



Department of Medical Assistance Services  
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[www.dmas.virginia.gov](http://www.dmas.virginia.gov)

# MEDICAID PROVIDER MANUAL UPDATE

TO: All Mental Retardation Community Services Providers  
participating in the Virginia Medical Assistance Programs

FROM: Patrick W. Finnerty, Director  
Department of Medical Assistance Services (DMAS)

MEMO: Update

DATE: 7/1/2009

SUBJECT: Update to the Mental Retardation Community Services Provider Manual

The purpose of this memorandum is to notify you of changes to your *Mental Retardation Community Services Provider Manual*. The attached table shows the changes to the Provider Manual to make it reflective of the most recent regulations. Please download the new pages to insert into your Provider Manual and retain the table attached below. Please review these changes carefully.

## **SUMMARY OF MAJOR CHANGES**

### **General**

- Reorganization and technical changes have been made throughout the manual to enhance user friendliness and to reflect person-centered language. The concept of “person-centered planning” is a variety of approaches or tools to organize and guide life planning with individuals with disabilities, their families, and friends.
- Recodifications to the sections of the Code of Virginia for the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Department of Social Services (DSS) required the update of several citations from the Code made throughout the manual.
- Forms and other exhibits previously included in the manual are now referenced and may be found on the Department of Medical Assistance Services (DMAS) website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov), with the exception of those beginning with “DMH.” Those forms can be located on the DMHMRSAS website at [www.dmhmrzas.virginia.gov](http://www.dmhmrzas.virginia.gov).

## **Chapter II**

- Record retention changed from five years to six years to reflect the current regulation.
- Language about abuse, neglect, and exploitation of children and vulnerable adults is updated.
- Services offered in the Mental Retardation (MR) and Day Support (DS) Waivers are added. All individuals in the MR Waiver must receive Targeted MR Case Management.
- Language clarifies that payment will not be made for companion, personal care, or respite services furnished by other family members living under the same roof as the individual being served unless there is objective written documentation as to why there are no other providers available to provide the care. This must be approved and documented by the case manager.
- This chapter now consolidates provider requirements for each waiver service.
- DMHMRSAS made changes to the training requirements for prevocational, residential support, day support, and personal assistance providers. Refer to the DMHMRSAS website for more information.
- The revision clarifies that the consumer-directed service facilitator (CDSF) cannot be the individual, the individual's case manager, direct service provider, spouse, or parent of the individual who is a minor child, or a family/caregiver employing the assistant/companion.
- Previous regulatory action changed the requirements for tuberculosis screenings, cardiopulmonary resuscitation training (CPR), and annual influenza immunizations for consumer-directed (CD) personal and respite assistants and companions. These providers must agree to receive an annual TB screening. There is no longer a requirement that they also have CPR training and an annual influenza immunization.
- CD personal assistance and respite assistants and companions shall not be spouses or parents of minor children. In accordance with current regulations, the term "legally responsible relatives" was removed from the list of those precluded from being CD personal or respite assistants or companions. This is a clarification.
- The revision clarifies that a case manager may not be the direct support staff, the immediate supervisor of a direct support staff, or the CDSF to an individual for whom he or she is providing case management services.
- Information on reconsiderations and appeals is updated to reflect current practice.

## **Chapter IV**

- The revision clarifies that, if the individual has a guardian, the guardian shall act for the individual consistent with the parameters of his or her appointment. Throughout this chapter, references to “individual” will be inclusive of the individual’s guardian when one has been named. A primary caregiver is the primary person who consistently assumes the role of providing direct care and support of the individual to live successfully in the community without compensation for providing such care.
- To clarify current federal requirements, the case manager must present the individual with a choice of types of services: agency-directed or consumer-directed (or a combination of the two). When the individual chooses the type of services to meet his or her needs, the case manager offers the individual a choice of providers for each service.
- The revision clarifies that individuals residing in Medicaid-covered therapeutic foster care placements are not eligible to receive any MR Waiver services, but may be placed on the MR Statewide Waiting List. Individuals residing in assisted living facilities (ALFs) licensed by DSS are ineligible to receive congregate residential support, agency-directed or consumer-directed personal assistance, agency-directed or consumer-directed respite, or personal emergency response services (PERS).
- The DMAS website at [www.dmas.virginia.gov/ltc-home.htm](http://www.dmas.virginia.gov/ltc-home.htm) added guidance for completing the LOF for children.
- The DMAS-122 (Patient Information Form) became obsolete effective March 1, 2009. See procedures for the new DMAS-225 (Medicaid LTC Communication Form).
- The revision reorganizes the chapter with descriptions of each MR Waiver service, alphabetized by service and including: 1) service description; 2) criteria; 3) service units and service limitations; and 4) documentation requirements. Provider requirements for each service are found in Chapter II.
- The revision clarifies that documentation (including that for the 60-day assessment period) must confirm the individual’s participation and amount of time in services and provide specific information regarding the individual’s response to various settings and supports as agreed to in the ISP. Sixty-day assessment results should be available in at least a daily note or a weekly summary.
- Language clarifies that medication-monitoring units must be physician-ordered and are not a stand-alone service. The PERS provider shall document and furnish, within 30 days of the action taken, a written report to the case manager for each emergency signal, which results in action being taken on behalf of the individual. This shall exclude test signals or activations made in error. Annual reauthorization of this service is required.

- The revision clarifies that the ISP must be reviewed by the provider when the individual's needs change significantly and at least every three months. Quarterly review documentation must include any revisions to the ISP and address the general status of the individual, significant events, and individual and family/caregiver, as appropriate, satisfaction with services.
- The case management services description, including the qualifications of the case manager, are enhanced and consolidated.
- Previous regulatory action eliminated interdepartmental licenses for children's residential facilities. DMHMRSAS now licenses these facilities with a children's residential services group home license. These facilities may provide and bill for congregate residential services.
- An update on consumer-direction procedures is provided. Changes were also made to the *Consumer-Directed Waiver Services Employer Manual* in November 2008. To access this manual, go to the DMAS website at [www.dmas.virginia.gov/ltc-home](http://www.dmas.virginia.gov/ltc-home).

## **Chapter V**

- This chapter is updated to reflect current billing practices.

## **Chapter VI**

- To reflect current practice, "utilization review" is changed to "quality management reviews (QMRs)" in the chapter title and throughout the text. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456, and may be conducted by DMAS or its designated agent.
- The revision adds that billing records will be matched to service delivery documentation. The revision changes that infractions may result in a request for a plan of correction or referral to the Division of Program Integrity for potential billing adjustments.
- The revision clarifies the purpose of the QMR. During the QMR, staff will offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures or may refer providers to DMHMRSAS for more in-depth technical assistance or training. Any uncorrected compliance issues may result in the termination of the provider contract.
- The CSB/BHA or other provider may request further discussion of findings identified in the written QMR report. The reconsideration process is no longer a part of the QMR. This is a change.
- The revision clarifies what, during an on-site review, DMAS staff will review in the individual's record in the provider's/service facilitator's place of business/offices to

determine if appropriate payment was made for services rendered. Staff will also meet or talk with at least one individual or primary caregiver to determine individual satisfaction with waiver services and the provider. The provider may be asked to assist in setting up this visit. In all cases, the primary caregiver is encouraged to participate in the review of the individual's supports.

- The revision changes that individuals less than age six who receive MR case management services only must have a psychological or developmental evaluation that documents that the child has MR as defined by American Association on Intellectual and Developmental Disabilities (AAIDD). This documentation does not have to specifically state a diagnosis of MR. However, the instrument must convey evidence of cognitive and adaptive development delay or presence of a syndrome typically associated with MR. The evaluation must reflect the individual's current status and be completed prior to service initiation.
- Language clarifies that there must be a Social Assessment in the case management record, completed by the case manager, no earlier than one year prior to start date of services and updated annually. The Social Assessment must include a review of the current situation. Language is added to require that the individual's talents, and gifts, and desires be discussed as part of the assessment as specified in the chapter.
- The revision clarifies that an individual's choice of providers must be documented. The individual's record must contain a copy of the form entitled, "Virginia Home- and Community-Based Waiver Choice of Providers" (DMAS-460).
- The revision clarifies that there must be documentation that the case manager reviews on a quarterly basis all services provided and documents this review (including MR Targeted Case Management services). The revision changes that a 30-day grace period to complete the quarterly review of the CSP is permitted (previously, these reviews had to be completed by the last day of the month in which they were due, with a grace period of up to the last day of the month).
- Language clarifies that there must be evidence that quarterly reviews for the MR or DS Waiver services are completed no more than 10 days following the end of each quarter as determined by the effective start date of the ISP. The original quarterly due dates remain unaffected by the date the review is completed.
- The revision adds that terminations of all waiver services must be reflected on a completed Medicaid LTC Communication Form (DMAS-225). The new DMAS-225 essentially replaces the DMAS-122, with the exception of patient pay information.
- Language adds that billing for transition services must be supported by item purchase receipts with a description of the item(s) included.

- The revision clarifies that all billing must be supported by the required documentation as outlined throughout this manual.
- Language clarifies that a plan of correction may be requested when review issues cited are pervasive, repetitive, or of a serious nature. Circumstances that may result in a request for a plan of correction or referral to the Division of Program Integrity when identified during reviews are added.
- The revision clarifies that case managers are required to verify to DMHMRSAS each year that the individual continues to meet eligibility using the LOF Survey. If it is found that an individual no longer meets the level of care, services shall be terminated in accordance with the procedures detailed in Chapter IV of this manual. DMAS can require repayment of overpaid money if agencies continue to serve individuals who do not meet the level of care for which they are authorized without notifying DMHMRSAS of the change in level of care and the need for discontinuation of services.
- The revision adds that documentation shall be maintained in accordance with applicable statutes and policies. Waiver services that fail to meet DMAS criteria are not reimbursable. A section on record retention and required documentation requirements is moved from Chapter IV and enhanced.
- The revision updates the responsibilities of the Division of Program Integrity as well as the appeals section to reflect current practice. The Division of Program Integrity now manages “paybacks” of DMAS reimbursements as a result of QMRs.

## **Chapter VII**

- The revision adds a list of services offered through the DS Waiver. To reflect current regulation, supported employment is added
- The revision clarifies that the individual or the individual’s family member/caregiver or authorized representative/guardian, as appropriate, must be provided choice as to the services and providers of the services.
- Language clarifies how DS Waiver slots are distributed and how waiting lists are to be maintained.

## **REQUESTS FOR DUPLICATE REMITTANCE ADVICES**

In an effort to reduce operating expenditures, requests for duplicate provider remittance advices will no longer be printed and mailed free of charge. Duplicate remittance advices will be processed and sent via secure email. A processing fee for generating duplicate paper remittance advices will be applied to paper requests, effective July 1, 2009.

## **ELIGIBILITY VENDORS**

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability,

and service limits for many service types and procedures are available. For more information on the services that are offered contact the vendors:

Passport Health Communications, Inc.  
[www.passporthealth.com](http://www.passporthealth.com)  
[sales@passporthealth.com](mailto:sales@passporthealth.com)  
Telephone #: (888) 661-5657

SIEMENS Medical Solutions – Health Services  
Foundation Enterprise Systems/HDX  
[www.hdx.com](http://www.hdx.com)  
Telephone #: (610) 219-2322

Emdeon  
[www.emdeon.com](http://www.emdeon.com)  
Telephone #: (877) 363-3666

### **ELIGIBILITY AND CLAIMS STATUS INFORMATION**

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is <http://virginia.fhsc.com>. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

Providers must check the recipient's eligibility via the web-based system or MediCall to verify enrollment in Plan First. The system will have a prompt stating the enrollee has "family planning coverage only". There is not an identifier on the Medicaid card to alert the provider of Plan First enrollment.

### **"HELPLINE"**

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on state holidays, to answer questions. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid provider identification number available when you call.

### **COPIES OF MANUALS**

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at [www.dmas.virginia.gov](http://www.dmas.virginia.gov). Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting

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Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

**PROVIDER E-NEWSLETTER SIGN-UP**

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at [www.dmas.virginia.gov/pr-enewsletter.asp](http://www.dmas.virginia.gov/pr-enewsletter.asp).

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.

**MENTAL RETARDATION COMMUNITY SERVICES PROVIDER MANUAL**

**REVISION CHART**

**July 1, 2009**

**SUMMARY OF REVISIONS**

<b>MANUAL SECTION</b>	<b>MATERIAL REVISED</b>	<b>NEW PAGE NUMBER(S)</b>	<b>REVISED PAGE(S)</b>	<b>REVISION DATE</b>
Chapter II	Chapter II, plus exhibits		Entire Chapter	7/1/2009
Chapter IV	Chapter IV, plus exhibits		Entire Chapter	7/1/2009
Chapter V	Chapter V		Entire Chapter	7/1/2009
Chapter VI	Chapter VI		Entire Chapter	7/1/2009
Chapter VII	Chapter VII		Entire Chapter	7/1/2009

**FILING INSTRUCTIONS**

<b>MANUAL SECTION</b>	<b>DISCARD</b>	<b>INSERT</b>	<b>OTHER INSTRUCTIONS</b>
Chapter II	Old Chapter II	New Chapter II	Discard old exhibits.
Chapter IV	Old Chapter IV	New Chapter IV	Discard old exhibits.
Chapter V	Old Chapter V	New Chapter V	
Chapter VI	Old Chapter VI	New Chapter VI	
Chapter VII	Old Chapter VII	New Chapter VII	