Module 4B: Other Responsibilities of Service Facilitators

SLIDE 1

Welcome to Part B of Module 4 in the series of training modules for Services Facilitators in Virginia. Completion of all four modules and successful completion of the corresponding learning assessments will satisfy DMAS training requirements to provide Consumer-Directed Services Facilitation in Virginia.

SLIDE 2

In Module 4, Part B, we will look at some general ongoing responsibilities of Services Facilitators that are not specifically tied to the CD services the individual is receiving. These include:

The Services Facilitator's role as a mandated reporter of abuse, neglect, and

exploitation; Changes or transfers in Services Facilitators;

Changes in EORs;

How to close Services

Facilitation; Documentation

reminders; Billing and

payment;

DMAS Quality Management Reviews or "QMRs";

Medicaid fraud; and

Program Integrity audits.

SLIDE 3

Services Facilitators and attendants are required by Virginia law to report suspected abuse, neglect, and exploitation to the local Department of Social Services, which is responsible for investigating any suspected abuse, neglect, or exploitation. If an adult is involved, the report goes to Adult Protective Services, and if a minor is involved, the report goes to Child Protective Services.

For DD Waivers and those enrolled in the CCC Plus managed care program, there may be additional reporting requirements. Service Facilitators are responsible for understanding additional reporting requirements and following these processes in addition to reporting to DSS.

SLIDE 4

You can make reports directly to the local unit or over the toll-free, 24-hour hotlines, using 1-888-832-3858 for adults and 1-800-552-7096 (out of state) or 804-786-8536 (in-state) for minors. People with hearing impairments can call 1-800-828-1120.

The contact with DSS may be made anonymously, but you must note the alleged abuse, neglect, or exploitation in the record and state that the appropriate report was made.

Two mandated reporting reference materials are included with the Module 4 training materials. One covers mandated reporting responsibilities to CPS, and the other gives an overview of APS' role.

SLIDE 5

From time to time you may part ways with an EOR, and on the other hand you may receive a transfer referral from an existing Services Facilitator.

Individuals have freedom of choice of providers and may choose to transfer to another Services Facilitator. When this happens, it is your responsibility to work with the new Services Facilitator to make that transition smooth and provide the appropriate documentation to the new Services Facilitator.

SLIDE 6

The Service Agreement provides that either party must give the other party 10 day notice of an intended change.

SLIDE 7

When a change in Services Facilitator occurs, it is required to be documented on the DMAS-99 for all Waivers and the EPSDT Program. In the CL and FIS Waivers, the services facilitator can also record Services Facilitators changes in the Support Log or on the Person-Centered Review Form.

When communicating a transfer to the service authorization contractor, document it on the DMAS-225. The DMAS-225 should include the last day of service with the former Services Facilitator.

SLIDE 8

The new Services Facilitator must conduct a reassessment visit, which is needed for the individual's annual level of care review. It is very important to remember that the new Services Facilitator does NOT conduct an initial (comprehensive) visit unless otherwise authorized by the enrollees MCO.

EORs must be reminded that attendants will not be paid unless an authorization is in place; otherwise the EOR may be liable for paying the attendant personally.

It is very important to avoid any interruption in services by ending the prior Services Facilitator's service on the day immediately preceding the day that the new Services Facilitator begins service. The former Services Facilitator must submit the discharge information in a timely manner and the new Services Facilitator must submit a request for service authorization in a timely manner. For more information regarding submission timeframes, refer to Appendix D of the appropriate provider manual.

In the CL and FIS Waivers, the "leaving" Services Facilitator also completes an ISAR and forwards it to the Support Coordinator in WaMS. However, if this is not completed, the Support Coordinator will submit the ISAR to the Service Authorization Analysts at DBHDS, noting the reason for the change. Then the new Services Facilitator completes an ISAR and forwards it to the Support Coordinator.

SLIDE 9

Just as there can be changes in Services Facilitators, there can also be changes in EORs. In the event the EOR changes, submit a Change of Employer of Record Form to the Fiscal/Employer Agent. Provide training if the new EOR has never served as an EOR. Provide management training if the EOR has previously served as an EOR.

SLIDE 10

In addition to transfers, there are several other instances in which Services Facilitation ends. These include when an individual dies, is discharged from services, when a hospitalization or other circumstances cause services to cease or become interrupted for more than 30 days, and when the person is admitted into a rehabilitation or psychiatric facility for at least 1 day.

If any of these circumstances occur, you must submit discharge information to the service authorization contractor using the DMAS-225.

SLIDE 11

In the CCC Plus Waivers and the EPSDT Program, the Services Facilitator must notify the local DSS using the DMAS-225, and in the CL and FIS Waivers the Support Coordinator completes the DMAS-225. The service authorization contractor must also be notified using the DMAS-225.

If an individual no longer meets the criteria for services, the Services Facilitator must notify DMAS. It is also important to instruct the individual that he or she could be responsible for payment of the attendant if there is no authorization. For example, this will occur if the individual no longer meets eligibility requirements and has been terminated from a waiver, but services continue to be provided.

When an individual is admitted to a Nursing Facility or Inpatient Rehabilitation, a discharge must be submitted to the service authorization contractor using the DMAS-225. The service authorizations and level of care for the waiver are closed and must be reopened upon discharge from the facility by submitting a new service authorization request and all appropriate forms (the DMAS-98, 99, and 97 A/B) to the service authorization contractor.

SLIDE 12

Throughout the four Modules, we have explained certain documentation requirements. By now, you know that Services Facilitators must maintain records for each individual served, and you know quite a bit about what they need to include. Documentation is extremely important for several reasons, including to support billing for services and for DMAS or a contracted provider to review in both the Quality Management Review and Program Integrity Audit processes we will cover in just a minute.

Note that these records must be separated from those of any other services that may be provided by the Services Facilitator or the agency that employs the Services Facilitator. Additionally, all visit and contact documentation must be filed in the individual's record within two weeks from the date of the visit or contact.

You are cautioned to ALWAYS refer to the applicable current provider manual and any updates to the manual for current documentation requirements and for documentation requirements that may not have been covered in this training. Additionally, it is the responsibility of the Services Facilitator to check the DMAS website frequently for updates and changes to programs.

SLIDE 13

Specifically, each record must contain the appropriate assessment.

All service plans, including all copies of the CD service plans, must also be maintained.

Also required are the appropriate Service Authorization Request Form and Service Authorization Approval, along with all information related to service authorization appeals (if services have been denied).

It is the Services Facilitator's responsibility to maintain and keep record of services with end dates and submit them for reauthorization (if needed) within a timely manner. For additional training on submitting service authorizations, go to the service authorization contractor's website which you can find in the "Websites Referenced" document in the Module 1 training materials.

All DMAS-225 forms must be maintained . . .

. . . along with the results of all visits and contacts,

including: the initial (comprehensive) visit;

subsequent reassessment visits;

all EOR training provided, including the EOR's responsibility for the accuracy of the attendant's time sheets;

all correspondence and notes recorded and dated related to contacts with the individual, EOR and family member, caregiver, DMAS, and the service authorization contractor; and

records of contacts made with physicians, formal and informal service providers and all professionals concerning the individual.

Keep copies of all quarterly reviews. . .

. . .and all documents signed by the individual or the family member or caregiver that acknowledge the responsibilities for receipt of the services.

Lastly, keep on file any APS or CPS complaints filed.

SLIDE 14

This billing and payment chart summarizes all services that are billable for Services Facilitators by code number, and the maximum allowed by DMAS for billing each type of service. Service Facilitators contracted to work under MCO provider agreements should consult with the MCO regarding billing, payment and maximum allowances and review the most recent Services Facilitation Visit Guidelines on the DMAS CCC Plus program website by clicking on the link on the slide and locating the most current 'Services Facilitation Chart' document under 'CHARTS: HOW TO DO BUSINESS WITH EACH HEALTH PLAN BY PROVIDER TYPE'.

SLIDE 15

Reimbursement rates for services can change at any time. To be certain of the current rates before you bill, go to the DMAS website on the Waiver Services and Rates page or click the link on the slide. Scroll to SFY Waiver Rates, then open the appropriate waiver link. Note that the EPSDT Program rates are the same as Waiver rates.

Always use the appropriate billing code for the service for which you are wishing to receive reimbursement.

SLIDE 16

Now let's review the DMAS Quality Management Review (QMR) process. DMAS and contracted providers conduct QMRs to assure:

•The health and safety of individuals using services;

•That services are rendered according to the regulations;

•That individuals' needs are being met through CD services; and

•That the individual is satisfied with the services he or she is using.

SLIDE 17

The process for QMR has four basic steps:

•First, DMAS or its designated agent identifies the provider and individuals for review. The review may be on-site, or it may be a “desk audit.” If a QMR takes place on site, it could take anywhere from one to five days to complete. DMAS staff or its designated agent will review a certain time period, which may be expanded if necessary.

•Next, interviews with individuals and caregivers are scheduled, and these can be conducted either face-to-face or by telephone. DMAS staff or its designated agent will provide a list of the individuals to be interviewed.

SLIDE 18

Following the QMR, DMAS will conduct an exit conference as a courtesy.

Finally, DMAS staff or its designated agent will send a letter of the findings of the review, offer technical support, and if necessary, request a Corrective Action Plan.

SLIDE 19

The next two slides contain possible citations that can be made during a QMR. The listing of possible citations is helpful because it also provides a quick review of many of the Services Facilitation requirements we have covered in this series of training Modules. Possible citations include:

•Visits or services are not being performed as required in the regulations, policy, and procedures or as the individual's condition changes. For example, visits were conducted late or not at all, or the dates for a visit and documentation differ;

•Documentation for a person living in the household caring for the individual does not meet requirements.

•The DMAS-96 form (if required) was not signed prior to services starting;

•Forms were not completed or were completed incorrectly;

•The individual was in a nursing facility, hospital, rehabilitation facility, or out of the country and therefore not eligible to receive the services; and

•Documentation in the record did not support the services received.

SLIDE 20

Other possible citations include:

•The attendant began working before all paperwork was cleared through, and authorization received from, the service authorization contractor.

•Documentation that is required to be shared with other providers has not been shared with them.

•During a visit a change is noted, but there is no change in the frequency of follow-up visits. These changes could relate to mental status, physical condition or caregiver status, which may necessitate more frequent review.

•The individual has an incident of abuse, neglect, exploitation or other health and safety concern that was not reported.

•Provider qualifications and/or credentials are not adequate or current.

•The documentation does not meet DMAS' requirements.

•There is no indication of coordination between agency-directed and consumer-directed services

SLIDE 21

Every Services Facilitator and every attendant should understand what Medicaid fraud is and that it is a crime. Common fraud schemes by providers include:

Billing for goods or services that were not actually provided or "up-coding" a minor service to a more labor intensive or expensive service;

Paying “kickbacks" in exchange for referring business. State and federal laws generally prohibit payments to individuals who refer individuals to a particular provider. Medicaid fraud prosecutions have been brought, for example, against corrupt doctors for splitting fees in return for rent, demanding cash payments from Medicaid patients, and taking money in exchange for patient referrals;

Billing for medically unnecessary services. An example of this would be a patient who visited the doctor for a common cold treatment, but the provider billed for pneumonia testing and treatment;

Charging personal expenses to Medicaid. For example, the inclusion of personal expenses such as a car or a house in a nursing facility cost report is fraudulent.

Inflating the bills for services provided. This occurs for example in the Medicaid transportation sector when van or taxi companies greatly inflate their claimed mileage in order to receive greater reimbursement; and

Double billing, which occurs when the provider obtains payment for the same thing from two sources.

SLIDE 22

If you suspect that any other provider, including an attendant, is engaging in Medicaid Fraud, report it by phone to:

Office of the Attorney General
Medicaid Fraud Control Unit 1-804-
371-0779 or 1-800-371-0824

or by email to MFCU_mail@oag.state.va.us

SLIDE 23

Some fraud is committed by individuals or possibly their EORs. This type of fraud is called recipient or consumer deception fraud. An example is falsifying CD attendant time sheets.

SLIDE 24

If you believe that an individual or EOR is engaging in recipient Medicaid fraud, report it to the DMAS Recipient Audit Unit by email at RecipientFraud@DMAS.virginia.gov.

DMAS' Recipient Audit Unit is responsible for the investigation of allegations of acts of fraud or abuse committed by individuals receiving Medicaid. The investigations may result in the identification of misspent funds, administrative recoveries from individuals, or criminal prosecution. These allegations typically involve eligibility issues such as deceit in a Medicaid application; illegal use or sharing of a Medicaid card; uncompensated transfer of property; excess resources or income; or fraudulent household composition.

The Recipient Audit Unit refers issues involving Services Facilitators and other providers to the Provider Review Unit who then determines if it should be referred to the Medicaid Fraud Control Unit at the Office of the Attorney General. Please note that the DMAS Unit has reviewed instances where an individual receives Medicaid and is also working as an attendant in consumer-directed services. The Unit may review these individuals to make sure their earnings have been reported to the local Department of Social Services in accordance with Medicaid policy and that no period of Medicaid ineligibility exists.
For additional information on Medicaid Fraud and the Recipient Audit Unit, please click on the DMAS Recipient Audit Unit icon on the slide.

SLIDE 25

Finally, let's take a look at DMAS' Program Integrity audits, which every Medicaid provider, including Services Facilitators, should be aware of. Audits are required by both the federal and state governments due to the large amount of public funding in the program. Virginia spends around $6 billion each year on the Medicaid program, with total spending expected to double by 2021. The public, therefore, has an interest in how effectively and how legally those public dollars are being spent.

While the QMR process we have already reviewed has its primary focus on health, safety, and welfare of individuals and CMS assurances, the major focus of Program Integrity is on claims and reviewing documentation and billing to demonstrate compliance with all program requirements. Basically, the auditors must assure that all Medicaid payments are for covered services that were actually provided and are properly billed and documented.

Provider reviews to be performed are selected using an approach that is based upon risk assessment. Claims-based data mining software packages determine which providers are exceeding the billing norms for their peer groups. The Program Integrity auditors also receive referrals from other DMAS divisions, the general public, current and past employees of providers, and other state agencies. An additional referral source is the Explanation of Medicaid Benefits statement itemizing the claims paid on behalf of the individual.

SLIDE 26

If you are audited, you will receive a medical record request which you will provide to the analyst.

The analyst will review your qualifications for accuracy, completeness, and appropriateness.

The records are then reviewed to ensure the documentation supports the services billed, levels of service, and medical necessity and that they contain appropriate signatures by qualified staff.

The review is specific to the services you have billed and is based on Medicaid policy requirements that were in effect during those dates of service.

SLIDE 27

A preliminary report of audit findings will be mailed to you, and you have 30 days to provide additional information or explanation of any documentation in question. Also, an exit conference is held with you by telephone.

If applicable, the preliminary report is revised, and a final report is written and mailed to you.

You have the right to appeal the final report.

SLIDE 28

As a Services Facilitator, you will definitely undergo QMRs and/or Program Integrity audits. Be as prepared as you can by understanding the Medicaid requirements contained in both the regulations and the provider manuals, and managing the review or audit process. Keep all of your records as if an audit was occurring tomorrow. Feel free to explain your understanding of the regulations to an auditor. If you disagree with the final audit report, request an appeal.

SLIDE 29

You have now completed the final module in the four-part online series for meeting the requirements for training as a Services Facilitator.

Please note that all of the web links provided in this Module are contained in the accompanying training materials.

Please complete the final, Module 4, Part B learning assessment at this time.

Thank you for your participation!