

## COP-Waiver QA Monitoring LONG Record Review Form

Participant: \_\_\_\_\_ Care Manager: \_\_\_\_\_ County: \_\_\_\_\_

Reviewer: \_\_\_\_\_ Review Date: \_\_\_\_\_ Response Due Date: \_\_\_\_\_

For every numbered item circle **YES**, **NO**, or **NA**.

<b>YES</b>	Circle YES next to an item if the necessary documentation exists, is accurate, and complete for that item. YES should only be indicated if the item can be verified by a federal auditor.
<b>NO</b>	Circle NO next to an item that cannot be verified, is not documented, if policies or procedures are out of compliance, and/or information or documentation is incomplete. <b>All items with a NO indication must include a Problem Description and Required Action.</b> (Except #9, where 1 missed CM contact will not require action)
<b>NA</b>	Circle NA next to an item if it is not applicable to the participant record being reviewed.

### ELIGIBILITY – Financial

1. A Medicaid Waiver Eligibility & Cost Sharing Worksheet OR the CARES ECED & ECSC were completed as needed to ensure Medicaid eligibility continued for the review period.

YES	Problem Description:	Required Action:	Potential Disallowance:
NO			System Issue?

### Care Management Contacts

START DATE: \_\_\_\_\_

MO/YR	1/09	2/09	3/09	4/09	5/09	6/09	7/09	8/09	9/07	10/09	11/09	12/09
Paperwork												
Coll. Contacts												
Direct Contacts												
Face to Face Contact												
6 Month Reviews												
I/H Days												
SPC 604												

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2. For a participant with a cost share obligation there is documentation to verify:

Cost Share Recorded											
1/07	2/07	3/07	4/07	5/07	6/07	7/07	8/07	9/07	10/07	11/07	12/07

- The cost share payments were made either to the county or vendor
- The service was provided
- The cost of services covered by the cost share payment was not billed to the waiver program
- The amount of cost share collected was correct (no underpayment or overpayment)
- The deductions used to determine if or what the cost share amount is, was calculated correctly (medical/remedial expenses over \$100 are correct; and for participants residing in substitute care, check if the special housing deduction given was correct, or should have been given)

YES  
NO  
NA

Problem Description:

Required Action:

Potential Disallowance:

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System Issue?

3. For a participant with a spenddown obligation, there is documentation to verify that the care manager monitored whether the spenddown obligation was met and/or paid out on a monthly basis.

YES  
NO  
NA

Problem Description:

Required Action:

Potential Disallowance:

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System Issue?

### ELIGIBILITY – Non-financial

4. For a participant on the waiver program less than 12 months, a Health Form and LTC-FS OR the LTC-FS and supplement (signed by a RN) were filled out correctly and completely, are in the file, and an appropriate LOC has been established for CIPII/COP-W. Reminder: A DD Only LOC is not acceptable.

For a participant on the waiver program more than 12 months, a Health Form and Automated LTC-FS were filled out correctly and completely, are in the file, and an appropriate LOC has been established for CIPII/COP-W. Reminder: A DD Only LOC is not acceptable.

2008      2009

**HF  
Auto LTC-FS  
Supplement**

YES  
NO  
NA

Problem Description:

Required Action:

Potential Disallowance:

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System Issue?

**COP-Waiver QA Monitoring  
Record Review Form**

**SERVICE PLAN**

5. All services paid by the waiver were allowable.

<b>YES</b>  <b>NO</b>  <b>NA</b>	Problem Description:	Required Action:	Potential Disallowance:
			System Issue?

**DOCUMENTATION OF STANDARDS AND REQUIREMENTS**

6. If applicable, there is documentation that the participant was granted an exception to the required face to face, care management contacts, and this exception was redocumented every twelve months.

<b>YES</b>  <b>NO</b>  <b>NA</b>	Problem Description:	Required Action	Potential Disallowance:
			System Issue?

7. All required care management contacts (recipient and/or collateral) were made. **\*Note: While still an error, there is no required action unless there is more than one missed required contact for this participant.**

<b>YES</b>  <b>NO</b>  <b>NA</b>	Problem Description:	Required Action:	Potential Disallowance:
			System Issue?

## COP-Waiver QA Monitoring Record Review Form

8. Documentation exists to verify that the standards, as outlined in the Medicaid Waiver Manual, were met for the following services (**Check all that apply**):

- Adaptive Aids/Adaptive Aids Vehicle Related* (SPC 112.99 & 112.57) – Cannot be paid by Medicaid. If item is over \$2,000.00, documentation from PT, OT, etc. is required.
- Communication Aids* (SPC 112.47) – Cannot be paid by Medicaid. If item is over \$2,000.00, documentation from PT, OT, etc. is required.
- Counseling & Therapeutic Resources* (SPC 507) – Cannot be paid by Medicaid. Must be related to a therapeutic goal or meet an assessed need.
- Daily Living Skills Training* (SPC 110) – Individual workers must be qualified (see manual). Provider must submit a written progress report every six months.
- Day Services/Treatment* (SPC 706) – Individual workers must be qualified (see manual). Provider must submit a written progress report every six months. There must be a copy of the Day Services Plan in the participant's file.
- Home Modifications* (SPC 112.56) – Documentation available that indicates home modification was completed to local/state code, and that applicable licensure or certification has been followed for all home modifications. All ramps require prior approval from BLTS/TMG. All other home modifications over \$2,000.00 also requires BLTS/TMG prior approval.
- Institutional Respite* (SPC 103.24) – Documentation of a variance request and TMG prior approval.
- Residential Respite* (SPC 103.22) – Facilities (AFH's and CBRF's) must be licensed or certified under the applicable statutes or administrative code.
- Relocation Related Utilities* (SPC 106.01) - A copy of telephone and utility connection billings paid by the agency is kept by the county agency.
- Specialized Medical Supplies* (SPC 112.55) – The SMS meets an assessed need and the Medicaid denial is documented.
- Specialized Transportation* (SPC 107) – If using a licensed public carrier (taxi, city bus) there is no need to verify standards. If the individual provider or driver is affiliated with COA/Office on Aging, a private provider or an employee with an agency, they must meet standards in the manual.

<b>YES</b>	Problem Description:	Required Action:	Potential Disallowance:
<b>NO</b>			System Issue?
<b>NA</b>			

**COP-Waiver QA Monitoring  
Record Review Form**

**BILLING**

9. All care management services billed to HSRS were provided.

YES  
NO  
NA

Problem Description:

Required Action:

Potential Disallowance:

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System Issue?

10. Waiver program payments were made only to waiver allowable providers (e.g. NOT to a spouse, parent of a minor child, or a program participant).

YES  
NO  
NA

Problem Description:

Required Action:

Potential Disallowance:

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System Issue?

11. During the time the participant resided in a non-waiver allowable setting (e.g. hospital or nursing home), none of his/her services were billed to the waiver program. There are two exemptions to this; One is that institutional discharge related care management can be provided for and billed for service provided 30 days before discharge from a hospital or nursing home; The second is PERS services can be billed while a waiver participant is in a hospital or nursing home.

Note: If reviewing a new plan (year 2007 start date) that was a Relocation case, it is allowable to bill care management (604), home modifications (112.56), relocation related housing start up (106.03) and relocation related utilities (106.01) services to the waiver up to 90 days prior to discharge. (All costs for these 4 specific SPC's should be entered on HSRS after the waiver start date).

YES  
NO  
NA

Problem Description:

Required Action:

Potential Disallowance:

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System Issue?

12. Based on the CIP II/COP-W L-300 Report, there were no HSRS billing or reporting problems such as "date of service" reporting problems, not entering institutional stay days, "double billing", billing the waiver program prior to the participant's start date, or entering the wrong dollar amount.

YES  
NO  
NA

Problem Description:

Required Action:

Potential Disallowance:

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System Issue?

**COP-Waiver QA Monitoring  
Record Review Form**

**13. If applicable:** Based on the COP L-300 Report, there were no HSRS billing or reporting problems such as "date of service" reporting problems, not entering institutional stay days, "double billing," or entering the wrong dollar amount.

<b>YES</b>  <b>NO</b>  <b>NA</b>	Problem Description:	Required Action:	Potential Disallowance:
			System Issue?

**SUBSTITUTE CARE ADDENDUM**

**14.** For a participant in a substitute care residence (AFH, CBRF or RCAC), there is 1) documentation that the actual room/board costs (detail) and actual care/supervision costs (detail) were calculated, and 2) the documentation and amount entered on HSRS confirm that waiver funds did not pay towards room/board costs, or that the dollar amounts entered on HSRS were correct.

<b>YES</b>  <b>NO</b>  <b>NA</b>	Problem Description:	Required Action:	Potential Disallowance:
			System Issue?

**15.** For Residential Care Apartment Complexes, check the following:

- Waiver program costs billed to SPC 711 on HSRS for the participant do not exceed \$88.31/ day (2009 amount).

<b>YES</b>  <b>NO</b>  <b>NA</b>	Problem Description:	Required Action:	Potential Disallowance:
			System Issue?

**16.** If waiver funds were used to pay for care/supervision in a CBRF after 9/1/2002, there is documentation that confirms the five conditions/criteria for the CBRF placement have been considered and this documentation is in the case file. (Exception: if COP or Waiver funds were funding care/supervision for the participant who was residing in the CBRF prior to 9/1/02, or the participant resides in a CBRF consisting entirely of independent apartments, or if the person has a dementia related diagnosis and lives in a CBRF with a dementia care program, the 5 conditions/criteria do not have to be considered.)

<b>YES</b>  <b>NO</b>  <b>NA</b>	Problem Description:	Required Action:	Potential Disallowance:
			System Issue?