

Date: April 4, 2011

To: Gabriela Ramos, Executive Director  
Provider: Carino Case Management, Inc.  
Address: 2701 San Pedro NE #10  
State/Zip: Albuquerque, New Mexico 87110

E-mail Address: [gbramos@comcast.net](mailto:gbramos@comcast.net)

Region: Metro  
Survey Date: March 7 – 10, 2011  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Case Management  
Survey Type: Routine  
Team Leader: Nadine Romero, LBSW Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Crystal Lopez-Beck BS Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Maurice Gonzales, BS, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau, Tony Fragua, BFA, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau & Wanda Durant, Case Management Coordinator Developmental Disabilities Supports Division

Dear Ms. Ramos,

The Division of Health Improvement/Quality Management Bureau has completed a compliance survey of the services identified above. The purpose of the survey was to determine compliance with federal and state standards; to assure the health, safety, and welfare of individuals receiving services through the Developmental Disabilities Waiver; and to identify opportunities for improvement. This Report of Findings will be shared with the Developmental Disabilities Supports Division for their use in determining your current and future provider contracts. Upon receipt of this letter and Report of Findings your agency must immediately correct all deficiencies which place Individuals served at risk of harm.

**Quality Management Compliance Determination:**

The Division of Health Improvement is issuing your agency a determination of “Substantial Compliance with Conditions of Participation.”

**Plan of Correction:**

The attached Report of Findings identifies deficiencies found during your agency’s compliance review. You are required to complete and implement a Plan of Correction. Please submit your agency’s Plan of Correction in the space on the two right columns of the Report of Findings. See attachment “A” for additional guidance in completing the Plan of Correction. The response is due to the parties below within 10 working days of the receipt of this letter:

1. **Quality Management Bureau, Attention: Plan of Correction Coordinator  
5301 Central Ave. NE Suite 400 Albuquerque, NM 87108**
2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**



*“Assuring safety and quality of care in New Mexico’s health facilities and community-based programs.”*  
**Roger Gillespie, Acting Division Director • Division of Health Improvement**  
Quality Management Bureau • 5301 Central Ave. NE Suite 400 • Albuquerque, New Mexico 87108  
(505) 222-8623 • FAX: (505) 222-8661 • <http://dhi.health.state.nm.us>

QMB Report of Findings –Carino Case Management, Inc. - Metro Region – March 7 – 10, 2011

Upon notification from QMB that your Plan of Correction has been approved, you must implement all remedies and corrective actions within 45 working days. If your Plan of Correction is denied, you must resubmit a revised plan as soon as possible for approval, as all remedies must still be completed within 45 working days of the receipt of this letter.

Failure to submit, complete or implement your Plan of Correction within the 45 day required time frames may result in the imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

**Request for Informal Reconsideration of Findings (IRF):**

If you disagree with a finding of deficient practice, you have 10 working days upon receipt of this notice to request an IRF. Submit your request for an IRF in writing to:

QMB Deputy Bureau Chief  
5301 Central Ave NE Suite #400  
Albuquerque, NM 87108  
Attention: IRF request

See Attachment "C" for additional guidance in completing the request for Informal Reconsideration of Findings. The request for an IRF will not delay the implementation of your Plan of Correction which must be completed within 45 working days. Providers may not appeal the nature or interpretation of the standard or regulation, the team composition or sampling methodology. If the IRF approves the modification or removal of a finding, you will be advised of any changes.

Please call the Plan of Correction Coordinator at 505-222-8647 if you have questions about the Report of Findings or Plan of Correction. Thank you for your cooperation and for the work you perform.

Sincerely,

*Nadine Romero, LBSW*

Nadine Romero, LBSW  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: March 7, 2011

Present: **Carino Case Management, Inc.**  
Gabriela Ramos, Executive Director  
Sherry Lewis, Case Manager

**DOH/DHI/QMB**

Nadine Romero, LBSW, Team Lead/Healthcare Surveyor  
Crystal Lopez-Beck, BS, Healthcare Surveyor  
Tony Fragua, BFA, Healthcare Surveyor  
Maurice Gonzales, BS, Healthcare Surveyor

Exit Conference Date: March 9, 2011

Present: **Carino Case Management, Inc.**  
Gabriela Ramos, Executive Director  
Sherry Lewis, Case Manager  
Linda Boddy, Case Manager

**DOH/DHI/QMB**

Nadine Romero, LBSW, Team Lead/Healthcare Surveyor  
Crystal Lopez-Beck, BS Healthcare Surveyor  
Tony Fragua, BFA, Healthcare Surveyor  
Maurice Gonzales, BS, Healthcare Surveyor

**DDSD – Metro Regional Office**

Wanda Durant, Case Management Coordinator

Administrative Locations Visited Number: 1

Total Sample Size Number: 21  
6 - *Jackson* Class Members  
15 - *Non-Jackson* Class Members

Case Managers Interviewed Number: 8

Records Reviewed (Persons Served) Number: 21

Administrative Files Reviewed

- Billing Records
- Medical Records
- Incident Management Records
- Personnel Files
- Training Records
- Agency Policy and Procedures
- Caregiver Criminal History Screening Records
- Employee Abuse Registry
- Quality Assurance / Improvement Plan

CC: Distribution List: DOH - Division of Health Improvement  
DOH - Developmental Disabilities Supports Division  
DOH - Office of Internal Audit  
HSD - Medical Assistance Division

## Provider Instructions for Completing the QMB Plan of Correction (POC) Process

### **Introduction:**

After a QMB Compliance Review, your QMB Report of Findings will be sent to you via US mail.

Each provider must develop and implement a Plan of Correction (POC) that identifies specific quality assurance and quality improvement activities the agency will implement to correct deficiencies and prevent continued non compliance.

Agencies must submit their Plan of Correction within 10 business days from the date you receive the QMB Report of Findings. (Providers who do not submit a POC within 10 days will be referred to the Internal Review Committee [IRC] for sanctions).

If you have questions about the Plan of Correction process, call the QMB Plan of Correction Coordinator at 505-222-8647 or email at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us). Requests for technical assistance must be requested through your DDS Regional Office.

If you wish to dispute a finding on the official Report of Findings, you must file an Informal Reconsideration of Findings (IRF) request within ten (10) days of receiving your report. The POC process cannot resolve disputes regarding findings. Please note that you must still submit a POC for findings that are in question (see Attachment "C").

### **Instructions for Completing Agency POC:**

#### **Required Content**

Your Plan of Correction should provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and information that ensures the regulation cited is in compliance. The remedies noted in your POC are expected to be added to your Agency's required, annual Quality Assurance Plan. (see page 3, DDW standards, effective; April 1, 2007, Chapter 1, Section I Continuous Quality Management System)

If a deficiency has already been corrected, the plan should state how it was corrected, the completion date (date the correction was accomplished), and how possible recurrence of the deficiency will be prevented.

The Plan of Correction you submit needs to address **each deficiency** in the two right hand columns with:

1. How the corrective action will be accomplished for all cited deficiencies in the report of findings;
2. How your Agency will identify all other individuals having the potential to be affected by the same deficient practice;
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not reoccur and corrective action is sustained;
4. How your Agency plans to monitor corrective actions utilizing its continuous Quality Assurance/Quality Improvement Plan to assure solutions in the plan of correction are achieved and sustained, including (if appropriate):
  - Details about how and when Consumer and Personnel files are audited by Agency personnel to ensure they contain required documents;
  - Your processes for ensuring that all staff are trained in Core Competencies, Incident Reporting, and Individual-Specific service requirements, etc;
  - How accuracy in Billing documentation is assured;
  - How health, safety is assured;

- For Case Management Providers, how ISPs are reviewed to verify they meet requirements, how the timeliness of LOC packet submissions and consumer visits are tracked;
  - Your process for gathering, analyzing and responding to Quality data, and
  - Details about Quality Targets in various areas, current status, Root Cause Analyses about why Targets were not met, and remedies implemented.
5. The individual's title responsible for the Plan of Correction and completion date.

**Note: Instruction or in-service of staff alone may not be a sufficient plan of correction.** This is a good first step toward correction, but additional steps should be taken to ensure the deficiency is corrected and will not recur.

### **Completion Dates**

The plan of correction must include a **completion date** (entered in the far right-hand column). Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 days.

Direct care issues should be corrected immediately and monitored appropriately. Some deficiencies may require a staged plan to accomplish total correction. Deficiencies requiring replacement of equipment, etc., may require more time to accomplish correction but should show reasonable time frames.

### **Plan of Correction Submission Requirements**

1. Your Plan of Correction must be completed on the official QMB Survey Report of Findings/Plan of Correction Form and received by QMB within ten (10) business days from the date you received the report of findings.
2. If you have questions about the POC process, call the POC Coordinator, George Perrault at 505-222-8647 for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
4. Submit your POC to George Perrault, POC Coordinator in any of the following ways:
  - a. Electronically at [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us)
  - b. Faxed to 505-222-8661, or
  - c. Mailed to QMB, 5301 Central Avenue SW, Suite 400, Albuquerque, NM 87108
5. Do not send supporting documentation to QMB until after your POC has been approved by QMB.
6. QMB will notify you when your POC has been "approve" or "denied."
  - a. Whether your POC is "approved," or "denied," you will have a maximum of 45 business days from the date of receipt of your Report of Findings to correct all survey deficiencies.
  - b. If your POC is "Denied" it must be revised and resubmitted as soon as possible, as the 45 working day limit is in effect.
  - c. If your POC is "Denied" a second time your agency may be referred to the Internal Review Committee.
  - d. You will receive written confirmation that your POC has been approved by QMB and a final deadline for completion of your POC.
7. Failure to submit your POC within 10 days without prior approval of an extension by QMB will result in a referral to the Internal Review Committee and the possible implementation of monetary penalties and/or sanctions.
8. Revisions, Modifications or Extensions to your Plan of Correction (post QMB approval) must be made in writing and submitted to the Plan of Correction Coordinator at QMB, prior to the due date and are approved on a case-by-case basis. No changes may be made to your POC or the timeframes for implementation without written approval of the POC Coordinator.

### ***POC Document Submission Requirements***

Once your POC has been approved by the QMB Plan of Correction Coordinator you must submit copies of documents as evidence that all deficiencies have been corrected, as follows.

1. Your internal documents are due within a maximum of 45 business days of receipt of your Report of Findings.
2. You may submit your documents by postal mail, fax, or electronically on disc or scanned and attached to e-mails.
3. All submitted documents must be annotated: please be sure the tag numbers and Identification numbers are indicated on each document submitted. Documents which are not annotated with the Tag number and Identification number may not be accepted.
4. Do not submit original documents; hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency file(s) per DDSD Standards.
5. In lieu of some documents, you may submit copies of file or home audit forms that clearly indicate cited deficiencies have been corrected, other attestations of correction must be approved by the Plan of Correction Coordinator prior to their submission.
6. For billing deficiencies, you must submit:
  - a. Evidence of an internal audit of billing documentation for a sample of individuals and timeframes;
  - b. Copies of “void and adjust” forms submitted to correct all over-billed or unjustified units billed identified during your internal audit.

## QMB Scope and Severity Matrix

Each deficiency in your Report of Findings is scored on a Scope and Severity Scale. The culmination of each deficiency's Scope and Severity is used to determine degree of compliance to standards and regulations and level of QMB Compliance Determination.

		SCOPE			
		Isolated 01% - 15%	Pattern 16% - 79%	Widespread 80% - 100%	
SEVERITY	High Impact	Immediate Jeopardy to individual health and or safety	J.	K.	L.
		Actual harm	G.	H.	I.
	Medium Impact	No Actual Harm Potential for more than minimal harm	D.	E.	F. (3 or more)
			D. (2 or less)		F. (no conditions of participation)
	Low Impact	No Actual Harm Minimal potential for harm.	A.	B.	C.

### Scope and Severity Definitions:

- **Isolated:**  
A deficiency that is limited to 1% to 15% of the sample, usually impacting few individuals in the sample.
- **Pattern:**  
A deficiency that impacts a number or group of individuals from 16% to 79% of the sample is defined as a pattern finding. Pattern findings suggest the need for system wide corrective actions.
- **Widespread:**  
A deficiency that impacts most or all (80% to 100%) of the individuals in the sample is defined as widespread or pervasive. Widespread findings suggest the need for system wide corrective actions as well as the need to implement a Continuous Quality Improvement process to improve or build infrastructure. Widespread findings could be referred to the Internal Review Committee for review and possible actions or sanctions.

## QMB Determinations of Compliance

- “Substantial Compliance with Conditions of Participation”

The QMB determination of “Substantial Compliance with Conditions of Participation” indicates that a provider is in substantial compliance with all ‘Conditions of Participation’ and other standards and regulations. The agency has obtained a level of compliance such that there is a minimal potential for harm to individuals’ health and safety. To qualify for a determination of Substantial Compliance with Conditions of Participation, the provider must be in compliance with all Conditions of Participation.

- “Non-Compliance with Conditions of Participation”

The QMB determination of “Non-Compliance with Conditions of Participation” indicates that a provider is out of compliance with one (1) or more ‘Conditions of Participation.’ This non-compliance, if not corrected, is likely to result in a serious negative outcome or the potential for more than minimal harm to individuals’ health and safety.

Providers receiving a repeat determination of ‘Non-Compliance’ may be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

- “Sub-Standard Compliance with Conditions of Participation”:

The QMB determination of “Sub-Standard Compliance with Conditions of Participation” indicates a provider is significantly out of compliance with Conditions of Participation and/or has:

- Multiple findings of widespread non-compliance with any standard or regulation with a significant potential for more than minimal harm.
- Any finding of actual harm or Immediate Jeopardy.

Providers receiving a repeat determination of ‘Substandard Compliance’ will be referred by QMB to the Internal Review Committee (IRC) for consideration of remedies and possible actions.

## **Guidelines for the Provider Informal Reconsideration of Finding (IRF) Process**

### **Introduction:**

Throughout the QMB Survey process, surveyors are openly communicating with providers. Open communication means that surveyors have clarified issues and/or requested missing information before completing the review. Regardless, there may still be instances where the provider disagrees with a specific finding. Providers may use the following process to informally dispute a finding.

### **Instructions:**

1. The Informal Reconsideration of the Finding (IRF) request must be in writing to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.
2. The written request for an IRF must be completed on the QMB Request for Informal Reconsideration of Finding Form available on the QMB website: <http://dhi.health.state.nm.us/qmb>
3. The written request for an IRF must specify in detail the request for reconsideration and why the finding is inaccurate.
4. The IRF request must include all supporting documentation or evidence.

### **The following limitations apply to the IRF process:**

- The request for an IRF and all supporting evidence must be received within 10 days.
- Findings based on evidence requested during the survey and not provided may not be subject to reconsideration.
- The supporting documentation must be new evidence not previously reviewed or requested by the survey team.
- Providers must continue to complete their Plan of Correction during the IRF process
- Providers may not request an IRF to challenge the sampling methodology.
- Providers may not request an IRF based on disagreement with the nature of the standard or regulation.
- Providers may not request an IRF to challenge the team composition.
- Providers may not request an IRF to challenge the QMB compliance determination or the length of their DDSD provider contract.

A Provider forfeits the right to an IRF if the request is not made within 10 working days of receiving the report and/or does not include all supporting documentation or evidence to show compliance with the standards and regulations.

QMB has 30 working days to complete the review and notify the provider of the decision. The request will be reviewed by the IRF committee. The Provider will be notified in writing of the ruling; no face to face meeting will be conducted.

When a Provider requests that a finding be reconsidered, it does not stop or delay the Plan of Correction process. **Providers must continue to complete the Plan of Correction, including the finding in dispute regardless of the IRF status.** If a finding is removed or modified, it will be noted and removed or modified from the Report of Findings. It should be noted that in some cases a Plan of Correction may be completed prior to the IRF process being completed. The provider will be notified in writing on the decisions of the IRF committee.

**Agency:** Carino Case Management, Inc. - Metro Region  
**Program:** Developmental Disabilities Waiver  
**Service:** Case Management  
**Monitoring Type:** Routine Survey  
**Date of Survey:** March 7 – 10, 2011

Standard of Care	Deficiency	Agency Plan of Correction and Responsible Party	Date Due
<p><b>Tag # 1A08 Agency Case File</b></p> <p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 1 II. PROVIDER AGENCY REQUIREMENTS:</b> The objective of these standards is to establish Provider Agency policy, procedure and reporting requirements for DD Medicaid Waiver program. These requirements apply to all such Provider Agency staff, whether directly employed or subcontracting with the Provider Agency. Additional Provider Agency requirements and personnel qualifications may be applicable for specific service standards.</p> <p><b>D. Provider Agency Case File for the Individual:</b> All Provider Agencies shall maintain at the administrative office a confidential case file for each individual. Case records belong to the individual receiving services and copies shall be provided to the receiving agency whenever an individual changes providers. The record must also be made available for review when requested by DOH, HSD or federal government representatives for oversight purposes. The individual's case file shall include the following requirements:</p> <p>(1) Emergency contact information, including the individual's address, telephone number, names and telephone numbers of relatives, or guardian or conservator, physician's name(s) and telephone number(s), pharmacy name, address and telephone number, and health plan if appropriate;</p> <p>(2) The individual's complete and current ISP, with</p>	<p><b>Scope and Severity Rating: B</b></p> <p>Based on record review, the Agency failed to maintain at the administrative office a confidential case file for 9 of 21 individuals.</p> <p>Review of the Agency individual case files found the following items were not found, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• <b>ISP Teaching &amp; Support Strategies</b> <ul style="list-style-type: none"> <li>◦ Individual #8 - TASS not found for:               <ul style="list-style-type: none"> <li>◦ Outcome Statement # 2                   <ul style="list-style-type: none"> <li>➤ Schedule Events</li> </ul> </li> <li>◦ Outcome Statement # 3                   <ul style="list-style-type: none"> <li>➤ Put pictures together in scrapbook</li> <li>➤ Will have completed book to show others</li> </ul> </li> <li>◦ Outcome Statement # 4                   <ul style="list-style-type: none"> <li>➤ Participate in weekly practice</li> <li>➤ Participate in finals and win medal</li> </ul> </li> </ul> </li> <li>• Positive Behavioral Plan (#9)</li> <li>• Positive Behavioral Crisis Plan (#2)</li> <li>• Speech Therapy Plan (#2)</li> <li>• Occupational Therapy Plan (#2)</li> </ul> <p><b>Health Care Plans</b></p> <ul style="list-style-type: none"> <li>• Gastrointestinal           <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by the IST</li> </ul> </li> </ul> </li></ul>		

<p>all supplemental plans specific to the individual, and the most current completed Health Assessment Tool (HAT);</p> <p>(3) Progress notes and other service delivery documentation;</p> <p>(4) Crisis Prevention/Intervention Plans, if there are any for the individual;</p> <p>(5) A medical history, which shall include at least demographic data, current and past medical diagnoses including the cause (if known) of the developmental disability, psychiatric diagnoses, allergies (food, environmental, medications), immunizations, and most recent physical exam;</p> <p>(6) When applicable, transition plans completed for individuals at the time of discharge from Fort Stanton Hospital or Los Lunas Hospital and Training School; and</p> <p>(7) Case records belong to the individual receiving services and copies shall be provided to the individual upon request.</p> <p>(8) The receiving Provider Agency shall be provided at a minimum the following records whenever an individual changes provider agencies:</p> <p>(a) Complete file for the past 12 months;</p> <p>(b) ISP and quarterly reports from the current and prior ISP year;</p> <p>(c) Intake information from original admission to services; and</p> <p>(d) When applicable, the Individual Transition Plan at the time of discharge from Los Lunas Hospital and Training School or Ft. Stanton Hospital.</p>	<p>section of ISP the individual is required to have a plan</p> <ul style="list-style-type: none"> <li>• Tardive Dyskensia <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan</li> </ul> </li> <li>• <b>Crisis Plans</b> <ul style="list-style-type: none"> <li>• Aspiration <ul style="list-style-type: none"> <li>◦ Individual #13 - As indicated by the IST section of ISP the individual is required to have a plan</li> </ul> </li> </ul> </li> <li>• <b>Special Health Care Needs:</b> <ul style="list-style-type: none"> <li>• Meal Time Plan <ul style="list-style-type: none"> <li>◦ Individual #2 - As indicated by the IST section of ISP the individual is required to have a plan.</li> </ul> </li> </ul> </li> </ul> <p><b>Other Individual Specific Evaluations &amp; Examinations:</b></p> <ul style="list-style-type: none"> <li>• <b>Psychiatric Evaluation</b> <ul style="list-style-type: none"> <li>◦ Individual #17 - Per documentation reviewed evaluation was completed on 1/29/10. Follow-up was to be completed on 7/2010. No evidence of follow-up was found.</li> </ul> </li> <li>• <b>Neurological Evaluation</b> <ul style="list-style-type: none"> <li>◦ Individual #10 - Per documentation reviewed evaluation was completed on 1/11/10. Follow-up was to be completed on 1/11/11. No evidence of follow-up was found.</li> <li>◦ Individual #13 - Per documentation reviewed evaluation was completed on 9/11/09. Follow-up was to be completed in 6 months. No evidence of follow-up was found.</li> </ul> </li> </ul>		
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	<ul style="list-style-type: none"> <li>◦ Individual #17 - Per documentation reviewed evaluation was completed on 12/09/09. Follow-up was to be completed in 6 months. No evidence of follow-up was found.</li> <li>• <b>Nutritional Evaluation</b> <ul style="list-style-type: none"> <li>◦ Individual #19 - Per documentation reviewed evaluation was completed on 2/25/10. Follow-up was to be completed on 2/25/11. No evidence of follow-up was found.</li> </ul> </li> <li>• <b>Dental Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #9 - As indicated by the documentation reviewed, exam was completed on 6/2010. Follow-up was to be completed in 6 months. No evidence of follow-up found.</li> <li>◦ Individual #13 - As indicated by the DDS file matrix Dental Exams are to be conducted annually. No evidence of exam was found.</li> </ul> </li> <li>• <b>Vision Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #7 - As indicated by the documentation reviewed, exam was completed on 1/25/10. Follow-up was to be completed in 1 year. No evidence of follow-up found.</li> <li>◦ Individual #10 - As indicated by the documentation reviewed, exam was completed on 11/10/08. Follow-up was to be completed in 2 years. No evidence of follow-up found.</li> <li>◦ Individual #13 - As indicated by the documentation reviewed, exam was completed on 11/05/07. Follow-up was to be completed in 2 years. No evidence of follow-up found.</li> </ul> </li> <li>• <b>Mammogram Exam</b> <ul style="list-style-type: none"> <li>◦ Individual #9 - As indicated by the documentation reviewed, exam was completed on 5/07/09. Follow-up was to be completed in 1</li> </ul> </li> </ul>		
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	<p>year. No evidence of follow-up found.</p> <ul style="list-style-type: none"><li>• <b>Bone Density Exam</b><ul style="list-style-type: none"><li>◦ Individual #10 - As indicated by the documentation reviewed, exam was completed on 8/10/04. Follow-up was to be completed in 2 years. No evidence of follow-up found.</li><li>◦ Individual #19 - As indicated by the documentation reviewed, exam was scheduled for 6/2010. No evidence found to verify visit was completed.</li></ul></li><li>• <b>Colonoscopy</b><ul style="list-style-type: none"><li>◦ Individual #6 - As indicated by the documentation reviewed, exam was completed on 8/2010. Follow-up was to be completed in 3 months. No evidence of follow-up found.</li></ul></li><li>• <b>Speech/Language Therapy Evaluation (#2)</b></li></ul>		
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Tag # 4C15.1 - QA Requirements - Bi-Annual Reports & Provider Quarterly Reports	Scope and Severity Rating: B		
<p><b>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>C. Quality Assurance Requirements:</b> Case Management Provider Agencies will use an Internal Quality Assurance and Improvement Plan that must be submitted to and reviewed by the Statewide Case Management Coordinator, that shall include but is not limited to the following:</p> <p>(1) Case Management Provider Agencies are to:</p> <p>(a) Use a formal ongoing monitoring protocol that provides for the evaluation of quality, effectiveness and continued need for services and supports provided to the individual. This protocol shall be written and its implementation documented.</p> <p>(b) Assure that reports and ISPs meet required timelines and include required content.</p> <p>(c) Conduct a quarterly review of progress reports from service providers to verify that the individual's desired outcomes and action plans remain appropriate and realistic.</p> <p>(i) If the service providers' quarterly reports are not received by the Case Management Provider Agency within fourteen (14) days following the end of the quarter, the Case Management Provider Agency is to contact the service provider in writing requesting the report within one week from that date.</p> <p>(ii) If the quarterly report is not received within one week of the written request, the Case Management Provider Agency is to contact the respective DDS Regional Office in writing within one business day for assistance in obtaining required reports.</p>	<p>Based on record review, the Agency failed to ensure that reports and ISP's meet required timelines and include the required contents for 8 of 21 individuals.</p> <p>The following quarterly/bi-annual reports were not found:</p> <ul style="list-style-type: none"> <li>• <b>Community Living Quarterly Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #6 – None found for 11/2010 – 1/2011</li> <li>◦ Individual #7 – None found for 11/ 2010 – 1/2011.</li> <li>◦ Individual #12 – None found for 2/2010 – 2/2011</li> <li>◦ Individual #19 – None found for 11/2010 – 1/2011</li> <li>◦ Individual #20 – None found for 11/2010 – 1/2011</li> </ul> </li> <li>• <b>Community Inclusion - Adult Habilitation Quarterly Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #6 – None found for 11/2010 – 1/2011.</li> <li>◦ Individual #19 – None found for 11/2010 – 1/2011</li> </ul> </li> <li>• <b>Community Inclusion - Supported Employment Quarterly Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #2 – None found for 12/2009 – 12/2010</li> <li>◦ Individual #4 – None found for 6/2010 – 8/2010.</li> </ul> </li> </ul>		

<p>(d) Assure at least quarterly that Crisis Prevention/Intervention Plans are in place in the residence and at the Provider Agency of the Day Services for all individuals who have chronic medical condition(s) with potential for life threatening complications and/or who have behavioral challenge(s) that pose a potential for harm to themselves or others.</p> <p>(e) Assure at least quarterly that a current Health Care Plan (HCP) is in place in the residence and day service site for individuals who receive Community Living or Day Services and who have a HAT score of 4, 5, or 6. During face-to-face visits and review of quarterly reports, the Case Manager is required to verify that the Health Care Plan is being implemented.</p> <p>(f) Assure that Community Living Services are delivered in accordance with standards, including responsibility of the IDT Members to plan for at least 30 hours per week of planned activities outside the residence. If this is not possible due to the needs of the individual, a goal shall be developed that focuses on appropriate levels of community integration. These activities do not need to be limited to paid supports but may include independent or leisure activities appropriate to the individual.</p> <p>(g) Perform annual satisfaction surveys with individuals regarding case management services. A copy of the summary is due each December 10<sup>th</sup> to the respective DDSD Regional Office, along with a description of actions taken to address suggestions and problems identified in the survey.</p> <p>(h) Maintain regular communication with all providers delivering services and products to the individual.</p>	<ul style="list-style-type: none"> <li>◦ Individual #5 – None found for 4/2010 – 6/2010</li> <li>● <b>Speech &amp; Language Pathology Bi-Annual Progress Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #2 – None found for 7/2010 – 1/2011</li> </ul> </li> <li>● <b>Occupational Bi-Annual Progress Reports:</b> <ul style="list-style-type: none"> <li>◦ Individual #2 – None found for 7/2010 – 1/2011.</li> </ul> </li> </ul>		
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<p>(i) Establish and implement a written grievance procedure.</p> <p>(j) Notify appropriate supervisory personnel within the Provider Agency if concerns are noted during monitoring or assessment activities related to any of the above requirements. If such concerns are not remedied by the Provider Agency within a reasonable mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or DHI as appropriate to the nature of the concern. This does not preclude Case Managers' obligations to report abuse, neglect or exploitation as required by New Mexico Statute.</p> <p>(k) Utilize and submit the "Request for DDSD Regional Office Intervention" form as needed, such as when providers are not responsive in addressing a quality assurance concern. The Case Management Provider Agency is required to keep a copy in the individual's file.</p> <p>(2) Case Managers and Case Management Provider Agencies are required to promote and comply with the Case Management Code of Ethics:</p> <p>(a) Case Managers shall provide the individual/guardian with a copy of the Code of Ethics when Addendum A is signed.</p> <p>(b) Complaints against a Case Manager for violation of the Code of Ethics brought to the attention of DDSD will be sent to the Case Manager's supervisor who is required to respond within 10 working days to DDSD with detailed actions taken. DDSD reserves the right to forward such complaints to the IRC.</p>			
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## ADDITIONAL FINDINGS: Reimbursement Deficiencies

### BILLING TAG #1A12

Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007 **Chapter 1. III. PROVIDER AGENCY DOCUMENTATION OF SERVICE DELIVERY AND LOCATION**

**B. Billable Units:** The documentation of the billable time spent with an individual shall be kept on the written or electronic record that is prepared prior to a request for reimbursement from the HSD. For each unit billed, the record shall contain the following:

- (1) Date, start and end time of each service encounter or other billable service interval;
- (2) A description of what occurred during the encounter or service interval; and
- (3) The signature or authenticated name of staff providing the service.

Billing for Case Management services was reviewed for 21 of 21 individuals. Progress notes and billing records supported billing activities for the months of November, December 2010, and January 2011.