs. The individual may document these requirements in the job description and requestthat the attendant sign and date an agreement that documents the specific duties prior to beginning employment.

Note: A sample attendant job application is found at the end of this manual. This is an optional form to use; however, it may be helpful for the EOR.

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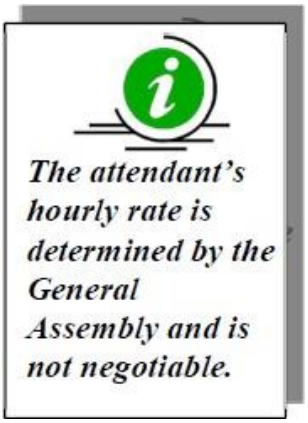
ADVERTISING FOR AN ATTENDANT

Now that the EOR has created a job description, the next step is to advertise for an attendant, if there is notalready someone in mind.

- ✓ The SF may help the EOR to find qualified applicants and will know how to access necessary community resources or know of some available candidates. The SF may help the EOR locate qualified applicants via family, friends, neighbors, or by placing job ads in local newspapers, or on community bulletin boards in local libraries, stores, colleges, hospitals, training centers, etc.
- ✓ The cost of recruiting for an attendant is the EOR's sole responsibility.
- ✓ DMAS does not reimburse the EOR or the SF for any expenses associated with the hiring process such as advertising or training attendants.

SCREENING APPLICANTS AND SCHEDULING INTERVIEWS

After placing the job ad, be ready to receive telephone calls. The EOR will want to ask which days and hours the applicants can work and discuss payment. The hourly rate is determined by the Virginia GeneralAssembly and <u>not</u> by the EOR, SF, or the F/EA. If the applicant wants more pay
than what is allowed, or cannot work the hours needed, the individual does not haveto interview them. Asking these questions can save time by helping to screen outapplicants who do not meet these basic criteria. Be sure that all applicants meet the basic qualifications for employment as identified earlier in this chapter.



The EOR may want to give a brief description of the job, hours, and pay rate to the applicant. Keep the job description near the telephone, along with paper and pencil fortaking notes. The SF can offer guidance and additional training to the EOR about how to screen applicants, as necessary.

If the person is interested in the job, and the EOR is interested in meeting them, the EOR may set up a time to conduct a formal interview. The EOR may request a completed job application and/or resume from the applicant in advance of the interview, if possible.

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INTERVIEWING APPLICANTS

The main purpose of the interview is to learn about the applicant, determine if they are qualified, and decideif the applicant is the person the EOR would like to hire to provide supports and services. It is recommendedthat the EOR meet the applicant in a public location (for safety reasons) to conduct the interview and complete an application if it was not received prior to the interview.

The purpose of the interview is to learn as much as possible about the applicant and to share information about the job and duties, so that both parties have enough information to make a good decision. The EOR may want to have someone that they trust present during the interview. During the interview, the EOR canassess many things about the person even without asking questions.

For example, is the applicant:

- On time for the interview?
- Dressed neat and clean?
- Interested in what you have to say?
- Polite?
- Answering questions completely?

When scheduling interviews, allow enough time between appointments to think about each applicant andwrite down some notes. It may be helpful to list the things that were important about each applicant.

Interview tips include:

- Introduce yourself and help the applicant feel comfortable.
- Have the written job description ready to give to the applicant and take some time to explain theduties, expectations and care needs of the individual.
- Talk about the rate of pay, how payment will be made and the number of hours required.
- Ask the applicant about their job history and relevant experience.
- Ask the applicant to provide a list of previous jobs and employers, and the reasons for leaving.
- Ask for at least two references from past employers and be sure to check the references provided.
- Ask the applicant why they want to perform this type of work.
- Explain that the applicant will have to submit to and pass a criminal background check, and CPS registry check if the individual being served is a minor child.
- At the end of the interview, thank the applicant for their time. You may tell them that they will benotified when a decision has been made. You should consider notifying all applicants of your finaldecision.

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SAMPLE QUESTIONS TO ASK IN AN INTERVIEW

During the interview, the individual/EOR should keep in mind the qualities that are desired in an attendant.The attendant should be someone that the individual likes and respects. Some of the following questions may help determine if the individual/EOR and the attendant will get along. Other questions about things that are important to the individual may also be asked.

Sample Questions to Ask During an Interview:

Job Experience

1. What is your experience working with individuals with disabilities?
2. What classroom and "hands on" training have you had with personal care needs?
3. Are you sensitive to the personal space and preferences of others?
4. How do you show respect, dignity and consideration with the individuals you have worked with?
5. Are you on time for your daily job?

Food and Eating Arrangements

1. Do you like to cook? What do you cook?
2. If you like different foods than I do, will you prepare my meals?
3. Will you assist me if I need help with eating?

Transportation

1. How do you feel about helping me with errands?
2. Would you be willing to drive my car?
3. Are you willing to drive me in your car? If so, do you have insurance?
4. What can you tell me about your driving record?

Housekeeping

1. What experience have you had with housekeeping and laundry?
2. Do you like things very neat or are you not very particular?
3. Do you work better with a definite schedule for cleaning and laundry (e.g., vacuum on Monday,scrub floors on Tuesday, etc.), or do you like to decide for yourself?
4. Are you willing to clean and do laundry based on my preferences?

Personal Care (examples: bathing, dressing, toileting, hygiene, feeding, transferring, and mobility)

1. I will need your assistance with toileting and/or suppositories. Are you comfortable with this?Have you assisted someone with personal care in the past?
2. I will need your assistance with bathing. Are you comfortable with this? Have you assistedsomeone with personal care in the past?
3. Is there any part of my personal care needs that make you feel uncomfortable?
4. What experience have you had in providing personal care?

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Preferred Activities and Other Questions

1. Do you smoke?
2. Do you like activities well-planned or do things on the spur of the moment?
3. How do you react if you have to change your plans at the last minute?
4. Why do you want this job?
5. Do you have any questions about the job description?
6. Do you have any concerns about this job?

The EOR May Not Ask Certain Questions During an Interview



When interviewing and hiring an attendant, federal and state law does not allow an employer to discriminate in employment decision. Questions in the following categories cannot be legally asked:

- Age,
- Gender,
- Gender Identity,
- Religion,
- Race,
- Ethnicity,
- Sexual orientation,
- Marital status,
- Pregnancy,
- Childbirth or related medical conditions including lactation,
- Military status,
- Color
- Disability or
- National origin.

MAKING A DECISION ON AN APPLICANT

Choosing the right attendant is one of the most important decisions the individual can make. If possible, interview several people and consider the advantages and disadvantages of each person before making a choice of whom to hire. The EOR should not hire an attendant over the telephone. A face to face interviewwith any applicant is strongly recommended. Checking work references of applicants may help to decide whom to hire. The individual can call the applicant's previous employers and explain the job the person isapplying for and ask if the applicant was dependable, honest, and got along well with others. There may be other questions that the individual wants to ask, such as whether the employer would hire the applicant again.

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NECESSARY TASKS WHEN HIRING AN ATTENDANT

- When an attendant is hired, the EOR must request an attendant application form from the F/EA and have the attendant complete all the required fields. The F/EA will mail the *Attendant Welcome Packet* to the EOR. The EOR completes and submits the *Attendant Welcome Packet* to the F/EA and keeps copies for their records.

- The attendant must complete the required forms in the *Attendant Employment Welcome Packet* before the attendant starts work or can be paid. The F/EA will include a self-addressed stamped envelope in each packet. **NOTE: that the F/EA cannot pay for any services until a completed packet is received and processed for the attendant.**

- It is the EOR's responsibility to assure the forms are completed correctly and submitted to the F/EA. An attendant ID number will be issued by the F/EA when all applicable paperwork has been processed. The SF can assist with these tasks.

- Attendants must complete a separate *Attendant Employment Welcome Packet* for each EOR who employs them.

- A written agreement between the EOR and the attendant will help both the EOR and the attendant to know what is required of their job. The written agreement is a part of the *Employer of Record Welcome Packet* and must be completed and sent to the F/EA. This document addresses wages, scheduling, attendant qualifications, duties, and the mutual responsibilities.

- Review the schedule of days and times that the attendant is expected to work and what days the attendant will be off. Document any sick leave taken by the CD attendant. The back-up support plan should be used on the attendant's regular days off, if needed. Talk about the date that the attendant will begin work. Decide on a time to train the attendant.

- Review the service plan and how the attendant will support the individual. Show the attendant where the service plan is located in the home.

- Talk with the attendant about the shift due dates and payroll schedule. The first payroll will occur after all authorizations have been received and enrollment information is processed by the F/EA. EORs (or their SFs) can verify payroll status by accessing the F/EA Web Portal, and clicking on *Shifts* or *Timesheet List*. The attendant can also view their payroll status within the F/EA Web Portal.

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BACKGROUND CHECKS

Criminal History Record Request

A *Criminal History Record Request* form must be submitted for every attendant that is hired. Crimes listedin the *Code of Virginia* §37.2-314 (FIS Waiver), §37.2-416 (CL Waiver) and §32.1-162.9:1 (CCC Plus Waiver) are considered barrier crimes and any conviction of any of these crimes would prohibit the attendant from receiving Medicaid payment for their services. The F/EA will notify the EOR when the background check indicates the attendant has been convicted of a crime. The F/EA will send the EOR a letter indicating if there is additional information needed.

CPS Central Registry

If the individual receiving CD services is a minor, a Virginia Department of Social Services (VDSS) *ChildProtective Services* (*CPS) Request for Search of the Central Registry* and *Release of Information* form must be completed as part of the packet sent to the F/EA.

TUBERCULOSIS (TB) TESTING

Virginia Department of Health (VDH) regulations require attendants providing CD personal care, respite,and companion services to have TB tests performed, such as a skin test or blood test. Frequency of TB tests is determined by VDH. Most tests may be conducted at the local health departments. Based on the VDH guidelines, a positive test for TB infection only tells that a person has been infected with TB germs.It does not tell whether or not the person has active TB disease. Other tests, such as a chest x-ray and a sample of sputum, are needed to see whether the person has TB disease.

For more information, refer to the Virginia Department of Health's (VDH's) guidelines for TB screeningsat: http://www.vdh.virginia.gov/

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CHAPTER SIX:
EVERYDAY EMPLOYER DUTIES

In this chapter, the everyday employer duties required for consumer-directed services are explained.

RECORD KEEPING

As an employer, the EOR should consider an organized record keeping system, such as a three-ringnotebook or folders, to keep all papers related to the attendant.

Documents that should be kept include:

- ✓ The attendant's job application
- ✓ Notes from the interview
- ✓ Reference checks
- ✓ Copies of shifts submitted
- ✓ The agreement between the EOR and the attendant
- ✓ Record of training provided to the attendant

Accurate and complete records can resolve disagreements. Remember to sign and date any documentation.Accurate and organized records will also be beneficial for the EOR if a Medicaid review is conducted.

TRAINING NEW ATTENDANTS

The most important part of training the attendant is giving clear directions that can be easily understood.A checklist based on the service plan may help the attendant learn the routine.

The following is a list of training tasks the EOR may conduct with the attendant:

- ✓ The EOR may explain the types of tasks that will be performed. Have the attendant repeat the tasks explained to them and have them demonstrate the task to makesure they perform it correctly.
- ✓ Explain any health or safety emergencies that might happen.
- ✓ Medical conditions should be written down and include anything that the attendant must do in an emergency.
- ✓ Keep a list in the same place with the name of the individual's doctor and telephone number, allergies, and preferred hospital. Keep all contact numbers readily available.
- ✓ If there is an emergency, make sure the attendant knows to call 9-1-

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1, but that the attendant may also need to act first before calling 9-1-1.

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- ✓ If a task needs to be performed in a certain way, explain how it should be done.
- ✓ Setting a routine of how and when tasks should be performed and regularly following that routinemay help the attendant provide services in the manner preferred.
- ✓ Make sure the attendant knows how to properly work with the equipment,including safety precautions.
- ✓ If a health or safety incident occurs with the individual, the attendant will need to know what steps to follow. Make sure there is a clear plan of where and how to report the incident.
- ✓ Be sure to explain how to use each piece of equipment before allowing the attendant to use it. Make sure the attendant knows exactly what to do in case the equipment malfunctions.
- ✓ Personal preferences of the individual including when and how supports should be provided.

Training must occur when an attendant is first employed and on a regular basis as needed. Regular trainingon how services and supports should be provided with the attendant is necessary to make sure that they arefollowing the service plan.

PAID SICK LEAVE FOR CONSUMER DIRECTED (CD) ATTENDANTS

Beginning 7/1/2021, paid sick leave benefits will be available to eligible attendants. Attendants who work an average of 20 hours per week or 90 hours per month will be eligible to earn paid sick leave. Eligible attendants will earn 1 hour of sick leave for every 30 hours worked. The attendant can earn and use up to 40 hours of sick leave each fiscal year (July 1 to June 30).

CD Sick Leave Program Guidelines

Sick Leave Eligibility Determination

Attendants must work an average of 20 hours a week or 90 hours per month during a quarter to be eligible for paid sick leave. Time worked providing personal care/personal assistance, respite services, and companion services is included. In order to determine that an attendant is eligible to earn sick leave, the Fiscal/Employer Agents (F/EAs) will calculate the average number of hours attendants worked each week during the previous quarter. The quarters are as follows: July 1st – September 30th, October 1st – December 31st, January 1st – March 31st, and April 1st – June 30th.

Once an attendant has been determined to meet the eligibility requirements to earn sick leave, the quarterly calculation will not occur again until the end of the 4th quarter. Attendants that do not meet the eligibility requirements will be reassessed at the end of the next quarter to see if they are eligible

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for sick leave.

It is important that time worked is submitted and approved each week in order to be counted in sick leave calculations. Shifts worked must be reimbursed by the 20th day of the month after the quarter ends in order to be included in the eligibility determination. Sick leave calculations will occur on the 21st day after the quarter ends. Late submissions will affect the attendant's eligibility for sick leave.

The sick leave eligibility determination is based on the EOR/attendant relationship. Some attendants work for more than one EOR. When determining eligibility, the hours worked for different EORs will be calculated separately.

Earning Sick Leave Hours

Eligible attendants will earn 1 hour of sick leave for every 30 hours worked. Accrual of sick leave will be retroactive to the beginning of the quarter in which the attendant became eligible for sick leave. Sick leave is first available for use in the second month after the quarter in which the attendant becomes eligible for sick leave.

Example: Quarter 1 (July 1 – September 30), the attendant is found eligible to earn sick leave. The total number of hours the attendant worked during Quarter 1 is 300 hours. The attendant earned 10 hours of sick leave that is available for use on November 1.

Quarter #	Months	Reimbursement Cutoff	Sick Leave Available for Use
1	July 1- September 30	October 20	November 1
2	October 1- December 31	January 20	February 1
3	January 1 –March 31	April 20	May 1
4	April 1 – June 30	July 20	August 1

An attendant can earn and use up to 40 hours of sick leave per State Fiscal Year (July 1 - June 30). Any unused sick leave hours at the end of the fiscal year will be carried over into the following fiscal year.

Using Sick Leave

Sick leave may be used for the following purposes:

- An employee's or employee's family member's mental or physical illness, injury, or health condition; need for medical diagnosis, care or treatment of a mental or physical illness, injury or health condition ; or an employee's need for preventative medical care.

- Family members includes a child, parent, spouse, grandparent, sibling, an individual for whom the attendant is responsible for providing or arranging care, and "any other individual related by blood or affinity whose close association with an employee is equivalent of a family relationship."

Attendants are responsible to notify the EOR when they are using sick leave. The request to use sick leave may be made verbally, in writing, or by electronic methods or by any other means the EOR finds acceptable. The request, whenever possible shall include the expected duration of the absence. When the sick leave is foreseeable, the attendant shall make a good faith effort to provide advance

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notice to ensure that the member's back-up plan is in place.

When an attendant uses three or more consecutive days of sick leave, the EOR may require reasonable documentation that the paid sick leave has been used for one the purposes identified.

EORs cannot require the attendant to find a replacement attendant to cover the hours the attendant is taking sick leave. The EOR cannot require the attendant to work an alternate shift or make up for the use of sick leave.

EORs <u>cannot</u> retaliate against the attendant for using sick leave. The EOR cannot terminate, discipline, threaten, discriminate against, or penalize an attendant because the attendant requests or takes sick leave.

Sick leave must be submitted within 30 days of being used. Sick leave hours submitted for payment after 30 days will not be paid by the F/EA.

Sick leave will not be paid when employment is terminated. If an attendant has a sick leave balance at the end of their employment, the sick leave balance will not be paid out to the attendant.

For additional sick leave questions, please contact your fiscal employer agent or services facilitator.

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CD ATTENDANT DOCUMENTATION FORM

EOR's are strongly encouraged to have the attendant document activities on a weekly basis. The *Consumer- Directed Attendant Documentation Form* (DMAS-487) may be used for this purpose. This form includes step by step instructions. Documentation of activities is important for the protection of boththe EOR and the attendant. The documentation can be used to justify care if a shift is in question.

The EOR may use the CD Attendant Documentation Form as follows**:**

- ✓ One form should be used for each attendant each week.
- ✓ Place the dates for that week across the top of the form in the date line section.
- ✓ Circle the activities from the list in the left-hand column that the attendant performs.
- ✓ Place a check mark next to the activities that the attendant assists with for that date.
- ✓ Refer to the definitions on the instruction page for specific tasks.
- ✓ Any "Special Activities" as described on the form, should include written documentation in the "Notes" section describing the activity.
- ✓ The individual or EOR should sign and date the form after the week is completed. The attendant also signs and dates the form. By signing, both parties agree that the information is true and accurate.
- ✓ The EOR should keep the completed forms in a folder or notebook as a record of services provided.

Note: The *Consumer-Directed Attendant Documentation Form* is not to be sent to the F/EA or to DMAS. Again, this form is for EOR record keeping purposes only and as justification of care provided if a shiftis in question. While the use of this form is optional, individuals are strongly encouraged to document the services provided by the attendant using this available form.

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SHIFT SUBMISSION PROCESS

Attendants want to be paid on time! The EOR is responsible for ensuring the attendant is paid correctlyand on time. It is very important to complete accurate shifts. Even a seemingly small error can causea delay in payment to the employee. The next section offers some helpful tips for getting the shift through the first time.

Helpful tips for the EOR when submitting shifts:

- ✓ EOR should review shifts carefully before submitting them for payment.
- ✓ Be aware that the F/EA **cannot** change a shift under any circumstances.
- ✓ A signed/approved and accurate shift will authorize the F/EA to issue apaycheck to the attendant for DMAS authorized services.
- ✓ A shift can be submitted electronically or through the IVR telephonesystem but must be fully completed and signed/dated.
- ✓ Paychecks are issued every other week.
- ✓ When completing shifts, be aware of the number of hours that have been authorized and do not approve attendant shifts for more hours thanhave been authorized. Doing so will delay processing of the shift.
- ✓ When employing multiple attendants, be sure that the shift attendant hours do not overlap. The F/EA cannot pay for overlapping hours.
- ✓ Shifts must not be submitted to the F/EA until service authorization for the hours worked on the shift has been received and approved.
- ✓ Shifts can be paid up to 12 months from the date of service.

The F/EA will make payments to the attendant based on an assigned pay schedule. Depending on where the individual lives, the EOR will use either Payroll Schedule A or Schedule B. Both schedules can be found on the F/EA website. Refer to Appendix A., Page 37 of this manual for the F/EA website address.

JOB EVALUATIONS

Evaluations given to the attendant provide feedback about how he or she is doing on the job. Evaluations are important because they let attendants know what they are doing well (through praise) and how they cando better (through recommendations).

When the EOR evaluates the attendant, the EOR should give him or her time to react to the feedback. TheEOR should give the attendant his or her full attention and really listen. After the attendant has finished speaking, the EOR should repeat in his or her own words what was said to make sure that the attendant understands. The EOR might begin with saying, “So what you are telling me is.....” or “So you are saying….?” This gives the EOR a chance to make sure that what the attendant has said is understood.

The EOR may use the attendant’s job description or a checklist that includes the job duties the attendant is expected to perform to help evaluate the attendant. Using the checklist and communicating regularly with the attendant helps the EOR to solve small problems before they become larger concerns. Checklistscan protect both the EOR and the attendant by providing a

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written record of the duties of the job. They

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are also helpful if the EOR is ever asked for a job reference for a former attendant or if the individualneeds to explain why he or she fired an attendant.

*Evaluations of the attendant's performance should be completed by the EOR at least annually and retainedin the individual's/EOR's records.

COMMUNICATING WITH THE ATTENDANT

Employers want attendants to be happy and satisfied with their work. Good communication is the key. Anattendant who is pleased in the work setting may stay longer and do a better job.

Here are some general communication tips:

1. Attendants want to feel that their work is appreciated, needed, and important. Provide constructive feedback when there is a problem. Be open and honest; make suggestions about how the performance of a task should be completed and/or improved.

2. Don't let small problems become big problems. If there are concerns, problems or issues, talk about itas soon as possible.

3. Respect the attendant and treat them the way you would like to be treated. Be honest, fair, kind, respectful, and patient.

4. Although the attendant works for the individual, the individual should not ask the attendant to do workoutside of the scope of the Plan of Care. The attendant hours and schedule agreed to and listed on the job description should be followed. Attendants should not be asked to complete tasks that are not in the job description.

5. Ask the attendant how he or she feels about the work and about the individual as an employer. Set upa regular time to share concerns and ideas about the work.

SAFETY AND UNIVERSAL PRECAUTIONS

The attendant and the individual should be safe at all times. It is important to be careful when handling human body fluids, such as blood, and other body fluids containing visible blood, mucous, urine, feces, vomit, and saliva. If there is a chance that the attendant will be in contact with bodily fluids, they should always wear disposable (plastic gloves that can be thrown away) gloves and coverings, such as aprons or eye goggles. This practice of universal precautions will help keep the individual and the attendant healthy.

Examples of universal precautions include wearing disposable gloves when changing bandages and/or assisting with bathing and treating the individual if they have broken skin. Disposable gloves are not to bewashed or re-used. They are to be thrown away as soon as they become soiled, torn, or damaged, and replaced with a new pair.

Face masks or goggles are to be used when there is a chance the attendant might be splashed or sprayed with blood or another body fluid. For example, splashing could include a cut that is bleeding so much thatsome might splash on the attendant, or a container of urine that is

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accidentally spilled or dropped on the

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floor. Sometimes a plastic apron or other protective clothing should be worn by the attendant to protect their own clothes from becoming soiled.

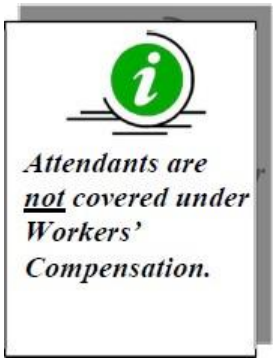
After taking off gloves, goggles or other protective items, the attendant should wash their hands and any other skin areas that might have touched the body fluid, with soap and water immediately. If the attendant touched any bodily fluids and is concerned, they should contact the local department of health or their primary care physician as soon as possible.

All of this information should be given to the attendant while the individual is training them. Remind the attendant daily of following these important health practices and universal precautions. If the attendant will be exposed to blood or other body fluids with blood in them, the individual *may* be able to obtain disposable gloves, gowns, or masks through Medicaid from a durable medical equipment and supply provider of the individual's choice.

For more current information on universal isolation precautions, go to: www.vdh.virginia.gov/epidemiology/surveillance/hai/standardprecautions.htm

ACCIDENTS ON THE JOB

As the employer, the EOR needs to be aware of any dangers in the individual's home that might cause anaccident or injury. The EOR is expected to give the attendant clear, safe directions
while assisting the individual or doing household tasks. "Attendant safety first" is atthe top of the list of the individual's duties as an employer.



If the employer isn't sure how to tell the attendant to do a certain task in the safest way (for example, help the individual transfer from the wheelchair to the toilet), have someone who has done this task before and knows the right way to do it workwith the individual and the attendant to show the safest way to transfer.

There may be training videos available on the internet to demonstrate proper transfertechniques and individuals may choose to show this to new attendants as part of their
training. Proper training and knowledge is critical to preventing injury to the individual or the attendant.

IMPORTANT: Attendants are not covered under Workers' Compensation through the Medicaidconsumer-directed program.

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CHAPTER SEVEN:

EMPLOYER/ EMPLOYEE RELATIONSHIP

PERFORMANCE EXPECTATIONS OF THE ATTENDANT

The EOR has job performance expectations of the attendant. Those expectations must be clearly spelled out. However, from time to time, difficult situations may arise between the EOR and the attendant. If there is a concern, the EOR and the attendant should first try talking about the problem together. Most of the time, talking it over and telling the attendant what is expected will help. Sometimes small problems can pile up or "mushroom" and become larger problems. Talking about the problems as they occur is a more proactive response than ignoring things of concern.

When talking to the attendant, here are some suggestions:

1. Calmly describe the attendant's actions that are of concern. Make sure the concerns are about specific job duties or actions, not personalities. An example of a way to describe actions is, "You have been late for work the last four mornings."

2. Describe how the problem impacts you and that you would like to resolve it. Don't describe it as a win or lose battle. An example of how to do this is, "When you are late for work, I am late for work. What can we do to solve this problem?"

3. Describe the problem as specifically and clearly as possible and give examples. For example, the EOR/individual could say, "When you are late for work, I can't get ready for work in time. I then miss the bus and I am late for work."

4. Describe feelings and reactions to the attendant's job performance. The EOR/individual might say, "When you don't show up for work on time I get frustrated and anxious because I am scared that I am going to miss work. This makes me feel that you don't value and respect my need to be at work on time."

5. Describe any part of the problem that may be the individual's responsibility. An example is, "I know I didn't tell you that the next bus that goes by my job gets me there an hour late."

After listening and talking together, try to agree on a plan that will solve the problem. Sometimes it's hard to tell people that you're unhappy with them. If the EOR/individual is concerned about talking with the attendant about performance concerns, ask a trusted family member or the SF for help in communicating with the attendant and working through the issues.

FIRING AN ATTENDANT

If repeated discussions and helpful guidance does not fix the problem, the EOR may have to give the attendant a warning. Let the attendant know that the EOR/individual is not happy with the way the attendant is doing the job. Explain the reasons for being unhappy and give examples. Ask the attendant for their

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understanding of the concern and give them a certain amount of time (maybe a week or so) to change. As the EOR/employer, you may fire the attendant immediately if a serious matter has taken place. It is a goodidea to write down (or have someone write down for the individual), the problems that the individual is having with the attendant

If things don't improve after talking over the concerns and discussing any changes that might be needed, the attendant's employment may need to be terminated. As the EOR/employer, you have this right.

NOTICE OF DISCONTINUED EMPLOYMENT

When an attendant is fired or leaves employment for any reason, the EOR/employer must submit a *Noticeof Discontinued Employment* form (found on the F/EA website) to the F/EA as soon as possible. This action will prevent the possibility of future shifts from being approved for payment for dates after the *Notice of Discontinued Employment* form is received by the F/EA.

FINDING A NEW ATTENDANT

If the back-up attendant cannot help the individual until a new attendant is hired, the individual may requesta list of potential attendants from their SF. The individual may use this list to find a new attendant or a substitute until another attendant can be found.

If hiring or keeping an attendant is difficult for the individual, this may put their health and safety at risk. This may especially be a problem if the back-up support plan cannot meet all of the individual's needs overtime. In this case, the EOR and the SF may need to talk about obtaining agency-directed services for the individual until other more permanent arrangements can be made. The individual and the EOR may decidethat hiring or keeping attendants is not working out and realize that there is no longer an interest in CD services. The EOR may ask the SF and the case manager, as appropriate, to help obtain other services thatbetter meets the individual's needs.

ABUSE, NEGLECT, OR EXPLOITATION

Abuse and neglect may be defined as physical, verbal, sexual, mental or emotional abuse and/or neglect toward an individual, often someone who is vulnerable due to a variety of reasons such as age, health, dependency, cognitive deficits, or disability. Exploitation is defined as taking advantage of someone, often an elderly individual or individual with a disability by misusing their money or personal property. Detailed definitions and examples are defined at the Virginia Department of Social Services (VDSS) web site at this link: http://dss.virginia.gov/family/as/aps.cgi.

If an attendant has abused or neglected the individual under their care, or suspicion of financial exploitationexists, the individual/employer has the right to fire the person immediately. In this case, the
employer should immediately report the abuse, neglect, or exploitation to Adult Protective Services (APS)or in the case of child abuse or neglect, Child Protective Services (CPS), in the

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individual's city/county locality social services department where they reside and to their Services Facilitator or case manager or CSB support coordinator.

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Anyone may report suspected child abuse or neglect to local departments of social services or the statewide **Child Abuse and Neglect Hotline** 24 hours per day, seven days a week. The statewide toll free hotline number within Virginia is: #800-552-7096.

Anyone may report suspected adult abuse, neglect, or financial exploitation to local departments of socialservices or the statewide **Adult Protective Service (APS) Hotline** 24 hours per day, seven days a week. The statewide toll free hotline number within Virginia is: #888-832-3858.

Attendants and Services Facilitators are mandated reporters in the Commonwealth of Virginia. As such, they are required to report any suspected abuse, neglect, or exploitation of the individual immediately to the local department of social services in the locality in which the individual resides or to the Statewide, toll-free hotline numbers listed above. The VDSS mandated reporters training and resources for APS and CPS may be located on the VDSS website at: http://dss.virginia.gov/family/as/aps.cgi (for APS) http://dss.virginia.gov/family/prevention.cgi (for CPS).

FRAUD AND ABUSE

The Attendant and the EOR/Individual who hires and supervises the attendant are responsible for reading and adhering to the applicable guidelines, State and Federal regulations, tax laws, and to the requirements set forth in this "Consumer-Directed Employer of Record Manual". The attendant and the employer certifies by his or her signatures on all required forms and shifts that the information submitted to DMAS and the F/EA is true, accurate, and complete.

Unethical practices or questionable or inaccurate record documentation, shifts, or other required documentation is subject to review and audit at any time by the DMAS or its contractors. Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. It is imperative that attendants and the employer/individual adhere to all of the requirements of this program to avoid any suspicion of fraudulent activity. This is also applicable to Services Facilitators, who are enrolled Medicaid providers of service.

Some Tips to prevent potential Fraud and Abuse are as follows:

- The EOR should never share their F/EA web portal login/password with anyone. It is important that the EOR never share their password with the attendant. Doing so could lead to approval of fraudulent shifts and improper Medicaid payments.
- The EOR should never sign shifts before the attendant hours are filled in and the EOR has reviewed for accuracy.
- When employment of an attendant ends under any circumstance it is important for the EOR to submit a *Notice of Discontinuation of Employment* form to the F/EA as soon as possible. This willprevent payment to the attendant past the last day actually worked.

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APPENDIX A:
RESOURCE INFORMATION AND CONTACTS

DMAS PROGRAM INFORMATION

For CCC Plus, CL, and FIS Waiver information, visit the DMAS web site at:
http://www.dmas.virginia.gov/#/longtermwaivers

DMAS EPSDT Benefit (Early and Periodic Screening, and Diagnostic and Treatment):
http://www.dmas.virginia.gov/#/maternalepsdt

For Medicaid Works information: https://www.dmas.virginia.gov/#/medicaidworks

DMAS Provider Call Center (for Services Facilitators): 1-800-552-

8627 **DMAS Recipient Helpline (for Medicaid individuals)**: 1-804-786-

6145 **DMAS Agency Electronic Information Inquiry:**

dmasinfo@dmas.virginia.gov

FISCAL EMPLOYER AGENTS (F/EA)

Consumer Direct Care Network (CDCN)

NOTE: For Fee-for-Service members and individuals in the Virginia Premier CCC Plus health plan

Website: www.consumerdirectVA.com
Email:
InfoCDVA@ConsumerDirectCare.com
Phone number: 1-888-444-8182
Fax number: 1-877-861-4523 (shifts only)
1-877-571-8649 (FARFS only)

Public Partnerships LLC (PPL)
NOTE: For individuals in the Aetna, Anthem, Optima, and United CCC Plus Health Plans
Website:
http://www.publicpartnerships.com/programs/virginia/index.htmlPhone number: 1-833-549-5672
Fax number: 1-866-709-3319Email:
pplVA@pcgus.com

ACES$ Financial Management Services
NOTE: For individuals in the Molina Complete Care CCC Plus Health Plan
Website: https://www.mycil.org/acess-

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virginia.htmlPhone number: 1-833-955-4545
Fax number: 1-888-862-
3840 Email:
SupportVA@mycil.org

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APPENDIX B: DEFINITIONS USED IN CONSUMER DIRECTED

Agency-Directed (AD) Services – A service for which a provider (not the individual receiving services) isresponsible for directing and managing services in accordance with the service plan.

Attendant – The person hired to provide consumer-directed personal assistance. The attendant is the person who provides personal care or supports for the individual. This term is also used in this manualto describe persons who provide respite or companion services through consumer-directed services. The attendant is also referred to as the "employee" in this manual.

Barrier Crimes – Serious offenses that, if found in an employee's or potential employee's Criminal Background History Record, are grounds for not being hired or immediate dismissal. The list includes such crimes as murder, abduction, assault, robbery, arson, or abuse and neglect.

Companion Services – Services available only to CL and FIS Waiver individuals who must be age 18 or older. Companion services are defined as assisting adult individuals with housekeeping, shopping and community and social activities.

Community Services Board (CSB) – A community services board (CSB) is the point of entry into the publicly-funded system of services for mental health, intellectual disability, and substance abuse. CSBs provide pre-admission screening services 24-hours per day, 7 days per week. In Virginia, there are 40 CSB's located throughout the Commonwealth to serve the general public.

Consumer-Directed (CD) Services – CD services are support services that are necessary to enable an individual to remain at or return home rather than enter an institution. Services may include assistance with bathing, dressing, toileting, transferring, and nutritional support necessary for consumers to remain intheir own homes or in the community. Services can also include supervision and respite services.

Criminal Background Records Check – A requirement of all CD employees prior to their employment. The CD services facilitator and the F/EA assist individuals/EORs in processing these checks through the Virginia State Police.

Department of Behavioral Health and Developmental Services (DBHDS) – The state agency that is responsible for managing mental health, substance abuse, behavioral health and developmental services.

The DBHDS is responsible for daily operations, determining eligibility, and service authorizations for the Community Living (CL), Family & Individual Supports (FIS), and Building Independence (BI) waivers inVirginia.

Department of Medical Assistance Services (DMAS) – The state agency that is responsible for managingMedicaid-funded long-term services and supports programs, including waivers. DMAS is responsible for determining waiver eligibility for the CCC Plus waiver.

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Department of Social Services (DSS) – The Local Departments of Social Services are the county or city agencies responsible for determining financial eligibility for Medicaid. These agencies also handle Child and Adult Protective Services.

Emergency Back-Up Plan – A plan developed by and for an individual using CD services, regardless of the waiver, that identifies a family member, neighbor, friend, or paid employee willing and available to assist an individual in case the CD employee/attendant is unable to work as expected or terminates employment without notice. Individuals who do not have a back-up plan are not eligible for CD services or Medicaid waivers until they have developed a back-up plan.

Employer Management Training – Training provided by the CD services facilitator to the CD employerwithin 7 days of authorization of services (at the Initial Comprehensive Visit) that explains the CD employer's responsibilities.

Employer of Record – (EOR) – The individual receiving CD services from a personal attendant who is hired, trained, and supervised by the individual/EOR. The EOR may also be the individual's representative. In this manual, the person receiving waiver services is referred to as "the individual."

EPSDT (Early and Periodic Screening, and Diagnostic and Treatment) – The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health careservices for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

Fiscal/Employer Agent (F/EA) – The DMAS contractor that pays the attendant, makes sure that paymentis within the approved number of hours of service, and follows all hiring and tax rules on the individual's behalf as the employer/EOR of an attendant.

Individual – The Medicaid individual or user of Medicaid services. Because of support provided by familymembers and other caregivers, the term "individual" often implies "with support and assistance from others."

Medicaid – The joint federal and state program to assist states in furnishing medical assistance to eligiblepersons.

Patient Pay – The amount of money paid directly to the attendant by the individual, if applicable. Patientpay is determined by the local department of social services and must be established before an attendant ishired. More detailed information on patient pay is located in Chapter Four.

Personal Assistance Services – Assistance with activities of daily living, instrumental activities of dailyliving, access to the community, self-administration of medication, or other medical needs, and the monitoring of health status and physical condition.

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Rate of Pay – This is the attendant's hourly rate established by the Virginia General Assembly forconsumer-directed services. This rate is not negotiable.

Respite Care – Services provided to eligible individuals who are unable to care for themselves; provided on an episodic or routine basis because of the absence or need for relief of those unpaid persons or primarycaregiver(s) normally providing the care.

Service Authorization (SA) – Prior approval for specific services provided by DMAS or its designated agent. KEPRO is the current SA agent for the FFS CCC Plus waiver, EPSDT, and Medicaid Works individuals and the health plans conduct authorization for CCC Plus waiver, EPSDT, and Medicaid Worksmanaged care members. DBHDS is the current SA agent for the CL and FIS waivers.

Services Facilitator (SF) – For consumer-directed services, the person who guides the individual receiving services in hiring, training, and supervising attendants as needed for the following waivers, benefits, and programs: CCC Plus, CL and FIS waivers, EPSDT, and Medicaid Works. For the FIS and CL Waiver, this person may also be the Case Manager or Support Coordinator.

Service Plan – A form that is completed by the individual, together with the services facilitator, that liststhe individual's personal outcomes and all the tasks that the attendant will perform on a daily basis, basedon the individual's needs, as well as informal supports in the community. The service plan must contain the types of services to be furnished, the amount, frequency, and duration of each service, and the type ofprovider to furnish each service. Payment may only be made for services that are authorized in the serviceplan.

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SAMPLE ATTENDANT APPLICATION

(Note: You may use this form or develop your own.)

Name:_____
Phone: _____

Street Address:

_____

City_____**State**_____**ZIP Code:**
_____

How long have you lived there? _____

Sex: **Are you age 18 or over?** _____
_____

In case of emergency, notify:

_____

Experience in attendant work/nursing/companion services?

_____

_____

How long? _____**If so, where?**
_____

Hours available to work:___**Part-time** _____**Days**_____**Nights**
_____**Weekends** _____
Back-Up_____**Date Available:** _____

How many hours per week?

_____

Are you willing and able to do emergency back-up work?

_____

Do you have reliable, steady transportation to and from work?

_____

Do you have a valid, current Virginia Driver's License?

_____

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Have you ever been convicted of a crime or other criminal offense?

_____

If so, explain. _____

Are there any jobs that you would not want to do (e.g., work for opposite sex,duties listed in job description, etc.)?

_____

The answers given in this application are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employmentdecision. I understand that this application is not a contract of employment.

Applicant Signature

_____

Date

_____

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SAMPLE JOB DESCRIPTION FOR AN ATTENDANT

Note: You may use this form or develop your own.)

I use an attendant to assist and support me in the following waysWeekdays:_____Weekends: _____Evenings: _____

I need my **attendant** to help me with activities of daily living that include:

Bathing:

Transferring:

Feeding/e

at

Grooming:

Hygiene:

Toileting:

Dressing:

I need my **attendant** to help me on the job by:

I need my **attendant** to help me with the following special activities (after getting trained and beingChecked from time to time by a nurse)

Bladder care:

Bowel care:

Wound care:

Range of motion Exercise:

I need my **attendant** to support me in these other

waysHelp with medication / self –Administration:

Lifting up to 50 pounds:

Meal preparation:

Housekeeping:

Laundry:

Grocery Shopping:

Making sure I am safe:

Going with me to appointments or social/recreational activities:

NOTE: I expect my attendant to be on time, neat, honest, and to enjoy working with people. I ask that you dress casually. Please give me at least two hours' notice if you are going to be late or sick and at least one week's notice for planned days off. Please give me two weeks to a month's notice if you have to leave this job. When providing personal care services to me (or my child), please inform me (the employer) if you notice any

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bruises, scrapes, or skin problems. Please feel free to ask any questions about my personal care or other needs. I feel more comfortable when people understand the purpose behind the support I need. The hourly wage for Consumer-Directed Services is determined by the Virginia General Assembly and is not negotiable.

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VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
SERVICE AGREEMENT BETWEEN THE INDIVIDUAL AND THE
CONSUMER-DIRECTED SERVICES FACILIATION PROVIDER

This agreement is made between_____hereafter referred to as "Consumer Directed(CD) Service Facilitator" a_____, hereafter referred to as "Individual", for the purposeof establishing the relationship, roles, and responsibilities of the parties. The CD service facilitator is a CD services facilitation provider enrolled in and authorized to provide services through the Virginia CD Service Programs of the waiver services program in which the individual is enrolled. The individual is eligible to receive CD personal care, respite services, and/or companion services, depending upon the services that are allowed in his or her service plan.

A. Individual

1. By this agreement, the individual chooses the CD service facilitator as the qualified provider of services facilitation services that the individual is authorized to receive through the Medicaid Waiver. The individual understands that the services that the CD service facilitator will provide are limited to those activities and tasks related to the individual's approved service plan.

2. The individual agrees to follow the policies and procedures of the CD service facilitator, of the CD service facilitator's designees, and of the Virginia CD Services Programs, including:

a) Reporting to the CD service facilitator any changes that would affect the individual's eligibility or need forCD services;
b) Receiving training and assistance from the CD service facilitator and participating in training for employees, asnecessary, to ensure the individual's health and safety and the individual's continued participation in the CDServices Program(s);
c) Allowing the CD service facilitator and/or representatives of the Virginia CD Services Program(s) into theindividual's home at least once per month to monitor the individual's participation in the Program(s); and
d) Making available for the CD service facilitator's inspection and copying documents and records required forthe individual's continued participation in the Virginia CD Services Programs.

The individual understands that failure to follow these policies and procedures may result in the individual'stermination from the Virginia CD Services Program(s).

3. The individual understands his or her right to select employees, make decisions about, direct the provision of, andcontrol the CD service(s) to the maximum extent that the individual desires and is capable. The individual understands that he or she may request and receive assistance and support from the CD services facilitator in coordinating the individual's CD services.

4. The individual is responsible for timely completion and delivery of employee time sheets according to the payrollschedule established by the fiscal agent. The individual understands that late arrival of time sheets may result in delays in the employee being paid.

5. The individual agrees to pay, through a fiscal agent acting on the individual's behalf, the employee's wages in full on a regular schedule for the approved hours worked by the employee.

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SERVICE AGREEMENT BETWEEN THE INDIVIDUAL AND THE CD SERVICES FACILIATION PROVIDER – page 2

6. When an employee's employment ceases, the individual agrees to notify the CD service facilitator and fiscal agent of the date and reason the employment ceased.

B. CD Service Facilitator

1. As an authorized service provider in a Department of Medical Assistance Services (DMAS) Waiver Services Program, and as the service facilitation provider selected by the individual, the CD service facilitator agrees to provide service facilitation services in accordance with DMAS regulations, policies, and guidelines.

2. The CD service facilitator will provide management training and skills development for the individual.

3. The CD service facilitator agrees to supervise the service plan in a manner that ensures the individual's health, safety, and personal autonomy, including periodic monitoring of the provision of the services. The CD service facilitator agrees to ensure that services provided to the individual are authorized and appropriate.

4. The CD service facilitator agrees to maintain appropriate records and to provide the individual with informationnecessary for the individual's continued participation in the Virginia CD Services Program(s).

C. Regulations

Any applicable federal, state, and/or local regulations, including this CD Waiver Services Employer Manual, pertaining to the provision and receipt of CD services are hereby incorporated by reference in this agreement. This includes agreeing to be available for any DMAS quality management reviews (QMRs).

D. Duration and Modification of Agreement

This written agreement constitutes the entire agreement and understanding between and among the individual receiving CD waiver services and the CD service facilitator. This agreement shall be in effect as of the date the agreement is signed by the individual and the CD service facilitator. The agreement can be modified by agreement of both parties. This agreement may be terminated immediately by either of the parties upon breach of any of its terms. This agreement may be terminated without cause upon ten (10) days' written notice of one party to the other.

_____ _____

Individual's / Employer of Record's Signature Date

_____ _____

CD Service Facilitator's Signature Date

DMAS-486

This form must be signed and a copy maintained in the employer's and the service facilitator's records.

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Revised 07/2009 (originally in 2005 Consumer-Directed Employer Manual)

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Virginia Department of Medical Assistance Services

Consumer-Directed Attendant Documentation Form

(Personal/Respite/Companion Care)

Consumer's Name: **Consumer**

MedicaidAttendant's Name:

In the activity list in the left column, circle the service(s) that the attendant provides. ***Place the date under the day of the week and placea next to the activity(ies) that the attendant assists the consumer with for that date.*** *Refer to the attached list of definitions for the activities..Activities listed under "Special Maintenance Activities" must have written documentation in the "**Notes"** section below.*

Day:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date: (Month/Date/Year):	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Activities of Daily Living (ADLs)							
Bathing							
Dressing/Undressing							
Toileting							
Transferring							
Eating/Feeding							
Ambulation (Walking, Wheeling, Stair Climbing)							
Turning/Changing of Position							
Personal Grooming							
Supervision							
Instrumental Activities of DailyLiving (IADLs)							
Meal/Snack Preparation							
Cleaning Kitchen							
Cleaning Other Areas Used by Consumer							
Making Bed/Changing Bed Linen							
Shopping/Making Shopping List							
Laundry (Consumer's)							
Money Management							
Medical Appointments							
Work/School/Social							
Transportation							
Using Telephone							
Other							
Special Maintenance Activities							
Bowel/Bladder Program							
Wound Care							
Range of Motion (ROM) Activities							
Vital Signs							
Assist with Self-Administration of Medication							
Other							
Supervision							

Notes:

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Instructions for Consumer-Directed Attendant Documentation Form

INSTRUCTIONS

1. Use one form for each attendant each week. Place dates for the week across the top shaded date line.
2. In the activity list in the left column of the form, circle the service(s) that the attendant provides.
3. Place a next to the activity or activities that the attendant assists the consumer with for that date. Refer to the definitions below for the activities.
4. Activities listed under "Special Activities" must have written documentation in the "**Notes"** section of the form.
5. The consumer or the employer of record must sign and date the form after the week is completed. The attendant must also sign and datethe form. By signing, both parties agree that the information is true and accurate.
6. Consumers should keep the completed forms in a folder or notebook as a record. **The form is not to be sent to DMAS or the F/EA.** The services facilitator (SF) may make a copy or review the form as agreed between the consumer and the SF. The use of the form is voluntary at this time.

DEFINITIONS

- ***Bathing****:* Includes all or part of getting in and out of the tub, preparing the bath (e.g., turning on the water), sponge bath, actually washing oneself and towel drying.
- ***Dressing/Undressing:*** Getting clothes from closets and/or drawers, putting them on, fastening, and taking them off. Clothing refers toclothes, braces and artificial limbs worn daily.
- ***Toileting:*** Getting to and from the bathroom, getting on/off the toilet, cleansing after elimination, managing clothes, and flushing thetoilet.
- ***Transferring:*** The ability to move between the bed, chair, vehicle, and/or wheelchair.
- ***Eating:*** The process of getting food/fluid by any means into the body.
- ***Ambulation:*** Ambulation is the ability to get around indoors (walking) and outdoors (mobility), climb stairs and wheel.
  1. ***Walking:*** The process of moving about indoors on foot or on artificial limbs.
  2. ***Wheeling****:* The process of moving about by a wheelchair.
  3. ***Stair Climbing****:* The process of climbing up and down a flight of stairs from one floor to another.
- ***Turn/Change of Position:*** Assisting with changing the position of the body to avoid pressure of skin, soft tissue, muscle, and boneagainst a hard surface that could lead to skin breakdown.
- ***Personal Grooming:*** Includes brushing teeth, combing and arranging hair, and basic hygiene.
- ***Supervision:*** Overseeing the health, safety, and welfare of the individual.
- ***Meal/Snack Preparation:*** Plan, prepare, cook, and serve food.
- ***Cleaning Kitchen:*** Washing and putting away dishes, wiping surfaces, etc.
- ***Cleaning Other Areas Used by Consumer***: Light housework such as dusting, vacuuming, cleaning floors, and cleaning the bathroomused by the consumer.
- ***Making Bed/Changing Bed Linens:*** Removing bed linens and replacing with fresh ones; arranging bed linens neatly.
- ***Shopping/Making Shopping List****:* Listing items needed from store; getting to and from the store, obtaining groceries and other necessary items such as clothing, toiletries, household goods and supplies, paying for them, and carrying them home.
- ***Laundry (the consumer's)***: This includes putting clothes in and taking them out of the washer/dryer and/or hanging clothes on andremoving them from a clothesline, and ironing, folding, and putting clothes away.
- ***Money Management:*** Managing day-to-day financial matters such as paying bills, writing checks, handling cash transactions, andmaking change.
- ***Medical Appointments:*** Scheduling and attending necessary medical appointments.
- ***Work/School/Social:*** Participating in community activities including work, school, and social/recreational activities.
- ***Transportation:*** Includes the ability to either transport oneself or arrange for transportation, to get to and from, and in and out of the vehicle (e.g., a car, taxi, bus, or van).
- ***Using the Telephone****:* Look up telephone numbers, dial, hear, speak on, and answer the telephone.

SPECIAL ACTIVITIES

The following activities, when part of an individual's Plan of Care or Individual Service Plan, require physician orders, training of the attendant, and monitoring by a licensed registered nurse (RN) or primary care physician and special documentation by the Consumer-Directed Services Facilitator, as appropriate per waiver.

- ***Bowel/Bladder Program:*** Assistance/training with duties related to incontinence of bowel and/or bladder elimination.
- ***Routine Wound Care:*** Attending to an open or break of the skin (that does not include sterile technique or sterile dressing).
- ***Range of Motion (ROM):*** The extent to which a joint is able to go through all of its normal movement. ROM exercise helps increaseor maintains the flexibility and movement in muscles, tendons, ligaments, and joints.
- ***Assist with Self-Administered Medication:*** Assisting with the administration of medication (not to include in any way determining thedosage of medication).
- ***Vital Signs:*** The temperature, pulse rate, and respiratory rate of an individual. May include notations on seizure chart.

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DMAS-487 July 2009 revision

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VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES CONSUMER-DIRECTED INDIVIDUAL COMPREHENSIVE TRAINING FORM

(Check (√) the box after completing each part of the training.)

❑ **I. Consumer-Directed Attendant Services**

- ❑ A. Definition of services
- ❑ B. The approach to provision of services (e.g., personnel involved including service facilitator, fiscal agent). Individual should read and sign service agreements for service facilitator and fiscal agent if they have not been signed.
- ❑ C. Role of the attendant in the provision of services
- ❑ D. Must have authorization prior to hiring an attendant. If there is no authorization, then the individualis liable for payment until authorization is received.

❑ **II. The Individual of Attendant Services**

- ❑ A. Inventory of the individual's needs (assessing needs as an individual (e.g., habits, personalcare)
- ❑ B. Selecting Attendants
  - ❑ 1. Creating an attendant job description (discuss sample)
  - ❑ 2. Advertising for attendants (discuss sample)
  - ❑ 3. Assessing an attendant's application
  - ❑ 4. Required qualifications of attendants
  - ❑ 5. Screening applicants and scheduling interviews
- ❑ C. Hiring Attendants
  - ❑ 1. Obtaining attendant work record
  - ❑ 2. Interviewing a prospective attendant (questions to think about)
  - ❑ 3. Consumer selection of attendant
  - ❑ 4. Recordkeeping
  - ❑ 5. Completing the Employment Packet

❑ **III. Employing Attendants**

- ❑ A. Philosophy/Policies of Attendants
- ❑ B. Payroll Requirements for Each Attendant
  - ❑ 1. Employment eligibility verification (I-9)
  - ❑ 2. W-4 Form completion
- ❑ C. Competency Determination of Attendants

❑ **IV. Contractual Agreements** (including the agreement between individual and attendant). Show sampleattendant agreement and sample contract.

CONSUMER-DIRECTED INDIVIDUAL COMPREHENSIVE TRAINING FORM – page 2

❑ **V. Training Attendants**

- ❑ A. The Provision of Services by the Attendant
  - ❑ 1. Included services/excluded services
  - ❑ 2. Sample attendant duties checklist

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❑ 3. Attendant job evaluations

❑ B. Communicating with the Attendant

❑ 1. Creating a good work environment
❑ 2. Establishing rapport
❑ 3. Resolving conflict

❑ C. Important Considerations

❑ 1. Firing the attendant
❑ 2. Emergency back-up attendant
❑ 3. Substitution of attendants
❑ 4. Accidents on the job
❑ 5. Unexpected death and the attendant

❑ VI. Completing Attendant Time Sheets

❑ A. Certification of services rendered (explanation of time sheet)

❑ B. Understanding of relinquishment of patient co-pay amount

❑ C. Discontinued employment

This form must be completed by the CD Service Facilitator during the training of the individual/employerof record and signatures obtained after the training. This form must be maintained in the individual's file by the Service Facilitator.

_____ _____
Individual's / Employer of Record's Signature Date

_____ _____
CD Service Facilitator's Signature Date

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VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INDIVIDUAL SELECTION OF CONSUMER-DIRECTED SERVICES

I have selected_____(hereafter referred to as Service Facilitator") as theapproved Services Facilitation provider to coordinate my consumer-directed (CD) services through the Virginia CD Services Programs. The service facilitator has informed me regarding how much control I have over the employees who will provide my personal assistance, respite, and/or companion services. I understand that the waiver will allow me to exercise my right to direct and supervise my CD services in a manner that is consistent with my needs, capacity, and interest in directing my own services.

Individual as the Employer

1. Under the_____attendant(s) who will provide my services. In selecting CD services, Iunderstand that I choose to be the legal employer of the attendants who will provide my services. As theiremployer, I have the right and responsibility to hire and direct them in the provision of my services and to perform and fulfill the duties of an employer, including recruiting, selecting, hiring, training, supervision,authorization of the payment of wages, and dismissing employees, as necessary. I understand that I can also receive, at my request as needed, assistance from the service facilitator in performing these tasks. I also understand that the Department of Medical Assistance Services or its designated agent will fulfill mypayroll and fiscal duties and obligations as an employer by being appointed as my payroll and fiscal agent,to act on my behalf, by signing the necessary forms in the *Employment Packet*.

2. Once I select and hire an attendant, I will notify the CD Service Facilitator. I will have the attendant sign the required forms in the *Employment Packet*, including a Criminal History Record Request. If the attendant has been convicted a crime as specified as a barrier crime for the waiver in which I am enrolled, I agree to dismisshim or her and search for another attendant.

3. I will establish the attendant's schedule to provide services within the limits established in my service plan.

4. I understand that I have the primary responsibility for making arrangements for back-up services in the event an attendant is unable to work on a regularly scheduled workday. I agree to use family, friends, and neighborsas sources of back-up services where possible.

5. I am responsible for supervising the attendant's record of hours worked. The attendant's and my signatures onthe time sheet attest that all times submitted for payment are actual and accurate. I understand that the Virginia CD Services Programs will only pay for hours consistent with my service plan.

My signature indicates that I have been informed of and accept my rights and responsibilities as an employer in theWaiver Program in which I am enrolled.

_____ _____
Individual's / Employer of Record's Signature Date

_____ _____
CD Service Facilitator's Signature Date

This form must be signed and a copy maintained in the employer's and the SF's records.

Revised 07/2009 (originally in 2005 Consumer-Directed Employer Manual)

DMAS-489

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Provider Manual Title: CCC Plus Waiver
Appendix D: Service Authorization

Revision Date: 9/24/2026

Appendix D
Service Authorization

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Provider Manual Title: CCC Plus Waiver Revision Date: 9/24/2026
Appendix D: Service Authorization

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INTRODUCTION – SERVICE AUTHORIZATION IN FEE-FOR-SERVICE (FFS) AND MANAGED CARE ORGANIZATIONS (MCO)

Service authorization is the process to review specific service requests for an enrolled Medicaid, FAMIS Plus or FAMIS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require service authorization, and some may begin prior to requesting authorization.

Psychiatric Residential Treatment Facility Services (PRTF) and Therapeutic Group Home Services (TGH) are covered for Medicaid members under age twenty-one (21) and are administered through the DMAS Service Authorization Contractor. Any member admitted to a PRTF or a TGH is not excluded from managed care coverage; however, the PRTF and TGH services are carved out of managed care and service authorization decisions are administered through the DMAS Service Authorization Contractor.

Purpose of Service Authorization

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claim's payment process, the individual's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity.

General Information Regarding Service Authorization

Submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests.

DMAS criteria for medical necessity will be considered if a service is covered under the State Plan or applicable waiver and is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve functional disability. Coverage may be denied if the requested service is not medically necessary according to this criteria or is generally regarded by the medical profession as investigational/experimental or not meeting the standard of practice. [42 CFR 441.302 (c) (1)]

DMAS, its FFS service authorization contractor, or the MCO will approve, pend, reject, or deny all service requests. Requests that are denied for not meeting the medical necessity criteria are automatically sent to medical staff for a higher-level review. When a final disposition is reached the individual and the provider are notified in writing of the status of the request. If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice sent by DMAS or its FFS service authorization contractor or MCO will identify the individual's right to

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appeal the decision, in accordance with 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 370. The provider and individual have the right to appeal adverse decisions to the Department.

If services cannot be approved for members under the age of 21 using the current criteria, DMAS, the FFS service authorization contractor, or the MCO will then review the request by applying EPSDT criteria. Individuals under 21 years of age qualifying under EPSDT may receive the requested services if services are determined to be medically necessary and, if applicable, are prior authorized by the Department, the FFS service authorization contractor, or a Cardinal Care managed care organization. A request cannot be denied as not meeting medical necessity unless it has been submitted for secondary physician review. DMAS, the FFS service authorization contractor and the MCO must follow the DMAS process for a secondary physician review of all denied service authorization requests.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply to an EPSDT request if the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Any treatment service that is not covered under the State's Plan for Medical Assistance can be covered for individuals under the age of 21 as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or its contractor as medically necessary. Treatment services that are approved under EPSDT but are not available through the State Plan for Medical Assistance are referred to as EPSDT Specialized Services. Refer to the EPSDT Supplement for additional information. Providers should contact the MCO for information on requesting EPSDT specialized services for youth enrolled in managed care. Providers should refer to Appendix A of the EPSDT Supplement for information on requesting EPSDT specialized services for youth in FFS.

CMS Interoperability Rule Mandate, Effective January 1, 2026

DMAS and its Prior Authorization Contractors and Managed Care Organizations (MCOs) have implemented changes mandated by the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule (CMS-0057-F). The initial notification is in the DMAS Medicaid Bulletin dated 12/5/2025.

The rule primarily shortens standard service authorization decision timeframes down from 14 days to 7 calendar days. These rules apply to Managed Care and Medicaid and CHIP Fee-for-Service (FFS). The following timeframes apply:

- Standard (non-urgent) requests: Response required from contractor to provider within 7 calendar days. This standard request timeframe can be extended by up to 14 calendar days if:
    - Member or provider requests an extension (for example, to gather additional information), or

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- The extension is justified due to the need for the service authorization contractor or MCO to request additional medical evidence, or due to extraordinary or other non-routine circumstances, and is in the member's best interest.

- Expedited (urgent) requests: A response is required from the contractor to the provider upon determination that the standard timeframe could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
  - The service authorization contractor or MCO must make an expedited authorization decision within 72 hours after receipt of the request.
  - This expedited request timeframe can be extended by up to 14 calendar days, only if the extension is in the Member's best interest due to the need for additional information.
- Decision details: Contractors must provide a specific reason for denying a service authorization request.
  - Denial decision letters from the MCOs and service authorization contractors adhere to 42 CFR §438.242(b)(8) and 42 CFR §431.80(a) by clearly stating the reason for denial and informing Members of their right to appeal the decision.

- Public reporting: to promote transparency, DMAS and its MCOs must publicly report on an annual basis, certain FFS and Managed Care service authorization metrics about their processes, beginning March 31, 2026. This initial report is required to include metrics data from calendar year 2025. Each health plan will report their metrics data annually on their websites and DMAS will report FFS metrics data annually on its website. The public, including providers, will be able to review the DMAS and MCO websites to gain more insight into the service authorization processes.

For additional information, see the DMAS Bulletin posted 12/5/2025, titled **"**Interoperability and Prior Authorization Final Rule Implementation Update."

TRANSITION OF CARE BETWEEN MANAGED CARE PROGRAMS AND FEE-FOR- SERVICE (FFS)

Individuals Transitioning into MCOs

Providers should reference the Cardinal Care managed care contract to learn more about the requirements for individuals transitioning from FFS to managed care or from one MCO to another.

Individuals Transitioning from Managed Care back to Medicaid FFS

Should an individual transition from an MCO back to Medicaid FFS, the provider must submit a request to the FFS service authorization contractor and must indicate that the request is for an MCO member who was disenrolled from an MCO into FFS. This will ensure honoring the MCOs approval of services for up to 60 days for the continuity of care period and waiving timeliness requirements. The FFS service authorization contractor will honor the MCO authorization up to the last approved

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date but no more than 60 calendar days from the date the MCO's disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the FFS service authorization contractor will apply medical necessity/service criteria.

- If the provider is not an enrolled Medicaid provider, the request will be rejected.
- If the service has been authorized by an MCO for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once an individual is in FFS, the MCO approvals for Medicaid-covered services will be honored for the continuity of care period.
- If an individual transitions from an MCO to FFS, and the provider requests an authorization for a service not previously authorized under an MCO, this will be considered as a new request. The continuity of care will not be applied, and timeliness requirements for the service authorization will not be waived.

After the continuity of care/transition period end date, providers must submit a request to the FFS service authorization contractor that meets the timeliness requirements for the service. The new request will be subject to a full clinical review (as applicable). The waiver services have exceptions, please refer to the waiver manuals for specific information.

Review Process for Requests Submitted to the FFS Service Authorization Contractor

After the Continuity of Care Period:

A. For dates of service beyond the continuity of care period, timeliness will not be waived and the request will be reviewed for level of care necessity; all applicable criteria will be applied on the first day after the end of the continuity of care period; and

B. For Managed Care Waiver services, if the provider does not submit a new service authorization during the continuity of care period, the individual's hours will be capped based on the Level of Care score in the Plan of Care at the conclusion of the continuity of care period. Changes to the authorized hours will not be made until the provider submits a new service authorization request. The FFS service authorization contractor will review whether service criteria continue to be met and make a determination on the hours going forward upon submission of the new service authorization request.

The best way to obtain the most current and accurate eligibility information is for providers to complete their monthly Medicaid eligibility checks at the beginning of the month. This will provide information for individuals who may be in transition to and from an MCO at the very end of the previous month.

Communication

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Provider manuals are located on the DMAS Medicaid Web Portal and the FFS service authorization contractor's websites. The FFS service authorization contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to https://vamedicaid.dmas.virginia.gov/sa. For educational material, click on the Training tab. The FSS service authorization contractor provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the service authorization process for the specific services outlined in this manual will be posted in the form of a Medicaid Bulletin to the DMAS MES Home Page. Changes identified in Medicaid Bulletins are incorporated within the manual.

The FAS and/or the FFS service authorization contractor generate letters to providers and enrolled individuals depending on the final determination. DMAS will not reimburse providers for dates of service prior to the date identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individual's medical record and are subject to review during post payment and Utilization Review.

MCOS: SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

In accordance with 42 CFR §438.210(b)(1), the Contractor's authorization process for initial and continuing authorizations of services must follow written policies and procedures and must include effective mechanisms to ensure consistent application of medical necessity review criteria for authorization decisions.

For more information, please refer to the Cardinal Care Managed Care contract. Please contact the individual's Medicaid MCO for information on submitting service authorization requests for individuals enrolled in managed care.

FEE-FOR-SERVICE: SUBMITTING REQUESTS FOR SERVICE AUTHORIZATION

Service authorization requests must be submitted electronically utilizing the DMAS MES Portal to access the contractor's application, Atrezzo Next Generation (ANG). All providers must log in through the DMAS MES portal, effective August 3, 2026.

Providers must submit requests for new admissions within the required timeframes for the requested service. If a provider is late submitting the request, the FFS service authorization contractor will review the request and make a determination based on the date it was received. The days/units that are not submitted timely are denied, and appeal rights provided.

Retrospective review will be performed when a provider is notified of an individual's retroactive eligibility for Virginia Medicaid coverage. It is the provider's

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responsibility to obtain a service authorization prior to billing DMAS. Providers must request a service authorization for retrospective review as soon as they are aware of the individual's Medicaid eligibility determination.

**Note: Information submitted for service authorization must be documented in the medical record at the time of request. The request for service authorization must be appropriate to adequately meet the individual's needs. Any person who knowingly submits information containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Specific Information for Out-of-State providers

Out-of-state providers are held to the same service authorization processing rules as instate providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of-state services to the FFS service authorization contractor. Out-of-state providers may enroll with Virginia Medicaid by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers. Procedures and/or services may be performed out-of-state only when it is determined that they cannot be performed in Virginia because it is not available or due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

Services provided out-of-state for circumstances other than these specified reasons shall not be covered:

1) The medical services must be needed because of a medical emergency;
2) Medical services must be needed, and the recipient's health would be endangered if he were required to travel to his state of residence;
3) The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4) It is the general practice for recipients in a particular locality to use medical resources in another state.

The provider needs to determine which item 1 through 4 is satisfied at the time of the request to the FFS service authorization contractor. If the provider is unable to establish one of the four, the contractor will pend or reject the request until the required information is provided.

Out-of-State Provider Questionnaire (Found on the Provider Portal at Service Authorizations Home (Acentra Health/DMAS) | MES)

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A. Question #2-Are the medical services needed; will the recipient's health be endangered if required to travel to state of residence? If a provider answers "Yes", then additional question #2.1.1 asks: "Please explain the medical reason why the member cannot travel".

B. Question #5- "In what state is the provider rendering the service and/or delivering the item physically located?"

C. Question #6- "In what state will this service be performed?"

D. Question #7- "Can this service be provided by a provider in the state of Virginia? If a provider answers "No", then additional question #7.2.1: "Please provide justification to explain why the item/service cannot be provided in Virginia."

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

Submitting Secure Electronic Requests for Services

The FFS service authorization contractor utilizes Atrezzo Next Generation (ANG) as the application for providers to submit service authorization requests. ANG is highly intuitive and user-friendly and includes enhanced security features. Providers must first be enrolled with DMAS. Once successfully enrolled with DMAS as an enrolled provider, the provider will register to use ANG by contacting Acentra Health Customer Service at 1-888-827-2884.

Current Portal Users

Effective August 3, 2026, all providers must log into the contractor's service authorization application through the DMAS MES Portal.

New Portal Users
Providers who have not used Atrezzo (ANG) are considered new portal users and need to register their service authorization provider account.

Already Registered with ANG but Need Help Submitting Requests

It is imperative that providers currently registered use the DMAS MES portal for submitting all requests. This includes admissions, discharges, changes in units requested, responding to pend requests, and all other transactions.

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Registered ANG providers do not need to register again. If a provider is successfully registered, but need assistance submitting requests through the portal, contact Acentra Health Customer Service at 1-888-827-2884 or VAProviderissues@Acentra.com.

Providers registered for ANG, who have forgotten their password, may contact the provider's administrator to reset the password or utilize the 'forgot password' link then respond to their security question to regain access. If additional assistance is needed by the provider's administrator contact Acentra Health Customer Service at 1-888-827-2884 or VAProviderissues@Acentra.com.

If the person with administrative rights is no longer with the organization, contact Acentra Health Customer Service at 1-888-827-2884 or VAProviderissues@Acentra.com to have a new administrator set up.

When contacting Acentra Health, please leave the requestor's full name, area code, telephone number and the best time to be contacted.

Additional Information for Ease of Electronic Submission

To make electronic submission easier for the providers, Acentra Health and DMAS have completed the following:

1. Rules Driven Authorization (RDA) – This is an automated decision-making process that determines eligibility for services, procedures, or medications by applying DMAS-defined clinical, administrative, and policy rules stored in ANG. Clinical criteria questions automatically populate in the ANG portal based on requested services or diagnostic codes. Providers must complete the questionnaire using information from the individual's medical record. If responses meet criteria, the case is auto-approved and sent to FAS. If not, it is routed to a reviewer for standard review and, if necessary, escalated to a physician for final determination.

2. Attestations – All providers will attest electronically that information submitted toAcentra Health is within the individual's documented record. If upon audit, the required documents are not in the record, and the provider attested that they were present; retractions may be warranted as well as a referral to the Medicaid Fraud Control Unit within the Office of the Attorney General.

3. Questionnaires – Acentra Health and DMAS have configured questionnaires so they are short, require less information, take less time to complete, and are user-friendly.

HOW TO DETERMINE IF SERVICES REQUIRE SERVICE AUTHORIZATION

To determine if services need to be authorized, providers may go to the DMAS website: Procedure Fee Files & CPT Codes This page is titled Procedure Fee Files & CPT Codes. The information provided there will help you determine if a

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procedure code needs service authorization or if a procedure code is not covered by DMAS.

The provider must determine whether to use the CSV or the TXT format. The CSV is a comma separated value and the TXT is a text format. Either version provides the same information.

The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. The Procedure Fee File will indicate when a code requires a service authorization as it will contain a numeric value as one of the following:

00- No PA is required

01- Always needs a PA

02- Only needs PA if service limits are exceeded

03- Always need PA, with per frequency.

To determine whether a service is covered by DMAS access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides special coverage and/or payment information. A Procedure Flag of "999"

indicates that a service is non-covered by DMAS.

Providers may also refer to the Provider Service Type Grid and Crosswalk available on the FFS service authorization contractor website at: https://vamedicaid.dmas.virginia.gov/sa.

SERVICE AUTHORIZATION FOR CCC+ WAIVER SERVICES:

A Screening for Long-Term Services and Supports (LTSS) is a requirement for all individuals requesting enrollment into the CCC Plus Waiver. For information regarding Screening for LTSS see the *Long-Term Services and Supports Screening* manual.

The individual will need to be determined eligible for CCC Plus Waiver services by the LTSS Screening Team and be Medicaid eligible to receive CCC Plus Waiver services.

The available services in the CCC Plus Waiver are: adult day health care, assistive technology, environmental modifications, personal care services, private duty nursing, personal emergency response system (PERS), respite care services, skilled respite care services, service facilitation and transition services.

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Depending on the service authorization entity, processes may vary slightly for requesting services. Please reference the chart at the end of this appendix for detailed instructions (Exhibits Section).

Private Duty Nursing Services

CCC Plus waiver referrals for private duty nursing (PDN) are received at DMAS for individuals enrolled in FFS. The screening process for enrollment and clinical criteria for PDN service is described in Chapter IV of this manual.

Upon meeting clinical criteria and Medicaid financial eligibility, DMAS' Health Care Coordinator (HCC) enrolls the individual in the waiver. The DMAS HCC collaborates with the Discharge Planner/Screening entities to secure a PDN agency. Once PDN is secured, the HCC coordinates the start of care and informs the provider of the number of hours needed per week for PDN. The HCC authorizes PDN for individuals 21 years of age or over based on the findings of the assessment of the PDN Adult Referral Form (DMAS 108). Skilled respite services for waiver individuals are for the unpaid primary caregiver and may be authorized when requested. The need for additional services for individuals are determined during home visits and phone contacts between the HCC and provider agency.

Once DMAS enrolls the individual in the level of care and authorizes PDN as appropriate, DMAS's service authorization contractor may begin receiving requests for other CCC Plus waiver services. Since most individuals enrolled in PDN have many needs related to DME, providers may contact DMAS's service authorization contractor for DME and medical supply needs which are covered under Medicaid's State Plan Option.

NOTE: Refer to the chart at the end of this Appendix for services that require service authorization .

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CCC PLUS WAIVER SERVICES

Procedure Code	Service Description	Required Service Authorization Documentation (Some services may require providers to complete a questionnaire. Visit the Service Authorization Contractor's website for more information.)	Service Authorization By:
S5126	Consumer Directed (CD) Personal Care	Provider must complete a personal care questionnaire in the Atrezzo Portal. Cannot exceed level of care cap without prior approval. Hours cannot exceed 56 hours per week unless exception criteria has been met. The maximum service authorization duration is up to 12 months.	DMAS Service Authorization Contractor
	Supervision Component of CD Personal Care	Providers must complete the personal care questionnaire, which includes criteria questions regarding supervision. Supervision is not retro authorized. DMAS-100 is required. A letter from the employer is needed to document work hours. The provider will need to upload the information in the Atrezzo Portal.	DMAS Service Authorization Contractor
T1019	Agency Directed (AD) Personal Care	Provider must complete a personal care questionnaire in the Atrezzo Portal Cannot exceed level of care cap without prior approval. Hours cannot exceed 56 hours per week unless exception criteria has been met. The maximum service authorization duration is up to 12 months.	DMAS Service Authorization Contractor

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	Supervision Component of AD Personal Care	Providers must complete the personal care questionnaire, which includes criteria questions regarding supervision. Supervision is not retro authorized. DMAS-100 is required. A letter from the employer is needed to document work hours. The provider will need to upload the information in the Atrezzo Portal.	DMAS Service Authorization Contractor
S5150	Respite Care (CD)	Provider must complete a T1005/S5150 questionnaire in the Atrezzo Portal May have multiple authorizations for multiple providers or types of respite services BUT combined utilization of hours cannot exceed 480 hours/ fiscal year July 1-June 30. The maximum service authorization duration is up to 24 months	DMAS Service Authorization Contractor
T1005	Respite Care (AD)	Provider must complete a T1005/S5150 questionnaire in the Atrezzo Portal Entered as **RESPI** in VAMMIS. May have multiple authorizations for multiple providers or types of respite services BUT combined utilization of hours cannot exceed 480 hours/ fiscal year July 1-June 30. The maximum service authorization duration is up to 24 months.	DMAS Service Authorization Contractor

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S9125 TD (RN) S9125 TE (LPN)	Respite Care Agency Respite Services Skilled	Provider must complete a tech waiver respite care questionnaire in the Atrezzo Portal Entered as **RESPI** in VAMMIS. May have multiple authorizations for multiple providers or types of respite services BUT combined utilization of hours cannot exceed 480 hours/ fiscal year July 1-June 30. There must be a skilled nursing need (e.g. tube feedings, injections, etc.) The maximum service authorization duration is up to 24 months.	DMAS Service Authorization Contractor
H2021 TD	PERS Nursing - RN	Provider must complete a PERS questionnaire in the Atrezzo Portal Must be authorized for S5185 (PERS and Medication Monitoring). PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 12 months.	DMAS Service Authorization Contractor
H2021 TE	PERS Nursing - LPN	Provider must complete a PERS questionnaire in the Atrezzo Portal Must be authorized for S5185 (PERS and Medication Monitoring).	DMAS Service Authorization Contractor

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		PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 12 months.	
S5160	PERS Installation	Provider must complete a PERS questionnaire in the Atrezzo Portal PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 30 calendar days.	DMAS Service Authorization Contractor
S5160 U1	PERS and Medication Installation	Provider must complete a PERS questionnaire in the Atrezzo Portal PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 30 calendar days.	DMAS Service Authorization Contractor
S5161	PERS Monitoring	Provider must complete a questionnaire in the Atrezzo Portal	DMAS Service Authorization

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		PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 12 months.	Contractor
S5185	PERS and Medication Monitoring	Provider must complete a PERS questionnaire in the Atrezzo Portal PERS cannot be a sole service. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. The maximum service authorization duration is up to 12 months.	DMAS Service Authorization Contractor
S5102	Adult Day Health Care	Provider must complete a PERS questionnaire in the Atrezzo Portal The maximum service authorization duration is up to 12 months.	DMAS Service Authorization Contractor
T2038	Transition Services	Transition services is available one-time per lifetime of an individual. Maximum lifetime available amount is $5000; Utilized within 9 months of request. The LOC must show that the individual was a resident of a Nursing Facility, a Long-Stay Hospital or IMD (1, 2, L, IMD or a combination thereof on the LOC) for 90 consecutive days prior to CCC Plus Waiver enrollment. Request for services must be	DMAS Service Authorization Contractor

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		made within 30 calendar days of transition from the institutional level of care to waiver level of care.	
S5165 99199 U4	Environmental Modifications (EM) EM Maintenance	Environmental Modifications/Maintenance: Maximum limit is $5,000 per fiscal year per individual for all EM procedure codes combined.	DMAS Service Authorization Contractor
T1999 T1999 U5	Assistive Technology (AT) AT Maintenance	Assistive Technology/Maintenance: Maximum limit is $5,000 per fiscal year per individual for all AT procedure codes combined.	DMAS Service Authorization Contractor
T1002	Private Duty Nursing Service RN	Refer to the CCC+ Waiver Manual, Chapter IV for requirements.	DMAS HCC
T1003	Private Duty Nursing Service LPN	Refer to the CCC+ Waiver Manual, Chapter IV for requirements.	DMAS HCC

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T1000 U1	Congregate Nursing RN	Refer to the CCC+ Waiver Manual, Chapter IV for requirements.	DMAS HCC
T1001 U1	Congregate Nursing LPN	Refer to the CCC+ Waiver Manual, Chapter IV for requirements.	DMAS HCC
T1030 TD	Congregate Nursing Respite RN	Refer to the CCC+ Waiver Manual, Chapter IV for requirements.	DMAS HCC
T1031 TE	Congregate Nursing Respite LPN	Refer to the Commonwealth Coordinated Care Plus Waiver Services Provider Manual, Chapter IV for requirements.	DMAS HCC

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Provider Manual Title: Brain Injury Services Revision Date: 2/3/2025
Chapter: Brain Injury Services Case Management

Brain Injury Services
Case Management Services

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DEFINITIONS

“Authorized Representative” means a person who is authorized to conduct the personal or financial affairs for an individual who is eighteen (18) years of age or older. Parents and other caretaker relatives are able to act on behalf of persons under eighteen (18) years of age.

“Brain Injury” or “Traumatic Brain Injury” (TBI) means, for purposes of this program, brain damage due to a blunt blow to the head; a penetrating head injury; injury resulting in compression to the brain; severe whiplash causing internal damage to the brain; or head injury secondary to an explosion.

“Brain Injury Services Case Management” (BIS CM) means those targeted case management services provided under the state plan to target those with severe TBI.

“Caregiver" means a person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Unpaid or informal caregivers include relatives, friends, or others who volunteer to help. Paid or formal caregivers provide services in exchange for payment for the services rendered.

“Case management” means A process to plan, seek, advocate for, and monitor services from different services or health care organizations and staff, on behalf of an individual. The process enables workers in an organization, or in different organizations, to coordinate their efforts to serve a given individual through professional teamwork, thus expanding the range of needed services offered. The Social Security Act, § 1915(g)(2), defines case management services as those assisting individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services do not include the direct delivery of an underlying medical, educational, social, or other service for which an eligible individual has been referred. Case Management includes some or all of the following activities:

- Assessing and planning services
- Linking the individual to services and supports identified in the individual support plan; assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources.
- Coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration.
- Making collateral contacts to promote the implementation of the individual support plan and community adjustment.
- Monitoring the individual to assess ongoing progress and ensuring that authorized services are delivered; and/or
- Educating and counseling the individual, family, or legal representative to guide them to develop supportive relationships that promote the individual support plan for the direct benefit of the individual.

“Centers for Medicare & Medicaid Services” (CMS) means the federal agency that administers the Medicare, Medicaid, and State Child Health Insurance programs.

“Certified Brain Injury Specialist” (CBIS) means a certification through The Academy of Certified Brain Injury Specialists that requires at least 500 hours of direct contact

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experience with individuals with brain injury, demonstrating the certificant's training and experience in the core disciplines of rehabilitation, behavior, speech, cognitive challenges, physical therapy, and community reintegration. Certification is valid per CBIS requirements, requiring certificants to renew their status and stay current with treatment issues and protocols in the process. Training information can be found here: https://www.biausa.org/professionals/academy-of-certified-brain-injury-specialists/certified-brain-injury-specialist/cbis-information-eligibility. For more information see https://www.biausa.org/professionals/acbis.

"Commission on Accreditation of Rehabilitation Facilities (CARF)" means the independent, nonprofit accreditor of health and human services. Through accreditation, CARF assists service providers in improving the quality of their services, demonstrating value, and meeting organizational and program standards. The accreditation process applies sets of standards to service areas and business practices during an on-site survey.

"Commonwealth Coordinated Care Plus (CCC Plus) Waiver" means the Home and Community Based waiver that covers a range of community support services offered to older adults, individuals who have a disability, and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care. The individuals, in the absence of services approved under this waiver, would require admission to a Nursing Facility, or a prolonged stay in a hospital or specialized care Nursing Facility. The CCC Plus Waiver has two benefit plans: the standard benefit plan and the technology assisted benefit plan. Individuals who are enrolled in the technology assisted benefit plan are technology dependent and have experienced loss of a vital body function, and require substantial and ongoing skilled nursing care.

"Critical Incident" means any incident that threatens or impacts the well-being of the member. Critical incidents shall include, but are not limited to, the following incidents: medication errors, theft, suspected physical or mental abuse or neglect, financial exploitation, and sentinel events.

"DBHDS" means the Department of Behavioral Health and Developmental Services.

"DMAS" means the Virginia Department of Medical Assistance Services. DMAS is the state Medicaid agency that is responsible for administering the Medicaid and CHIP programs.

"Enhanced Benefits" means benefits that the Contractor may choose to offer outside of the required covered services. Enhanced benefits are not considered in the development of the Contractor's capitation rate.

"Enrollment (DMAS Managed Care Program)" means the assignment of an individual to receive healthcare coverage through a DMAS contracted managed care plan. This does not include attaining eligibility for the Medicaid program.

"Enrollment (Waiver)" means the process whereby an individual has been determined to meet the eligibility requirements (financial and functional and medical/nursing) for a

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service and the approving entity has verified the availability of services for that individual. It is used to define the entry of an individual into a HCBS waiver, effective

the first day a waiver service is rendered. This does not include attaining eligibility for the Medicaid program.

"Face-to-face contact" means an in-person meeting between the case manager and the individual and family/caregiver, as appropriate, for the purpose of assessing the individual's status and determining satisfaction with services, including the need for additional services and supports.

“Facility” means, for the purpose of coordinating services between the community and facility, an acute care hospital, freestanding psychiatric hospital, long term care hospital, psychiatric or addictions focused residential treatment facility or nursing facility.

"Family" means the unpaid people who live with or provide care to the member, and may include a parent, a legal guardian, a spouse, children, relatives, a foster family, or in-laws but shall not include persons who are compensated to care for the individual.

“FAMIS” means Virginia's Children’s Health Insurance Program (CHIP). FAMIS stands for Family Access to Medical Insurance Security. FAMIS is a separate federal program from Medicaid. FAMIS members are not eligible for Medicaid and are not eligible for certain EPSDT specialized services (Ex: Personal Care, and Residential Treatment) when enrolled in a FAMIS managed care organization.

"Functional Impairment” means impairments which are typically classified as difficulty completing basic activities of daily living (e.g., dressing, grooming, getting in and out of bed) and instrumental activities of daily living (e.g., preparing meals, managing finances, housework).

“Home” means a place of temporary or permanent residence, not including a hospital, ICF/ID, nursing facility, or licensed residential care facility.

“Home and Community Based Services (HCBS)” or "waiver services" means the range of community services approved by CMS pursuant to § 1915(c) of the Social Security Act to be offered to persons as an alternative to institutionalization. They provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

"Immediate family member" means spouses, parents (as "parent" is defined in this section), children (biological, adoptive, foster, step,) and siblings of the individual in the waiver.

"Individual" means the Commonwealth's citizen, including a child, who meets the income and resource standards in order to be eligible for FAMIS or Medicaid-covered services, has a diagnosis of brain injury, and is eligible for the BIS CM service.

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“Individual Service Plan” (ISP) means a comprehensive, person-centered plan that sets out the supports and actions to be taken during the year by each provider, as detailed in each provider's plan for supports to achieve desired outcomes and goals. The ISP shall be developed collaboratively by the individual, the individual's family/caregiver as appropriate, providers, the case manager, and other interested parties chosen by the individual.

“Managed Care Plan or Managed Care Organization (MCO)” means an organization which offers Managed Care health insurance plans (MCHIP), as defined by Virginia Code § 38.2-5800, which means an arrangement for the delivery of health care in which a health carrier undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for eligible members. The Virginia Department of Medical Assistance Services (DMAS) has transitioned to Cardinal Care, a unifying brand encompassing all health coverage programs for Medicaid members. The overarching brand and program alignment also includes fee-for-service Medicaid members, ensuring smoother transitions for individuals whose health care needs evolve over time.

“Mayo Portland Adaptability Inventory (MPAI-4)” means an evaluation tool that measures functional outcomes for post-acute brain injury programs, based upon 29 functional measures in three clinical areas- Ability, Adjustment, and Participation indexes.

"Medically necessary" means an item or service provided for the diagnosis or treatment of an individual's condition consistent with community standards of medical practices determined by DMAS and needed to maintain an individual in the community instead of placement in an institution.

"Member" means an individual who is enrolled with the Virginia Medicaid program.

"Physician or Primary care provider" means a practitioner who provides preventive and primary medical care and certifies service authorizations and referrals for all medically necessary specialty services. Primary care providers may include pediatricians, family and general practitioners, internists, obstetrician/gynecologists, and specialists who perform primary care functions such as surgeons, clinics including, but not limited to health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

“Qualified Brain Injury Support Provider (QBISP)” means a certificate in a training program through the Neurobehavioral Training Institute that promotes practical skill acquisition for direct care staff to enhance care for persons with behavioral challenges. Training information can be found here: https://qbisp.training/.

“Registered Nurse (R.N.)” means a person who is licensed or holds a multi-state licensure privilege to practice professional nursing as defined in the Nurse Practice Act.

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"Service Authorization" means the process of determining whether or not the service request meets all criterion for that service and gives authority to providers to allow reimbursement for services.

"State Child Health Plan" means the set of Children's Health Insurance Program (CHIP) benefits approved by the Commonwealth of Virginia and the Centers for Medicare and Medicaid Services (CMS).

"State Plan for Medical Assistance" means the set of Medicaid benefits approved by the Commonwealth of Virginia and the Centers for Medicare and Medicaid Services (CMS).

"Telehealth" as defined in the Telehealth Services Supplement means use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices.

PROVIDER REQUIREMENTS

Case Management Agency Requirements

The provider agency shall:

- Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Or

- Be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of case management services.

The provider agency also must:

- Have a current, signed agreement with DMAS or its contractor to provide Brain Injury Services Case Management. If the individual is enrolled with an MCO, BIS CM providers for MCO members must be contracted with the member's assigned MCO.
- Guarantee that individuals have access to emergency assistance either directly or on-call 24 hours per day, seven days per week and holidays. This may be done via telephone and/or face-to face contact and/or coordination with other providers and/or DBHDS administered crisis services.
- Demonstrate the ability to serve individuals in need of comprehensive services regardless of an individual's ability to pay or eligibility for Medicaid or FAMIS reimbursement. (i.e., lapse in coverage, transitional care, etc.).
- Have the administrative and financial management capacity to meet state and federal requirements; and,
- Document and maintain individual case records in accordance with state and federal requirements.

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In addition, the provider agency:

- Shall participate in activities designed to safeguard individual's health and safety in accordance with either CARF Accreditation standards or DBHDS Licensing requirements.
- Shall participate in reporting activities defined by DMAS that are designed to assure ongoing program compliance.
- Pursuant to 42 CFR 441.301(c)(1)(vi), "providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS."

In order to meet this requirement an individual that provides case management services must not be employed (directly, or as a contractor) by an entity that provides other HCBS services

Brain Injury Services Case Manager Staff Qualifications

Providers may bill for Brain Injury Services (BIS) case management only when the services are provided by qualified case managers. Providers must verify that qualified case managers possess the qualifications/credentials, knowledge, skills, and abilities specified in this section.

Qualifications/Credentials:

BIS case managers must either hold a bachelor's degree OR be licensed by the Commonwealth as a registered nurse.

BIS case managers must also be certified as a Qualified Brain Injury Services Provider (QBISP) or a Certified Brain Injury Specialist (CBIS) prior to independently delivering billable BIS case management services.

BIS case managers must have knowledge of:

- BI conditions, its causes, and best practices in supporting individuals who have BI.
- Treatment modalities and intervention techniques, such as positive behavior supports, person-centered practices, independent living skills training, community inclusion/employment skills, supportive guidance, family education, crisis intervention, discharge planning, and support coordination.
- Different types of assessments and their uses in service planning.
- Individuals' civil and human rights.
- Local community resources and service delivery systems, including support services or programs, eligibility criteria and intake process, termination criteria and procedures, and generic community resources.
- Types of BI related programs and services.
- Effective oral, written, and interpersonal communication principles and techniques.
- General skills of documentation.

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- The service planning process and the major components of an ISP.
- Cultural diversity and competency.
- An understanding of working on a multi-disciplinary care team and principles of care coordination; and,
- Awareness of and commitment to ethical care practices and professional conduct.

Case managers must have skills in*:*

- Interviewing individuals with a brain injury and their responsible parties/caregivers.
- Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to conduct a complete needs assessment of the eligible individual.
- Negotiating with individuals and service providers.
- Observing, recording, reporting, and documenting an individual's behaviors.
- Identifying and documenting an individual’s needs for resources, services, and other assistance, including public benefits such as WIC, SNAP, Employment, Auxiliary Grants.
- Identifying services within the established service system to meet the individual’s person-centered needs and preferences.
- Coordinating the provision of services for the individual by diverse public and private providers, generic and natural supports.
- Using information from assessments, evaluations, observations, and interviews to develop and revise support plans as needed.
- Formulating, writing, and implementing individualized service plan to promote goal attainment and community adjustment for individuals with BI.
- Monitoring and follow-up activities to include making necessary adjustments to the individual service plan and service arrangements with providers as necessary and ensuring the services are implemented per the ISP.
- Using information from assessment tools, evaluations, observations, and interviews to develop and revise as needed individual support plans (for example to ensure the ISP is implemented appropriately, identify change in status or to determine risk of crisis/hospitalization).
- Identifying community resources and organizations and coordinating resources and activities.

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- Advocating for continuity of services, system flexibility and community integration, proper utilization of facilities and resources, accessibility, and individual rights.
- Assessing or being aware of risks and accessing appropriate emergency services as needed; and,
- Identifying safety barriers and potential disruptions in care and implementing steps to resolve.

Case managers also must have abilities in:

- Demonstrating a positive regard for individuals and their families (e.g., treating people as individuals, allowing risk taking, avoiding stereotypes of people with a brain injury, respecting individual and family privacy, and believing individuals can grow and contribute to their communities).
- Being persistent and remaining objective.
- Working as a team member maintaining effective inter-interagency and intra-agency working relationships.
- Working independently, performing position duties under general supervision.
- Communicating effectively both verbally and in writing.
- Establishing and maintaining ongoing supportive relationships with individuals and their families; and,
- Conducting face-to-face contacts with the individual (and family members, as appropriate).

Providers of case management must ensure that enrolled individuals have free choice of the available providers of support coordination/case management services within the specified geographic area and free choice of the providers of other medical care under the State Plan for Medical Assistance or State Child Health Plan.

BIS CASE MANAGEMENT ELIGIBILITY DETERMINATION

Required Activities

The following services and activities must be provided:

Assessment and Service Initiation Process

Upon receipt of a referral, and prior to the delivery of BIS case management, the case manager must make an evaluation visit to where the individual resides to conduct an assessment for service planning and begin the MPAI-4 assessment of severity of the brain injury and the person-centered planning process.

The MPAI-4 may be completed in collaboration with individuals with BI, their, caregiver or family member(s), medical or rehabilitation professionals, and/or other designated observers who know the individual well. Comparisons among independent ratings are critical for effective rehabilitation planning, and for revealing more subtle

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problem areas. Scoring and interpretation of the MPAI-4 require professional training and experience.

The BIS Case Manager will use the collected clinical information to: determine whether the individual meets medical necessity criteria, assess the individual's immediate service, health, and safety needs; determine services to meet the individual's identified needs and preferences to the maximum extent possible; explore the use of local community resources available to the general public to meet those needs; and, determine whether the case management provider agency has the capability and staffing to provide ongoing support coordination if the individual meets criteria.

As part of the intake or assessment process, the case manager must collect existing medical documentation that demonstrates the member's diagnosis of a traumatic brain injury. If there is no documented diagnosis, then the case manager and/or the member's managed care organization care coordinator shall assist the member in accessing a physician who can document whether the member has a diagnosis that is eligible for receipt of the brain injury case management service.

Additionally, the BIS case manager must complete the Mayo-Portland Adaptive Index-4 screening to determine whether the member meets the required severity threshold for BIS case management service.

Members who do not meet the DMAS definition of TBI criteria nor have physician documented TBI should not be assessed using the MPAI-4 and shall be referred to their MCO to receive coordination of care.

Medical Necessity Criteria

To be eligible to receive brain injury case management services, the individual must reside in the community or be planning for discharge from a facility within 180 days.

Individuals shall have a physician documented diagnosis of traumatic brain injury (TBI) with associated functional impairments resulting from the injury that meet the severity threshold.

- A TBI is defined as brain damage due to a blunt blow to the head; a penetrating head injury; injury resulting in compression to the brain; severe whiplash causing internal damage to the brain; or head injury secondary to an explosion.
  Exclusions: Brain damage secondary to other neurological insults (e.g., infection of the brain, stroke, anoxia, brain tumor, Alzheimer's disease and other conditions causing dementia, and other neurodegenerative diseases) is not considered to be a TBI.

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- The TBI is severe as indicated by a T-score of 50 or above on the MPAI-4, and has caused chronic, residual deficits and disability, including significant impairment of behavioral, cognitive and/or physical functioning, resulting in difficulty managing everyday life activities, and an ongoing need for assistance with accessing needed medical, social, educational, behavioral health, and other services.

- If an individual has a MPAI-4 T-score of 50 through 59 the individual must meet **at least one** of the following indicated functional deficits on the assessment:

Ability Index:

Physical Abilities:

A score of 4 on Item 1. Mobility: Problems walking or moving about including balance problems; *and a* score of 4 on Item 2. Use of Hands: Impaired strength or coordination in one or both hands.

OR

A score of 4 on Item 3. Vision and a score of 4 on Item 4. Audition.

OR

Cognition:

A score of 4 on Item 8. Attention/Concentration

OR

A score of 4 on Item 9. Memory, and a score of 4 on Item 10. Fund of Information

OR

A score of 4 on Item 9. Memory, and a score of 4 on Novel Problem-solving

OR

A score of 4 on Item 10. Fund of Information, and a score of 4 on Novel Problem-solving

OR

Adjustment Index:

A score of 4 on Item 14. Depression.

OR

A score of 4 on Item 15. Irritability, anger, aggression.

OR

A score of 4 on Item 20. Impaired self-awareness.

OR

Participation Index:

A score of 4 on Item 25: Self-care.

OR

A score of 4 on Psychotic symptoms.

COVERED SERVICES

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BIS Case management services are activities designed to assist an individual with a traumatic brain injury in accessing and maintaining needed medical, behavioral health, social, educational, employment, residential, and/or other supports essential for living in the community and in developing his, her or their desired lifestyle.

Services shall include:

- Comprehensive assessment to include but not limited to the MPAI-4.
- Development and periodic revision of an ISP that is based on the information collected through the assessment.
- Linking individuals to needed services such as through a waiver, other State Plan services, as well as medical, social, educational, and other direct service activities; and coordinating and monitoring those services.
- Identifying a course of action to respond to the assessed needs of the eligible individual. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that link the person with medical, social, educational providers, or other programs and services that are capable of addressing identified needs and achieving goals specified in the ISP.
- At least one face-to-face contact with the individual every 90 days, which may vary based on intensity of case. Other contacts are required as warranted by an individual's needs and conditions.
- Case management may be provided for up to 6 months prior to discharge from facility-based services.

Service Requirements

BIS Case management services shall:

- Gather materials to document that the member meets the medical necessity criteria for the service and submit the documentation for review and authorization of reimbursement.
- Link to and assist the individual with services and supports specified in the ISP. These may include medical, social, educational, housing, transportation, vocational or other resources that help address identified needs and risk factors to achieve person-centered goals.
- Assist the individual with locating, identifying, obtaining, or scheduling needed services and resources. Aid the individual in accessing appointments and community resources, such as enabling their access to care and receipt of services. This may include finding and locating provider and service resources, including the use of MCO supports; help with completing appointments; and coordination with other service providers to ensure appropriate supports are in place.

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- Coordinate services and service planning with other agencies and providers involved with the individual. This shall include:
- Providing the member's MCO, Care Coordinator with useful feedback, and alerting MCO Care Coordinators of concerns regarding potential issues that could lead to a member's disenrollment. or disruption in services
- Notifying the MCO Care Coordinator of concerns about the status of the health and welfare of member that require attention.
  - Ensuring access to care and successful facilitation of service delivery.
- Alerting other providers of observed concerns as needed and related to other areas of specialty when an individual's health, safety and welfare are compromised.
- Participating in an individual's Interdisciplinary care team meeting as invited and needed.
- Enhance community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills and to use vocational, civic, and recreational services.
- Assist the individual to participate in appointments and community resources to ensure access to care and successful facilitation of service delivery.
- Make collateral contacts with the individual's significant others to promote implementation of the ISP and community adjustment.
- Monitor service delivery and utilization to ensure ongoing progress and delivery of services. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home when applicable), and all services. Monitoring may also include review of service provider documentation.
- Monitor and track designated outcomes as required by the program.
- Provide education and counseling that guides the individual and develops a supportive relationship that promotes the ISP.
- Follow-up and make necessary reporting related to the individual regarding the submission of critical incidents.

The activities listed above will not automatically qualify a provider for reimbursement if they are determined to be unrelated to the needs and goals on the ISP.

Service Limitations:

Payment for BIS case management services under the State Plan for Medical Assistance or State Child Health Plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

The case manager maximum caseload is not to exceed 35 individuals at any time.

Case managers are responsible for identifying when an individual is residing in a provider owned or controlled service setting that does not meet the Home and Community Based Services settings requirements.

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Individuals under 18 years old would be served through the DD or ID Case Management process or other state plan case management services that the individual is eligible to receive.

Individuals may choose case management agencies and case management service types including periods of time when a specific service need is based on the primary diagnostic and treatment needs. However, it is preferable for the Brain Injury Services Case Manager to coordinate all services on behalf of the individuals without any impact on choice of treatment or waiver service needs.

Billing can be submitted for an active individual only for months in which direct or individual related contacts, activity, or communications occur, consistent with the ISP.

The provider shall be reimbursed for no more than one BIS Assessment, per member, every six months.

Person-Centered Planning

Individual Service Plan (ISP) Development

This activity includes discovering the individual's strengths, needs, goals, and preferences. The case manager will appropriately facilitate the assessment process through utilization of person-centered discovery tools and practices to engage the individual and their circle of support, and will coordinate referrals and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including medical, social, educational, or other programs and services. The ISP must align with other care plans from other rendering providers to avoid duplication of services and contraindications.

Development and implementation of a person-centered ISP, including action and/or service plans, begins with an assessment and is a process to determine the resources needed to meet the individual's functional and social needs. The ISP is developed with the active participation of the individual, (or the individual's authorized health care decision maker) and others and shall be based on the information collected through the assessment. The ISP must specify the goals and actions that will address the medical, social, educational, and other services identified through the assessment.

To determine the need for any medical, educational, social or other services, these assessment activities include:

- taking client history;
- identifying the individual's needs, strengths and wants and completing related documentation; and

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- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual, and assuring completion of the annual reassessment of eligibility and level of care.

Person-Centered Planning Requirements

BIS case managers are responsible for monitoring and evaluating progress for all services goals and outcomes displayed in the ISP.

The case manager will provide and coordinate high quality services to the individual, while promoting seamless, integrated, coordinated care. Monitoring the person-centered ISP will be completed by the case manager in a face-to-face contact every 90 days from the date of the initial ISP. After the initial ISP is activated, the case manager will either call or visit the individual within 30 days and no more than 40 days from initial ISP activation to ensure implementation of services.

The case manager should routinely engage in assessment and person-centered planning activities to review eligibility for case management and other services needed by the individual by referencing existing medical necessity criteria and the needs of the individual. At a minimum, the case manager shall perform annual person-centered assessments to review eligibility and service planning. The case manager is responsible for coordinating changes in the ISP to:

- Ensure Medicaid or FAMIS coverage is maintained to promote continuity of care and avoid disruptions in receiving services.
- Assist the member with completing enrollment applications for benefits and annual redeterminations.
- Ensure eligibility for needed services is consistent and based on the member's needs.
- Notify all providers about a change and when they are to begin or end services. Notify all providers when an individual service plan is in a terminated or re-start status. The case manager will be responsible for evaluating the effectiveness of all services. Evaluation is demonstrated through monitoring the progress from identifying need to meeting goals/preferences identified by the individual; direct collaboration and coordination with providers to ensure services are within the individual's preferences; and adjusting action and plans of care appropriately to identify changing needs that meet the individual's needs.
- At a minimum, the BIS case manager must review the ISP every 90 days to determine whether service goals and objectives are being met, and whether any modifications to the ISP are necessary.
- The case manager will follow the DMAS provider manual and MCO rules for BIS CM termination procedures when an individual is no longer eligible or willing to receive services. This includes providing a thirty (30) day notice to individuals.

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Service Monitoring

Monitoring consists of ongoing contact with the individual and his or her family to ensure services are implemented per the ISP. Monitoring is intended to ensure that individuals and his or her family are getting the support they need, when they need them, in order to see measurable improvements in their lives.

- Monitor ISP implementation through visits with the individual, at the minimum frequency outlined in this document or increased monitoring frequency based on the need of the individual;
- Visit with the individual and his or her family, and providers of service for monitoring of health and welfare, community adjustment, and ISP implementation;
- Respond to and assess emergency situations and incidents and assure that appropriate actions are taken to protect the health and welfare of individuals;
- Review individual progress on outcomes and initiate ISP team discussions or meetings when services are not achieving desired outcomes;
- Monitor individual and his or her family satisfaction with services;
- Arrange for modifications in services and service delivery, as necessary to address the needs of the individual, and modify the ISP accordingly;
- Ensure that services are identified in the ISP;
- Work with the authorizing entity regarding the authorization of services on an ongoing basis and when issues are identified regarding requested services;
- Communicate the authorization status to ISP team members, as appropriate;
- Validate that service objectives and outcomes are consistent with the individual's needs and desired outcomes;
- Advocate for continuity of services, system flexibility and community integration, proper utilization of facilities and resources, accessibility, and individual rights;
- Monitoring outcomes as selected by the member and addressing goals not being actively pursued at the choice of the support team/member.

APPEALS and RIGHTS

Please see Chapters II and III of the CCC+ Waiver, Developmental Disabilities Waiver, Addiction & Recovery Treatment Services, Mental Health Services, Rehabilitation, Hospital, Practitioner, or the Nursing Facilities Manual for information regarding appeals.

See Chapter II of the CCC+ Waiver, Developmental Disabilities Waiver, Addiction & Recovery Treatment Services, Mental Health Services, Rehabilitation, Hospital, Practitioner, or the Nursing Facilities Manual for information regarding Section 504 of the Rehabilitation Act and the Civil Rights Act of 1964.

Members enrolled in managed care, should contact their MCO for additional information on the grievance process, complaints process, and redirect to DBHDS for rights complaints. Members may also contact their MCO to request support for any serious incident involving the member or a service provider.

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SERVICE AUTHORIZATION

All BIS Case Management services must be authorized by DMAS or its contractor. Reimbursement for BIS case management services requires a service authorization. The provider agency that submits the service authorization request must also complete the assessment.

Service authorization requests may require supplemental documentation from the member's record to include:

- A letter or other signed documentation from a physician that documents the traumatic brain injury; and
- The Mayo Portland Adaptability Index-4 documentation, including the T-score; and
- Any specific functional scoring required to document the functional limitations of the member.

Member Benefit Program	**Service Authorization Entity**
FFS*	**Acentra Health**
Managed Care	Contact the MCO for service authorization information.*

*In order to be reimbursed for BIS TCM provided to an individual enrolled in managed care, providers must contract with and follow their respective MCO contract(s). Additional information and requirements are included in the "Doing Business Spreadsheet" on the DMAS website (https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/brain-injury-services/). Contracted MCO's must follow DMAS program rules when authorizing Brain Injury Services.

The following codes must be used to submit service authorization requests and to submit claims:

SERVICE NAME	REIMBURSEMENT CODE
BIS Case Management	S0281
BIS Case Management Assessment	S0280*

* S0280 requires a service authorization request only when more than 2 assessments are performed within 365 days.

A provider's service authorizations request for BIS TCM (S0281) shall be no greater than 6 months.

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Upon the initiation of services, a provider may bill for the assessment code (S0280) and will submit a service authorization request for BIS TCM (S0281). The provider will request authorization for the case management by submitting the MPAI-4 assessment and the physician diagnosis confirmation. The provider's request for BIS TCM can span the subsequent months.

> For example: on July 20, 2023, a provider bills for the assessment (which was completed between June 25th and July 19, 2023) with an additional authorization request for ongoing BIS TCM. The initial BIS TCM service will be authorized from August 1, 2023, through January 31, 2024.

Following the initial service authorization request, ongoing requests for BIS TCM (S0281) will be authorized for up to a six-month duration.

DOCUMENTATION REQUIREMENTS

1. The assessment, subsequent re-assessments, and the annual reassessment by a qualified BIS case manager must be reflected with appropriate documentation and maintained in the individual's record. The physician documented TBI diagnosis and the relevant MPAI-4 documents (including treatment provider records) shall also be maintained in the individual's record.

2. The Individual's ISP must include the dated signature of the individual or the individual's authorized health care representative and other relevant family members or friends involved in the development of the ISP. All ISP (originals, updates, and changes) must be maintained for a period not less than five years from the date of service or as provided by applicable state laws, whichever is longer.

3. There must be documentation that the choice of a provider has been offered when services are initiated and when there are changes in services. The choice must be documented in writing by having the individual (or parent or guardian when appropriate) sign a document verifying freedom of choice of providers was offered and this provider was chosen.

4. A release form must be completed and signed by the individual for the release of any information.

5. There must be an ISP from each provider rendering services to the individual. The ISP is developed by the individual service provider related solely to the specific tasks required of that service provider and the desired outcomes. Plans of care help to determine the overall goals for the individual. The plans must state long-term service goals and specified short-term objectives in measurable terms. For case

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management services, specific objectives for monitoring, linking, and coordinating must be included.

6. Case management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the plan. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs.

7. The case manager shall document review of the ISP every 90 days to determine whether service goals and objectives are being met, satisfaction with the program, and whether any modifications are necessary. Other providers must coordinate reviews of the POC with the case manager every three months.

8. Documentation must demonstrate that the case manager provides active case management monthly and a face-to-face contact with the individual occurs at least once every 90 calendar days.

9. The case manager must revise the ISP whenever the amount, type, or frequency of services rendered by the individual service provider's change. When such a change occurs, the case manager must involve the individual or the individual's authorized health care representative in the discussion of the need for the change.

B.I.S. CASE MANAGEMENT BILLING REQUIREMENTS

The unit of service for Case Management Assessment is one unit which equals one calendar month. A claim for the BIS TCM procedure code, S0281, cannot be submitted in the same month as the TCM Assessment code, S0280.

The unit of service for BIS Case Management is one unit which equals one calendar month. Payment for BIS TCM is available only for allowable activities that are pre-authorized and provided by a qualified provider in accordance with an approved POC that meets Brain Injury Case Management program criteria. BIS Case Management services are limited to the number of months authorized by DMAS or its designee.

- Case Management services for the same individual must be billed by only one type of Case Management provider. See Chapter V for billing instructions.

Billing can be submitted for case management only for months in which direct or client-related contacts, activity, or communications occur. These activities must be documented in the clinical record and be identified in the ISP. The provider should bill for the specific date of the face-to-face visit, or the date the monthly summary note has been documented, or a specific date service was provided. Providers are NOT to span the month for Case Management services.

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Reimbursement shall be provided only for "active" case management clients, as defined in the “service requirement” section. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

Federal regulation 42 CFR § 441.18 prohibits providers from using case management services to restrict access to other services. An individual cannot be compelled to receive case management or condition receipt of case management on the receipt of other Medicaid services, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.

In accordance with 42 CFR § 441.18(a)(8)(vii), reimbursement is allowed for case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in institutions of mental diseases (IMDs) and individuals of any age who are inmates of public institutions. An IMD is a facility that is primarily engaged in the treatment of mental illness and is greater than 16 beds.

Services rendered during the same month as the admission to the IMD is reimbursable for individuals ages 22 – 64, if the service was rendered prior to the date of the admission.

Two conditions must be met to bill for Case Management services for individuals that are in acute care psychiatric units or who are in institutions and who do not meet the exclusions noted above. The services may not duplicate the services of the facility discharge planner or other services provided by the institution, and the community case management services provided to the individual are limited to six months of service, 180 calendar days prior to discharge from the facility.

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Appendix E: EXTRAORDINARY CARE GUIDE
Revision Date: 9/02/2026

APPENDIX E CCC PLUS WAIVER

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EXTRAORDINARY CARE GUIDE (Ages 0-18)

FOR USE WHEN THE AIDE/ATTENDANT IS A LEGALLY RESPONSIBLE INDIVIDUAL (LRI) OF A CHILD

This guide is intended for attendants/aides *legally* responsible for individuals 0-18 years of age. It outlines guidelines for providing extraordinary care based on the individual's age and specific needs. The guide will assist providers in identifying extraordinary care needs. ***Plans of Care must be person-centered and activities below identified as "NOT extraordinary" care may be justified though additional documentation.***

Activities of Daily Living (ADL)

BATHING (Suggested Time Allowance: 15-45 min.)

Ages 0-4 - **NOT Extraordinary**	Ages 0-4 ✓ **Extraordinary**	Ages 5-18 - **NOT Extraordinary**	Ages 5-18 ✓ **Extraordinary**
- Mechanical Help Only - Needs No Help - Supervision - Physical Assistance - Mechanical and Physical Assistance - Performed by Others	✓ Performed By Others (confined)	- Mechanical Help Only - Needs No Help - Supervision	✓ Physical Assistance ✓ Mechanical and Physical Assistance ✓ Performed by Others

DRESSING/GROOMING (Suggested Time Allowance: 15-45 min.)

Ages 0-4 - **NOT Extraordinary**	Ages 0-4 ✓ **Extraordinary**	Ages 5-18 - **NOT Extraordinary**	Ages 5-18 ✓ **Extraordinary**
- Mechanical Help Only - Needs No Help - Supervision - Physical Assistance - Mechanical and Physical Assistance - Performed by Others	✓ Performed By Others (confined)	- Mechanical Help Only - Needs No Help - Supervision	✓ Physical Assistance ✓ Mechanical and Physical Assistance ✓ Performed by Others

TOILETING (Suggested Time Allowance: 15-45 min.)

Ages 0-4 - **NOT Extraordinary**	Ages 0-4 ✓ **Extraordinary**	Ages 5-18 - **NOT Extraordinary**	Ages 5-18 ✓ **Extraordinary**
- Mechanical Help Only - Needs No Help - Supervision - Physical Assistance - Mechanical and Physical Assistance - Performed by Others (Confined)	* Nothing is permitted for ages 0-4 when Toileting	- Mechanical Help Only - Needs No Help - Supervision	✓ Physical Assistance ✓ Mechanical and Physical Assistance ✓ Performed by Others

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Activities of Daily Living (ADL)			
TRANSFERRING (Suggested Time Allowance: 15-45 min.)			
Ages 0-4 - **NOT Extraordinary**	Ages 0-4 ✓ **Extraordinary**	Ages 5-18 - **NOT Extraordinary**	Ages 5-18 ✓ **Extraordinary**
- Mechanical Help Only - Needs No Help - Supervision - Physical Assistance - Mechanical and Physical Assistance	✓ Performed By Others (confined)	- Mechanical Help Only - Needs No Help - Supervision	✓ Physical Assistance ✓ Mechanical and Physical Assistance ✓ Performed by Others
- **ASSIST EATING** (Suggested Time Allowance: 15-45 min.)			
Ages 0-4 - **NOT Extraordinary**	Ages 0-4 ✓ **Extraordinary**	Ages 5-18 - **NOT Extraordinary**	Ages 5-18 ✓ **Extraordinary**
- Mechanical Help Only - Needs No Help - Supervision - Physical Assistance - Mechanical and Physical Assistance	* Nothing is permitted for ages 0-4 with Eating/Feeding	- Mechanical Help Only - Needs No Help - Supervision	✓ Physical Assistance ✓ Human and Mechanical Help ✓ Performed by Others

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