

MED - Long Term Care Waivers - Certification Process

Purpose: To determine level of care (LOC) for members applying for the specified waiver programs:

- Physical Disability Waiver (PD)
- Health and Disability Waiver (H&D)
- AIDS Waiver
- Elderly Waiver (EW)

The function of the long term care (LTC) certification process is to assess members for LOC. The certification review provides an objective determination of LOC for the member.

Identification of Roles:

Review Assistant (RA) – logs documents within the OnBase workflow, opens the case within MQUIDS, assigns review to RCs and provides additional program support as needed.

Review Coordinator (RC) – completes LOC review.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Physician/Peer Reviewer (PR) – reviews medical records for a specialty review or when the MMD is not available.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards:

- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure:

Step 1: The LOC certification form will be completed by a qualified medical professional and faxed to Medical Services at 515-725-1349. A qualified professional is a medical doctor (MD), doctor of osteopathy (DO), physician's assistant or certified nurse practitioner.

Step 2: Medical Services review staff may be reached by telephone, facsimile or during regular business hours of 8:00 a.m. to 4:30 p.m. Monday through Friday with the exception of state holidays at the Iowa Medicaid Enterprise facility.

Step 3: It is the goal of Medical Services to provide timely and responsive information when requested by providers and members. URAC standards of completion within 15 days will be followed. For urgent requests see Administrative Functions – Urgent Requests.

Step 4: The Department of Human Services (DHS) Assessment and Services Evaluation (A.S.E) criteria are utilized by RCs to determine if the member meets the LOC based upon the information provided on the LOC certification form.

- a. The criteria are located on the share drive at Med Srv/Criteria/All Programs Criteria.
 - 1) Nursing Facility Level of Care Criteria
 - 2) Skilled Level of Care Criteria
 - 3) ICF/ID for the HCBS Waiver Criteria
 - 4) Pediatric Skilled Nursing Facility Level of Care Criteria
- b. Review staff have access to a desk guide for review which is divided into nine areas:
 1. Cognitive, mood and behavior patterns
 2. Physical functioning and mobility
 3. Skin condition
 4. Pulmonary Status
 5. Continence
 6. Dressing and personal hygiene
 7. Eating
 8. Medications
 9. Communication, hearing and vision

Step 5: When the RC cannot approve the member's LOC based upon the LOC certification form, the provider is contacted by telephone in an attempt to gather all available information regarding the member's status prior to taking the case to PR. See Level of Care Determinations Lack of Information.

Step 6: If not already provided the RC will obtain the following information:

- a. Member's medication lists
- b. Member's current diagnoses list
- c. Any additional useful information regarding the member for the PR.

Step 7: Any RC who is requesting additional information will only request what is needed to complete the review.

Step 8: The RC will review submitted documentation to insure that the request is complete.

Step 9: The RC will complete a request for additional information letter if needed.

Step 10: The RA will send the request for additional information letter.

- a. The RAs do not make clinical decisions or complete clinical interpretation of information.

Step 11: The RC will review the submitted documentation to insure that the request is complete.

Step 12: Only peer reviewers make denial decisions. Peer reviewers include licensed health care professions in the same category as the attending provider or the Medical Director of Iowa Medicaid. Denials made by the CAMD will be reviewed by the MMD or other licensed physician.

Step 13: Notice of the availability of the peer-to-peer conversation is included on the Iowa Medicaid Enterprise (IME) website (<http://www.ime.state.ia.us>). Refer to MED Administrative Functions Peer-to-Peer Conversations for details on this procedure.

Step 14: The manager will arrange for the peer-to-peer conversation within one business day of the request unless there are extenuating circumstances outside of Medical Services' control.

Forms/Reports:

N/A

RFP Reference:

6.2.4.2

URAC Reference:

HUM 17

Interfaces:

N/A

Attachments:

N/A

Level of Care Form

Iowa Department of Human Services
Level of Care Certification for HCBS Waiver Program

| | | | |
|--|---|---|--|
| ATTENTION: Fax Form to: Iowa Medicaid Enterprise - Medical Services (515) 725-1349 | | | |
| Form should be completed in office with member present. Medical professional completing this form must provide a copy to the member. | | | |
| Today's Date | Iowa Medicaid Member Name | State ID or Social Security Number | Birth Date |
| Provider Name (please print) | | Provider Telephone Number with Area Code | |
| HCBS Program: <input type="checkbox"/> AIDS <input type="checkbox"/> Elderly <input type="checkbox"/> Ill and Handicap <input type="checkbox"/> Physical Disability <input type="checkbox"/> Admission <input type="checkbox"/> Annual Review | | | |
| Diagnoses (please list or attach DX list): | | Medications (include dose and frequency) or attach full medication list: | |
| 1. | | 1. | |
| 2. | | 2. | |
| 3. | | 3. | |
| 4. | | 4. | |
| 5. | | 5. | |
| 6. | | 6. | |
| 7. | | 7. | |
| 8. | | 8. | |
| 9. | | 9. | |
| Level of Care Criteria: Mark all that apply, review each category | | Was the member seen in the office at the time the form was completed? _____ | |
| Cognitive <input type="checkbox"/> No problem <input type="checkbox"/> Language Barrier <input type="checkbox"/> Short/Long term memory problem <input type="checkbox"/> Problems with decision making <input type="checkbox"/> Interferes with ability to do ADLs | Dressing <input type="checkbox"/> Independent <input type="checkbox"/> Supervision or cueing needed <input type="checkbox"/> Physical assistance needed How often is assistance needed? <input type="checkbox"/> 1 - 2 X weekly <input type="checkbox"/> 3 - 4 X weekly <input type="checkbox"/> > 4 X weekly <input type="checkbox"/> Age-appropriate child | Elimination <input type="checkbox"/> Continent <input type="checkbox"/> Bladder incontinence <input type="checkbox"/> Bowel incontinence <input type="checkbox"/> Urinary Catheter <input type="checkbox"/> Colostomy ostomy <input type="checkbox"/> Nephrostomy <input type="checkbox"/> Age-appropriate child | Medications <input type="checkbox"/> Independent <input type="checkbox"/> Requires set up <input type="checkbox"/> Needs administered by others <input type="checkbox"/> Daily IV Duration: <input type="checkbox"/> Daily IM Duration: <input type="checkbox"/> Insulin, set dosage <input type="checkbox"/> Insulin, sliding scale <input type="checkbox"/> Frequent lab values <input type="checkbox"/> Age appropriate |
| Ambulation <input type="checkbox"/> Independent <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Motorized scooter <input type="checkbox"/> Needs human assistance <input type="checkbox"/> Age-appropriate child <input type="checkbox"/> Restraint used <input type="checkbox"/> Transfer Assist | Therapy Check all applicable: <input type="checkbox"/> Speech therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physical Therapy Duration of therapy expected: | Living Arrangement <input type="checkbox"/> Lives alone <input type="checkbox"/> Assisted Living <input type="checkbox"/> Lives with family/spouse <input type="checkbox"/> Senior apartment <input type="checkbox"/> Danger to live alone <input type="checkbox"/> Nursing facility | Eating <input type="checkbox"/> Independent <input type="checkbox"/> Assistive Devices <input type="checkbox"/> Requires Human Assistant |
| Bathing/Grooming <input type="checkbox"/> Independent <input type="checkbox"/> Has assistive devices, independent <input type="checkbox"/> Supervision or cueing needed <input type="checkbox"/> Physical assistance needed How often is assistance needed: <input type="checkbox"/> 1 - 2 X weekly <input type="checkbox"/> 3 - 4 X weekly <input type="checkbox"/> > 4 X weekly | Behaviors <input type="checkbox"/> Noncompliant <input type="checkbox"/> Destructive or disruptive <input type="checkbox"/> Repetitive movements <input type="checkbox"/> Antisocial <input type="checkbox"/> Aggressive or self injurious <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression | Respiratory <input type="checkbox"/> No issue <input type="checkbox"/> O2 use daily <input type="checkbox"/> O2 PRN <input type="checkbox"/> Trach <input type="checkbox"/> Ventilator <input type="checkbox"/> Suctioning Frequency: Tube Feedings <input type="checkbox"/> Tube feeding If requires tube feedings, order: | Skin <input type="checkbox"/> Intact <input type="checkbox"/> Ulcer - stage = _____ <input type="checkbox"/> Open wound <input type="checkbox"/> Daily treatment <input type="checkbox"/> Treatment PRN <input type="checkbox"/> Home Health for wound care |
| <input type="checkbox"/> Age-appropriate child | | <input type="checkbox"/> Requires 24 hour supervision <input type="checkbox"/> None | |
| I attest the above information is correct. Signature of Healthcare Professional (MD, DO, ARNP, PA): DATE: | | | |
| Additional Comments: | | Home services in place: | |

**Instructions for Certification for Level of Care
Home and Community Based Services (HCBS)**

- Purpose:** Form 470-4392, *Certification for Level of Care Home and Community Based Services (HCBS)*, provides a mechanism for a Medical Professional (MD/DO/ARNP/PA) to report a Medicaid member's admission, change in condition or annual assessment for level of care. Providers are encouraged to conduct the level of care process during a routine or preventative office visit. See informational letter number **XXX**
- Source:** This form is available on the DHS website under provider forms.
- Completion:** A provider (MD/DO/ARNP/PA) must complete the form when:
- Medicaid member is going to receive services provided in their home or community.
 - Medicaid member has a significant change in condition.
 - Medicaid member has an annual assessment.
- Distribution:** Providers fax / email the certification for level of care form to the IME Medical Services unit (515-725-1349) and provide a copy to the Medicaid member.
- The form may be faxed by the medical professional completing the form or by others involved in assisting in arranging the services (i.e. facility staff, hospital discharge planner, case manager or family member). The IME Medical Services unit will make a level of care determination upon receipt of the form.**
- Data:**
- Today's Date:** The actual date the form is completed. (MM/DD/YY)
- Iowa Medicaid Member Name:** The Medicaid member's first, middle initial and last name as it appears on the eligibility card.
- Social Security Number or State ID#:** The member's social security number or State ID number as it appears on the eligibility card.
- Birth date:** The Medicaid member's birth date (MM/DD/YY)
- Name, Telephone Number with Area Code:** The medical professional specific information of who is filling out the form.
- Admit to HCBS Waiver:** Contains the specific Medicaid home and community based (HCBS) waiver type.
- Diagnoses and Medications:** The member specific health information related to diagnoses and medications, Supporting documentation, H&P along with a medication list may be submitted with the form in order to complete the review.
- Level of care criteria:** **Mandatory** criterion sections. Please review each category and check all applicable criteria. Please check **all** that apply, as well as additional comments the medical professional may want/need to add.
- Signature with Title of Medical Professional MD/DO/PA/ARNP:** The signature of the medical professional completing the form.

MED - Long Term Care Waivers - Level of Care Determination

Purpose: To provide a LOC determination for members who are applying or recertifying for the waiver.

Identification of Roles:

Review Coordinator (RC) – completes the level of care review.

Performance Standards:

- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure:

Step 1: The RC will enter LOC determination into Medicaid Quality Utilization Improvement Data System (MQUIDS).

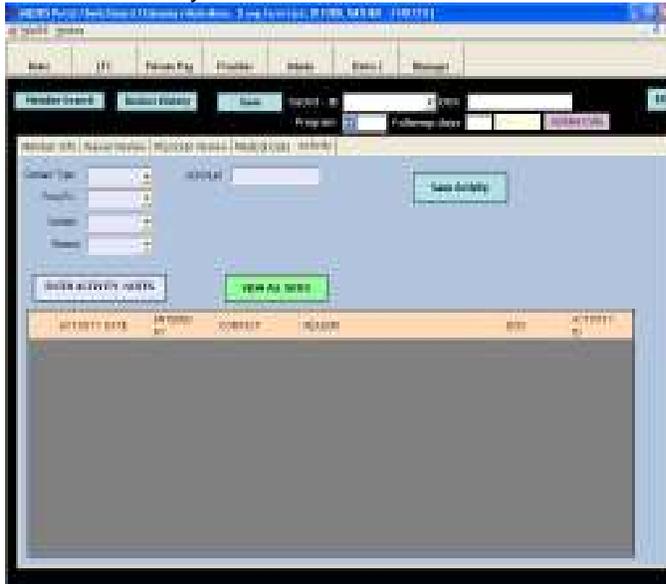
MQUIDS Main Screen

The screenshot displays the MQUIDS Main Screen, a web-based interface for entering Level of Care (LOC) determinations. The screen is divided into several sections:

- Member Information:** Includes fields for Member ID, Name, and Address.
- Program Information:** Includes fields for Program, Start Date, and End Date.
- Provider Information:** Includes fields for Provider ID, Name, and Address.
- Level of Care (LOC) Information:** Includes fields for LOC Code, Description, and Start Date.
- Buttons:** Includes buttons for "Add Provider", "Add Waiver", and "Save Case".

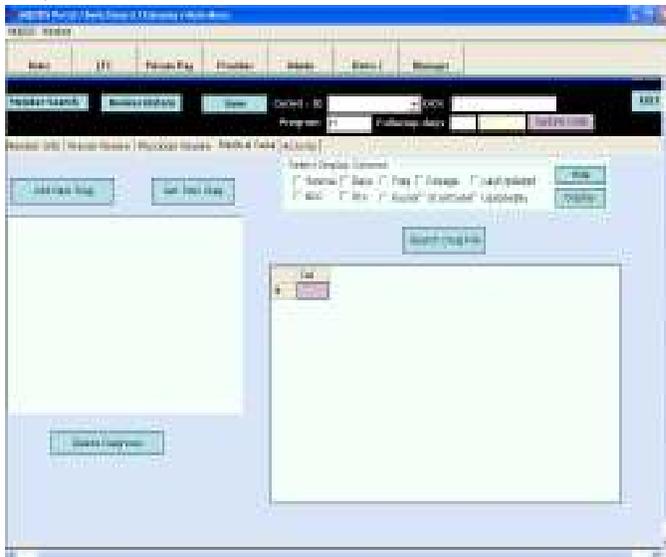
Step 2: The RC will enter all case notes under the activity tab. This will include any communication being sent to CM/SW or providers and any additional information or communication being received in regards to the member. When a review is being sent to PR it will be documented in the activity notes.

MQUIDS Activity Screen

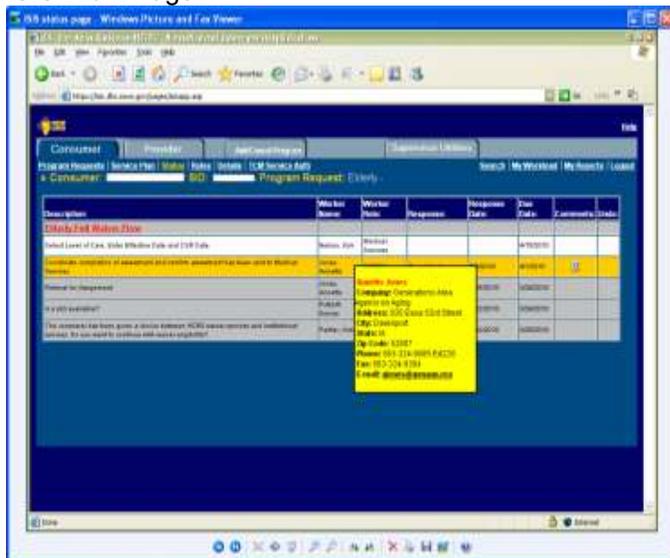


Step 3: The RC will enter the diagnoses into MQUIDS under the Medical Data tab. Medications are not required for entry. ICD diagnosis codes are populated from the most current version of the AMA ICD manual.

MQUIDS Medical Data Screen

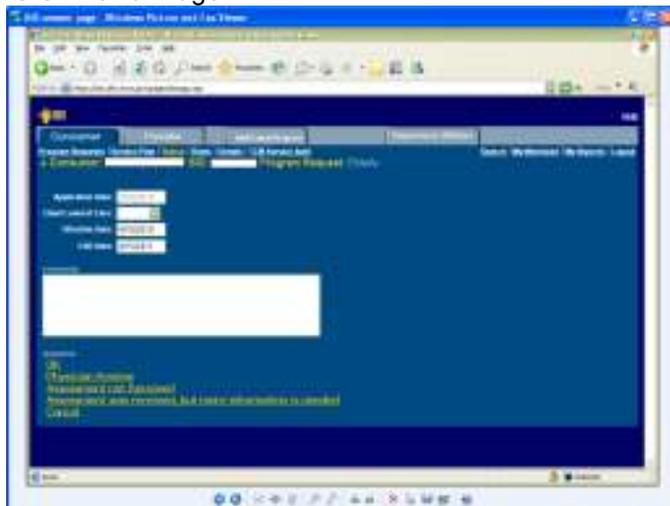


ISIS Work Page



- a. URAC standards of completion within 15 days will be followed.

ISIS Answer Page



- b. From the Consumer tab click on status. The RC will select level of care key task (milestone) and click on the open line to access the LOC screen that follows.
- c. The RC will enter the LOC along with an effective date and a date for a subsequent service review.
- d. Client Level of Care: select the correct level of care from the pull-down menu.
- e. Note that the choice of denied means the member does not meet any of the levels of care.
- f. Effective Date: Enter the date the LOC becomes effective.
- g. Continued Stay Review Date (CSR Date): Enter the date chosen for the subsequent service review.

1. If an entry is not made, the CSR Date will default to one year after the entered Effective Date.
- h. Comments: Allows text entry of information that will be useful to others who will be involved in processing this case. If the LOC is being denied, RC enters the reason and rationale as an ISIS note.
- i. OK Response: Submits answers chosen above
- j. Cancel Response: Back to Status page

Forms/Reports:

N/A

RFP Reference:

6.2.4.2

Interfaces:

MQUIDS

ISIS

Attachments:

N/A

**MED - Long Term Care Waivers - Level of Care Determination
Lack of Information**

Purpose: To obtain any additional information from the attending physician or case manager on a case that was not provided on the cert form.

Identification of Roles:

Review Coordinator (RC) – when needed, telephones the physician who filled out LOC cert form and/or email the case manager to obtain additional information.

Review Assistant (RA) –forwards to RC any additional information that is faxed in.

Performance Standards:

- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

Path of Business Procedure:

Step 1: If the RC is unable to determine LOC due to lack of information the RC will contact the medical professional by telephone to request additional information. This may include a medication and/or diagnosis list, verification of marked or unmarked criterion and any additional information that would support the level of care determination.

Step 2: If the medial professional provides additional information, it can be taken over the telephone by the RC or faxed to medical services at 515-725-1349.

Step 3: The RC will not require any additional information that is not needed to review for level of care.

Step 4: The RC may also contact the case manager/service worker assigned to the case and request additional information about the member. This may include the service plan, assessment, or Consumer Directed Attendant Care (CDAC) agreement or the Service Worker Comprehensive Assessment, form number 470-5844 (rev12/11).

Step 5: The RC will respond in the ISIS milestone, “assessment received, but more information is needed”, if milestone is due in ISIS.

Step 6: If the RC does not receive additional information within the referenced time frame, the RC may attempt to obtain additional information or proceed with PR with the information available. URAC standards of completion within 15 days will also be followed.

Forms/Reports:

N/A

RFP Reference:

6.2.4.2

Interfaces:

N/A

Attachments:

N/A

MED - Long Term Care Waivers – Peer Review

Purpose: To determine if LOC can be approved when identified criteria are not met.

Identification of Roles:

Review Coordinator (RC) – requests physician or consultant review for LOC and forwards request to physician reviewer.

Medicaid Medical Director (MMD) – reviews member cases and makes a determination based on the medical record and any supporting documentation. Approves peer reviewer credentials, additions to peer reviewer panel, re-certification of peer reviewer. Oversees peer reviewer decision outcomes.

Physician Reviewer (PR) – reviews medical records for a specialty review or when the MMD is not available.

Clinical Assistant to the Medicaid Medical Director (CAMD) - reviews cases and makes a determination based on the medical record and additional documentation provided.

Performance Standards:

- Complete 95 percent of LOC determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.
- Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

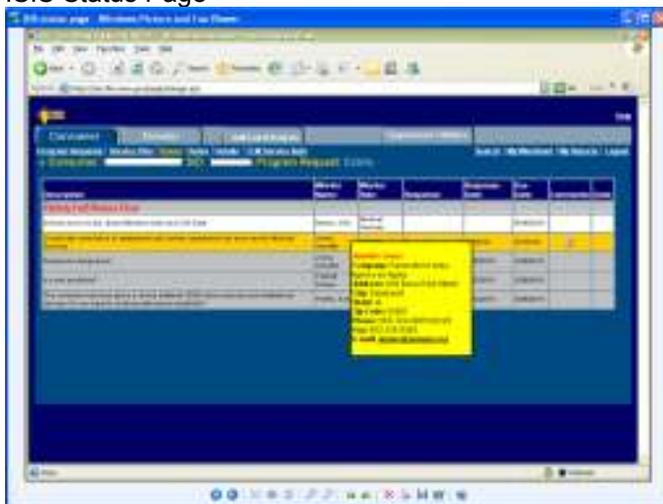
Path of Business Procedure:

Step 1: Upon determination that a LOC request requires a PR, the RC will create a letter task and open a physician/peer review form from template in OnBase or Microsoft Word and attach it to the LOC request.

Step 2: The RC may also complete a telephonic review if needed.

Step 3: The RC will select PR when answering ISIS milestone on the status page for the member to let the CM/SW know that peer review is being pursued.

ISIS Status Page



Step 4: The RC will fill out the physician/peer review form to reflect the member's review and then fill in the appropriate information on the request.

- 1) The member's current status and services they are receiving.
- 2) Information obtained from the physician.
- 3) Information obtained from the CM/SW.
- 4) Information obtained from providers of services.
- 5) Any other information that may have been obtained during the investigation.

Step 5: The RC will import form into OnBase and fill out appropriate key words.

- a. This will attach the physician/consultant review request to the LOC request or create letter task will attach MD Router.

Step 6: The RC will then click "send to consultant" in the tasks bar.

- a. The document then will go to the PR queue.

Step 7 : After the peer reviewer has completed review, the RC will find the document in the "Back from Phys/Con queue.

Step 8 : The RC will click on complete after all the information is documented and the results are documented in ISIS.

Step 9 : The RC will enter authorization in ISIS and complete OnBase approval, modification or denial.

Step 10 : If the PR results in approval of LOC, the RC will follow the procedures outlined for LOC met.

Step 11: If the PR results in denial determination, the RC will document the denial in ISIS. All denials require a rationale of why the member was denied in the comments section for the milestone.

Step 12: The RC will choose denied in the LOC of care choice in ISIS.

Step 13 : The RC will document the PR under the PR tab in MQUIDS.

Step 14 : The member is notified of the denial determination from the NOD generated from the ISIS system.

MED - Long Term Care Waivers - Appeal Process

Purpose: A Medicaid member who disagrees with a Medicaid decision regarding Medicaid services has the right to appeal within 30 days of the date of the notice of decision letter by contacting the local DHS office, by writing a letter to DHS Appeals Section or by filing on line at <http://www.dhs.state.ia.us/dhs/appeals/appealdecision.html>. The notice of decision (NOD) letter contains instruction on how to request an appeal. Medical Services provides testimony for assigned appeal hearings.

Identification of Roles:

Review Coordinator – composes initial draft of appeal summary.

Lead Review Coordinator – provides testimony at appeal hearings.

Manager – reviews appealed cases to determine if additional information submitted with the appeal allows approval of the case, assigns appeal summaries to be written, reviews appeals summaries and packets before dissemination, provides testimony at appeal hearings.

Performance Standards:

- Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: Designated RA receives appeal and logs on team tracking spreadsheet.

Appeal Tracking Log

| Date Appeal Received | Program Type | Review Assistant | Review Coordinator | SID | Member Name | Letter to AP - 2nd Request | Out come | Proposed Decision Received Date | If Reinstated, Date of Reinstatement Letter or Approval Date in MQUIDS if no Letter | Re-instatement Reason |
|----------------------|--------------|------------------|--------------------|-----|-------------|----------------------------|----------|---------------------------------|---|-----------------------|
|----------------------|--------------|------------------|--------------------|-----|-------------|----------------------------|----------|---------------------------------|---|-----------------------|

Step 2: Manager reviews appeal to see if additional information submitted will allow approval of the case.

Step 3: If continuing with the case, manager assigns RC to complete case summary.

Step 4: Refer to appeals section of MED Policy Support and Exception to Policy procedure.

Step 5: The following appeal summaries are used as templates for each case. The following exhibits are used depending on the details of each case: Criteria, Documentation, Code of Federal Regulations / Iowa Administrative Code, Director Review Final Decision and Adverse Service Actions.

Forms/Reports

SNF CASE SUMMARY TEMPLATE:

Appeal Summary for [Member's Full Name], State ID [SID#]

On [Date LOC rcvd], Iowa Medicaid Enterprise (IME), Medical Services received a request for approval of skilled level of care on behalf of [Member's Full Name]. The level of care request is necessary to secure [waiver type] Waiver services for [Mr./Mrs. Member's Last Name]. The information submitted did not support approval of skilled level of care; [(if applicable); however, did support the intermediate (nursing facility) level of care.]

The information provided by [Dr Name], on the level of care certification form ([D#]), identified [Member's Full Name] as a [Age]-year-old-[male/female] [Info on Cert form]. The diagnoses at the time of the review were [diagnoses].

Throughout the course of the review, the office of attending provider, _____, was contacted to discuss the information submitted during the review process and was given the opportunity to submit additional information. _____ nurse reported

[info from CM]

[Info from other providers]

IME Medical Services gathers information related to the criteria from a member's physician or other providers at the time of the eligibility review. The review is initially conducted by a nurse reviewer who may approve if the member requires daily supervision or prompting with both bathing and dressing.

The criteria used by Medical Services are physician-developed criteria and are approved by the Department of Human Services. The criteria for nursing facility level of care indicates nursing facility level of care can be approved if the member requires at a minimum daily supervision or prompting with both dressing and personal hygiene; i.e., criterion number six. This would need to be provided on a daily basis by the physical assistance of at least one person for dressing and personal hygiene. If the member does not meet criterion in number six, the case must be referred to a physician reviewer for a level of care determination. There was no evidence provided that indicated this member met criteria for nursing facility level of care.

If the nurse reviewer is unable to match a member's functional ability to the criteria, the review is submitted to a physician reviewer for a level of care determination. The physician relies on medical expertise and judgment to determine the medical necessity of approving a member to receive waiver services. Medical eligibility for waiver services

shall be consistent with the diagnosis and treatment of the member's condition, be in accordance with standards of good medical practice, be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver, and be the least costly type of service which would reasonably meet the medical need of the patient.¹ This is the same process used to determine if a member would meet the level of care requirement to be in a nursing facility.² Services must be needed on a daily basis.³

In order to approve skilled level of care for the waiver programs, the following conditions must be met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with general provisions for all Medicaid providers and services as described within 441-79.9.
3. Documentation submitted for review must indicate that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that addresses identified deficit areas.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services provided by, or under the supervision of medical personnel as described above.
 - f. Skilled nursing services needed and provided seven days a week or skilled rehabilitation services needed and provided at least five days a week.

There was no evidence provided that indicated this member met criteria for skilled level of care.

The physician reviewer looks at the purpose set forth for the waiver programs: to provide in-home and community based services to people who would otherwise require care in a nursing home or other medical institution.⁴ Evaluation is made to determine if a member would require the same care that would be provided in a nursing facility⁵ and the waiver program services is medically necessary.⁶

Based on direction given by Department of Human Services Director, Charles Palmer, 249J.11 is not applicable to Waiver level of care reviews and was not considered during the level of care review (E1-3).

Physician review was completed by

Iowa Administrative Code states in 441-79.9(1) "Medicare definitions and policies shall apply to services provided unless specifically defined differently.

The state of Iowa defines the process to determine if a member meets nursing facility level of care in Iowa Administrative Code 441-81.3(1)(a). Nursing facility is defined in Iowa Administrative Code 441-81.1.

Medicare defines skilled nursing services as “Services from a registered nurse, which include tube feedings; catheter changes; wound care; teaching and training activities; observation and assessment of a patient's condition; and management and evaluation of a patient's plan of care”. Skilled Therapy is defined as “Services from licensed physical, speech/language, and occupational therapists (if originally accompanied by [physical therapy](#) or [speech/language pathology](#) services)”.

IME Medical Services maintains that this same criterion must be met in order to qualify for skilled level of care under the waiver program. The medical waiver programs use the same level of care qualifiers as a nursing facility and skilled nursing facility that follow the guidelines outlined here.

The nurse reviewer submitted the case information to _____ for a medical necessity determination on _____ occasions. The physician reviewer did not approve the level of care for _____ based on the following rationale:

- The level of care form and further conversations with _____ nurse, and information from other providers and the case manager, indicate the member _____.

Services which are not covered under skilled level of care are outlined in 42 CFR 409.33: *Personal care services*. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in §409.32(b). Personal care services include, but are not limited to, the following:

- (1) Administration of routine oral medications, eye drops, and ointments;
- (2) General maintenance care of colostomy and ileostomy;
- (3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;
- (4) Changes of dressings for non-infected postoperative or chronic conditions;
- (5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;
- (6) Routine care of the incontinent patient, including use of diapers and protective sheets;
- (7) General maintenance care in connection with a plaster cast;
- (8) Routine care in connection with braces and similar devices;
- (9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;
- (10) Routine administration of medical gases after a regimen of therapy has been established;
- (11) Assistance in dressing, eating, and going to the toilet;
- (12) Periodic turning and positioning in bed; and

(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.

The focus of the level of care review is to determine if limitations rise to the level at which requires services to be provided by a licensed skilled nurse or licensed therapist, and that these services meet the requirements in order to qualify for the skilled level of care, as stated previously. It is noted although has these services do not rise to the level of requiring skilled level of care. In the absence of daily skilled nursing services or a home exercise program under the supervision of a licensed physical therapist; care needs meet the nursing facility level of care for continued participation in the Waiver program.

NF CASE SUMMARY TEMPLATE:

Appeal Summary for _____, State ID _____

On date LOC from submitted, Iowa Medicaid Enterprise (IME), Medical Services received a request for approval of intermediate (nursing facility) level of care on behalf of Members full name. The level of care request is necessary to secure Name of waiver program Waiver services for Members name. The information submitted did not support approval of What level of care requested level of care for Continued or admission participation in the waiver program.

The last review was completed on Date of last review if it is a CSR - delete if admit. IME Medical Services was informed member name required why were they approved last year. During the last year he/she utilized the following waiver services: list the services received in last year from ISIS. Review of the information submitted indicates that this is no longer the case for Member name. All of the information submitted has indicated he/she is able to complete his/her own personal cares without supervision, cueing, or prompting and any other info that helps appeal like driving, working, etc

The level of care form (C) was completed by Dr's name and submitted for review. The information provided by Dr's name indicated Member's name is an age in years-year-old gender who List here what the certification form shows The diagnoses at the time of the review were submitted for review and are included in Exhibit C.

Throughout the course of the review, the office of attending provider, Dr's name, was contacted to discuss the information submitted during the review process and was given the opportunity to submit additional information. Dr's name nurse reported Describe all the things you learned from the Dr. office here in a clear and well written manner

The case manager submitted Describe what the case manager submitted and what it stated in significance to the denial

Information was submitted from Here is what you describe any information you obtained from other providers.

IME Medical Services gathers information related to the criteria from a member's physician or other providers at the time of the eligibility review. The review is initially conducted by a nurse reviewer who may approve if the member requires daily supervision or prompting with both bathing and dressing.

The criteria used by Medical Services are physician-developed criteria and are approved by the Department of Human Services. The criteria for nursing facility level of care indicates nursing facility level of care can be approved if the member requires at a minimum daily supervision or prompting with both dressing and personal hygiene; i.e., criterion number six. This would need to be provided on a daily basis by the physical assistance of at least one person for dressing and personal hygiene.

If the member does not meet criterion in number six, the case must be referred to a physician reviewer for a level of care determination. There was no evidence provided that indicated this member met criteria for nursing facility level of care.

If the nurse reviewer is unable to match a member's functional ability to the criteria, the review is submitted to a physician reviewer for a level of care determination. The physician relies on medical expertise and judgment to determine the medical necessity of approving a member to receive waiver services. Medical eligibility for waiver services shall be consistent with the diagnosis and treatment of the member's condition, be in accordance with standards of good medical practice, be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver, and be the least costly type of service which would reasonably meet the medical need of the patient.⁷ This is the same process used to determine if a member would meet the level of care requirement to be in a nursing facility.⁸ Services must be needed on a daily basis.⁹

What is Nursing Facility level of care? A nursing facility means an institution or a distinct part of an institution housing, which is primarily engaged in providing health-related care and services, including rehabilitative services, but which is not engaged primarily in providing treatment or care for mental illness or mental retardation.¹⁰ Nursing facility level of care is provided for those who have the presence of a physical or mental impairment which restricts the ability to perform the essential activities of daily living; bathing, dressing, and personal hygiene and impedes the capacity to live independently. The member's physical or mental impairment is such that self-execution of the required nursing care is improbable or impossible. Therefore, the member would require nursing facility placement to perform the health-related services.

The physician reviewer looks at the purpose set forth for the waiver programs: to provide in-home and community based services to people who would otherwise require care in a nursing home or other medical institution.¹¹ Evaluation is made to determine if a member would require the same care that would be provided in a nursing facility¹² and the waiver program services is medically necessary.¹³

Based on direction given by Department of Human Services Director, Charles Palmer, 249J.11 is not applicable to Waiver level of care reviews and was not considered during the level of care review (F1-3).

Physician review was completed by Copy in Pr credentials

The nurse reviewer submitted the case information to PR name for a medical necessity determination on How many times did it go to PR occasions. The physician reviewer did not approve the level of care for Members name based on the following rationale:

- The level of care form and further conversations with Dr. Name nurse, and information from other providers and the case manager, indicate the member List PR rationale here. Each rationale should have new point.

The focus of the level of care review is to determine if Members name limitations rise to the level at which he/she would require imminent nursing facility placement.

All documentation and information obtained during the review process indicates Members name is independent with his/her personal cares. Member name did not meet the criteria requiring assistance with both bathing and dressing. There was no indication that he/she would be facing imminent nursing home placement at this time or that the member's physical or mental impairment is such that self-execution of the required nursing care is improbable or impossible. In addition, Member name did not meet the medical necessity determination for nursing facility level of care. Mr./Ms. member last name care needs can be met at a lower level of care or by other programs that may be available to him/her.

The Department maintains the original decision to deny was correct. (Manager's name) may be reached at (manager's phone number).

Sincerely,

(manager's name, title)
Medical Services, Iowa Medicaid Enterprise

Manager/RA initials

Enclosures:

- Case Summary: Waiver overview
- Exhibit A: ASE criteria
- Exhibit B: Documentation
- Exhibit C: Code of Federal Regulations
Iowa Administrative Code
- Exhibit D: Director Review Final Decision
- Exhibit F: Adverse Service Actions

cc member's name
member's address

ALJ LETTER / CASE SUMMARY:

 **Iowa Department of Human Services**
Terry E. Stensrud, Governor | Kim Reynolds, Governor | Charles M. Feltner, Director

TO: Iowa Department of Inspections and Appeals
Division of Administrative Hearings

ATTENTION: [redacted], Administrative Law Judge
FROM: Division of Medical Services, [redacted]

DATE: [redacted]

SUBJECT: Appeal Summary for [redacted], State ID Number [redacted]
Appeal Number [redacted]

[redacted]

The Department maintains the original decision to deny was correct. Cynthia Fletcher may be reached at 1-800-383-1173, extension 3050.

Thank you for your consideration in this matter. If you have any questions, please contact me.

Sincerely,

[redacted]
Medical Services, Iowa Medicaid Enterprise

Enclosures:
Exhibit A: Appeal Letter
Exhibit B: Waiver Overview
Exhibit C: ASE criteria
Exhibit D: Documentation
Exhibit E: Code of Federal Regulations
Iowa Administrative Codes
Exhibit F: Director Review Final Decision
Exhibit G: Adverse Service Actions

cc: [redacted]

Iowa Medicaid Enterprise • 303 Army Post Road • Des Moines, IA 50319

Case Summary

EXHIBIT A

IOWA MEDICAID ENTERPRISE
Home & Community Based Waiver Services
Overview of Level of Care for Elderly, Ill & Handicapped,
Physical Disability and AIDS Waiver Services

Medical Services performs utilization review of health care provided to Medicaid members through the Home and Community Based Services (HCBS) Waiver Programs. Members are reviewed to determine the medical necessity and the appropriateness of the care provided.

The Medical Services Unit utilizes physician-developed, explicit criteria when conducting a review. The nursing facility, skilled nursing facility, pediatric skilled, and ICF/MR criteria are screening tools for use by non-physician reviewers and do not constitute physician standards of care. When information provided by the attending physician and/or provider does not meet criteria for review staff approval, the attending physician is contacted to request additional information for the review. After the attending physician's response is received, or after receiving no response from the attending physician, and the nurse reviewer determines the member still does not meet medical necessity criteria, a Medical Services peer reviewer is contacted. Medical Services peer reviewers are licensed, practicing doctors of medicine, osteopathy or psychology. Whenever possible, Medical Services uses peer reviewers of similar specialty as the attending physician/psychologist.

The peer reviewer's determination will be made based on medical judgment, not criteria. Only peer reviewers may make a denial determination involving medical necessity in accordance with Iowa Administrative Code 79.9(2), which states the services covered by Medicaid shall:

- Be consistent with the diagnosis and treatment of the patient's condition.
- Be in accordance with standards of good medical practice.
- Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- Be the least costly type of service which would reasonably meet the medical need of the patient.

The case manager and Income Maintenance Worker are notified of Medical Services denial determination via ISIS.

The Medical Services Unit performs its responsibilities in accordance with regulations governing disclosure of confidential information regarding deliberation under the provision of 42 C.F.R. § 480.139 et. Sec. and the Medicaid Act 42 USC 1320 c-9(a)

Exhibit A-1

EXHIBIT B

Nursing Facility Level of Care Criteria

| | | | |
|-----------------------|-----------------------------|-------------------|------------|
| Iowa Medicaid Program | LTC Medical Criteria | Effective Date: | 1/29/2012 |
| Revision Number: | | Last Review Date: | 10/18/2013 |
| Reviewed By: | Clinical Advisory Committee | Next Review Date: | 10/2014 |
| Approved By: | Medicaid Medical Director | Approved Date: | 11/13/2013 |

Criteria:
 Nursing facility level of care can be approved if the following conditions are met:

1. Presence of a physical or mental impairment which restricts the ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene and impedes the capacity to live independently. The member's physical or mental impairment is such that self-execution of the required nursing care is improbable or impossible.
2. Services are provided in accordance with general provisions for all Medicaid providers and services as described within 441-79.9.

Change History:

| Change Date: | Changed By: | Description of Change: | New Version Number: |
|--------------|-------------|------------------------|---------------------|
| | | | |

Jason Kessler, MD
 Jason Kessler, MD

Exhibit B-1 Page 1 of 9

Skilled Level of Care Criteria

| | | | |
|-----------------------|-----------------------------|-------------------|------------|
| Iowa Medicaid Program | LTC Medical Criteria | Effective Date: | 1/29/2012 |
| Revision Number: | | Last Review Date: | 10/18/2013 |
| Reviewed By: | Clinical Advisory Committee | Next Review Date: | 10/2014 |
| Approved By: | Medicaid Medical Director | Approved Date: | 11/13/2013 |

Criteria:
 In order to approve skilled level of care for the waiver programs, the following conditions must be met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 405.311(1), 409.32, and 409.34.
2. Services are provided in accordance with general provisions for all Medicaid providers and services as described within 441-79.9.
3. Documentation submitted for review must indicate that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that addresses identified deficit areas.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services are provided by, or under the supervision of medical personnel as described above.
 - f. Skilled nursing services needed and provided seven days a week or skilled rehabilitative services needed and provided at least five days a week.

Change History:

| Change Date: | Changed By: | Description of Change: | New Version Number: |
|--------------|-------------|------------------------|---------------------|
| | | | |

Jason Kessler, MD
 Jason Kessler, MD

B-2 Page 2 of 9

Iowa Administrative Code - HUMAN SERVICES DEPARTMENT [441]

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

- a. Be consistent with the diagnosis and treatment of the patient's condition.
- b. Be in accordance with standards of good medical practice.
- c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- d. Be the least costly type of service which would reasonably meet the medical need of the patient.
- e. Be eligible for federal financial participation unless specifically covered by state law or rule.
- f. Be within the scope of the licensure of the provider.
- g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.
- h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 75 and 80.

441—81.1(249A) Definitions.

"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) Need for nursing facility care. Residents of nursing facilities must be in need of either nursing facility care or residential nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

D-2

CHAPTER 83. MEDICAID WAIVER SERVICES PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) Eligibility criteria.

d. Certified as being in need of the intermediate or skilled level of care. The IME medical services unit shall be responsible for approval of the certification of the level of care.

441—83.23(249A) Application.

83.23(3) Approval of application.

c. An applicant must be given the choice between elderly waiver services and institutional care. The consumer, guardian, or attorney in fact under a durable power of attorney for health care shall sign the service plan indicating the consumer's choice of caregiver.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A).

441—83.28(249A) Adverse service actions.

83.28(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.

441—79.9(249A) effective 7/1/09

441—81.1(249A) effective 4/1/11

441—81.3(249A) effective 4/1/11

441—Chapter 83 effective 7/1/09

|

D-3

EXHIBIT E


Fields of Opportunity

STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

April 5, 2011

RE: Appeal # MED 11000155 [REDACTED]
Case# [REDACTED]

FINAL DECISION

After review of the record the **PROPOSED DECISION** you received dated December [REDACTED] is **REVERSED**. This is the **FINAL DECISION** with modifications in the Decision, the Conclusions of Law and the Order.

DISCUSSION

On [REDACTED] the administrative law judge issued a Proposed Decision stating that the department incorrectly denied an application for waiver services. The judge determined that the appellant meet the level of care requirements.

This determination was based on the Code of Iowa Chapter 249J.11 as follows:

***249J.11 Nursing facility level of care determination for facility-based and community-based services.**
The department shall amend the medical assistance state plan to provide for all of the following:

1. That nursing facility level of care services under the medical assistance program shall be available to an individual admitted to a nursing facility, who meets eligibility criteria for the medical assistance program pursuant to section 249A.3, if the individual also meets any of the following criteria:
 - a. Based upon the minimum data set, the individual requires limited assistance, extensive assistance, or has total dependence on assistance, provided by the physical assistance of one or more persons, with three or more activities of daily living as defined by the minimum data set, section G, entitled "physical functioning and structural problems".
 - b. Based on the minimum data set, the individual requires the establishment of a safe, secure environment due to moderate or severe impairment of cognitive skills for daily decision making."

The administrative law judge indicated that the Code of Iowa set out two criteria for eligibility under the nursing facility level of care. The judge determined that the department determines someone meets level of care criteria based on subsection a. However, the judge believed that the department did not afford the same weight to the factors set out in subsection b. The judge determined the appellant met the criteria in subsection b and therefore met the level of care requirements for the elderly waiver.

1305 E WALNUT STREET - DES MOINES, IA 50319-0114 Exhibit E-1

- 2 -

However, the Code of Iowa reference given by the judge was related to when the department has to amend the medical assistance state plan for IowaCare. This is not related to this appeal and is therefore removed from the Conclusions of Law.

ISSUE

Whether the Department correctly denied an application for waiver services because the level of care the applicant needs is not the level of care that matches the waiver applied for.

DECISION

The department's decision is **AFFIRMED**.

CONCLUSIONS OF LAW

The **CONCLUSIONS OF LAW** of the Proposed Decision are **MODIFIED** in the following manner:

Delete all the paragraphs after the one that begins, [REDACTED], and insert the following in its place:

During the appeal hearing, the appellant testified that [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] The appellant explained that [REDACTED]
[REDACTED]
[REDACTED]

Based on the information in the appeal record, the appellant is [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Upon review of the appeal record, the appellant's abilities do not indicate that [REDACTED]. Based on this, the department's determination that the appellant did not meet level of care is **AFFIRMED**.

ORDER

The department's decision is **AFFIRMED**. The local office shall take any action necessary to implement this decision.

E-2

130.5(3) Reduction. A particular service may be reduced when the department determines that:

- a. Continued provision of service at its current level is not necessary. The department shall determine the level to which the service may be reduced without jeopardizing the client's continued progress toward achieving or maintaining the goal. The client shall be notified of the decision.
- b. Another community resource is available to provide the same or similar service to the client at no financial cost to the client, that will meet the client's needs.
IAC 7/2/06 Human Services[441] Ch 130, p 5
- c. Funding is not available to continue the service at the current level. The client shall be reassessed to determine the level of service to be provided.
- d. Rescinded IAB 6/9/04, effective 7/1/04.

130.5(4) Rescinded, effective 6/1/04.

130.5(5) Pending changes. Workers shall endeavor to make clients aware of pending changes in services to be provided by social services block grant from one program year to the next, particularly for those services that will no longer be available. This requirement also applies to time-limited services.

130.5(6) Inability of eligible cases to pay fees. After billing or notification of termination and when the client reports in writing the inability to pay the fee due to the existence of one or more of the conditions set forth in the paragraphs below, and the worker assesses and verifies the condition, service shall be continued without fee until the condition no longer exists and the client is able to participate in the current fee for service. The worker shall assess all inability to pay cases to determine whether any case can be charged a reduced fee. The reduced fee shall then be charged until full participation in fees is possible.

- a. Extensive medical bills for which there is neither payment through the medical assistance program, Title XVIII of the Social Security Act, nor other insurance coverage.
- b. Shelter costs in excess of 30 percent of the household income.
- c. Utility costs not including the cost of a telephone, in excess of 15 percent of the household income.
- d. Rescinded 10/30/91, effective 11/1/91.
- e. Additional expenses for food resulting from diets prescribed by a physician.
This rule is intended to implement Iowa Code section 234.6.

F

| | | | |
|---|--|---------|--------------|
|  | CHAPTER SUBJECT: | CHAPTER | PAGE |
| | COVERAGE AND LIMITATIONS HCBS ELDERLY WAIVER SERVICES | | E - 24 |
| | | DATE: | July 1, 2000 |

III. COVERED SERVICES

All services are provided according to the individualized consumer need as identified in the service plan. Prior to service provision, the provider must obtain documentation of services, units, rates and time period authorized. The documentation should include one of the following:

- A copy of the Notice of Decision.
- A copy of the Service Plan.

The following sections list the general exclusion and limitations of waiver services, then detail the coverage requirements for each specific service.

A. Exclusions

1. Services Otherwise Available

Consumers may use services available under the regular State Medicaid Plan in addition to using the waiver services. When the same or similar service is available from an alternate source free of charge, the consumer must also use that service before using the waiver services.

Nursing and home health aide services may be reimbursed through the waiver only after the regular State Medicaid Plan or alternate-source reimbursement limits are met.

Consumers must obtain durable adaptive equipment available under the State Medicaid program, if applicable, before accessing the waiver's home and vehicle modifications or assistive devices services.

2. Duplicate Services

A person may be enrolled in only one waiver program at a time. For example, a person enrolled in the HCBS ill and handicapped waiver may not be enrolled in the HCBS elderly waiver at the same time.

F

RFP Reference:

6.2.1.2.e

Interfaces:

N/A

Attachments:

N/A

MED - Long Term Care Waivers - Review Coordinator Peer-to-Peer Internal Quality Control

Purpose: Internal quality control (IQC) is a peer-to-peer review process completed on a percentage of LOC reviews from the previous month.

Identification of Roles:

Lead Review Coordinator - Coordinates IQC reviews for inconsistencies; resolves discrepancies.

Review Coordinator - Completes selected reviews for IQC process, enters results into spreadsheet.

Manager – Reviews inconsistencies and provides additional staff feedback.

Performance Standards:

- Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: By the fifth business day of the month the LRC will manually select random internal quality control (IQC) reviews and assign to review coordinator to complete IQC.

Step 2: The statistically valid samples of admission and subsequent service reviews are pre-determined.

Step 3: The LRC will distribute lists to staff folders located on the “L” drive – Staff IQC Pulls 2014.

Step 4: See Administrative Functions – Internal Quality Control for general procedures.

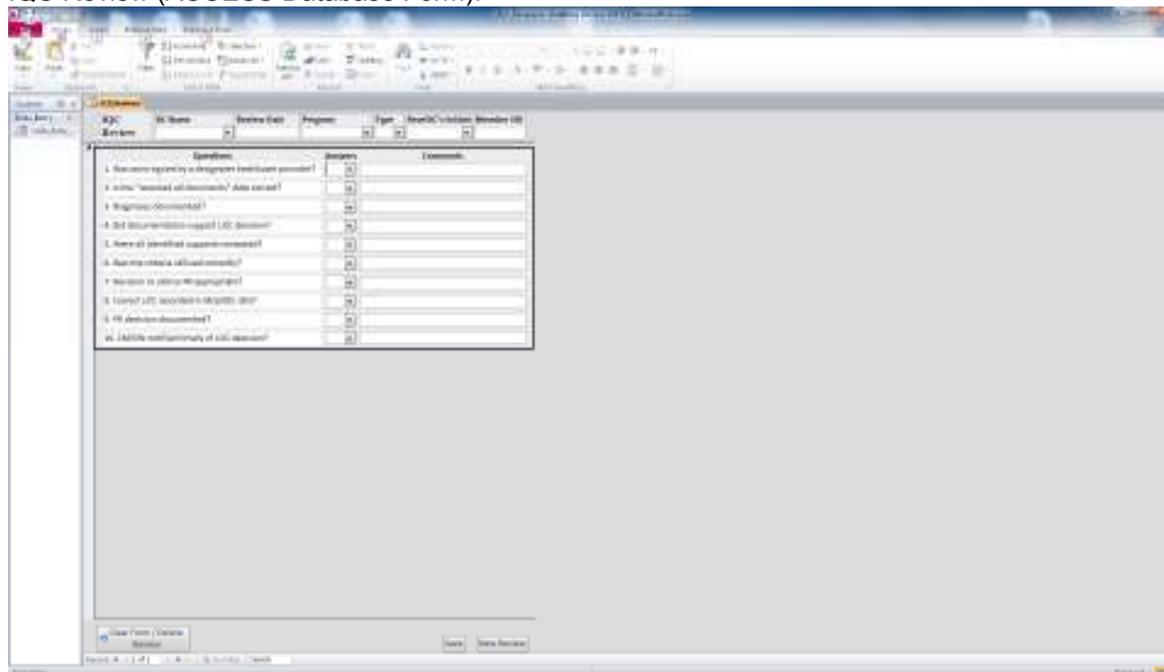
Step 5: The RC will complete the IQC review:

Step 6: The review coordinator completes the IQC review by entering the data onto the Access database form.

- a. RC completing the data entry form goes into RC Name box. This is a drop down box.
- b. The Review Date is the date the review was completed in MQUIDS.
- c. Program is a dropdown of all waiver programs to choose from.
- d. The initials of the RC being reviewed are entered into the initials of Reviewed RC box. This is a drop down box.
- e. The SID# of the member needs to be entered.
- f. Q1 - Is the document signed by a designated health care professional?
- g. Q2 - The “received all documents” date is the date the decision is made to approve or send to physician review.
- h. Q3 – Were diagnoses entered for all but denials? If denial, mark NA.
- i. Q4 – Did the documentation support the LOC decision?
- j. Q5 – Were attempts made to contact the physician prior to PR?

- k. Q6 – Were the criteria utilized correctly? This question is looking to assure that the correct criteria were coded. For example, for skilled level of care check to see that the skilled criteria were entered into MQUIDS.
- l. Q7 – Decision to utilize PR appropriate? Should the case have gone to PR?
- m. Q8 – Was the correct level of care recorded in MQUIDS/ISIS?
- n. Q9 – PR decision documented? Were the PR and rationale charted under the Physician Review tab in MQUIDS?
- o. Q10 – CM/SW notified timely of LOC decision? Checking in ISIS that decision was entered timely and if not, looking in MQUIDS for an entry indicating the RC did not have an open milestone.

IQC Review (ACCESS Database Form):



The screenshot displays a software interface for an IQC Review. It features a table with three columns: 'Questions', 'Answers', and 'Comments'. The 'Questions' column contains ten items, each with a corresponding 'Answers' column containing a dropdown menu and a 'Comments' column. The questions are:

| Questions | Answers | Comments |
|--|------------|----------|
| 1. Questions signed by a designated individual provider? | [Dropdown] | |
| 2. Were "medical milestones" data coded? | [Dropdown] | |
| 3. Diagnosis documented? | [Dropdown] | |
| 4. Did documentation support LOC decision? | [Dropdown] | |
| 5. Name of identified equipment? | [Dropdown] | |
| 6. Skilled criteria utilized correctly? | [Dropdown] | |
| 7. Reason to stop appropriate? | [Dropdown] | |
| 8. Correct LOC recorded in MQUIDS/ISIS? | [Dropdown] | |
| 9. PR decision documented? | [Dropdown] | |
| 10. Milestone entry/entry of LOC decision? | [Dropdown] | |

Step 7: The LRC will review spreadsheet and forward appropriate feedback to each RC insuring that corrections are made in a timely manner and provide education training or other remediation as needed.

Step 8: The LRC will review IQC findings at monthly meetings.

Step 9: The manager will discuss with each RC their IQC error or inconsistency rate during coaching sessions.

Step 10: Manager will report the team’s monthly IQC outcomes on MedSrv_Reports/ Quarterly Workbooks/ FYXX IQC.

Forms/Reports:

IQC Outcome Report (Microsoft Excel)

| IQC | | | | | | |
|----------------------|-------------|-----------------|--------------|-------------|------------|----------|
| Programs | Reviewed | Possible Points | Points >95% | Peer | Manager | |
| AIDS | 63 | 630 | 622 | 55 | 6 | 0 |
| BI | 180 | 720 | 720 | 179 | 1 | 0 |
| CMH | 167 | 668 | 668 | 167 | 0 | 0 |
| WPA | 738 | 2952 | 2949 | 735 | 3 | 0 |
| Elderly | 536 | 5360 | 5174 | 418 | 118 | 0 |
| ID | 361 | 1444 | 1444 | 361 | 0 | 0 |
| IH | 522 | 5220 | 5041 | 459 | 63 | 0 |
| PD | 470 | 4700 | 4507 | 359 | 111 | 0 |
| Total Waivers | 3037 | 21694 | 21125 | 2733 | 304 | 0 |
| Acute and OTP Retro. | 101 | 909 | 907 | 100 | 1 | 0 |
| PA | 775 | 5425 | 5392 | 755 | 20 | 0 |
| NF | 465 | 3720 | 3700 | 445 | 20 | 0 |
| ICFIID | 0 | 0 | 0 | 0 | 0 | 0 |
| HAB | 182 | 1092 | 1087 | 177 | 5 | 0 |
| Prepay | 990 | 4950 | 4933 | 973 | 17 | 0 |
| HH Retro. | 0 | 0 | 0 | 0 | 0 | 0 |

This page is READ ONLY - to make entry, go to the appropriate month

RFP Reference:

6.2.4.2

Interfaces:

- IQC Access Database
- MQUIDS
- ONBASE
- ISIS

Attachments:

N/A

MED - Long Term Care Waivers - Reports

Purpose: To meet all performance standards and complete all required reports.

Identification of Roles:

Manager - Tracks and reports performance standards, updates manual and completes reports

Performance Standards:

Provide the required reports within ten business days of the end of the reporting period (quarter). Provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in the prior month of June.

Path of Business Procedure:

Step 1: The manager will access ISIS management reports and clinical data documented in WPM to report the following to DHS policy staff monthly:

- a. IQC Outcome Reports
- b. Timeliness Report
- c. Waiver Late Assessments
- d. LTC Complete Monthly Report

Step 2: The manager enters quarterly outcome and timeliness data in spreadsheet located at MedSrv_Reports/ Quarterly Workbooks within specified timeframes.

Step 3: From the MQUIDS reports, the manager will provide the program specialist with review outcomes for each type of waiver.

- a. Number of members in each level of care
- b. Number of denials
- c. Percentage of determinations completed within 2 business days for admits and 5 days of receipt of all information for CSRs.
- d. Percentage of LOC determinations within 5 days for admits and 10 days of receipt of all information for CSRs.
- e. Number of Pending reviews
- f. Late assessment remediation date.

Step 4: Manager completes cost avoidance report and provides data to program specialist within specified timeframes.

Forms/Reports:

Quarterly Review Outcome Report

| Waiver | 1 st Quarter | | 2 nd Quarter | | 3 rd Quarter | | 4 th Quarter | | Year to Date | |
|---------------|-------------------------|--|-------------------------|--|-------------------------|--|-------------------------|--|--------------|--|
| Admission LOC | | | | | | | | | | |
| Approvals | | | | | | | | | | |
| Denials | | | | | | | | | | |
| Annual LOC | | | | | | | | | | |
| Approvals | | | | | | | | | | |
| Denials | | | | | | | | | | |

RFP Reference:

- 6.1.3.4.1
- 6.1.3.4.3
- 6.2.4.2

Interfaces:

- ISIS
- MQUIDS

Attachments:

N/A

MED - Long Term Care Waivers - Quality Assurance Review Member Information Request

Purpose: To request information supporting CMS quality assurance requirements of the Medicaid member's interdisciplinary team records.

Identification of Roles:

Review Coordinator (RC) – completes a quality assurance interdisciplinary review of all information received.

Program Specialist – manages the quality assurance database.

Review Assistant (RA) – completes support activities of mail merge, requesting documents, preparing letters and printing letters and final tools.

Manager – monitors database, review outcomes, data and process to ensure consistency, efficiency and accuracy.

Performance Standards: Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: DHS determines sample to be pulled by Data Warehouse.

Step 2: Data warehouse prepares and submits list to the OnBase team.

Step 3: RA sends the TCM/CM/SW and specific provider(s) a letter requesting information using names and addresses from ISIS.

Step 4: RA mails second request letter to those TCM/CM/SWs and provider(s) who have not submitted information within 15 business days.

Step 5: Medical records and/or documentation received at IME facility from providers at the front desk, through a fax or the mailroom will be electronically scanned and forwarded to the RC upon arrival.

Step 6: Compact discs of information will be forwarded to the RA to batch together, import into OnBase and forward to the RC.

Step 7: RC begins the quality review upon receipt of requested records.

Forms/Reports: First and Second Request letter



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

[REQUEST_NUMBER] REQUEST

[Worker_Name]
[Worker_Addr]
[Worker_City], [Worker_State] [Worker_Zip]

RE: [Member_Name] SID# [State_ID]

The Iowa Medicaid Enterprise (IME) Medical Services Unit conducts quality reviews of waiver provider records under contract with the Iowa Department of Human Services. The purpose is to perform a comprehensive quality review of all services received by randomly selected Medicaid members.

Do not send original documents. Please submit copies of [Member_Name_2] records for the dates of [Begin_Date] through [End_Date], including:

- Waiver assessment tool
- Comprehensive assessment
- Service plan
- Crisis plan
- Safety plan
- CDAC agreement
- Contact records
- Documentation regarding referrals and follow-up
- Documentation supporting identified level of care
- Incident reports
- Goals and outcome documentation

Use this request as your face sheet to better process your information. This information should be received by IME within fifteen (15) business days from date of this request. Documentation should not include paper clips, staples or highlighting. Information should be faxed or mailed to:

Iowa Medicaid Enterprise
[Unit_Name]
P.O. Box 36478
Des Moines, IA 50315
Fax number [Fax_Number]

Information can also be submitted on compact disc (CD) in PDF format only. Your cooperation in submitting the member's record for review is mandated by the Department of Human Services.
[Contact_Info]

Iowa Medicaid Enterprise
Medical Services

cc: [Worker_Supervisor]

Reference #: [Reference]

A copy of this letter must be included as the first page of your documentation.

470-4964 (8/10)

MED - Quality Long Term Care Waivers - Quality Assurance Review Completion

Purpose: To review documentation from providers to confirm compliance with CMS quality assurance requirements

Identification of Roles:

Review Coordinator (RC) – completes a quality assurance interdisciplinary review of all information received.

Review Assistant (RA) – completes review support tasks including mail merge, preparing letters and printing letters and final tools.

Manager – monitors process and ensures consistent and accurate outcomes.

Performance Standards:

Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: RC utilizes the member's record and all records submitted by providers from the interdisciplinary team to complete the identified measures located in the quality tool.

Step 2: RC completes one tool to be submitted to all the providers who submitted records within 10 days of receiving information.

Step 3: RC reviews submitted records to identify the following items:

- a) Service plan addresses the member's assessed health risks
- b) Service plan has intervention/s to address assessed safety risks.
- c) Service plan addresses the member's assessed needs
- d) Service plan contains a plan for emergencies and supports available to the member in the event of an emergency
- e) Service plan addresses the member's personal goals.
- f) Service plan contains signature of member or guardian.
- g) Service plan names all of the member's providers.
- h) Service plan lists the funding source for all services listed on the plan.
- i) Service plan lists the amount of services to be received by the member.
- j) Services identified on the service plan appear to be received by the member.

Step 4: RC records information as specified on the quality assurance form in OnBase, providing a score and rationale as follows:

| Measure | Scoring Set | Set 1 - Used for scoring Set 2 - Optional additional comments or education that can be provided Set 3 - Remediation for those that score a "No" |
|----------------|--------------------|--|
| QC1A | | QC1A |

Service plan addresses the member's assessed health risks

Set 1

All assessed health risks were addressed. – Yes

Not all assessed health risks were addressed. – No
Documentation was not provided to IME that identifies health risks. – No
Documentation provided and no health risks were identified on assessment; member has notable health risks.– No

Set 2

Service plan needs to be updated and include information about identified health risks.
Assessment does not contain a health risk section.

Set 3

Recommend health risks be reviewed and interventions put into place.
Recommend health assessment be completed and findings documented in the service plan.

QC1B

Service plan has intervention/s to address assessed safety risks.

Set 1

All assessed safety risks were addressed on service plan.– Yes

Not all assessed safety risks were identified on service plan. – No
Safety risks were not identified on service plan. – No
Safety plan documentation not provided to IME. – No

Set 2

Safety risks identified in assessment were not addressed in a safety plan.
Safety risks identified in provider documentation, were not addressed in safety plan.
Service plans must address the member's safety risks.

Set 3

Recommend safety assessment be completed and findings documented in the service plan.
Recommend service plan be updated to include interventions for all safety risks that are identified.
Recommend safety interventions be documented in the service plan.

QC1C

Service plan addresses the member's assessed needs

Set 1

Service plan addresses all identified needs. – Yes

Not all identified needs were on the service plan. – No
Service plan does not address any of the identified needs. – No
Service plan was not provided to IME. – No
Service plan identified needs that are not consistent with the member's abilities described on the assessment. - No

| | | |
|--|--------------|--|
| | Set 2 | Service plan must address all identified needs of the member. Service plan includes services that were provided when the member was assessed to be independent in that area. |
| | Set 3 | Recommend service plan be updated to address all identified needs. Recommend needs assessment be updated. Recommend new level of care review be initiated to determine accurate appropriate level of care. Recommend updating service plan to remove services that do not match an assessed need. |

QC1D

Service plan contains a plan for emergencies and supports available to the member in the event of a emergency

QC1D

| | | |
|--|--------------|---|
| | Set 1 | Service plan contains an emergency plan. – Yes Service plan did not contain an emergency plan.– No Emergency plan does not address all identified risks. - No |
| | Set 2 | Good documentation of an emergency plan is present in the service plan. Emergency plan must identify all identified risks. |
| | Set 3 | Recommend emergency plan be documented in the service plan. Recommend emergency plan be updated to address identified risks. |

QC1E

Service plan addresses the member's personal goals.

QC1E

| | | |
|--|--------------|---|
| | Set 1 | Service plan reflects individual personal goals. - Yes Service plan does not address personal goals. - No Goals were not provided to IME for review. - No Services are present without identified goals - No |
| | Set 2 | Goals were written; however, they were not personalized. Goals are not current for this member. All services must have an identified goal. |
| | Set 3 | Recommend service plan be updated to include the member's personal goals. Recommend development of goals for all services. |

| | | |
|--|--------------|---|
| | Set 2 | All service plans should indicate the amount of services to be received by the member. |
| | Set3 | Recommend updating the service plan to indicate the amount of service to be received by the member. |
| QC1J Services identified on the service plan appear to be received by the member. | | QC1J |
| | Set 1 | All services listed appear to be received by the member.- Yes Services listed on the plan do not appear to be received by the member. - No |
| | Set 2 | Verification should be completed ensuring the member is receiving all services identified in the service plan. Not all providers have submitted records to determine if services were provided. Unable to verify receipt of services. |
| | Set3 | Recommend verification of services with member. |

| Member Name: [REDACTED] | | SO: [REDACTED] |
|--|------|---|
| Date of Desk Review: 04/01/2013 | | Reporting Month: 201302 |
| Review Coordinator: [REDACTED] | | |
| MEDICAL SERVICES - - WAIVER QUALITY TOOL | | |
| Quality Component: (1) Member's service plan developed and implemented toward a positive outcome. | | |
| Measure | Met? | Comments |
| A Service plan addresses the member's assessed health risks. | Y | All assessed health risks were addressed. (Yes) [Set 2 - Optional] [Set 3 - Remediation] |
| Notes | | |
| B Service plan has intervention/s to address assessed safety risks. | Y | All assessed safety risks were addressed on service [Set 2 - Optional] [Set 3 - Remediation] |
| Notes | | |
| C Service plan addresses the member's assessed needs. | Y | Service plan addresses all identified needs. (Yes) [Set 2 - Optional] [Set 3 - Remediation] |
| Notes | | |
| D Service plan contains a plan for emergencies and supports available to the member in the event of a emergency. | Y | Service plan contains an emergency plan. (Yes) [Set 2 - Optional] [Set 3 - Remediation] |
| Notes | | |
| E Service plan addresses the member's personal goals. | Y | Service plan reflects individual personal goals. (Yes) [Set 2 - Optional] [Set 3 - Remediation] |
| Notes | | |
| F Service plan contains signature of member or guardian. | Y | Service plan contains signature of member or guardian [Set 2 - Optional] [Set 3 - Remediation] |
| Notes | | |
| G Service plan names all of the member's providers. | Y | Documentation indicates the service plan lists all pro [Set 2 - Optional] |

Above is a partial picture of the form that the RC uses to enter the information in OnBase.

Step 5: RC's completion of the form will populate the outcome of the quality assurance review that will be included in a follow-up letter to the TCM/CM/SW and provider.

Step 6: RC will provide additional comments to assist the TCM/CM/SW and provider in improving scores.

Step 7: Manager reviews completed form for accuracy and ensures appropriate clarifying comments are included to provide feedback to TCM/CM/SW and providers.

Step 8: RA mails completed quality assurance tools to provide the review outcome details to the TCM/CM/SW and providers. Written outcomes are provided to TCM/CM/SW and providers within 30 calendar days of receipt of information. If a provider did not supply documentation for a review then the provider will receive the "records not received" letter.

Forms/Reports:

Final letter and tool if records were submitted:



[Prov_Name]
[Prov_Addr]
[Prov_City], [Prov_State] [Prov_Zip]

RE: [Member_Name] SID# [State_ID]

Dear Waiver Provider:

The Iowa Medicaid Enterprise (IME) Medical Services Unit conducts quality reviews of waiver provider records under contract with the Iowa Department of Human Services. The purpose is to perform a comprehensive quality review of all services received by randomly selected Medicaid members. The review results are shared with all providers that submitted documentation as part of the quality review. Enclosed is the completed review.

[Contact_Info]

Iowa Medicaid Enterprise
Medical Services

Enclosure

470-4867 (5/10)

Iowa Medicaid Enterprise – 100 Army Post Road - Des Moines, IA 50319

Member Name:

SID:

Date of Desk Review:

Reporting Month:

Review Coordinator:

MEDICAL SERVICES - - WAIVER QUALITY TOOL

Quality Component: (1) Member's service plan developed and implemented toward a positive outcome.

| Measure | Met? | Comments |
|--|------|-----------------------|
| A Service plan addresses the member's assessed health risks. | - | [Set 1 - Scoring] |
| | | [Set 2 - Optional] |
| | | [Set 3 - Remediation] |
| Notes | | |
| B Service plan has intervention/s to address assessed safety risks. | - | [Set 1 - Scoring] |
| | | [Set 2 - Optional] |
| | | [Set 3 - Remediation] |
| Notes | | |
| C Service plan addresses the member's assessed needs. | - | [Set 1 - Scoring] |
| | | [Set 2 - Optional] |
| | | [Set 3 - Remediation] |
| Notes | | |
| D Service plan contains a plan for emergencies and supports available to the member in the event of a emergency. | - | [Set 1 - Scoring] |
| | | [Set 2 - Optional] |
| | | [Set 3 - Remediation] |
| Notes | | |
| E Service plan addresses the member's personal goals. | - | [Set 1 - Scoring] |
| | | [Set 2 - Optional] |
| | | [Set 3 - Remediation] |
| Notes | | |
| F Service plan contains signature of member or guardian. | - | [Set 1 - Scoring] |
| | | [Set 2 - Optional] |
| | | [Set 3 - Remediation] |
| Notes | | |
| G Service plan names <u>all</u> of the member's providers. | - | [Set 1 - Scoring] |
| | | [Set 2 - Optional] |
| | | [Set 3 - Remediation] |
| Notes | | |

| | | | |
|--------------|--|---|---|
| H | Service plan lists the funding source for all services listed on the plan. | - | <input type="text" value="[Set 1 - Scoring]"/> <input type="text" value="[Set 2 - Optional]"/> <input type="text" value="[Set 3 - Remediation]"/> |
| Notes | | | |
| I | Service plan lists the amount of services to be received by the member. | - | <input type="text" value="[Set 1 - Scoring]"/> <input type="text" value="[Set 2 - Optional]"/> <input type="text" value="[Set 3 - Remediation]"/> |
| Notes | | | |
| J | Services identified on the service plan appear to be received by the member. | - | <input type="text" value="[Set 1 - Scoring]"/> <input type="text" value="[Set 2 - Optional]"/> <input type="text" value="[Set 3 - Remediation]"/> |
| Notes | | | |

WAIVER QUALITY TOOL - OVERALL SCORE - NOTES

| Score | Notes |
|---------|-------|
| 0 of 10 | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Records not received letter:



Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

[Worker_Name]
[Worker_Addr]
[Worker_City], [Worker_State] [Worker_Zip]

RE: [Member_Name] SID# [State_ID]

Dear Waiver Provider:

The Iowa Medicaid Enterprise (IME) Medical Services Unit conducts quality reviews of waiver provider records under contract with the Iowa Department of Human Services. The purpose is to perform a comprehensive review of all services received by randomly selected Medicaid members. However, a review was not conducted as no records were submitted to IME.

[Contact_Info]

Iowa Medicaid Enterprise
Medical Services

cc: [Worker_Supervisor]

MED - Long Term Care Waiver - Quality Assurance Review Reporting

Purpose: To complete and submit reports to DHS on an adhoc basis. DHS Quality Assurance Specialist has access to all of the data collected. At times, specific data may be requested of Medical Services.

Identification of Roles:

Program Specialist - Assembles data and positions data into report format

Manager - Reviews reports

Performance Standards:

Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: Upon request of the department, the program specialist will utilize OnBase database and run queries to extract data.

Step 2: The program specialist will place data into approved report formats and submit to the manager as requested.

Step3: The manager will review reports and submit to DHS.

Forms/Reports:

Medical Services will provide ad hoc report data

RFP Reference:

6.2.4.2.G

Interfaces:

N/A

Attachments:

N/A

MED - Long Term Care Waivers - Disruption of Business Plan

Purpose: To provide procedures for the continuation of business in the event of inability to utilize electronic programming.

Identification of Roles:

Review Coordinator (RC) – responds to LOC requests. All activities will be noted on the manual tracking log.

Review Assistant (RA) – receives LOC request, enters on spreadsheet, routes to the appropriate RC and sends notices to providers as needed. All activities will be noted on the manual tracking log.

Manager – provides training and oversight in the field, tracks performance standards, produces reports for medical services and conducts internal quality control for review decisions.

Performance Standards:

Performance standards are not specified for this procedure.

Path of Business Procedure:

Step 1: The RA will receive LOC certification forms by fax.

Step 2: The RA will forward the request by telephone to the RC based on the criteria established by the manager.

Step 3: The RA will log calls and capture the following information:

- a. Date received
- b. Member name
- c. Member SID
- d. Caller name
- e. Services requested
- f. RC assigned

Step 4: The RC will document LOC determinations in a paper tool:

- a. Date Received
- b. Member Name
- c. Member SID
- d. Type of program request
- e. Date additional information requested
- f. Date additional information received
- g. Date of PR
- h. Status of request

Step 5: The RC will document review information following the LOC review outline.

Step 6: The RC will enter review information in WPM and ISIS when systems are restored.

Step 7: The RC will document compliance with criteria by paper copies of criteria utilized for IQC process.

Step 8: See operational procedure Medical Services Business Disruption Plan located at IME Universal/Operational Procedures/Medical Services for additional actions to be taken.

Forms/Reports:

Following is the paper tool the RC will complete.

Iowa Department of Human Services
 Iowa Medicaid Enterprise (IME)
 Medical Services Unit

| <i>Date Received</i> | Member Name | Member SID | Service Requested | Date additional information requested | Date information received | Date of PR | Status of LOC determination |
|----------------------|-------------|------------|-------------------|---------------------------------------|---------------------------|------------|-----------------------------|
| | | | | | | | |

Following is the Call Log Spreadsheet the RA will complete

| Date received | Date/Time RC contacted | Member name | Member SID | Caller Name | RC assigned | Services Requested |
|---------------|------------------------|-------------|------------|-------------|-------------|--------------------|
| | | | | | | |

RFP Reference:

6.2.4.2

Interfaces:

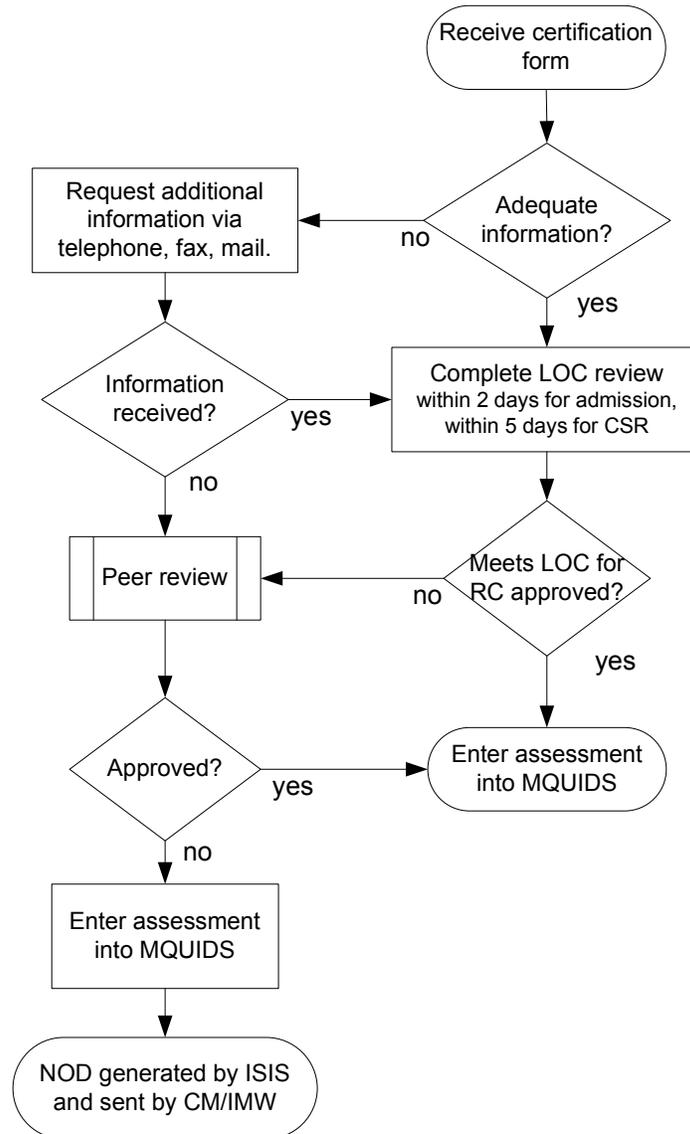
N/A

Attachments:

N/A

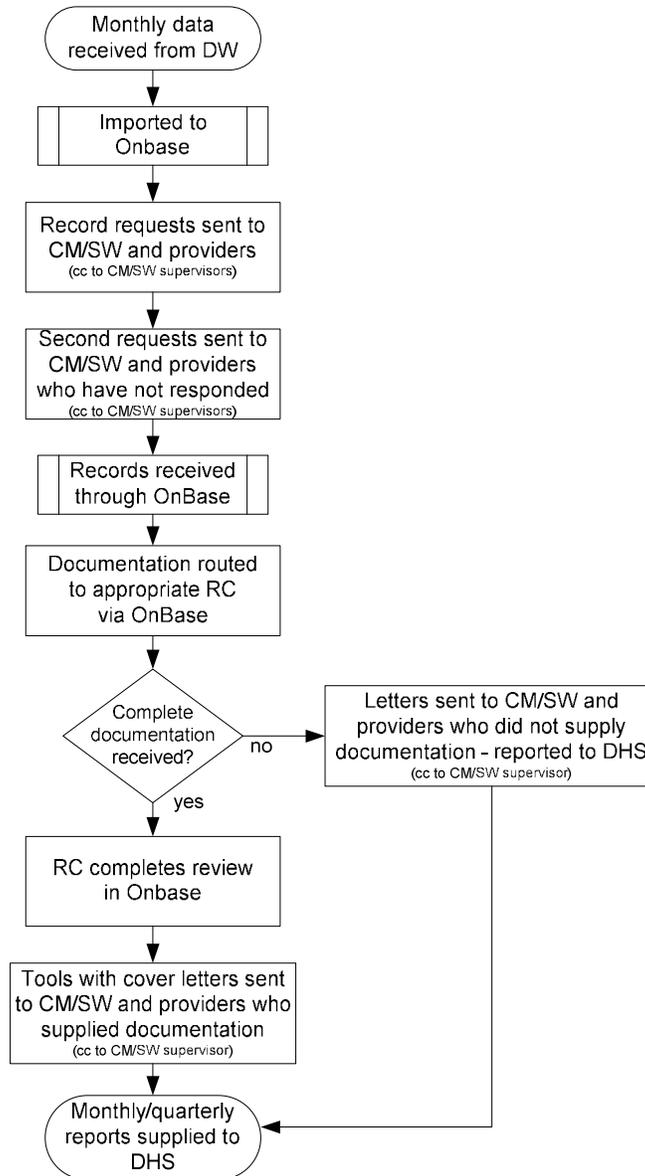
Attachment A:

Medical Waiver Assessments



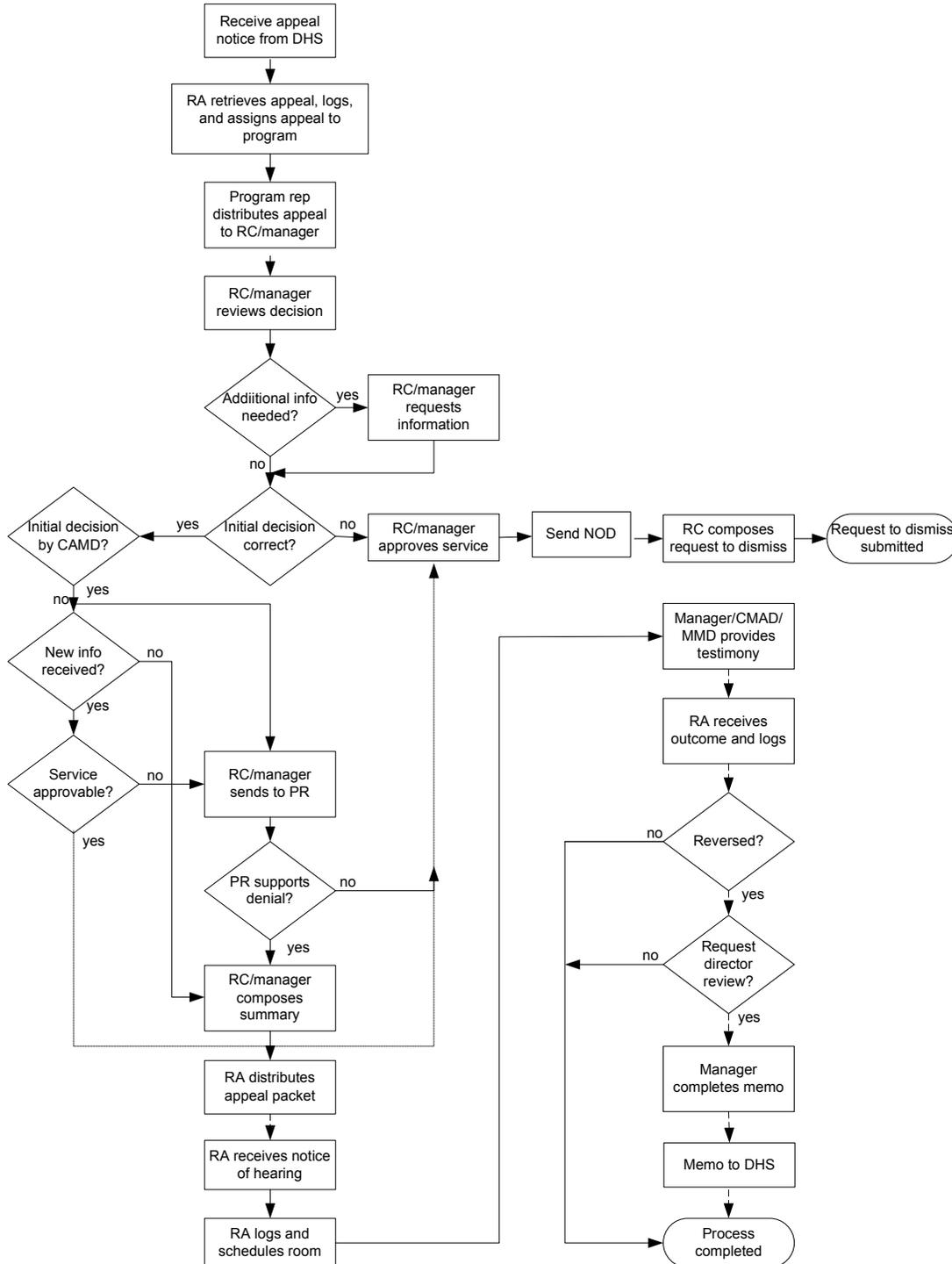
Attachment B:

Waiver QA



Attachment C:

ADMINISTRATIVE LAW JUDGE APPEALS



¹ Iowa Administrative Code 441-79.9(2)

² Iowa Administrative Code 441-81.3(1)(a)

³ 42 CFR 440.40

⁴ Iowa Administrative Code 441- Chapter 83 Preamble and 42 CFR 440.302(c)(1)

⁵ 42 CFR 441.302(c)(1)

⁶ Iowa Administrative Code 441-79.9(2) and Iowa Administrative Code 441-81.3(1)(a)

⁷ Iowa Administrative Code 441-79.9(2)

⁸ Iowa Administrative Code 441-81.3(1)(a)

⁹ 42 CFR 440.40

¹⁰ Iowa Code 135C.1(13); Iowa Administrative Code 441-81.1; Sec. 1919. [42 U.S.C. 1396r] ; 42 CFR 440.40

¹¹ Iowa Administrative Code 441- Chapter 83 Preamble and 42 CFR 440.302(c)(1)

¹² 42 CFR 441.302(c)(1)

¹³ Iowa Administrative Code 441-79.9(2) and Iowa Administrative Code 441-81.3(1)(a)