CHAPTER VI

UTILIZATION REVIEW AND CONTROL

CHAPTER VI
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CHAPTER VI
UTILIZATION REVIEW AND CONTROL

INTRODUCTION

Under the provisions of federal regulations, the Virginia Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid. The federal regulations, found in 42 CFR 455-456, set forth requirements for detection and investigation of Medicaid fraud and abuse. It provides details to maintain program integrity and requires implementation of a statewide program of utilization control that ensures high quality care and the appropriate provision of services.

This chapter provides information on Utilization Review (UR) and control requirements handled by the Virginia Department of Medical Assistance Services (DMAS). The general information sections may be followed by specific utilization control requirements that apply to specific programs and services covered in this Provider Manual.

Individuals Enrolled in CCC Plus Managed Care

Most individuals enrolled in the Medicaid program have their services furnished through contracted managed care organizations (MCOs) and their network of providers. Hospice providers serving individuals enrolled within an MCO shall reference their MCO provider agreement regarding Utilization Review and Control. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations. For those who are enrolled in Medicaid and continue to receive care under Medicaid fee-for-service, the provider is responsible for adhering to state and federal regulations, as well as this manual.

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.

REVIEW AND EVALUATION OVERVIEW

DMAS routinely conducts UR to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. Participating Medicaid providers are responsible for ensuring that requirements, such as record documentation for services rendered, are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider agrees to give DMAS representatives, the Attorney General of Virginia or his/her authorized representatives, and authorized federal personnel access to the facility and its records.

Providers and recipients are identified for review from sampling methodologies or by referrals from other agencies or individuals. Some provider reviews are initiated on a regular basis to meet federal requirements.

To ensure a thorough and fair review, trained professionals employed by DMAS review cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to regulations or statutes, 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 any of the above problems, Medicaid may limit, suspend, or terminate the provider's Participation Agreement.

Corrective actions for recipients include education on the appropriate use of health care, restriction on designated providers for utilization control, recovery of misspent funds, and referral for further investigation of allegations of fraudulent activities. Loss of Medicaid coverage can result from a conviction of Medicaid fraud.

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 Virginia Medicaid Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature, or the signature of his/her authorized agent, on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Program Integrity
Department of Medical Assistance Services

600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: 1-804-692-0480
Fax: 1-804-371-8891

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 East Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

The Recipient Audit Unit of DMAS investigates allegations regarding issuance of non-entitled benefits and/or fraud and abuse by non-providers. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid and/or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that non-entitled benefits were issued, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the State Plan, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: 1-804-786-0156
Fax: 1-804-786-6229

Federal regulations mandate that all Nursing Facilities (NFs) have in place utilization controls to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate person(s).

These controls may be applied prior to admission, while the resident is in the facility, or after the claim for payment has been submitted. Participating Medicaid providers are responsible for ensuring that the utilization control requirements described in this chapter are met in order to receive payment from DMAS.

Throughout this chapter, sections have been specified as applying to Nursing Facilities (NFs), Specialized Care Services, Institutions for Mental Disease (IMDs), or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

ADMISSION CONTROLS

For all Long-Term-Care residents, medical care and treatment data must be kept on each resident and will include (in addition to the necessary identifying NF information): the Physician's progress notes; the Physician's Plan of Care (POC), which includes orders, the prescribed treatments, medications, services to be rendered, diagnostic studies, therapies, activities, social services, special procedures, and diet, as well as the diagnoses, symptoms, and complaints; a description of the functional level of the resident; written objectives and plans for continuing care and discharge; and a general statement of prognosis.

CHANGES IN LEVEL OF CARE

Attending Physician Changes in Level of Care

The individual's attending Physician may recommend a discharge of the resident back into the community or discharge the resident to a facility that provides a different level of care. When the Physician initiates the change, it is the responsibility of the facility to immediately notify by telephone the resident, the resident's family, or responsible party, and the Social Services Department handling Medicaid eligibility. Immediately following the telephone communication, the family and social services department must receive written notice advising them of the Physician's decision.

The Facility and Home-Based Services Unit must also be notified of the change within 48 hours via the Resident Assessment Instrument - RAI (Discharge Tracking Form), DMAS-121 or DMAS-121A, by letter or by other written notice. Medicaid payment can continue up to 10 days when the change is to a lower level of care.

If a recipient is pending a transfer or discharge, the facility must provide the recipient with written notification of: a) the reason for transfer or discharge; b) the effective date of the transfer or discharge; c) the location to which the resident will be transferred or discharged; and d) a statement that the recipient has the right to appeal the action to DMAS.

Level-of-Care Criteria

Criteria for NF care, specialized care, and care in intermediate care facilities for the mentally retarded are included in Appendix B of this manual.

ADMISSION PROCESS

Resident - Definition

A resident is defined as an individual who is admitted to a medical institution on the recommendation of a physician because of illness, injury, or other defect, who is in need of and receiving professional services, and for whom there is planned continuing medical treatment, including nursing care directed toward the improvement, maintenance, or protection of health or the alleviation of illness, disability, or pain. There is no requirement for prior hospitalization under Medicaid (Title XIX) for persons who have been admitted to a NF for the purpose of receiving services.

Nursing Facility (NF) Admission Package

Note that the submission of incomplete or inaccurate data will result in a delay in the issuance of the Permission to Bill letter.

When to Submit

Submit a completed PIRS (Patient Intensity Rating System, DMAS-80) form within 30 days of admission or notification of financial Medicaid eligibility. A new PIRS (DMAS-80) form must also be submitted to DMAS for any recipient who:

- Has not been financially eligible for Medicaid for more than 30 days (for state facilities, 60 days); or
- Has been transferred to or from a Specialized Care Unit (only applies to those NFs which have a contract to provide Specialized Care).

NOTE: Edit 0919 - Inpatient Hospital versus Nursing Facility (NF) is being captured due an incorrect admission date for the NF claim being submitted. If a NF has received payment for a hospitalized recipient where the NF did not adjust the admission date to reflect a new admission date upon return from the hospital, the NF claim(s) must be voided by the NF and resubmitted with the correct re-admission date for all claims submitted incorrectly. Updating the admission date on the claim does not have any effect on the PIRS admission process, nor does it require the submission of a new PIRS form to change an admission date.

What to Complete

Only the completed legible PIRS form (DMAS-80) must be submitted to DMAS using the following methods (see the “Exhibits” section at the end of this chapter for form and instructions):

Mail:

Facility and Home-Based Services Unit
Department of Medical Assistance Services

600 East Broad Street, 10th Floor
Richmond, VA 23219

Fax:
Attention: Administrative Office Specialist
Fax #: Deloris Harris (804-452-5456) All Others (804-612-0050)

The original PIRS forms must remain in the resident's chart for review by DMAS staff during on-site reviews. If any part of the required documentation on the PIRS form is incomplete or inaccurate, the NF will receive a letter describing the problem areas and requesting that corrections be sent.

Providers do not send copies of the completed MDS (Minimum Date Set) 2.0 documents or pre-admission screening (PAS) documents along with the admission packages. Copies of the DMAS-96 form, MI/MR (Mental Illness/Mental Retardation) forms, MDS, and UAI (Uniform Assessment Instrument) must be maintained in the resident's medical record and be made available for on-site review.

An admission package is required for eligible recipients even when Medicare or another insurance carrier is the primary payment source.

Admissions for State Facilities Certified as Nursing Facilities

State facilities, which are certified as NFs, are required to use the Resident Assessment Instrument (RAI) designated by the Commonwealth of Virginia. These facilities include Eastern State Hospital [Intermediate Care Facility (ICF)/Skilled Nursing Facility (SNF)], Southwestern Virginia Mental Health Institute (NF), Shenandoah Geriatric Treatment Center, Hiram Davis Medical Center (ICF/SNF), the Skilled Nursing Facility/MR units of Central Virginia Training Center (CVTC) and Southside Virginia Training Center, and the Adult Treatment Center at CVTC. These facilities must comply with the documentation requirements for NFs as found in Section I of this chapter. The admission package for these facilities must include the Minimum Date Set (MDS 2.0), the MDS 2.0 Face Sheet, documentation of Physician Recommendation for Admission, and the DMAS 119, DMAS 121A, and DMAS 121B forms.

Medicare Residents with Medicaid Co-pay

A complete admission package must be submitted by the NF for new Medicare or Medicaid residents in order for facilities to bill Medicaid for Medicare co-insurance for these residents. Clearly mark on the PIRS (DMAS-80) form the resident's primary payment source.
A new admission package is not required when a resident changes primary sources of payment from Medicaid to Medicare (and vice versa). However, DMAS must be notified in writing when a resident becomes eligible for Medicare as the result of a hospitalization or when Medicare days have been exhausted. This notice may be made by sending a copy of the Medicare Benefits Exhausted letter, a copy of the blue Authorization to Bill letter, or a letter to DMAS. Clearly note the effective date(s) and reason for the change (e.g., hospitalization, Medicare benefits exhausted, etc.), as well as the provider number and the recipient's Medicaid number. Send or fax to:

Mail:

Facility and Home-Based Services Unit
Department of Medical Assistance Services
600 East Broad Street, 10th Floor
Richmond, VA 23219

Fax:

Attention: Administrative Office Specialist
Fax #: Deloris Harris (804-452-5456) All Others (804-612-0050)

Upon receipt of this information, NFs will receive an authorization letter that shows the resident's new status. Medicare or Medicaid residents are denoted with "Type of Service (Exception Indicator) = 2," and Medicaid-only NF residents are denoted with "Type of Service (Exception Indicator) = 1." DMAS will pay applicable Part A co-insurance (the combined payments of Medicare and Medicaid will not exceed the Medicaid per-diem rate for the specific NF in which the Medicare or Medicaid recipient resides) for NF residents with Type of Service Indicator 2. Medicare Part A Co-insurance Invoices will be denied for Reason 371 when the Type of Service Indicator is 1 (non-Medicare). DMAS does pay Part B Medicare deductible and co-insurance charges associated with Physical Therapy, Speech Therapy, and Occupational Therapy Services for NF residents.

Mail:

Facility and Home-Based Services Unit
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

Fax:

Attention: Administrative Office Specialist
Fax #: 1-804-371-4986

Resident Assessment Instrument (RAI)

The Omnibus Budget Reconciliation Act (OBRA) of 1987 requires that each state designate a RAI for use by NFs participating in Medicare or Medicaid programs. The Commonwealth of Virginia has elected to use as its instrument the RAI developed by the Centers for Medicare and Medicaid Services (CMS), which is the MDS 2.0. All Virginia NFs participating in Medicare and Medicaid were required to use MDS 2.0 (10/18/94) by January 1, 1996. The Minimum Data Set (MDS 2.0) (see the "Exhibits" section at the end of this chapter for a sample of the form) consists of the Basic Assessment Tracking Form, the Face Sheet, the Full Assessment Form, the Discharge and Re-entry Tracking Forms, Resident Assessment Protocol (RAP) Summary, Quarterly Assessment, and Section "S" Form.

Any computer software used by NFs to produce RAIs must comply with CMS's current requirements for vendor software products for version 2.0 of the MDS 2.0 (effective for records after January 1, 1996). DMAS will not review or approve computer software related to the revised RAI. DMAS recommends that NFs obtain verification that the vendor's software complies with CMS's current requirements for software products for the MDS 2.0. Long-Term-Care Facilities are responsible for using software that complies with CMS's current requirements.

CMS's approval of a state's RAI-covered items includes in the instrument the working and sequence of those items and all definitions and instructions for the RAI. The state must ensure that any RAI form in the resident's record accurately and completely represents the designated RAI. That is, it must be identical to the state instrument with the exact wording and in the same sequence.

The RAI is shown in the "Exhibits" section at the end of this chapter. NFs must use these designated forms. Forms necessary for the completion of the RAI [Form 1827, Minimum Data Set Face Sheet; Form 1828, Minimum Data Set (MDS 2.0); Form 1830 plus Section "S" Form, MDS 2.0 Quarterly Review; and Form 1831, Resident Assessment Protocol Summary/Trigger Legend] may be ordered from:

Briggs Forms and Supplies
7887 University Boulevard
Des Moines, Iowa 50306
(Toll-free phone number: 1-800-247-2343)

Additional RAI Training Manuals may be ordered from:

Eliot Press
262 Eliot Street
Natick, Massachusetts 01760
(Telephone number: 1-508-655-8123)

Authorization to Bill

A complete, legible copy of the PIRS (DMAS-80) form must be sent to DMAS for review and for the assignment of an authorization to bill. DMAS will notify NFs that they may bill for the resident by letter. Do not bill until this letter is received. If any part of the required documentation is incomplete or inaccurate, the NF will receive a letter describing the problem areas and requesting that corrections be sent.

Please note that the submission of incomplete or inaccurate data will result in a delay in the notification letter. All forms should be sent to DMAS within 30 days of admission for the notification of Medicaid eligibility. No payment will be made prior to all data being entered into the DMAS Virginia Medicaid Management Information System (VAMMIS).

Resource Utilization Groups (RUGs)

Effective on and after July 1, 2002, all NFs subject to the prospective payment system shall be reimbursed under "The Resource Utilization Group-III (RUG-III) System" as defined in Appendix IV (12VAC30-90-305 through 12VAC30-90-307). RUG-III is a resident classification system that groups NF residents according to resource utilization. Case-Mix Indices (CMIs) are assigned to RUG-III groups and are used to adjust the NF's per-diem rates to reflect the intensity of services required by a NF's resident mix. See 12VAC30-90-305 through 12VAC30-90-307 for details on the RUGs. Three areas have been identified as most likely to predict differences in resource utilization. These areas are clinical characteristics (such as diseases and conditions), service types and counts, and activities of daily living (ADLs). Using these factors, the classification process established thirty-four (34) RUGs for use in NFs. A resident is assigned to a RUG by comparing his/her characteristics to the requirements for each group, using three components in the assignment process:

1. The seven major classification groups are:
    - Rehabilitation (Special)
    - Extensive Services
    - Special Care
    - Clinically Complex
    - Impaired Cognition
    - Behavioral Problems
    - Physical Functions

2. Resident Functionality as measured by ADLs

3. Additional problems or services (e.g. depression, Nursing Rehabilitation, or Extensive Services)

The RUG Element Worksheet using MDS 2.0 and Nursing Only CMIs describe the algorithm used to assign residents to specific RUG sub-categories (see the “Exhibits” section at the end of this chapter). The principal of Index Maximization is used when a resident qualifies for two different categories. He/She is placed in the category with the highest CMI (See Appendix C -Virginia Department of Medical Assistance Services RUG Item Review Guidelines - MDS 2.0).

DISCHARGES: NOTIFICATION TO DMAS

As soon as possible, NFs must notify DMAS of all permanently discharged residents who are eligible for Medicaid. Permanent discharges are defined as: death, transfer to another facility, discharged home, or transferred to the hospital without expected return.

The local Department of Social Services (DSS) office must also be notified of all discharges or deaths by using the Patient Information Form (DMAS-122).

The MDS 2.0 Discharge Tracking Forms are the preferred forms for notification of discharges. Forms should be submitted to:

Mail:
Facility and Home-Based Services Unit
Department of Medical Assistance Services
600 East Broad Street
Richmond, VA 23219

UTILIZATION REVIEW (UR) FOR NURSING FACILITIES (NFs)

Utilization controls applied concurrent with the resident’s stay in a Long-Term-Care Facility (LTCF) are important in ensuring high-quality care as well as the appropriate provision of services and the medical necessity for services. Many of the review and control requirements respond to federal regulations. All of the requirements must be complied with by all participating LTCFs. DMAS will routinely conduct on-site UR to ensure that the services provided to Medicaid recipients are medically necessary, appropriate, and provided by the appropriate provider. Participating Medicaid providers are responsible for ensuring that requirements, such as record documentation for services rendered, are met in order to receive payment from DMAS.

For NFs not under RUGS [i.e., Eastern State Hospital (ICF/SNF), Southwestern Virginia Mental Health Institute (NF), Shenandoah Geriatric Treatment Center, Hiram Davis Medical Center (ICF/SNF), the SNF/MR units of Central Virginia Training Center (CVTC) and Southside Virginia Training Center, and the Adult Treatment Center at CVTC], the facility must submit a copy of the MDS 2.0 or Quarterly Review Form, whichever has been completed most recently. Data should be reviewed to assure that they are complete and accurate and reflect the current needs and condition of the recipient. The RN (Registered Nurse) Coordinator and any other staff, who completed any part of the MDS 2.0, must sign, date, and indicate which sections he/she completed. If the recipient has been transferred, discharged, or has expired, indicate the date on the review letter and return it to DMAS with the completed forms. The DMAS-118 form will no longer be used by these facilities.

WITHHOLDING NURSING FACILITY COST EFFICIENCY INCENTIVE

A cost efficiency incentive shall not be paid to a NF for the pro-rated period of time that the Virginia Department of Health (VDH) determines that a NF is not in substantial compliance with federal Long-Term-Care participation requirements. Facilities, that VDH determines are not in substantial compliance, have a deficiency rating greater than widespread deficiencies that constitute no actual harm with potential for minimal harm. On the Remedy Matrix (see the “Exhibits” section at the end of this chapter), this is a deficiency rating of D, E, F, G, H, I, J, K, or L. The Health Care Financing Administration developed the Remedy Matrix, which VDH uses to establish the scope and severity of deficiencies.

The cost efficiency incentive is reinstated from the date that VDH determines that a NF is in substantial compliance. If a NF disputes a determination of non-compliance via the informal dispute resolution (IDR) process and prevails at the conclusion of the IDR process, DMAS will pay the cost efficiency incentive retroactive to the date of the VDH survey that determined the non-compliance.

DOCUMENTATION REQUIREMENTS - NURSING FACILITIES

Resident Records - Nursing Facilities (NFs)

The NF must maintain resident records on each resident in accordance with accepted professional standards and practices. Resident records must be complete, accurately documented, readily accessible, and systematically organized. Records must be retained for at least five years from the date of discharge. The NF must safeguard record information against loss, destruction, or unauthorized use and keep all information in the resident records confidential. At a minimum, the record must contain sufficient information to identify the resident, a record of the resident’s assessments, the Plan of Care (POC) and services provided, the results of any PAS conducted, and progress notes. All entries in the resident records must be signed with the first initial, last name, and professional title of the author and completely dated with the month, day, and year.

Resident Assessment - Nursing Facilities (NFs)

The NF must conduct an initial and periodic comprehensive, accurate, standardized, and reproducible assessment of each resident’s functional capacity. The assessment instrument designated by Virginia is the Resident Assessment Instrument (RAI) developed by CMS. Using the RAI, the NF must assess new admissions no later than

14 calendar days after the date of admission. Residents must also be assessed promptly after a significant change in the resident's physical or mental condition and at least annually.

The RAI consists of the Minimum Data Set (MDS 2.0) and the Resident Assessment Protocols (RAPs). RAPs must be completed with the MDS 2.0. The RAI is shown in the "Exhibits" section at the end of this chapter. Complete instructions for the RAI may be found in the *Resident Assessment Instrument Training Manual & Resource Guide*, Eliot Press, 262 Eliot Street, Natick, MA 01760 (1991).

These assessments must be coordinated by a registered nurse (RN) who signs, dates, and certifies the completion of the assessment. Each individual who completes a portion of the assessment must sign, date, and certify the accuracy of that portion of the assessment. Any individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil monetary penalty of not more than $1,000 with respect to each assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil monetary penalty of not more than $5,000 with respect to each assessment.

The RAI must reflect accurately and completely the resident's condition and capabilities. All of the information recorded on the RAI must be found in the medical record. Any information recorded on the RAI that cannot be verified in the medical record will be considered not applicable to the resident.

Physician's Documentation - Nursing Facilities (NFs)

- **Medical Plan of Care or Orders** - A physician must approve a recommendation that an individual be admitted to a NF. Each resident must remain under the care of a physician. At the time each resident is admitted, the NF must have physician orders for the resident's immediate care. All residents must be seen by a physician and orders must be renewed at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. "Renew Orders" are acceptable if all current orders are on the same page of the physician's order sheet. The most current page of the physician's orders must be the first page of the physician's orders section in the medical record.

  The Plan of Care (POC) must include diagnoses, symptoms, complaints, complications, and any orders for medications, treatments, Restorative and Rehabilitative Services, activities, therapies, Social Services, diet, and plans for discharge. Orders for Rehabilitative Services that may be found on the Rehabilitative Therapy POC must also be found on the physician's order sheet. Orders must be specific for individual needs, and all orders must be complete (i.e., the medication orders must include the medication name, dosage, frequency, and route of administration; restraint orders must include the specific times in which the restraint may be applied, the type of restraint to be used, and the periods of time in which the restraint will be removed for resident exercise).

  A physician visit is considered timely if it occurs not later than 10 days after

the date the visit was required. The physician must make the initial physician visit personally. Subsequent required physician visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

- **Progress Notes** - It is expected that the Physician will visit the resident and write progress notes that reflect the observed medical condition of the resident. Physician progress notes should record any significant change between visits or record or elaborate when the resident's condition is unchanged. The record must indicate the progress at each visit, any change in diagnosis or treatment, and the resident's response to treatment. Progress notes must be written for every NF visit to a recipient and at least every 60 days. These notes must be dated and signed by the Physician. It is the Physician's responsibility to sign (name, title) and date (month, day, year) this required documentation. Any dictated, typed reports must be signed in script by the Physician and dated the actual date of the Physician signature. The typed date of the dictation will not be accepted.

  NOTE: Mailing the Physician's progress notes or orders is prohibited. All Physician documentation must be signed with the initials, last name, and title and dated with the month, day, and year. A required Physician signature for Medicaid purposes may include signatures, written initials, computer entry, or a rubber stamp initialed by the Physician. These methods do not preclude other requirements that are not for Medicaid purposes. If the Physician chooses to use a rubber stamp on documentation requiring his/her signature, the Physician, whose signature the stamp represents, must provide the NF administration with a signed statement to the effect that he/she is the only person who has the stamp and is the only one who will use it. The Physician must initial and completely date all rubber-stamped signatures.

  History and Physical - A thorough evaluation of the resident must be completed by the Physician within 14 days of admission to the NF. Hospital admission history and physicals or complete discharge summaries can be used as the admission history and physical if they are current (within the past 30 days) and complete and a notation is made by the NF attending Physician that he/she has reviewed the information and accepts it as a current, accurate description of the resident. This admission history and physical must be maintained in the resident's current medical record.

Nursing Documentation - Nursing Facilities (NFs)

The following components are required for nursing documentation:

- **Nursing Assessment** - A thorough evaluation must be completed by a RN within 14 days of admission to the NF. This initial evaluation must be maintained in the medical records.

- **Nursing Care Plans** - Nursing care plans based on an admission assessment are required for all residents and should indicate realistic resident needs and measurable goals and objectives and specifically state the method by which they are to be accomplished. They should be updated as needed, but at least every 90 days for each resident.

- **Nursing Summaries** - Nursing summaries, in addition to p.r.n. notes (as needed), are required at least monthly for NF residents. Nursing summaries must give a current, written picture of the resident, his/her nursing needs, the care being provided, and the resident's response to treatment. This summary should address the following: medical status; functional status in ADLs, elimination, mobility, and emotional/mental status; special therapies; nutritional status; special nursing procedures; and identification and resolution of acute illnesses or episodes.

  If other documentation in the record adequately reflects an overall assessment of the resident's condition and needs, nursing summaries may not be needed. If the NF has descriptive daily/weekly nursing notes, which present a current picture of the resident and his/her individual nursing needs, the care received, and the response to treatment, the requirements of DMAS will be met. Unusual occurrences and episodic illness must be documented in the p.r.n. notes, however, DMAS will not consider these notes as nursing summaries.

Restorative Nursing Documentation - Nursing Facilities (NFs)

Federal regulations require that NFs implement a consistent program of documenting Restorative Nursing Activities that are being performed. Restorative Nursing Activities include: range-of-motion (ROM), ambulation, positioning, assistance, and instruction in ADLs such as feeding, grooming, and bowel and bladder training as well as re-orientation and reality orientation. Documentation must define the resident's needs and identify a Restorative Nursing POC to assist the resident in reaching and maintaining his/her highest level of potential. Goals must be resident-specific, realistic, and measurable.

Restorative Nursing documentation may be included as a part of the generalized nursing documentation if the restorative components are clearly identified (this would not require a separate assessment, POC, or progress notes), or the NF may choose to have separate Restorative Nursing documentation (this would require a separate assessment, POC, and progress notes). The medical record must also include documentation that planned Restorative Nursing Services were administered as planned or as ordered by the Physician.

Documentation must contain objective and measurable information so that progress, maintenance, or regression can be recognized from one report to the next. Specific information should be included concerning the resident's response to the treatment plan (i.e., the amount of assistance required, the device used, the distance, the progress made, and how well the resident tolerated the activity). This information should be included when describing transfers, ambulation, wheelchair mobility, ADLs, and ROM. If Restorative Nursing documentation is separate from General Nursing documentation, then the Restorative Nursing information must follow the same requirements as those of General Nursing. Where possible, Restorative Nursing Activities should be incorporated into the resident's daily care. The rehabilitative potential, regardless of the provider of services, must be incorporated into the Interdisciplinary POC. Documentation in the medical record must include periodic evaluation by a Licensed Nurse.

Social Services - Nursing Facilities (NFs)

Each NF is required to have a designated staff member, qualified through training or experience, who is responsible for identifying the psychosocial needs of residents and implementing plans and efforts to meet these needs. A NF with more than 120 beds must employ a full-time qualified Social Worker as described in Chapter IV.

The Social Worker assists the Physician and other team members with understanding the significant social and emotional factors related to the health problems, participates in the development of the plan of treatment, prepares the progress notes, works with the family, utilizes appropriate community resources, coordinates the discharge planning, and acts as a consultant to other agency personnel.

Social Services documentation must include the following:

- **Social Evaluation and History** - A social history and evaluation must be completed within 14 days of the resident's admission to the NF and should include the initial contact (source of referral); the family background and relations; the education and work background; the physical, mental, and emotional status; and the functional capacity as seen by the resident and his/her family;

- **Social Services Care Plans** - Social Services POCs will be reviewed by the Long-Term-Care Unit and are expected to meet acceptable professional standards. The Social Services POC is initially developed from the information gathered from the social history and evaluation. This plan should include the Social Worker's evaluation of the resident's motivational capacities, functional level, strengths, and weaknesses. Plans and goals should be made to improve or maintain the family or resident's strengths. The weaknesses of the family or resident should also be evaluated with plans to minimize, eradicate, or control maladaptive behavior or other problem situations. Other social or emotional needs of the resident should also be considered and addressed with specific goals and objectives. The care plans must include measurable goals with realistic time frames. The Social Services POC must be recorded in the resident's record, evaluated, and updated with the resident's participation as needed at least every 90 days;

- **Social Services Progress Notes** - Progress notes must be written as often as needed, but at least every 90 days when the care plan is evaluated and updated. Quarterly notes must address the psychosocial needs of the resident including, but not limited to: mental status, orientation, behavior, and family or community concerns; and

- **Discharge Planning** - Discharge planning must be a part of the original Social Services POC and must be updated every 90 days. It is the responsibility of the Social Services staff to know family and community resources that could be of benefit to the resident at the time of discharge. Discharge planning should be an ongoing process in the continuing care of the resident and should be an integral part of the total care plan.

  Transfer trauma will be significantly reduced if the resident (and family) begin to think of discharge at the time of admission and throughout the stay rather

than at the time of discharge. While it is recognized that discharge plans are not feasible for some residents, it is still necessary to re-evaluate the status of each resident periodically and to note the reason discharge plans are not currently feasible. Social Services documentation is expected to demonstrate at least minimum standards of insightful and realistic evaluation, planning, and follow-through skills. Discharge plans must address the current functioning status of the resident, medical nursing needs, and the availability of family or community resources to meet the needs of the resident.

When the NF anticipates discharge, a resident must have a discharge summary that includes a recapitulation of the resident's stay and a post-discharge POC, which will assist the resident to adjust to his/her new living environment.

Activities - Nursing Facilities (NFs)

The NF must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. The Activities Program must be directed by a qualified professional who is a Qualified Therapeutic Recreation Specialist (QTRS), who is registered or licensed by the state in which he/she practices or has two years of experience in a social or recreational program within the last five years, one of which was full-time in a Resident Activities Program in a health care setting, or who is a Qualified Occupational Therapist or Occupational Therapy Assistant. The Activities Director will maintain a current list of residents for whom precautions are noted which might restrict or modify their participation. The Activity Program is designed to encourage each resident to: 1) maintain normal activity, 2) return to self-care, and 3) maintain an optimal level of psychosocial functioning. Activities documentation requirements are as follows:

- **Activities Assessment** - A thorough evaluation of an individual's interests, past hobbies, skills, physical and mental status, personal care requirements, and functional capabilities must be performed within 14 days of the individual's admission to the NF;

- **Activities Plan of Care (POC)** - The Activities POC must be based on the comprehensive admission assessment. Individual and group activities must be included in the POC. The POC must include measurable goals with realistic time frames. The Activities POC must be updated as needed, but not less often than every 90 days; and

- **Activities Progress Notes** - The activity record documentation for each resident must include the resident's participation or refusal to participate in the activities and efforts to motivate the uninvolved, as well as the progress toward meeting these established measurable goals within realistic time frames. Progress notes must be written as needed and every 90 days when the POC is updated and reviewed.

Dietary Services - Nursing Facilities (NFs)

The Dietary Services requirements are:

- **Dietary Evaluation:** Each resident's record must contain a dietary evaluation. The initial evaluation must be completed with 14 days of the individual's admission to the NF and include any dietary restrictions as well as food preferences;

- **Dietary Plan of Care (POC):** The Dietary POC must be based on the comprehensive admission evaluation and have measurable goals with realistic time frames. This POC must be updated as needed but not less often than every 90 days for NF residents; and

- **Dietary Progress Notes:** Progress notes should be written as needed, but not less often than every 90 days.

These POCs and progress notes may be written by a qualified Dietary Supervisor, except when the resident has an obvious need for professional dietary intervention. For instance, it would be expected that the registered Dietitian, rather than a Dietary Supervisor, would be directly involved when the resident has problems with diabetes control, receives enteral feedings, excessive unexpected weight loss or gain, or any newly-diagnosed medical condition in which dietary changes or controls are required. The NF must employ a qualified Dietitian either full-time, part-time, or on a consultant basis. If a qualified Dietitian is not employed full-time, the NF must designate a person to serve as the Director of Food Service who receives frequently scheduled consultation from a qualified Dietitian.
The NF must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. Menus must be prepared in advance and followed. Substitutes of similar nutritive value must be offered to residents who refuse foods served.

<u>Rehabilitation Therapies - Nursing Facilities (NFs)</u>

If Rehabilitative Services (such as Physical Therapy, Occupational Therapy, or Speech Language Pathology Services) are required in the resident's comprehensive POC, the NF must provide the required services or obtain the required services from a provider of Rehabilitative Services. An initial assessment must be completed as soon as practicable upon a Physician's referral, but no later than 14 days after the Physician's order. The POC must be updated as needed, but not less often than every 90 days. Progress notes are to be written at least monthly. Documentation must contain objective and measurable information so that progress, maintenance, or regression can be noted from one report to the next when describing transfers, ambulation, wheelchair mobility, ADLs (dressing, feeding, bowel or bladder programs), and ROM. All Rehabilitative Services rendered by a rehabilitative professional shall be performed only upon written medical referral by a Physician.

Rehabilitative Services may be indicated when the resident has lost or has shown a change in his/her ability to respond to or perform a given task and requires professional Rehabilitative Services in an effort to restore lost function. Rehabilitative Services may also be indicated to evaluate the appropriateness and individual response to the use of Assistive Technology (AT). When the resident reaches his/her anticipated potential, he/she should be discharged from professional Rehabilitative Services, and efforts should be made to transfer the resident's learned skills into his/her daily routine assisted by the nursing staff as necessary.

Physical Therapy Services can be provided by Physical Therapists, Physical Therapy Assistants licensed by the Board of Medicine, or a Physical Therapy Aide. The Physical

Therapist's responsibilities are to evaluate a resident, plan the treatment program, and administer and document the treatment within the limit of his/her professional knowledge, judgment, and skills.

A Physical Therapist Assistant is permitted to perform all Physical Therapy functions within his/her capabilities and training as directed by a Physical Therapist. The scope of such functions excludes an initial evaluation of the resident, the initiation of new treatments, and the alteration of the POC for the resident. Direction by the Physical Therapist shall be interpreted as follows:

- The initial resident visit shall be made by the Physical Therapist for evaluation of the resident and establishment of the POC;

- The Physical Therapist Assistant's first visit to the resident shall be made jointly with the Physical Therapist;

- The Physical Therapist shall provide on-site supervision for one out of every five visits made to the resident by the Physical Therapist Assistant during a 30-day period. Should there be fewer than five visits to a resident by the Physical Therapist Assistant in a 30-day period, the Physical Therapist Assistant must be supervised on-site at least once during that period by the Physical Therapist; and
- Failure to abide by this regulation due to the absence of the Physical Therapist in the case of illness, vacation, or a professional meeting, for a period not to exceed five consecutive days, will not constitute a violation of the foregoing provisions.

A Physical Therapist may not delegate Physical Therapy treatments to Physical Therapy Aides except those activities that are available without prescription in the public domain. Supervision of a Physical Therapy Aide means that a Licensed Physical Therapist or Licensed Physical Therapy Assistant must be within the NF to give direction and instruction when procedures or activities are performed. Such non-licensed personnel must not perform those resident care functions that require professional judgment or discretion.

Occupational Therapy Services may be provided by an Occupational Therapist registered and certified by the American Occupational Therapy Certification Board or an Occupational Therapy Assistant certified by the American Occupational Therapy Certification Board under the direct supervision of an Occupational Therapist. Occupational Therapy Services are not limited to "Occupational" Services, but may also include training for ADLs (dressing, hygiene, mobility, etc.), Cognitive Remediation and Homemaking Activities, or the use of AT, etc.

The treatment plan developed by the Occupational Therapist may be implemented by the Registered Occupational Therapist or the Certified Occupational Therapy Assistant under the supervision of a Registered Occupational Therapist.

Speech Language Pathology Services may be provided by a Speech Language Pathologist licensed by the Board of Audiology and Speech Pathology. These services may address concerns with the production of speech, voice, and language as well as disorders with perception and recognition, as well as dysphagia.

Pharmacist Medication Review - Nursing Facilities (NFs)

A Pharmacist must review medications monthly in all NFs and document that review. Documentation should indicate a review of medications for each recipient with a dated and signed statement of the appropriateness of the Drug Therapy regimen and if there are potential problems with the therapy. In instances where potential problems are identified, the Pharmacist must notify the attending Physician and the Director of Nursing, and the report must be acted upon. The documentation must include the month, day, and year and must be signed with the first initial and last name followed by "Pharmacist" or "R.Ph." Medication reviews must be completed monthly. "Monthly" is defined as approximately every 30 days. A grace period of no more than 10 days will be allowed. The medical record must contain all action taken by the Physician or Director of Nursing in response to notification by the Pharmacist.

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug used in excessive dose (including duplicate drug therapy), for excessive duration, without adequate monitoring, without adequate indications for its use, in the presence of adverse consequences, which indicated the dose should be reduced or discontinued, or any combinations of the above reasons.

Residents who have not used antipsychotic drugs must not be given these drugs unless Antipsychotic Drug Therapy is necessary to treat a specific condition as diagnosed and documented.

Comprehensive (Interdisciplinary) Care Plan - Nursing Facilities (NFs)

NFs must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs as identified in the comprehensive assessment (the RAI). The comprehensive care plan must be developed within seven days after the completion of the Minimum Data Set (MDS 2.0). The care plan must be prepared by an interdisciplinary team that includes the attending Physician, a RN with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, including Nurses, Social Workers, Activity Coordinators, Dietitians, Therapists, administrative personnel, and direct care staff. To the extent practicable, the resident and his/her family or legal representative must participate.

The POC must describe: 1) the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and 2) any services that are required but not provided due to the resident's exercise of rights, including the right to refuse treatment. At a minimum, the Nurse, Social Worker, Dietary Supervisor, and Activity Coordinator must review and update as necessary the comprehensive care plans at least every 90 days based upon the resident assessment. Facilities must use the Quarterly Review Forms shown in the "Exhibits" section at the end of this chapter for the required quarterly review.

Therapeutic Specialty Bed

The NF shall furnish to the Medicaid recipient in the NF all the services, equipment, and supplies necessary to carry out the POC ordered by the Physician. NF Care under the Virginia Medicaid Program must not be of any less or greater duration, scope, or quality than that provided to residents not receiving state or federal assistance.

DMAS will conduct UR of the use of the therapeutic specialty beds used by a NF in the treatment of recipients with Stage IV ulcers. These visits may be done in conjunction

with the current Medical Data Summary (MDS) validation reviews currently conducted by the agency or be unannounced.

Documentation must be available and in the medical record that shows the following:

1. A Physician order for the therapeutic bed dated and signed must be in the medical record.
2. The order must be for a low-air-loss or air-fluidized bed. Overlays are not covered under the $10-per-day reimbursement.
3. Documentation must be in the medical record stating the recipient is on the bed and for how long.
4. Documentation must be noted on the Medical Data Summary (MDS) Form indicating a Stage IV pressure ulcer.

Services not specifically documented in the recipient's medical record as rendered shall be deemed as not rendered, and no reimbursement will be provided.

Cost Settlement

Effective for services on or after July 1, 2005, NFs shall be reimbursed an additional $10 per day for those recipients who require a specialized treatment bed due to their having at least one stage IV pressure ulcer. Recipients must meet criteria as outlined in 12 VAC 30-60-350, and the additional reimbursement must be pre-authorized as provided in 12 VAC 30-60-40. NFs shall not be eligible to receive this reimbursement for individuals whose services are reimbursed under the Specialized Care methodology. Beginning July 1, 2005, this additional reimbursement shall be subject to adjustment for inflation in accordance with 12 VAC 30-90-41B, except that the adjustment shall be made at the beginning of each state fiscal year, using the inflation factor that applies to provider years beginning at that time. This additional payment shall not be subject to direct or indirect ceilings and shall not be adjusted at year-end settlement.

SECTION II: SPECIALIZED CARE CRITERIA

SCOPE OF SERVICES - SPECIALIZED CARE

The NF shall furnish to the Medicaid recipient in the NF all the services, equipment, and supplies necessary to carry out the POC ordered by the Physician. NF Care under the Virginia Medicaid Program must not be of any less or greater duration, scope, or quality than that provided residents not receiving state or federal assistance.

NFs providing services to residents with Specialized Care needs must have a separate contract with Medicaid to receive reimbursement for Specialized Services and a separate provider number (effective December 1, 1996). The following are required services for the provision of Specialized Care:

- Physician visits at least every seven (7) days - The initial Physician visit must be made by the Physician personally. At the discretion of the Physician, subsequent required Physician visits may alternate between personal visits and visits by a Physician Assistant or Nurse Practitioner;

- Skilled Nursing Services 24 hours a day (A RN, whose sole responsibility is the designated unit on which the resident resides, must be on the unit 24 hours a day.);

- Nursing Services shall be of a level of complexity and sophistication or the condition of the resident shall be of a nature that the services can only be performed by a RN or Licensed Professional Nurse (LPN) or a Nursing Assistant under the direct supervision of a RN, who is experienced in providing the Specialized Care required by the resident;

- A coordinated multidisciplinary team approach that meets the needs of the resident. Based on the Physician's POC, the Interdisciplinary Team should include, but is not limited to, Nurses, Social Workers, Activity Coordinators, Dietitians, Rehabilitative Therapists, and any direct care staff;

- If the resident is age 21 or younger, the NF must coordinate with appropriate state and local agencies for the educational and habilitative needs of the child. These services must be age-appropriate and appropriate to the cognitive level of the child. Services must be individualized to meet the specific needs of the child and must be provided in an organized and proactive manner. Services may include, but are not limited to, school, active treatment for mental retardation, habilitative therapies, social skills, and leisure activities. These services must be provided for a minimum of two hours per day. (Educational and Habilitative Services are not reimbursable under Medicaid.);

- Rehabilitative Services shall be directly and specifically related to the written POC designed by a Physician after any needed consultation with the rehabilitation professional;

  Physical Therapy Services shall be of a level of complexity and sophistication or the condition of the resident shall be of a nature that the services can only be performed by a Physical Therapist licensed by the Board of Medicine or a Physical Therapy Assistant, who is licensed by the Board of Medicine and under the direct supervision of a Physical Therapist licensed by the Board of Medicine;

  Occupational Therapy Services shall be of a level of complexity and sophistication or the condition of the resident shall be of a nature that the services can only be performed by an Occupational Therapist registered and certified by the American Occupational Therapy Certification Board or an Occupational Therapy Assistant certified by the American Occupational Therapy Certification Board under the direct supervision of an Occupational Therapist as defined;

  Speech Language Pathology Services shall be of a level of complexity and sophistication or the condition of the resident shall be of a nature that the services can only be performed by a Speech Language Pathologist licensed by the Board of Audiology and Speech Pathology;

- If the resident is age 21 or younger and requires two out of the three Rehabilitative Therapy Services (Occupational or Physical Therapy and Speech Language Pathology Services), Therapy Services must be provided a minimum of six therapy sessions, 15 minutes per session, five days a week. This is equivalent to 90 minutes a day, five days a week. It is

expected that the length of each session be adjusted to allow for individual review of the resident's ability to participate in or tolerate therapeutic interventions. If a resident can only tolerate 10-minute sessions at a time, the number of sessions would have to be adjusted so that the total therapy time in a day equals 90 minutes;

- Provision of Ancillary Services directly and specifically related to a POC designed by the Physician. The Ancillary Services may include, but are not limited to, Dietary, Respiratory Therapy Services, and Psychological Services.

  Dietary Services must be of the level of complexity or sophistication or the nature of the resident shall be that the services can only be performed or supervised by a Dietitian registered with the American Dietetic Association;

  Respiratory Therapy Services must be of a level of complexity and sophistication or the condition of the resident shall be of a nature that the services can only be performed by a Respiratory Therapist who is certified by the Board of Medicine;

  If the NF agrees to provide care to a resident who is dependent on mechanical assistance for respiration (positive or negative pressure mechanical ventilators), Respiratory Therapy Services must be available 24 hours daily. If the NF contracts for Respiratory Therapy Services, a Respiratory Therapist must be on call 24 hours a day and available to the NF in a timely manner;

  Psychology Services shall be of a level of complexity or sophistication or the condition of the resident shall be of a nature that the services can only be performed by a Psychologist licensed by the Board of Medicine;

- Provision of all of the necessary durable medical equipment (DME) to sustain life or monitor vital signs and to carry out a POC designed by the Physician. This equipment may include, but is not limited to, a mechanical ventilator, an apnea monitor, Kinetic Therapy devices, etc.;

- Provision of all medical supplies necessary to provide care as directed by the Physician's POC for the resident. These supplies may include, but are not limited to, suction catheters, tracheostomy care supplies, oxygen, etc.;

- Provision of all nutritional elements, including those that must be administered intravenously. This includes providing any necessary equipment or supplies necessary to administer the nutrients;

- Provision of an acceptable plan for assuring that residents requiring Specialized Care are afforded the same opportunity for participating in integrated NF activities as the other NF residents;

  Each NF must provide for its residents a program of activities under the supervision of a qualified Activity Coordinator. This program of activities must include both individual and group activities that are based on the consideration of interest, skills, physical and mental status, and personal care

requirements;

- Provision of non-emergency transportation so that the resident may participate in community activities sponsored by the NF or community activities in which the NF is providing transportation for other NF residents;

- Coordination of discharge planning for the resident utilizing all available resources in an effort to assist the resident reach his/her maximum potential for independence and self-sufficiency and to assure that services are being provided at the most effective level of care;

- Provision of family or caregiver training in the skills necessary for them to care for the resident in the community, should the resident or his/her caregiver so desire;

- Provision of Social Services to each resident in an effort to assist the resident, his/her family, and the NF staff in understanding the significant social and emotional factors related to the health problems, to assist with the appropriate utilization of community resources, and to coordinate discharge plans. Social Services must be provided by a Social Worker with at least a bachelor's degree in social work or similar qualifications;

- Submission of all necessary health care and medical Social Services information on the resident to DMAS for pre-authorization; and

- Provision of UR activities as described in the section of this manual titled "Documentation Requirements - Specialized Care."

ADMISSION PROCESS - SPECIALIZED CARE

An important component of utilization control in the Specialized Care area is the monitoring of the initial admission of the resident to the NF. The success of the Medicaid Program in avoiding inappropriate placements of residents in NFs is directly related to the program's ability to ensure that residents are receiving needed care at the lowest reasonable cost. A key to DMAS' capacity to provide this control is the Nursing Facility (NF) Pre-Admission Screening (PAS) Program. The NF PAS is a process designed to:

- Evaluate the medical, nursing, social, psychological, and developmental needs of each individual referred for PAS;

- Analyze what specific services the individual needs; and

- Evaluate whether a service or a combination of existing community services is available to meet the individual's needs.

NF PAS must be completed prior to an individual's admission to any Medicaid-funded Long-Term-Care Service. Pre-admission guidelines described in Appendix C for NFs are applicable to all residents requiring Specialized Care and admitted to the NF.

In addition, the NF must obtain pre-admission authorization from DMAS prior to admitting any Medicaid recipient requiring Specialized Care Services. The NF must complete the DMAS Admission Authorization - Specialized Care Cover Sheet (SPEC-

100), including the Physician's signature certifying the need for Specialized Care and the admission date. The certification must be completed by the attending Physician for the NF resident or by the Medical Director for the NF. No Physician's signature is necessary for discharge date notification. The SPEC-100 form will be the only form utilized by providers to notify DMAS of admissions, discharges, and re-admission dates.

- If a resident is transferred from NF Care to Specialized Care Services in the same NF, the authorization request must be submitted to DMAS within 72 hours (three working days) of the transfer.

- If a resident requiring Specialized Care is being re-admitted to the NF after being hospitalized, the NF may re-admit the resident as a Specialized Care or Long-Stay Hospital resident. The NF must assume responsibility for determining that the resident meets Specialized Care criteria, and DMAS must be notified within 72 hours in writing of the re-admission date using the SPEC-100 form. If DMAS is not notified within 72 hours of re-admission, the assigned begin date for Specialized Care will be the date that DMAS was notified. If the NF re-admits a resident as a Specialized Care resident, and it is determined that the resident did not or does not meet criteria for Specialized Care Services, reimbursement for Specialized Care Services will not be made. If the resident meets NF criteria, the NF may submit a NF admission package.

- The SPEC-100 form and admission packets are to be sent to:

  Facility and Home-Based Services Unit
  Department of Medical Assistance Services
  600 East Broad Street, Suite 1300
  Richmond, Virginia 23219

  Or via fax at: Deloris Harris (804-452-5456) All Others (804-612-0050)

Specialized Care criteria are found in Appendix B of this manual. DMAS will conduct retrospective review to determine whether Specialized Care criteria have been met and will retract payment if the patient did not qualify for Specialized Care Services.

It is the responsibility of the NF to continue to monitor the resident's continued Medicaid eligibility. If the resident's eligibility is canceled for any reason during his/her stay, Medicaid reimbursement will be terminated effective on the date of the Medicaid eligibility termination. If Medicaid coverage is reinstated, the NF must submit a new SPEC-100 form for authorization of the services prior to transferring the resident back into the Specialized Care program.

<u>Specialized Care Reimbursement and MDS 2.0 Submissions</u>

Reimbursement will be based on service intensity or case mix using RUGs. The RUG Element Worksheet Using MDS 2.0 and Nursing Only CMIs describes the algorithm used to assign residents to specific RUGs sub-categories (see the "Exhibits" section at the end of this chapter). Specialized Care providers must send MDS 2.0 data (submit only full MDS 2.0 forms) monthly to the DMAS Contractor for processing MDS 2.0 data to support the use of RUGs in connection with Specialized Care to:

John McCue

Clifton Gunderson L.L.C.
6053 Arlington Expressway
Jacksonville, Florida 32211

This submission is in addition to and separate from the routine submission of MDS 2.0 data that occurs for all NF patients. Specialized Care providers should continue to submit this data in hard copy even after the implementation of electronic submission of MDS 2.0 data by NFs. VDH will administer the electronic submission process under guidelines and oversight by CMS. DMAS will have access to the electronic database to calculate the CMIs that are used to set Specialized Care rates; however, this will not be operational when electronic submission is first in place. DMAS will notify providers when access is available to electronic MDS 2.0 data and DMAS uses this data to calculate the necessary CMIs without the submission of hard copies of MDS 2.0 data.

A MDS 2.0 form will be due whenever: (1) a patient is admitted to Specialized Care, (2) 12 months have elapsed since the most recent full assessment, or (3) there is a significant change of status. The following MDS 2.0 Specialized Care assessment documentation must be submitted within 30 days of the end of that month. This monthly submission is separate from the submission of MDS 2.0 data for all NF residents (Non-Specialized Care). The documentation must include the admission assessment (if the resident is admitted as a Specialized Care resident), the assessment required by DMAS upon admission to Specialized Care, the annual assessment, and significant change assessments. The MDS 2.0 Version 2.0 form must be submitted; specifically, the Basic Assessment Tracking Form (Section AA), Background (Face Sheet) Nursing Information at Admissions (sections AB, AC, and AD), and the Full Assessment Form (Sections A - R) must be submitted to DMAS. Do not send any quarterly assessments or care plans. Include a cover transmittal sheet that lists the Specialized Care resident names, Medicaid numbers, dates of assessments, and the “from” and “through” dates of Specialized Care Services for each resident. Also include a home contact name and phone number in case there are questions regarding the assessments. Make sure that all required resident assessments and all pages (as specified above) have been copied for each assessment and are properly assembled. Review the assessments to assure that the copies are legible and properly aligned so that all item responses are present on the page.

UTILIZATION REVIEW (UR) FOR SPECIALIZED CARE

Under federal regulations, DMAS must provide for the continuing review and evaluation of the care and services covered by Medicaid. This includes the review of the utilization of the services rendered by providers to recipients. In evaluating the Contractor’s performance, DMAS will utilize the regulations found in Title 42 of the *Code of Federal Regulations*, the Virginia *State Plan for Medical Assistance*, and the guidelines found in this manual. In addition, the Contractor must provide the services and fully complete all of the requirements for providing Specialized Care.

Utilization controls applied concurrent with the resident’s stay in a LTCF are important in ensuring high-quality care as well as the appropriate intensity of service assignment and the medical necessity of services. Residents receiving Specialized Care will be subject to review by all federal and state surveyors as are other Medicaid recipients in the NF.

The DMAS Utilization Review (UR) Team will visit the NF at least annually. During this visit, the team will visit with residents receiving Specialized Care and will review all

current and retroactive medical records of residents who have been authorized for Specialized Care reimbursement.

An interdisciplinary professional review (including physical, emotional, social, and cognitive factors) will be conducted with respect to the:

- Care being provided by the NF;
- Adequacy of the services available to meet the current health needs and to provide the maximum physical and emotional well-being of each resident;
- Necessity and desirability of the continued placement of the resident;
- Feasibility of meeting his/her health needs in alternate care arrangements; and
- Verification of the existence of all documentation required by Medicaid.

DOCUMENTATION REQUIREMENTS - SPECIALIZED CARE

Resident Records - Specialized Care

The NF must maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than five years from the date of service or as provided for 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. The record must identify the resident on each page. Entries must be signed and dated (month, day, year) by the author, followed by his/her professional title. The documentation for the care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

With the exception of the documentation requirements listed below, NFs that have contracts for Specialized Care must adhere to the documentation requirements as outlined in Section I of this chapter and page 7 of Chapter II of this manual. Services not specifically documented in the resident's medical record as having been rendered will be deemed not to have been rendered, and no coverage will be provided.

Physician Documentation - Specialized Care

The attending Physician must certify at the time of admission that the resident requires Specialized Care and meets the Specialized Care criteria as defined by DMAS. The record must contain a preliminary working diagnosis and the elements of a history and physical examination, upon which the diagnosis is based.

All services provided, as well as the treatment plan, must be entered in the record. Any drugs prescribed and administered as part of a Physician's treatment plan, including the quantities, the dosage, and the route of administration, must be entered in the record.

The record must indicate the resident's progress, any change in the diagnosis or treatment, and the response to treatment.

Physician progress notes must be written at least every seven (7) days and must reflect that the resident has been seen and examined by the physician.

Nursing Documentation - Specialized Care

A comprehensive nursing assessment must be made by a RN at the time of admission to the NF. Nursing Care plans based on an admission assessment must be resident-specific and must indicate realistic nursing needs, measurable goals, and specifically state the method by which the goals are to be accomplished. The plans must be updated as needed, but at least every month.

Nursing summaries, in addition to the p.r.n. notes (as needed), are required weekly. Nursing summaries must give a current, written picture of the resident, his/her nursing needs, the care being provided, and the resident's response to treatment. The nursing summary must address the following: category and reason the resident is assigned to Specialized Care; medical status; functional status in ADLs; elimination and mobility; emotional or mental status; special therapies; nutritional status; special nursing procedures; and the identification and resolution of acute illnesses or episodes.

For Comprehensive Rehabilitation residents, nursing staff are responsible for Rehabilitative Nursing and supporting documentation. The documentation must incorporate a nursing-related assessment of the outcome of the overall therapeutic regime, including progress as assessed on the unit.

Social Services Documentation - Specialized Care

Social Services documentation must include a social evaluation and history and a Social Services POC including a discharge plan. The Social Services POC must be resident-specific and include measurable goals with realistic time frames. Social Services POCs and discharge plans must be updated as needed and at least monthly. Social Services progress notes must be written at least monthly. Social services progress notes must address the psychosocial needs, orientation, cognitive function, and behavior of the resident.

Activities Documentation - Specialized Care

Activities documentation must be based on a comprehensive assessment completed by a qualified Activity Coordinator. An Activity POC must be developed for each resident and must include the consideration of the individual's interests and skills, the Physician's recommendations, the social and rehabilitation goals, and the personal care requirements. Individual and group activities must be included in the POC. The Activity POC must be updated as needed, but at least every month. Activity progress notes must be written at least monthly. Activity progress notes must include documentation as to individual or group activities attended and the resident's response to the activity.

Rehabilitative Therapy Documentation - Specialized Care

Rehabilitative Therapy (Physical and Occupational Therapy or Speech Language Pathology Services) or other health care professional (Psychologist, Respiratory Therapist, etc.) documentation must include an assessment completed by the qualified

rehabilitation professional. A POC specific to the resident must be developed and must include measurable goals with realistic time frames. The POC must be updated as needed, but at least monthly. Rehabilitative Therapy or other health care professional progress notes must be written at least monthly. At a minimum, the progress notes must address the length and frequency of therapy sessions, specific therapy provided, resident's response to therapy, problems encountered, and progress toward meeting established goals. The Respiratory Therapist must write monthly progress notes for all residents in the mechanical ventilator and complex care respiratory category.

The NF is responsible for maintaining documentation to demonstrate that therapy was provided and the resident's response to the intervention. Services not documented will be considered not rendered, and reimbursement for Specialized Care will not be made.

Dietary Services Documentation - Specialized Care

Each resident's record must contain a dietary evaluation and POC completed by a registered Dietitian. The POC must be resident-specific and must have measurable goals with realistic time frames. The POC must be updated as needed, but at least monthly. The dietary assessment and monthly POCs must be completed by a registered Dietitian. Dietary progress notes must be written at least monthly and must be written or co-signed by a registered Dietitian. Monthly progress notes must address the specific diet ordered, significant weight loss and, when applicable, problems related to dietary intake (i.e., enteral feeding, total parenteral nutrition, decubitus ulcers, or significant skin lesions).

Pharmacist Medication Review - Specialized Care

A Pharmacist must review medications monthly in all NFs and must document that review. Documentation should indicate a review of the medications for each recipient with a dated and signed statement of the appropriateness of the Drug Therapy regimen and whether there are potential problems with the therapy. In instances where potential problems are identified, the Pharmacist must notify the attending Physician and the Director of Nursing, and this report must be acted upon. The documentation must include the month, day, and year and must be signed with the first initial and last name followed by "Pharmacist" or "R.Ph." Medication reviews must be completed monthly. "Monthly" is defined as approximately every 30 days. A grace period of no more than 10 days will be allowed. Documentation exceeding 40 days from the last medication review will be considered delinquent. The medical record must contain all actions taken by the Physician or Director of Nursing in response to notification of potential problems identified by the Pharmacist.

Interdisciplinary Team Requirements - Specialized Care

A coordinated Interdisciplinary POC must be developed for each resident. The POC must be resident-specific and must contain measurable goals with realistic time frames. It is strongly suggested that the resident or responsible party participate in the team conference. Based on the Physician's POC, the Interdisciplinary Team should include, but is not necessarily limited to, Nurses, Social Workers, Activity Coordinators, Dietitians, Rehabilitative Therapists, and any direct care staff. The Nurse, Social Worker, Dietitian, Activity Coordinator, and Rehabilitative Therapists or other direct health care staff must review and update the Interdisciplinary POC as needed, but at least monthly. The Interdisciplinary POC Review must identify those attending the meeting, any changes in goals and approaches, and the progress made toward meeting

established goals and discharge. The Interdisciplinary POC must specifically note how the resident continues to meet the criteria for Specialized Care reimbursement.

SECTION III: TRAUMATIC BRAIN INJURY (TBI)

PROVIDER CRITERIA

The provider must provide all services that are available to the general NF population in accordance with the established standards and regulations for NF Care to include programming that is individual and geared toward the needs and interests of the unit's population. The provider must meet the following specified criteria to receive the add-on reimbursement for the TBI program:

- Have a dedicated 20 bed-or-more unit that is separated by a doorway that shall be either locked or maintained with an alarm system that sounds at the unit nursing station when opened;
- Certify all beds on this dedicated unit for licensed NF Care;
- Locate at least one nursing station on the unit and that nursing station must serve the dedicated unit only;
- Provide additional professional staff to support the special needs of the TBI residents;
- Maintain a contractual agreement with a Psychiatrist and a Neuropsychologist to serve the resident population as needed;
- Provide a RN to function in a Charge Nurse capacity on the unit whose sole responsibility is for the care and oversight of the designated unit. The RN working in the Charge Nurse capacity must have sufficient experience working with the head injuries population before serving in this capacity;
- Ensure that each resident on the unit is evaluated on an annual basis by a Licensed Clinical Psychologist with expertise in Neuropsychology or a Neurologist. If a resident is admitted and has not been evaluated by a Neuropsychologist or Neurologist in the past calendar year, an evaluation must be completed within the first 30 days of the resident's stay in the TBI program;
- Coordinate Educational Services for the resident with the appropriate public school system, if the resident has not completed all educational requirements for high school education as specified by the State Board of Education. Coordination is defined as making the necessary contacts and providing necessary information to the appropriate school division. The NF shall keep records of such coordination contacts;
- Provide all services that are available to the general NF population.

ADMISSION PROCESS - TRAUMATIC BRAIN INJURY (TBI)

An important component of utilization control in the TBI area is the monitoring of the initial admission of the resident to the NF. The success of the Medicaid Program in avoiding inappropriate placements of residents in NFs is directly related to the program's ability to ensure that residents are receiving needed care at the lowest reasonable cost. A key to DMAS' capacity to provide this control is the Nursing Facility (NF) Pre-Admission Screening (PAS) Program. The NF PAS Program is a process designed to:

- Evaluate the medical, nursing, social, psychological, and developmental needs of each individual referred for PAS;

- Analyze what specific services the individual needs; and

- Evaluate whether a service or a combination of existing community services is available to meet the individual's needs.

NF PAS must be completed prior to an individual's admission to any Medicaid-funded Long-Term-Care Service. Pre-admission guidelines described earlier in this chapter for NFs are applicable to all residents requiring Specialized Care and admitted to the NF.

In addition, the NF must obtain pre-admission authorization from DMAS prior to admitting any Medicaid recipient requiring TBI Services. The NF must complete the DMAS Admission Authorization – Traumatic Brain Injury Cover Sheet (this form is in the "Exhibits" section at the end of this chapter), including the Physician's signature certifying the need for TBI Services and the admission date. The certification must be completed by the attending Physician for the NF resident or by the Medical Director for the NF. No Physician's signature is necessary for discharge date notification. The SPEC-100 form will be the only form utilized by providers to notify DMAS of admissions, discharges, and re-admission dates.

- If a resident is transferred from NF Care to TBI Services in the same NF, the authorization request must be submitted to DMAS within 72 hours (three working days) of the transfer.

- If a resident requiring TBI Services is being re-admitted to the NF after being hospitalized, the NF may re-admit the resident as a TBI resident. The NF must assume responsibility for determining that the resident meets TBI criteria, and DMAS must be notified within 72 hours in writing of the re-admission date using **a new cover sheet that has been signed by the Physician**. If DMAS is not notified within 72 hours of re-admission, the assigned begin date for Specialized Care will be the date that DMAS was notified. If the NF re-admits a resident as a TBI resident, and it is determined that the resident did not or does not meet criteria for TBI Services, reimbursement for TBI Services will not be made. If the resident meets NF criteria, the NF may submit a NF admission package.

- The cover sheet is to be sent to:

  Facility and Home-Based Services Unit
  Department of Medical Assistance Services
  600 East Broad Street, Suite 1300
  Richmond, Virginia 23219

  Or via fax at: Deloris Harris (804-452-5456) All Others (804-612-0050)

TBI criteria can be found in Appendix B of this manual. DMAS will conduct retrospective review to determine whether TBI criteria have been met and will retract payment if the patient did not qualify for TBI services.

It is the responsibility of the NF to continue to monitor the resident's continued Medicaid eligibility. If the resident's eligibility is canceled for any reason during his/her stay, Medicaid reimbursement will be terminated effective on the date of the Medicaid eligibility termination. If Medicaid coverage is reinstated, the facility must submit a new Cover Sheet for authorization of the services prior to transferring the resident back into the TBI program.

DOCUMENTATION REQUIREMENTS - TRAUMATIC BRAIN INJURY (TBI) UNIT

In addition to the documentation requirements listed in Section I of this chapter, the following are required:

- Evaluation by a Neuropsychologist or Neurologist;
- An annual evaluation by a Licensed Clinical Psychologist with expertise in Neuropsychology or a Neurologist. If a resident is admitted and has not been evaluated by a Neuropsychologist or Neurologist in the past calendar year, an evaluation must be completed within the first 30 days of the resident's stay; and
- Documentation of coordination correspondence for Educational Services for the resident with the appropriate public school system, if the resident has not completed all the educational requirements for high school education as specified by the State Board of Education.

SECTION IV: INSTITUTIONS FOR MENTAL DISEASE (IMDs)

An institution for mental disease (IMD) is defined by 42 CFR § 435.1009 as a Hospital, NF, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services. A critical criterion for evaluating the overall character of the NF is the determination as to whether more than 50 percent of the patients have mental diseases that require inpatient treatment according to the patients' medical records.

ADMISSION PROCESS

For IMDs (such as Catawba Hospital and Piedmont State Hospital), the DMAS-119 and the DMAS-121 forms must be filled out in their entirety, reflect the justification and support for the need for services, and be signed and dated by the Physician. The DMAS-119 (Social History Form) form must be completed by the Social Worker or Social Worker designee of the NF. It is the responsibility of the NF staff to secure social history information on admission from the individual's family, friends, or other social agencies. All DMAS-121, DMAS-121A, and DMAS-119 forms will be returned to the NFs after the review is completed, along with the control number for billing.

State facilities, which are certified as NFs, are required to use the Minimum Data Set (MDS 2.0) as their RAI. These facilities include Eastern State Hospital (ICF/SNF), Southwestern Virginia Mental Health Institute (NF), Shenandoah Geriatric Treatment Center, Hiram Davis Medical Center (ICF/SNF), the SKILLED NURSING FACILITY/MR units of Central Virginia Training Center (CVTC) and Southside Virginia Training Center, and the Adult Treatment Center at CVTC. These facilities must comply with the documentation requirements for NFs as found in Section I of this chapter and on page 14 of Chapter II in this manual.

UTILIZATION REVIEW (UR) IN INSTITUTIONS FOR MENTAL DISEASE (IMDs)

Under federal regulations, DMAS must provide for the continuing review and evaluation of the care and services covered by medical assistance. This includes the review of the utilization of services rendered by providers of care in IMDs.

DOCUMENTATION REQUIREMENTS - INSTITUTIONS FOR MENTAL DISEASE (IMDs)

Resident Records - IMDs

The NF must maintain records on each resident in accordance with accepted professional standards and practices. Resident records must be complete, accurately documented, readily accessible, and systematically organized. Records must be retained for at least five years from the date of discharge. The NF must safeguard record information against loss, destruction, or unauthorized use and keep all information in the resident records confidential. At a minimum, the record must contain sufficient information to identify the resident, a record of the resident's assessments, the POC and services provided, the results of any PAS conducted, and the progress notes. All entries in the resident records must be signed with the first initial, last name, and title and completely dated with the month, day, and year.

Physician's Documentation - IMDs

- **Medical Plan of Care/Orders** - A physician must approve a recommendation that an individual be admitted to a NF. Each resident must remain under the care of a Physician. At the time each resident is admitted, the NF must have Physician orders for the resident's immediate care. All residents must be seen by a Physician, and orders must be renewed at least once every 30 days for the first 90 days after admission and at least once every 90 days thereafter. The most current page of Physician's orders must be the first page of the Physician's orders section in the medical record. "Renew orders" are acceptable if all current orders are on the same page of the Physician's order sheet.

  The POC must include the diagnoses, symptoms, complaints, and complications; any orders for medications, treatments, Restorative and Rehabilitative Services, activities, therapies, Social Services, diet, and plans for discharge. Orders for Rehabilitative Services that may be found on the Rehabilitative Therapy POC must also be found on the Physician's order sheet. Orders must be specific for individual needs, and all orders must be complete (i.e., medication orders must include the medication name, dosage, frequency, and route of administration; restraint orders must include specific times in which the restraint may be applied, the type of restraint to be used, and the periods of time in which the restraint will be removed for resident exercise).

  A Physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Physician visits must be made by the Physician personally, except, at the option of the Physician, required visits after the initial visit may alternate between personal visits by the Physician and visits by a Physician Assistant or Nurse Practitioner.

- **Progress Notes** - It is expected that the Physician will visit the resident and write progress notes that reflect the observed medical condition of the resident. Physician progress notes should record any significant change between visits and record and elaborate when the resident's condition is unchanged. The record must indicate the progress at each visit, any change in the diagnosis or treatment, and the resident's response to treatment. Progress notes must be written for every NF visit to a recipient and at least every 90 days. These notes must be dated and signed by the Physician. It is the Physician's responsibility to sign (name and title) and date (month, day, and year) this required documentation. Any dictated, typed reports must be signed in script and dated the actual date of the Physician signature. The typed date of the dictation will not be accepted.

NOTE: Mailing the Physician's progress notes or orders is prohibited. All Physician's documentation must be signed with the first initial, last name, and title and dated with the month, day, and year. If a Physician chooses to use a rubber stamp on documentation requiring his/her signature, the Physician, whose signature the stamp represents, must provide the NF administration with a signed statement to the effect that he/she is the only person who has the stamp and is the only one who will use it. The Physician must initial and completely date all rubber-stamped signatures.

Nursing Documentation - IMDs

The following components are required for nursing documentation:

- **Nursing Assessment** - A thorough evaluation must be made by a RN within 14 days of admission to the NF. This initial evaluation must be maintained in the medical records;

- **Nursing Care Plans** - Nursing Care plans based on an admission assessment are required for all residents, should indicate realistic resident needs and measurable goals and objectives, and should specifically state the method by which they are to be accomplished. They should be updated as needed but at least every 90 days for NF residents;

- **Nursing Summaries** - Nursing summaries, in addition to p.r.n. notes (as needed), are required monthly for NF residents. Nursing summaries must give a current, written picture of the resident, his/her nursing needs, the care being provided, and the resident's response to treatment. This summary should address the following: medical status; functional status in ADLs, elimination, mobility, and emotional or mental status; special therapies; nutritional status; special nursing procedures; and identification and resolution of acute illnesses or episodes; and

If other documentation in the record adequately reflects an overall assessment of the resident's condition and needs, nursing summaries may not be needed. However, this decision is made by the Utilization Review (UR) Team and is not at the discretion of the NF. DMAS strongly recommends nursing summaries, but if the NF has descriptive daily or p.r.n. nursing notes, which present a current picture of the resident and his/her individual nursing needs, the care received, and the response to treatment, the requirements of DMAS will be met.

Restorative Nursing Documentation - IMDs

Federal regulations require that NFs implement a consistent program of documenting Restorative Nursing Activities that are being performed. Restorative Nursing Activities include: ROM, ambulation, positioning, assistance, and instruction in ADLs such as feeding, grooming, and bowel and bladder training as well as remotivation and reality orientation. The documentation must define the resident's needs and identify a Restorative Nursing POC to assist the resident in reaching and maintaining his/her highest level of potential. Goals must be resident-specific, realistic, and measurable.

Restorative Nursing documentation may be included as part of the generalized nursing documentation if the restorative components are clearly identified (this would not require a separate assessment, POC, or progress notes), or the NF may choose to have separate Restorative Nursing documentation (this would require a separate assessment, POC, and progress notes). The medical record must also include documentation that planned Restorative Nursing Services were administered as planned or as ordered by the Physician.

The documentation must contain objective and measurable information so that the progress, maintenance, or regression can be recognized from one report to the next. Specific information should be included concerning the resident's response to the treatment plan (e.g., amount of assistance required, the assistive device used, distance, progress made, and how well the resident tolerated the activity). A Licensed Nurse must periodically evaluate Restorative Nursing Activities and write a progress note.

Where possible, Restorative Nursing Activities should be incorporated into the resident's daily care. Rehabilitative potential, regardless of the provider of services, must be incorporated into the Interdisciplinary POC.

<u>Social Services - IMDs</u>

Each NF is required to have a designated staff member, qualified through training or experience, who is responsible for identifying the psychosocial needs of residents and implementing the plans and efforts to meet these needs.

The Social Worker assists the Physician and other team members with understanding the significant social and emotional factors related to the health problems, participates in the development of the plan of treatment, prepares the progress notes, works with the family, utilizes the appropriate community resources, coordinates the discharge planning, and acts as a consultant to other agency personnel.

Social Services documentation must include the following:

- **Social Evaluation and History** - The social history and evaluation must be completed within 14 days of admission and should include the initial contact (source of referral); the family background and relations; the education and work background; the physical, mental, and emotional status; and the functional capacity as seen by the resident and his or her family;

- **Social Services Plans** - Social Services POCs will be reviewed by the Long-Term-Care Unit and are expected to meet acceptable professional standards. The Social Services POC is initially developed from the information gathered from the social history and evaluation. This plan should include the Social Worker's evaluation of the resident's motivational capacities, functional level, strengths, and weaknesses. Plans and goals should be made to improve or

maintain the family and resident's strengths. Weaknesses of the family or resident should also be evaluated with plans to minimize, eradicate, or control maladaptive behavior or other problem situations. Other social or emotional needs of the resident should also be considered and addressed with specific goals and objectives. The care plans must include measurable goals with realistic time frames. The Social Services POC must be recorded in the resident's record, evaluated, and updated with the resident's participation as needed and at least every 90 days;

- **Social Services Progress Notes** - Progress notes are to be written as often as needed, but at least every 90 days, when the care plan is evaluated and updated; and

- **Discharge Planning** - Discharge planning must be a part of the original Social Services POC and must be updated every 90 days. It is the responsibility of the Social Services staff to know the family and community resources that could be of benefit to the resident at the time of discharge. Discharge planning should be an ongoing process in the continuing care of the resident and should be an integral part of the total care plan.

  Transfer trauma will be significantly reduced if the resident (and family) begin to think of discharge at the time of admission and throughout the stay rather than at the time of discharge. While it is recognized that discharge plans are not feasible for some residents, it is still necessary to re-evaluate the status of each resident periodically and to note the reason discharge plans are not currently feasible. Social Services documentation is expected to demonstrate at least the minimum standards of insightful and realistic evaluation, planning, and follow-through skills.

  When the NF anticipates discharge, a resident must have a discharge summary that includes a recapitulation of the resident's stay and a post-discharge POC, which will assist the resident to adjust to his/her new living environment.

<u>Activities - IMDs</u>

The NF must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. The activities program must be directed by a qualified professional who is a Qualified Therapeutic Recreation Specialist and is certified by the National Council for Therapeutic Rehabilitation in which he/she is practicing or has two years of experience in a social or recreational program within the last five years, one of which was full-time in a Resident Activities Program in a health care setting, or who is a Qualified Occupational Therapist or Occupational Therapy Assistant. The Activity Director will maintain a current list of residents for whom precautions are noted, which might restrict or modify their participation. The activity program is designed to encourage each resident to: 1) maintain normal activity, 2) return to self-care, and 3) maintain an optimal level of psychosocial functioning. Activities documentation requirements are as follows:

- **Activities Assessment** - A thorough evaluation of an individual's interests, past hobbies, skills, physical and mental status, personal care requirements,

and functional capabilities must be performed within 14 days of the individual's admission to the NF;

- **Activities Plan of Care** - The Activities POC must be based on the comprehensive admission assessment. Individual and group activities must be included in the POC. The Activities POC must be updated as needed, but not less often than every 90 days; and

- **Activities Progress Notes** - The activity record for each resident must include the resident's participation or refusal to participate in the activities and efforts to motivate the uninvolved, as well as the progress toward meeting these established measurable goals within realistic time frames. Progress notes must be written as needed and every 90 days when the POC is updated and reviewed.

Dietary Services - IMDs

Each resident record must contain a dietary evaluation and POC. The initial evaluation must be completed within 14 days of the individual's admission to the NF and must include any dietary restrictions as well as food preferences of the individual. The POC must have measurable goals with realistic time frames. This plan must be updated as needed and at least every 90 days for NF residents. Progress notes should be written as needed and at least every 90 days.

These POCs and progress notes may be written by a Qualified Dietary Supervisor, except when the resident has an obvious need for professional dietary intervention. For instance, it would be expected that the Dietitian, rather than a Dietary Supervisor, would be directly involved when the resident has problems with diabetes control, excessive unexpected weight loss or gain, or any newly-diagnosed medical condition in which dietary changes or controls are required. The NF must employ a qualified Dietitian either full-time, part-time, or on a consultant basis.

The NF must provide each resident with a nourishing, palatable, and well-balanced diet that meets the daily nutritional and special dietary needs of each resident. Menus must be prepared in advance and followed. Substitutes of a similar nutritive value must be offered to residents who refuse the foods served.

Rehabilitation Therapies - IMDs

If Rehabilitative Services (such as Physical Therapy, Occupational Therapy, or Speech Language Pathology Services) are required in the resident's comprehensive POC, the NF must provide the required services or obtain the required services from a provider of Rehabilitative Services. An initial assessment must be completed upon referral. The POC must be updated as needed, but not less often than every 90 days. Progress notes are to be written at least monthly. Documentation must contain objective and measurable information so that progress, maintenance, or regression can be noted from one report to the next when describing transfers, ambulation, wheelchair mobility, ADLs (dressing, feeding, bowel or bladder programs, etc.), and ROM. All Rehabilitative Services rendered by a rehabilitative professional shall be performed only upon a written medical referral by a Physician.

Rehabilitative Services may be indicated when the resident has lost or has shown a change in his/her ability to respond to or perform a given task and requires professional

Rehabilitative Services in an effort to restore lost function. Rehabilitative Services may also be indicated to evaluate the appropriateness and individual response to the use of Assistive Technology (AT). When the resident reaches his/her anticipated potential, he/she should be discharged from professional Rehabilitative Services, and efforts should be made to transfer his/her learned skills to the nursing unit.

Physical Therapy Services can be provided by Licensed Physical Therapists or Physical Therapy Assistants licensed by the Board of Medicine or a Physical Therapy Aide. The Physical Therapist's responsibilities are to evaluate a resident, plan the treatment program, and administer and document the treatment within the limit of his/her professional knowledge, judgment, and skills.

A Physical Therapist Assistant is permitted to perform all Physical Therapy functions within his/her capabilities and training as directed by a Physical Therapist. The scope of such functions excludes the initial evaluation of the resident, the initiation of new treatments, and the alteration of the POC of the resident. Direction by the Physical Therapist shall be as follows:

- The initial resident visit must be made by the Physical Therapist for the evaluation of the resident and the establishment of the POC;
- The Physical Therapist Assistant's first visit to the resident must be made jointly with the Physical Therapist;
- The Physical Therapist must provide on-site supervision during one of every five visits made to the resident by the Physical Therapist Assistant during a 30-day period. Should there be fewer than five visits to a resident by the Physical Therapist Assistant in a 30-day period, the Physical Therapy Assistant must be supervised on-site at least once during that period by the Physical Therapist; and
- Failure to abide by this regulation due to the absence of the Physical Therapist in case of illness, vacation, or a professional meeting for a period not to exceed five consecutive days, will not constitute a violation of the foregoing provisions.

A Physical Therapist may not delegate Physical Therapy treatments to Physical Therapy Aides, except those activities that are available without prescription in the public domain. Supervision of a Physical Therapy Aide means that a Licensed Physical Therapist or Licensed Physical Therapy Assistant must be within the home to give direction and instruction when procedures or activities are performed. Such non-licensed personnel must not perform those resident care functions that require professional judgment or discretion.

Occupational Therapy Services may be provided by an Occupational Therapist registered and certified by the American Occupational Therapy Certification Board or an Occupational Therapy Assistant certified by the American Occupational Therapy Certification Board under the direct supervision of an Occupational Therapist. Occupational Therapy Services are not strictly limited to "Occupational" Services, but may also include training for ADLs (dressing, hygiene, mobility, etc.), Cognitive Remediation, Homemaking Activities, or the use of AT. The treatment plan developed by the Occupational Therapist may be implemented by the Registered Occupational

Therapist or the Certified Occupational Therapy Assistant under the supervision of a Registered Occupational Therapist.

Speech Language Pathology Services may be provided by a Speech Language Pathologist licensed by the Board of Audiology and Speech Pathology. These services may address concerns with the production of speech, voice, and language, as well as disorders with perception and recognition and dysphagia.

Pharmacist Medication Review - IMDs

A Pharmacist must review medications quarterly in IMDs. Documentation should indicate a review of medications for each recipient with a dated and signed statement of the appropriateness of the Drug Therapy regimen and if there are potential problems with the therapy. In instances where potential problems are identified, the Pharmacist must notify the attending Physician and the Director of Nursing, and this report must be acted upon. The documentation must include the month, day, and year and must be signed with the first initial and last name followed by "Pharmacist" or "R.Ph." Quarterly is defined as approximately every 90 days.

A grace period of no more than 10 days will be allowed. The medical record must contain all action taken by the Physician or Director of Nursing in response to notification by the Pharmacist.

Comprehensive (Interdisciplinary) Care Plan - IMDs

Facilities must develop a Comprehensive Care Plan for each resident that includes measurable objectives and time tables to meet the resident's medical, nursing, and psychosocial needs that are identified in the comprehensive assessment. The Comprehensive Care Plan must be developed within seven days after the completion of the resident assessment. The Comprehensive Care Plan must be prepared by an Interdisciplinary Team that includes the attending Physician, a RN with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, including Nurses, Social Workers, Activity Coordinators, Dietitians, Therapists, administrative personnel, and direct care staff. To the extent practicable, the resident and his/her family or legal representative must participate. At a minimum, the Nurse, Social Worker, Dietary Supervisor, and Activity Coordinator must review and update the Comprehensive Care Plans at least every 90 days.

Psychiatric Assessments - IMDs

In addition to the above requirements, there must be a psychiatric assessment in the medical record for IMD residents.

SECTION V: INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MRs)

ADMISSION PROCESS

All ICF/MRs, except state facilities, must complete and submit the DMAS-121, DMAS-121A, and DMAS-119 forms to the Facility and Home-Based Services Unit of DMAS. State ICF/MRs must submit the DMAS-119 and DMAS 121A forms. Forms will

be returned to the facilities after the review is completed, along with the control number for billing.

These forms must be completed at the time of admission or when an application for medical assistance is completed. They are also required if the recipient is on convalescent leave for more than 60 days or when there has been a change in the level of care. The forms must be completed in their entirety, reflect the justification and support for the certified level of care, and be signed and dated by the Physician.

UTILIZATION REVIEW (UR) - ICF/MRs

Federal regulations require that DMAS provide for the continuing review and evaluation of the care and services covered by DMAS. This includes review of the utilization of the services rendered by providers to mentally retarded recipients.

The NF has responsibility for documenting that:

- The services available in the NF are adequate to meet the health needs of each recipient, as well as the rehabilitative and social needs of each recipient, and to promote his/her maximum physical, mental, and psychosocial functioning;

- It is necessary and desirable for the recipient to remain in the NF;

- It is feasible to meet the recipient's health and rehabilitative needs through alternative Institutional or Non-Institutional Services; and

- Each recipient in an institution for the mentally retarded, or persons with related conditions, is receiving Active Treatment.

Payment denied or retracted for lack of Active Treatment, as well as reinstatement of payment, will be based on the absence or presence of a continuous Active Treatment Program. The components of Active Treatment are a comprehensive functional assessment, the individual program plan (IPP), program implementation, program documentation, and program monitoring and change. All components of Active Treatment are based on the client's need for care and services as identified in the functional assessment. Documentation of the client's progress, or lack of progress, is based on the client's condition and the requirements for documentation found in the IPP.

While there is no requirement for a given number or type of programs to be offered to each recipient, it is expected that the client's schedule will embody the requirements of Active Treatment so that each recipient receives a continuous program directed toward the acquisition of behaviors necessary for the recipient to function with as much self-determination and independence as possible and toward the prevention, deceleration, regression, or loss of current optimal functional status. Prolonged periods of unscheduled time or inappropriately scheduled time will result in a close review of whether the recipient is, in fact, receiving Active Treatment.

In making the determinations on the adequacy of services and related matters, DMAS may consider the following:

- The medical evaluation, any required social and psychological evaluations,

and the IPP are complete and current; the IPP is followed; and all ordered services are provided and properly recorded;

- The attending Physician reviews prescribed medications at least quarterly;
- Tests or observations of each recipient indicated on his/her medication regimen are made at appropriate times and properly recorded;
- Physician, Nurse, and other professional progress notes are made as required and appear to be consistent with the observed condition of the recipient;
- The recipient receives adequate services, based on such observations as: cleanliness; absence of skin breakdown; absence of signs of malnutrition or dehydration; and apparent maintenance of maximum physical, mental, and psychosocial functions;
- The recipient receives adequate Rehabilitative/Habilitative Services (both Skilled and Restorative), as evidenced by a planned program of activities to prevent regression and encourage progress toward meeting objectives of the IPP;
- The recipient needs any service that is not furnished by the NF or through arrangements with others; and
- The recipient needs continued placement in the NF or there is an appropriate plan to transfer the recipient to an alternate method of care.

The NF must have written agreements with outside resources to furnish the required services not directly provided by the NF, and the NF must assure that the outside services meet the client's needs.

Desk Reviews

Semi-annual Desk Reviews are to be completed by the local NF to determine whether the resident continues to meet the criteria for continued stay.

The Desk Review in state-owned facilities has been carried out through an agreement with the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). These facilities are responsible for the completion of the assessment and review (effective January 1, 1998). The assessment and documentation of the review will be kept as part of the resident's medical record and must be available for review upon request by DMAS staff.

ICF/MRs not operated by the state are referred to as community ICF/MRs. They provide programming, often in conjunction with workshops, emphasizing prevocational skill training. The semi-annual Desk Review is conducted by the completion of an assessment by the NF. This assessment, the MR-77 and MR-77A forms, identifies the recipient's physical condition, intellectual functioning, functional capabilities, the programs provided, and the client's response to programs. (Note: St. Mary's Infant Home uses the DMAS-118A form as the Desk Review assessment.) Community ICF/MRs do not have to submit the assessment to DMAS (effective January 1, 1998).

The assessment and documentation of the review will be kept as part of the resident's medical record and must be available for review upon request by DMAS staff.

Those performing the UR will review and evaluate the documentation described in 42 CFR § 456.411 against the criteria developed under § 456.432 and will apply close professional scrutiny to cases described under § 456.432(b). If the recipient is found to meet the continued stay requirements, a new review date is assigned in accordance with § 456.434. If the resident does not meet the criteria for continued stay, notify the DMAS Long-Term-Care Unit of these findings in writing.

BILLING FOR SKILLED REHABILITATIVE SERVICES

When Skilled Rehabilitative Services are appropriately provided directly to the Medicaid recipient by an enrolled Outpatient Rehabilitation provider, they may be billed to Medicaid by the Outpatient Rehabilitation provider. When reasonable and necessary Skilled Rehabilitative Services are provided to the NF (e.g., staff instruction and program monitoring), they are not billable to Medicaid for a specific recipient; however, they are considered an administrative cost and must be billed to the ICF/MR. Reasonable and necessary administrative cost will be considered under the cost settlement process for the ICF.

ACTIVE TREATMENT - ICF/MRs

The components of Active Treatment are a comprehensive functional assessment, the IPP (Individual Program Plan), program implementation, program documentation, and program monitoring and change. Recipients who are admitted to an ICF/MR must need and receive Active Treatment, and admission decisions must be based on a preliminary evaluation that contains background information and currently valid assessments. Each Medicaid recipient must be receiving Active Treatment for his/her needs. "Active Treatment" includes each of the following:

- Each recipient must receive a continuous Active Treatment program, which includes the aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services directed toward:

  1) The acquisition of behaviors necessary for the recipient to function with as much self-determination and independence as possible; and

  2) The prevention or deceleration of regression or loss of current optimal functional status. (Active Treatment does not include services to maintain generally independent recipients, who are able to function with little supervision or in the absence of a continuous Active Treatment program.);

- Each recipient must have an IPP developed by an Interdisciplinary Team representing professions, disciplines, or service areas relevant to identifying the client's needs and designing programs to meet those needs; and

- Appropriate home staff must participate in Interdisciplinary Team meetings. Participation by the recipient and his/her parent or guardian is required unless unobtainable or inappropriate. Meetings should be scheduled and conducted to facilitate the participation of all team members, the individual,

and the individual's guardian or legal representative. Documentation must show that appropriate staff, the recipient, and the client's guardian or legal representative were asked to participate in the meetings, and absences must be documented.

DOCUMENTATION REQUIREMENTS - ICF/MRs

Recipient Records

The NF must develop and maintain a record-keeping system that includes a separate record for each recipient; that documents the client's health care, Active Treatment, and social information; and that protects the client's rights. The NF must keep confidential all information contained in the client's records, regardless of the form or storage method of the records. The NF must develop and implement policies and procedures governing the release of any recipient information, including consents necessary from the recipient or parents (if the recipient is a minor) or legal guardian. Any individual who makes an entry in the record must make it legibly and sign with the first initial, the last name, and the title and completely date the entry with the month, day, and year. Care rendered by personnel under the supervision of responsible licensed personnel must be countersigned by the licensed staff. The NF must provide a legend to explain any symbols or abbreviations used in a client's record. The record must identify the recipient on each page. The NF must provide each identified residential living unit with appropriate aspects of each client's record.

The client's record must fully document the client's condition, needs, and all services provided. Any information that cannot be verified in the client's record will be considered not applicable to the recipient. Services not specifically documented in the recipient record as having been rendered shall be deemed not to have been rendered. When it is determined that Active Treatment has not been provided, Medicaid will not continue to make payment. If payment has already been made, the reimbursement shall be retracted.

Program Documentation

The ICF/MR determines the type of data it wishes to collect, as long as the data is relevant to accurate measurement of the criteria stated in the individual's current IPP objectives. Data relative to the accomplishment of the criteria specified in the recipient's IPP objectives must be documented in measurable terms. The NF must document significant events that are related to the client's IPP and assessments that contribute to an overall understanding of the client's ongoing level of functioning. Data is defined to be performance information collected and reported in numerical or quantifiable form on training objectives assigned priority in the IPP. Data are those performance measurements recorded at the time the treatment, procedure, intervention, or interaction occurs with the individual. In addition, they should be located in a place accessible to staff who conduct training.

Professional summaries must be written by the individual disciplines that provide services to a recipient. Summaries must include such information as why programs were not attended or scheduled and an indication of whether there has been progress, regression, or stability for the period of time being reviewed. Target dates must be current, and the program must be appropriate for the recipient. Information on the

summaries is an important, though not the sole determinant of whether Active Treatment has been provided. Payment denied or retracted for lack of Active Treatment, as well as reinstatement of payment, will be based on summary data.

Physician's Documentation

It is the Physician's responsibility to properly sign (name and title) and date (month, day, and year) all required Physician documentation. If a Physician chooses to use a rubber stamp on documentation requiring his/her signature, the Physician whose signature the stamp represents must provide the home administration with a signed statement to the effect that he/she is the only person who has the stamp and is the only one who will use it. The Physician must initial and completely date all rubber-stamped signatures.

"Renew orders" are acceptable if all current orders are on the same page of the Physician's order sheet. The most current page of Physician's orders must be the first page of the Physician's orders section in the recipient record. All services provided must be entered in the recipient record. Any drugs prescribed as part of a Physician's treatment plan must include the quantity, frequency, route of administration, and dosage.

Note the related requirements in the following sections: "Certification and Recertification for Inpatient Care," "Physician's Plan of Care (POC)," and "Professional Services."

Dental Services Documentation

If a NF maintains an In-House Dental Service, the NF must keep a permanent dental record for each recipient, with a dental summary maintained in the client's living unit. If the NF does not maintain an In-House Dental Service, the NF must obtain a dental summary with the results of dental visits and maintain the summary in the client's living unit.

Note the related requirements in the following section: "Professional Services."

Pharmacy Services Documentation

The Pharmacist must prepare a record of each client's drug regimen reviews, and the NF must maintain that record. An individual Medication Administration Record must be maintained for each recipient. Drug administration errors and adverse drug reactions must be recorded and reported immediately to a Physician. The NF must maintain records of the receipt and disposition of all controlled drugs. The NF must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV.

Documentation must include the month, day, and year and must be signed with the first initial and last name followed by "Pharmacist" or "RPh."

Note the related requirements in the following section: "Professional Services."

General Requirements and Definitions

All professional summary notes must be written as often as necessary, including points of contact with a recipient for intervention, treatment, or observation. Summary notes must describe the client's response to the intervention.

"Monthly" means approximately every 30 days. A grace period of no more than 10 days will be allowed. Documentation exceeding 40 days from the previous documentation will be considered out of compliance. "Quarterly" means approximately every 90 days. A grace period of no more than 10 days will be allowed. Documentation exceeding 100 days from the previous documentation will be considered out of compliance. "Annually" means approximately every 365 days. A grace period of no more than 10 days will be allowed. Documentation exceeding 375 days from the previous documentation will be considered out of compliance.

CERTIFICATION AND RECERTIFICATION OF NEED FOR INPATIENT CARE

Certification: A Physician must certify that Intermediate Care Facility (ICF) Services are needed for each applicant or recipient. The certification must be made at the time of admission or, if an individual applies for assistance while in an ICF, before the Medicaid agency authorizes payment.

Recertification: A Physician, or Physician Assistant or Nurse Practitioner acting within the scope of practice as defined by state law and under the supervision of a Physician, must recertify that ICF Services are needed for each applicant or recipient. Recertification must be made at least every 12 months after certification.

PRE-ADMISSION EVALUATION REQUIREMENTS

Admission decisions must be based on a preliminary evaluation of the individual that is conducted or updated by the NF or by outside resources. The preliminary evaluation must contain background information, as well as currently valid assessments of functional, developmental, behavioral, social, health, and nutritional status, to determine whether the NF can provide for the individual's needs and whether he/she is likely to benefit from placement in the NF.

A psychological evaluation must be made before admission or authorization for payment, but not more than three months before admission. In addition, there must be an evaluation of the resources available in the NF, family, and community. If an individual becomes Medicaid-eligible after admission, these evaluations must be completed before authorization for Medicaid payment.

DISCHARGE AND TRANSFER REQUIREMENTS

Consideration of the appropriateness of community alternatives must be a part of the annual review. It is the responsibility of NF staff to know the family and community resources that could be of benefit to the recipient at the time of discharge. No admission should be regarded as permanent.

If a recipient is to be either discharged or transferred, the NF must: 1) have documentation in the client's record that the recipient was transferred or discharged for

good cause; and 2) provide a reasonable time to prepare the recipient and his/her parents or guardian for the transfer or discharge (except in emergencies). At the time of the discharge, the home must: 1) develop a final summary of the client's developmental, behavioral, social, health, and nutritional status and, with the consent of the recipient, parents (if the recipient is a minor), or legal guardian, provide a copy to authorized persons and agencies; and 2) provide a post-discharge POC that will assist the recipient with adjusting to the new living environment.

PHYSICIAN'S PLAN OF CARE (POC)

Before admission to an ICF/MR or before authorization for payment, a Physician must establish a written POC for each recipient. The POC must include diagnoses, symptoms, complaints, and complications indicating the need for admission; a description of the functional level of the individual; objectives; any orders for medications, treatments, Restorative and Licensed Rehabilitative Services, activity restrictions, therapies, Social Services, diet, and special procedures or treatments designed to meet the objectives of the POC (Medical/Nursing/Skilled Rehabilitative Services); plans for continuing care, including review and modification of the POC; and plans for discharge. This documentation may be found in the history and physical examination, physician orders, and in progress notes.

A Physician must develop, with Licensed Nurses, a medical care plan for recipients who are determined to require 24-hour Licensed Nursing Care. This plan must be integrated with the IPP. The Physician must perform a complete physical examination of each recipient annually which must include vision and hearing evaluations, immunizations, routine lab studies, and tuberculosis control.

Each recipient must remain under the care of a Physician. On admission, the NF must have Physician orders for the client's immediate care. The Physician's POC must be reviewed at least every 90 days. Physician notes must be written as often as necessary, including points of contact with a recipient for treatment or observation. The Physician must visit the recipient when there is a significant change in the client's medical condition.

COMPREHENSIVE FUNCTIONAL ASSESSMENT

Within 30 days after admission, the Interdisciplinary Team must perform accurate assessments or re-assessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the client's age and the implications for Active Treatment and:

(a) Identify presenting problems and disabilities and, when possible, their causes;

(b) Identify the client's specific developmental strengths;

(c) Identify the client's specific developmental and behavioral management needs;

(d) Identify the client's needs for services without regard to the actual availability of the services needed; and

(e) Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development, auditory functioning, cognitive development, social development, adaptive behaviors, and, as applicable, vocational skills.

INDIVIDUAL PROGRAM PLAN (IPP)

The IPP (encompassing services to be provided by all members of the Interdisciplinary Team) is developed based on the comprehensive functional assessment, implemented as designed, and monitored by the team. The IPP includes the Physician POC.

Within 30 days after admission, the Interdisciplinary Team must prepare an IPP for each recipient that states specific objectives and a planned sequence for dealing with these objectives. Program objectives must be stated separately, in terms of a single behavioral outcome; be assigned completion dates; be expressed in measurable terms; be organized to reflect developmental progression; and be assigned priorities.

Each written training program, designed to implement the objectives in the IPP, must specify the methods to be used; the schedule (including the frequency and duration of a planned activity); the responsible person; the type of data and frequency of data collection; inappropriate recipient behaviors, if applicable; and a provision for the appropriate expression of behavior, if applicable. As indicated by the recipient needs, the IPP must also:

- Describe relevant interventions to support the individual toward independence;
- Identify the location where program strategy information can be found;
- Include, for those recipients who lack them, the personal skills training necessary for privacy and independence (including, but not limited to, toileting, hygiene, feeding, bathing, dressing, grooming, and communication of basic needs);
- Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment;
- Specify the reasons for each support, the situations in which each is to be applied, and a schedule for the use of each support;
- Provide that recipients, who have multiple disabling conditions, spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible; and
- Include the opportunities for recipient choice and self-management.

A copy of each client's IPP must be made available to all relevant staff (including staff of other agencies who work with the recipient), the recipient, parents, (if the recipient is a minor), or legal guardian.

PROGRAM IMPLEMENTATION

As soon as the Interdisciplinary Team has formulated a client's IPP, each recipient must receive a continuous Active Treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the IPP. The NF must develop an Active Treatment schedule that outlines the current Active Treatment program and that is readily available for review by relevant staff. Except for those facets of the IPP that must be implemented only by licensed personnel, each client's IPP must be implemented by all staff who work with the recipient, including professional, paraprofessional, and non-professional staff.

PROGRAM MONITORING

The IPP must be reviewed at least by the Qualified Mental Retardation Professional (QMRP) and revised as necessary, including, but not limited to, situations in which the recipient: 1) has successfully completed an objective or objectives identified in the IPP; 2) is regressing or losing skills already gained; 3) is failing to progress toward identified objectives after reasonable efforts have been made; or 4) when the recipient is being considered for training toward new objectives.

At least annually, the comprehensive functional assessment of each recipient must be reviewed by the Interdisciplinary Team for relevancy and updated as needed. The IPP must be revised, as appropriate.

QUALIFIED MENTAL RETARDATION PROFESSIONAL (QMRP)

Each client's Active Treatment program must be integrated, coordinated, and monitored by a QMRP. It is the responsibility of the QMRP to ensure the delivery of each client's IPP, integrating the various aspects of the NF's program, record each client's progress, review the client's IPP, and ensure that the individual receives those services and interventions necessary by competent persons capable of delivering them. The QMRP is responsible for serving as the primary advocate for the individual and for ensuring that monitoring functions are completed appropriately. QMRPs must have at least one year of direct experience with persons with mental retardation or a developmental disability and be a Physician or Nurse or have at least a bachelor's degree in Occupational Therapy, Physical Therapy, Speech Language Pathology, Psychology, Social Work, Audiology, Recreation, or a human services field.

The Interdisciplinary Team or the QMRP must review each IPP at least every 90 days. A report of each evaluation and IPP must be entered in the client's record. The IPP must be reviewed by the QMRP and revised as necessary, including but not limited to, the situations listed above under "Program Monitoring."

BEHAVIOR MANAGEMENT - ICF/MRs

The NF must designate and use a specially constituted committee to review and approve an individual program designed to manage inappropriate behavior and other programs involving risks to recipient protection and rights. The NF must develop and implement written policies and procedures for the management of conduct between staff and recipients which promote recipient independence, emphasize self-determination, specify allowable conduct, and are available to all staff, recipients, parents of minors, and legal guardians. The NF must also have written policies and procedures governing the management of inappropriate recipient behavior which

specify the approved interventions, designate interventions in a hierarchy, ensure that less intrusive techniques are used and deemed ineffective before more intrusive techniques are used, and address the use of time-out rooms, physical restraints, drugs, noxious stimuli, authorized staff, and a monitoring system. Interventions must be used with sufficient safeguards and supervision, and techniques must not be for disciplinary purposes, staff convenience, or as a substitute for Active Treatment. The use of systemic interventions must be incorporated in the client's IPP. Recipients must be free from unnecessary drugs or restraints.

PROFESSIONAL SERVICES

Physician Services

The NF must ensure the availability of Physician Services 24 hours a day. The Physician must develop, in coordination with licensed nursing personnel, a Medical Care Plan of Treatment for a recipient if the Physician determines that recipient requires 24-hour Licensed Nursing Care. This plan must be integrated into the IPP. The NF must provide or obtain preventive and general care as well as annual physical examinations of each recipient that, at a minimum, include an evaluation of vision and hearing, immunization, routine screening laboratory examinations as determined necessary by the Physician, special studies when needed, and tuberculosis control. If appropriate, Physicians must participate in the review and update of the Interdisciplinary Team process either in person or through written report to the team.

The attending Physician must review prescribed medications at least quarterly.

A Physician, Physician Assistant, or Nurse Practitioner, as defined by state law and under the supervision of a Physician, must recertify at least annually that ICF/MR Services continue to be needed. While facilities may utilize Physician Assistants and Nurse Practitioners to provide Physician Services, there are certain tasks that a Physician must perform under Medicaid utilization control guidelines. These tasks, which a Physician must perform, include: the initial certification that ICF/MR Services are needed; the development of the Medical POC (including orders for medications, therapies, diet, activities, etc.); and the quarterly review of each client's prescribed medications. A Physician Assistant or Nurse Practitioner may perform other Physician tasks in an ICF/MR for which there is no specific requirement that a Physician perform them.

Nursing Services

Facilities must provide recipients with Nursing Services in accordance with their needs. When the Physician determines that a Medical POC is not required, a Nurse must perform a review of the client's health status, which must:

1) Be by a direct physical examination;

2) Be by a Licensed Nurse;

3) Be on a quarterly or more frequent basis depending on recipient need;

4) Be recorded in the client's record; and

5) Result in any necessary action, including referral to a Physician and the Interdisciplinary Team.

Nursing documentation must be performed by a Licensed Nurse, be recorded in the client's record, and result in any necessary action, such as referral to a Physician. Any drugs or treatments administered or provided as part of a Physician's treatment plan must be entered in the record, regardless of who administers the drug or provides the treatment.

A Nurse must participate as appropriate in the development, review, and update of the IPP and must develop, with the Physician, a Medical POC, if required.

Nurses providing services in the NF must have a current license to practice in the state. The NF must employ or arrange for Licensed Nursing Services sufficient to care for clients' health needs including those recipients with Medical POCs. The NF must utilize RNs as appropriate and required by state law to perform the health services specified in this section. If the NF utilizes only Licensed Practical or Vocational Nurses to provide health services, it must have a formal arrangement with a RN to be available for verbal or on-site consultation with the Licensed Practical or Vocational Nurses. Non-licensed nursing personnel who work with recipients under a Medical POC must do so under the supervision of licensed persons.

Dental Services

The NF must provide or make arrangements for Comprehensive Diagnostic and Treatment Services for each recipient from qualified personnel, including Licensed Dentists and Dental Hygienists either through organized Dental Services in-house or through arrangement. Comprehensive Dental Diagnostic Services include a complete extra-oral and intra-oral examination, not later than one month after admission to the NF unless the examination was completed within 12 months before admission; periodic examination and diagnosis performed at least annually; and a review of the results of examination and entry of the results in the client's dental record. The NF must ensure Comprehensive Dental Treatment Services that include the availability for Emergency Dental Treatment on a 24-hour-a-day basis by a Licensed Dentist and Dental Care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

Pharmacy Services

The NF must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its recipients. Drugs and biologicals may be obtained from community or contract Pharmacists or the NF may maintain a licensed pharmacy. A Pharmacist, with input from the Interdisciplinary Team, must review the drug regimen of each recipient at least quarterly. The Pharmacist must report any irregularities in clients' drug regimens to the prescribing Physician and Interdisciplinary Team. As appropriate, the Pharmacist must participate in the development, implementation, and review of each client's IPP either in person or through written report to the Interdisciplinary Team.

Laboratory Services

If the NF chooses to provide Laboratory Services, the Laboratory Director must be technically qualified to supervise the laboratory personnel and test performance and must meet licensing or other qualification standards established by the state with respect to Directors of Clinical Laboratories. The Laboratory Director must provide adequate technical supervision of the Laboratory Services and assure that tests, examinations, and procedures are properly performed, recorded, and reported. The Laboratory Director must ensure that the staff has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently.

Food and Nutrition Services

A qualified Dietitian must be employed at least on a consultant basis. If the Dietitian is not full-time, the NF must designate a Director of Food Services.

Physical Therapy, Occupational Therapy, and Speech Language Pathology Services

Physical Therapy means services prescribed by a Physician and provided to a recipient by or under the direction of a qualified Physical Therapist. Occupational Therapy means services prescribed by a Physician and provided to a recipient by or under the direction of a Qualified Occupational Therapist. Services for individuals with speech, language, and hearing disorders means Diagnostic, Screening, Preventive, or Corrective Services provided by or under the direction of a Speech Pathologist or Audiologist, for which the recipient is referred by a Physician. Routine communication programs, which are not the result of a specific speech, language, or hearing disorder, do not need a Physician referral, nor do they require summary notes by the Speech Language Pathologist unless he/she is directly involved in implementing the program.

When Physical Therapy, Occupational Therapy, or Speech Language Pathology Services are provided, there must be an initial assessment and measurable objectives with assigned completion dates in the recipient record. For recipients requiring Physical Therapy, Occupational Therapy, or Speech Language Pathology Services, there must be an annual reassessment as part of the Interdisciplinary Team Review.

As directed by the IPP, summary notes must be written for recipients receiving Physical Therapy, Occupational Therapy, or Speech Language Pathology Services when they are provided by or under the direction of a Skilled Rehabilitation Therapist (such as by a Physical Therapy or Occupational Therapy Assistant). If services are rendered directly by the Skilled Therapist, the Therapist must write the note.

If therapy is rendered by an assigned program staff member (such as direct care staff), he/she can write the summary note that must be written as often as outlined in the IPP. However, the Therapist continues to be responsible for reviewing the IPP and presenting revisions or updates to the Interdisciplinary Team. The recipient record must document dates, treatment provided, and who provided the services.

DENIAL OF PAYMENT: ACTIVE TREATMENT NOT PROVIDED

One of the functions of the Inspections-of-Care Review is to ensure that Active Treatment is being provided. The reviewer will evaluate the care actually being provided based on the following documented evidence:

- A comprehensive functional assessment;
- An IPP;
- Program implementation;
- Program documentation; and
- Program monitoring and change.

The needs, abilities, and skills deficits of the recipient are considered in the evaluation of the provision of Active Treatment. It is essential that programs and training be established and carried out on a case-by-case basis to ensure the continued payment for the client's care. If the recipient is not receiving Active Treatment, payment will be denied.

The reviewer's recommendation will be evaluated by management staff. If the evaluators support the recommendation, then written notice will be sent to the NF that payment will be denied effective the date of the review. The NF may request a reconsideration of this decision to deny payment. The request should include:

- A completed DMAS-121A form;
- A Strengths and Deficits List;
- A copy of the daily activity sheet and program attendance records;
- Program plans, including objectives and methods used to implement the IPP;
- Summary notes; and
- Any other documentation, which may demonstrate that appropriate and adequate programming is being provided.

The request should be sent to:

Manager, Long Term Care Operations Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The NF will receive written notice of the reconsideration decision. Following that notice, the recipient or the responsible party may appeal this denial of payment. The process for the recipient appeal of this decision is the same as for the level-of-care decisions. To be considered valid, the appeal must be submitted within 30 days of the receipt of the letter. It should be addressed to: Manager, Long-Term-Care Operations Unit. The Administrator, on behalf of the NF, makes a written request for reconsideration within 30 days. Refer to Chapter II of this manual for the procedure under the "Reconsideration of Adverse Actions" section.

EXHIBITS

(NOTE: The following documents and forms related to this chapter can be downloaded from the DMAS website at www.dmas.virginia.gov.)

- Social History Form (MAP-119, Revised 4/74)

- Certificate of Patient Status (MAP-121, Revised 7/78)
- Certificate of Patient Status - Rehabilitative Service - Intermediate Care Facility (MAP-121A, Revised 1/73)
- Admission/Authorization - Specialized Care Bed/Long-Stay Acute Care Hospitals
- Cover Sheet (SPEC-100)
- ICR/MR Utilization Review Assessment Form (MR–77)
- Resident Developmental Status (MR-77)
- Patient Information Form (DMAS-122, Revised 12/98)
- Patient Intensity Rating System Review (PIRS) Form (DMAS-80)
- Sample MI/MR Screening Policy
- Serious Mental Disorders
- Remedy Matrix
- RUG Element Worksheet Using MDS 2.0 and Nursing Only CMIs