CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) or its designated contractor(s) conducts periodic utilization reviews on all programs. In addition, DMAS or its designated contractor(s) conducts compliance reviews on providers that are found to provide services that are not within the established Federal or State codes, DMAS guidelines, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that Participation Agreement, contracts, state and federal regulations, Medicaid Memos and Provider Manual requirements for services rendered are met in order to receive payment from DMAS and its contractors. Under the Participation Agreement/contract with DMAS, Magellan of Virginia and the Medicaid Managed Care Organizations (MCOs) the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives or its designated contractor(s), the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control procedures conducted by DMAS. The MCOs conduct audits for services provided to Members enrolled in Managed Care. Providers shall contact the specific MCO for information about the utilization review and control procedures conducted by the MCO.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

COMPLIANCE REVIEWS

DMAS or its designated contractor(s) routinely conduct compliance reviews to ensure that the services provided to Medicaid individuals are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455.

Providers and individuals are identified for review by system-generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group.

To ensure a thorough and fair review, trained professionals review all cases using available resources, including appropriate consultants, and perform on-site or desk reviews.

Overpayments will be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by DMAS, the Behavioral Health Services Administrator (BHSA) or the MCOs if they are found to have billed these entities contrary to law or manual requirements, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, DMAS, the BHSA or the MCOs may restrict or terminate the provider's participation in the program.

DMAS contracts with Health Management Systems, Inc. (HMS) to perform audits of FFS Mental Health Services in-state and out-of-state providers that participate in the Virginia Medicaid program. DMAS will also continue to audit mental health services as well. Providers that have been audited by HMS and have questions directly pertaining to their audit may contact HMS at: VABH@HMS.com

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading, understanding, and adhering to applicable state and federal regulations, Medicaid Memos, their provider agreement with DMAS or its contractor, and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature or the signature of his/her authorized agent on each invoice that all information provided to DMAS and its contractors is true, accurate, and complete. If provider attests to having all required licensed as required they must be able to furnish such documentation. Although claims may be prepared and submitted by an employee or contracted business partner, providers will still be held responsible for ensuring their completeness and accuracy.

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

Department of Medical Assistance Services
Division of Program Integrity
Supervisor, Provider Review Unit
600 East Broad Street
Richmond, Virginia 23219

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

Office of the Attorney General
Director, Medicaid Fraud Control Unit
202 North Ninth Street
Richmond, Virginia 23219

Member Fraud

Allegations about fraud or abuse by Medicaid enrolled individuals are investigated by the Recipient Audit Unit of the DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction

an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction. The sanction period may only be revoked or shortened by court order.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (LDSS) or to the DMAS Recipient Audit Unit via the RAU Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the RAU email address: recipientfraud@dmas.virginia.gov or forwarded to:

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

PATIENT UTILIZATION AND MANAGEMENT SAFETY PROGRAMS (PUMS)

The DMAS contracted MCOs must have a Patient Utilization Management & Safety Program (PUMS) for MCO enrolled members which is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and care coordination program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the MCO must refer members to appropriate services based upon the member's unique situation.

Once a Member meets the placement requirements for PUMS, the MCO may limit a member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO may limit a member to providers and pharmacies that are credentialed in their network.

If the member changes MCOs while the member is enrolled in a PUMS, the receiving MCO must re-evaluate the member within thirty (30) calendar days to ensure the member meets the minimum criteria above for continued placement in the health plan's PUMS.

UTILIZATION REVIEW – GENERAL REQUIREMENTS

Utilization reviews of enrolled providers are conducted by DMAS, the designated contractor or the MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

Utilization reviews are comprised of desk audits, on-site record review, and may include observation of service delivery and review of all provider policies and procedures and human resource files. Dependent upon the setting, the utilization review may also include a tour of the program. Staff will visit on-site or contact the provider to request records. Utilization Review may also include face-to-face or telephone interviews with the individual, family, or significant other(s), or all. In order to conduct an on-site review, providers may also be asked to bring program and billing records to a central location within their organization. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

DMAS and the MCOs shall recover expenditures made for covered services when providers' documentation does not conform to standards specified in all applicable regulations. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider’s care. Such documentation shall fully disclose the extent of services provided in order to support provider’s claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered or within one business day from the time the services were rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

The review will include, but is not limited to, the examination of the following areas / items:

- If a provider lacks a full or conditional license or a provider enrollment agreement does not list each of the services provided and the locations where the provider is offering services, then during a utilization review the provider will be subject to retraction for all unlisted service and/or locations.
- Health care entities with provisional licenses shall not be reimbursed by Medicaid.

- An assessment of whether the provider is following The U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009).
- An assessment of whether the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.).
- The appropriateness of the admission to service and for the level of care, and medical or clinical necessity of the delivered service.
- A copy of the provider's license/certification, staff licenses, and qualifications to ensure that the services were provided by appropriately qualified individuals and licensed facilities.
- Verification that the delivered services as documented are consistent with the documentation in the individual's record, invoices submitted, and specified service limitations.
- The reviewer determines that all documentation is specific to the individual and their unique treatment needs. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient services and may not be adequate recordkeeping mechanisms for these services.
- The reviewer determines whether all required aspects of treatment (as set forth in the service definitions) are being provided, and also determines whether there is any inappropriate overlap or duplication of services.
- The reviewer determines whether all required activities (as set forth in the appropriate sections of this manual and related regulations) have been performed.
- The reviewer determines whether inappropriate items have been billed.
- The reviewer determines whether the amount billed matches the documented amount of time provided to the individual.

Services must meet the requirements set forth in the Virginia Administrative Code (12 VAC 30) and in the Virginia State Plan for Medical Assistance Services and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

Upon completion of on-site activities for a routine utilization review, the MCO, DMAS, or its designated contractor(s) may be available to meet with provider staff for an Exit

Conference. The purpose of the Exit Conference is to provide a general overview of the utilization review procedures and expected timetables.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be noted. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting medical record documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, DMASor its designated contractor(s) will contact the provider to conduct an Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the provider.

If a billing adjustment is needed, it will be specified in the final audit findings report.

If the provider disagrees with the final audit findings report, they may appeal the findings. Refer to Chapter II for information on the provider appeal process.

MEDICAL RECORDS AND RETENTION

The provider must recognize the confidentiality of recipient medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The recipient's written consent is required for the release of information not authorized by law. Current recipient medical records and those of discharged recipients must be completed promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical/medical record.

Records of Medicaid covered services must be retained for not less than five years after the date of service or discharge. Records must be indexed at least according to the name of the recipient to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). Refer to 42 CFR 482.24 for additional requirements.

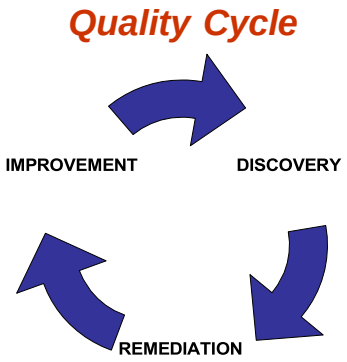
The provider must maintain medical records on all recipients in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. All medical record entries must be fully signed,

and dated (month, day, and year) including the title (professional designation) of the author. Documentation should be clear and legible.

QUALITY MANAGEMENT REVIEWS

~~If it is found that an individual no longer meets the waiver level of care, DMAS will terminate services in accordance with the procedures detailed in Chapter IV of this manual.~~

A typical QMR encompasses the follow elements:



Discovery: The review of documentation findings and individual interviews.

Remediation: Based on Discovery, the provision of technical assistance or provision of a corrective action plan ensure needed changes are implemented. Corrective action is taken by Provider to ensure compliance.

Improvement: The follow up activities to assure that recommended or mandated corrective
action and/or improvements to service delivery have been initiated**.**

By federal law, DMAS is the single state authority responsible for the supervision of the administration of home and community-based services waivers in the Commonwealth of Virginia and shall perform routine QMRs of waiver services and providers. QMRs are not to be confused with URs, which is a separate review, as described in this chapter.

DMAS analysts or its contractors shall conduct ongoing monitoring of provider compliance with DMAS participation standards and policies. QMR includes a review of the provision of services to ensure that services are being provided in accordance with DMAS regulations, policies and procedures. A provider's noncompliance may result in a request for a corrective action plan, provision of technical assistance, and/or referral to the

Division of Program Integrity. DMAS uses the following procedures when conducting a QMR:

- DMAS or its designated agent will conduct an on-site review and/or desk review of services rendered by providers periodically.
- The sampling method includes both random selections and records reviewed to examine specific variables, such as numbers of individuals served, types of services rendered, etc.
- QMR visits may be unannounced.
- Providers may be asked to bring program records to a central location.
- During an on-site QMR, staff will review the individual's record in the provider's place of business/office, paying specific attention to the Plan of Care, supervisory notes (RN and SF), daily records, support logs or progress notes, screening documentation, and any other documentation that is necessary to determine if services were rendered appropriately. Staff may also conduct home visits to meet and talk with individuals and/or their family/caregiver to determine satisfaction with waiver services and the provider. The provider may be asked to assist in setting up this visit.
- During the review, staff will offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. Upon completion of on-site activities for a QMR, DMAS staff will meet with designated staff to conduct an exit conference. The purpose of the exit conference is to provide a general overview of the QMR findings, preliminary actions required, and recommendations that may help the provider correct problems in documentation or billing practices.
- Following the QMR review, a written report of the findings is sent to the provider.
- If there are findings related to licensing procedures, a referral with these findings may be made to other agencies, as appropriate (e.g. Department of Health Professions, Department of Health).
- If a corrective action plan is requested, the provider will have 30 days (unless otherwise indicated) from receipt of the QMR report to submit the plan to DMAS or its contractor for approval. The provider may submit additional documentation that supports their corrective action plan.
- DMAS or its contractor will follow up with any corrective action plans that are submitted to ensure that corrective procedures are implemented by the provider.

When the team arrives at the provider's place of business/offices, the team will request a minimum number of records per team member in order to begin the review process. The QMR review team will also request the provider to provide the rest of the records on the review list within two (2) hours of their arrival time for open records and by close of business on the arrival day for closed records.

~~DMAS analysts with the Division of Integrated Care or its contractors shall conduct ongoing monitoring of compliance of a provider with DMAS participation standards and~~

~~policies. QMR includes a review of the provision of services to ensure that services are being provided in accordance with DMAS regulations, policies, and procedures. A provider's noncompliance may result in a request for a corrective action plan, provision of technical assistance, and/or referral to the Division of Program Integrity.~~

DMAS analysts shall conduct QMRs of waiver services provided to ensure the health, safety, and welfare of the individual and individual satisfaction with services. The reviews shall focus on the Centers for Medicare and Medicaid's (CMS) assurances of health, safety and welfare, level of care determination, plan of care, and qualified providers, including individual preferences and choices, services being delivered in accordance with the plan of care and the identification of inclusion and risk. In addition to assessing the individual's ongoing need for Medicaid-funded home and community based services (HCBS), another purpose of the reviews is to ensure a waiver individual's satisfaction with waiver services and providers, and that individual choice of services and person-centered planning are being carried out. This may involve interviews with the individual and/or the family/caregiver, as appropriate.

During the on-site QMR review, DMAS analysts monitor the provider's compliance with overall provider participation requirements. Providers must maintain separate employee files for each person hired and make available to QMR staff upon request. Particular attention is given to qualifications of provider staff such as work references (or proof in the personnel file of a good faith effort to obtain such references) and documentation of criminal background checks from the Virginia State Police ~~within 30 days of the date of hire~~, as described in Chapter II of this manual. However, no employee shall be permitted to work in a position that involves direct contact with an individual in the waiver until an original criminal background record clearance from the Virginia State Police has been received unless such person works under the direct supervision of another employee for whom a background check ~~or CPS (Child Protective Service)~~ check has been completed in accordance with the Code of Virginia. If the employee is hired to provide waiver services to a minor under the age of 18, the employee must also have a CPS check performed prior to initiating care to the minor with the CPS check documented in the employee's record. The employee record should contain proof that a check with the Virginia State Police, and as necessary the CPS check, has been requested and conducted within 30 days of hire; however, Virginia State Police rules state that the results of the background check should be properly destroyed and not disseminated to other parties or maintained in the employee's file. DMAS analysts will request to see health professionals' licenses, training certificates for personal care aides, etc. and required documentation that staff who have provided services meet all qualification requirements as identified in DMAS regulations and policies. The provider is responsible for ensuring that all staff of the provider meets the minimum requirements and qualifications at the start of the employment and continues to meet the requirements of the monthly LEIE list check compliance. Personal care aides hired by a personal care agency or an Adult Day Health Care Center must also receive 12 hours of training relating to their job responsibilities on

an annual basis. Such record of training, including the training subject, length, and date of training, must be maintained in the employee's record. Information on required documentation in employee files can be found in Chapter II of this manual.

During the QMR, DMAS analysts will discuss with the provider's administration the provider's overall status as a Medicaid provider, any areas of concern, technical assistance needs, the plans for addressing those needs, and any recommendations that staff may have. DMAS may also require additional documentation to verify that the provider is in compliance with DMAS provider agreements and policies, including requirements for ownership of provider agencies. It is the responsibility of the provider to know and fulfill all applicable state and federal requirements relating to the services the provider is authorized to provide per a Medicaid participation agreement.

Providers are continually assessed to ensure that they conform to Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, high-quality care to individuals who are receiving services through the Commonwealth Coordinated Care Plus (CCC Plus) waiver. Information used to make this assessment may include desk reviews of the documentation submitted by the provider, on-site reviews of the provider's files, interviews with staff and with individuals during visits to their homes or place of residence, and by responses to quality assurance survey letters.

DMAS analysts will base an assessment of the provider on a comprehensive evaluation of the provider's overall performance in relation to the following program goals:

1. Individuals served by the provider meet the waiver program's eligibility criteria. If DMAS determines, during the QMR or at any other time, that the individual receiving waiver services no longer meets eligibility standards or criteria for waiver enrollment and services as set forth in DMAS regulations, the provider shall notify level of care staff ~~within the DMAS Division of Aging and Disability Services (~~by emailing LOCreview@dmas.virginia.gov~~),~~ and request that the provider discuss alternative services with the individual. The provider has a responsibility to be aware of the criteria for the waiver program and to evaluate, on an ongoing basis, the individual's appropriateness for waiver services.

2. Services rendered must meet the individual's identified needs and be within the program's guidelines. The provider is responsible for continuously assessing the individual's needs through home visits made by the provider and communication between the provider, services facilitator, provider staff, the waiver individual and/or primary caregiver. The provider must be notified of any substantial change in the individual's status, the individual's record must contain documentation of any such change, and additional orders must be obtained from the physician, if appropriate. This also includes the provider's responsibility to identify and make

referrals for any other services that the individual requires to remain in the community (e.g., durable medical equipment and supplies, skilled nursing visits, etc.).

3. Provider documentation must support all services billed. For services that utilize Electronic Visit Verification, this includes the provider being able to present the appropriate DMAS-90 or electronic equivalent for the shifts being reviewed.

4. Services must be delivered by qualified individuals and providers as required and in accordance with the plan of care. The Plan of Care must be adequate and appropriate for the individual and revised at a minimum annually, and as needed to address changing needs. Services should be received in the frequency, duration, type, scope, and amount as specified in the Plan of Care.

5. Prepare and maintain unique person-centered progress note written documentation in each individual's record about the individual's responses to services and rendered supports and of specific circumstances that prevented provision of the scheduled service or visit, should that occur. Such documentation should be written, signed, and dated on the day that the services were provided. Documentation that occurs after the date services were provided must be dated for the date the entry is recorded and the date of actual delivery of services is to be noted in the body of the note. Examples of unacceptable person-centered progress notes may include:

   - Standardized or formulaic notes;
   - Notes copied from previous service dates and simply re-dated;
   - Notes that are not signed and dated by staff who deliver the service, with the date that the services were rendered, and/or
   - Notes that do not document the individual's personal opinions or observed responses to services.

6. Providers opting to use an electronic signature for documentation purposes must comply with the following:
   - The electronic signature can be clearly identified;
   - The electronic signature identifies the individual signing the document and the signature of the date;
   - The electronic signature cannot be altered once it is attached to a document;
   - The date of the signature cannot be altered once it is attached to the signature;
   - Document cannot be signed electronically by anyone other than the individual required to sign the document; and
   - Documents containing electronic signatures can be printed out upon request of the QMR analyst.

4.7. Services must be of a quality that meets the health, safety and welfare needs and the rights of the individual. Quality of care is best assured through an emphasis on communication and respect between the individual and provider staff, and between the individual and the providers who are responsible for the oversight of the plan of care. Some of the elements included in quality of care are:

- Consistency of care;
- Continuity of care;
- Adherence to the person-centered plan of care; and
- Consideration for the health, safety, and welfare needs of the individual.

5.8. The provider shall maintain a record for each individual. Forms that may be used are available on the Medicaid Web Portal at: https://vamedicaid.dmas.virginia.gov/provider/forms#gsc.tab=0~~https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/~~

DMAS analysts will review the provider's performance in all outcome areas to determine the provider's ability to achieve high quality of care and conform to DMAS regulations and policies. The DMAS analysts are responsible for providing feedback to the provider regarding those areas that need improvement. DMAS analysts will work with the individual to evaluate the individual's status, satisfaction with the service, and appropriateness of the current Plan of Care (POC). If the POC is found to be inadequate, DMAS analysts may require a revision of the plan to meet the needs of the individual.

EXIT CONFERENCE

Following the DMAS analyst's or its contractors on-site review of the medical records and home visits, the DMAS analyst will meet during the exit conference with the appropriate provider staff to discuss general findings from the review. The provider may include any staff the provider would like to attend the exit conference~~,~~ but must provide appropriate staff (as requested by the analyst) for this meeting. The Exit Conference is a courtesy meeting offered by DMAS. If the DMAS analysts determine that a face-to-face conference is not possible or not able to occur, the provider will be informed. The Exit Conference may be conducted face-to-face or by telephone, if necessary.

During the exit conference, the provider will be informed of the number of records reviewed, number of participants interviewed, general recommendations regarding level-of-care issues, general recommendations regarding the changes in Plan of Care documentation, and any pertinent information regarding documentation, service verification issues, quality of care, or provision of services. The provider is expected to

use the findings of the QMR review to comply with regulations, policies, and procedures in the future. Records that have been reviewed shall not be altered to meet the compliance issues. The DMAS analyst will send a letter to the provider verifying that the review was conducted. This letter will also describe the findings of the review or will give an update as to the status of the review. This letter will also include a list of any citations and technical assistance.

During the QMR review process, the DMAS analyst will be available to offer technical assistance and consultation to the provider regarding DMAS regulations, policies, and procedures. If questions arise regarding compliance issues, the analyst will provide information and assistance. Any uncorrected compliance issues may result in the termination of the provider contract.

ANNUAL LEVEL-OF-CARE REVIEWS

The federal regulations under which waiver services are made available mandates that every individual receiving services be reviewed each year to assure he or she continues to meet level-of-care criteria for the waiver's targeted population.

~~Providers will be required to submit documentation each year for review to DMAS at: LOCreview@dmas.virginia.gov, to demonstrate the individual's functional status and medical/nursing needs using the Level-of-Care Review Instrument. DMAS LOC review analysts will send the provider a letter each year indicating when the provider's level-of-care review is due and what documentation is required. For all agency-directed personal/respite care services, the level-of-care review must be completed by an RN. For all CD personal/respite care services, the level-of-care review must be completed by a CD Services Facilitator.~~

~~continue to serve individuals who do not meet the level of care without notifying the service authorization contractor of the change in level of care and the need for discontinuation of services.~~

If it is found that an individual no longer meets the waiver level of care, DMAS will terminate services in accordance with the procedures detailed in Chapter IV of this manual.