



**Alfredo Vigil, MD**  
Secretary

DEPARTMENT OF

*Building a Healthy New Mexico!*

**Bill Richardson, Governor**

**Katrina Hotrum**  
Deputy Secretary

**Duffy Rodriguez**  
Deputy Secretary

**Jessica Sutin**  
Deputy Secretary

**Karen Armitage, MD**  
Chief Medical Officer

Date: September 3, 2009

To: Patricia Posey, President/CEO  
Provider: A New Vision Case Management, Inc.  
Address: 3949 Corrales Road, NW, Suite 105  
State/Zip: Albuquerque, New Mexico 87048

CC: Elaine Sweeney, Secretary of the Board  
Address: 3949 Corrales Road, NW, Suite 105  
State/Zip: Albuquerque, New Mexico 87048

E-mail Address: ANewVisionCM@aol.com

Region: Metro  
Survey Date: August 4 – 10, 2009  
Program Surveyed: Developmental Disabilities Waiver  
Service Surveyed: Case Management  
Survey Type: Routine  
Team Leader: Stephanie R. Martinez de Berenger, MPA, GCDF, Healthcare Surveyor, Division of Health Improvement/Quality Management Bureau  
Team Members: Tony Fragua, BFA, Healthcare Surveyor Division of Health Improvement/Quality Management Bureau

Dear Ms. Posey,

The Division of Health Improvement/Quality Management Bureau has completed a quality review 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.

**Quality Management Approval Rating:**

The Division of Health Improvement is pleased to grant your agency a “MERIT” certification for compliance with DDSD Standards and regulations

**Plan of Correction:**

The attached Report of Findings identifies deficiencies found during your agency’s survey. You are required to complete and implement a Plan of Correction (POC). Please submit your agency’s Plan of Correction (POC) in the space on the two right columns of the Report of Findings. See attachment A for additional guidance in completing the POC. 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 900 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.”*

**David Rodriguez, Division Director • Division of Health Improvement**

Division of Health Improvement • Quality Management Bureau • 5301 Central Ave NE • Suite 900 • Albuquerque, New Mexico 87108  
(505) 222-8623 • FAX: (505) 841-5815

Survey #: Q10.01.D3715.METRO.001.RTN.01

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 ASAP for approval. All remedies must still be completed within 45 working days of the original submission.

Failure to submit, complete or implement your POC within the required time frames will 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 determination of noncompliance (finding) 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 #900  
Albuquerque, NM 87108  
Attention: IRF request

A 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, sampling methodology or the Scope and Severity of the finding.

If the IRF approves the change or removal of a finding, you will be advised of any changes.

This IRF process is separate and apart from the Informal Dispute Resolution (IDR) and Fair Hearing Process for Sanctions from DOH.

Please call the Team Leader at 505-222-8641, if you have questions about the survey or the report. Thank you for your cooperation and for the work you perform.

Sincerely,

*Stephanie R. Martinez de Berenger, MPA, GCDF*

Stephanie R. Martinez de Berenger, MPA, GCDF  
Team Lead/Healthcare Surveyor  
Division of Health Improvement  
Quality Management Bureau

## Survey Process Employed:

Entrance Conference Date: August 4, 2009

Present: **A New Vision Case Management, Inc**  
Patricia Posey, President/CEO  
Elaine Sweeny, Vice President  
Josie Pflieger, Case Manager

**DOH/DHI/QMB**

Stephanie R. Martinez de Berenger, MPA, GCDF  
Team Lead/Healthcare Surveyor  
Tony Fragua, BFA, Healthcare Surveyor

Exit Conference Date: August 7, 2009

Present: **A New Vision Case Management, Inc**  
Patricia Posey, President/CEO  
Elaine Sweeny, Vice President

**DOH/DHI/QMB**

Stephanie R. Martinez de Berenger, MPA, GCDF  
Team Lead/Healthcare Surveyor  
Tony Fragua, BFA, Healthcare Surveyor

**DDSD - Metro Regional Office**

Lori Ellison, Metro Case Management Coordinator  
Tony de Jesus, Metro Case Management Coordinator  
Wanda Durant, Metro Case Management Coordinator

Administrative Locations Visited Number: 1

Total Sample Size Number: 19  
17- Non Jackson  
2 - Jackson Class Members

Case Managers Interviewed Number: 11

Records Reviewed (Persons Served) Number: 19

Administrative Files Reviewed

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

- After a QMB Quality Review, your Survey Report will be sent to you via certified mail. You may request that it also be sent to you electronically by calling George Perrault, Plan of Correction Coordinator at 505-222-8624.
- Within 10 business days of the date you received your survey report, you must develop and send your Plan of Correction response to the QMB office. (Providers who do not pick up their mail will be referred to the Internal Review Committee [IRC]).
- For each Deficiency in your Survey Report, include specific information about HOW you will correct each Deficiency, WHO will fix each Deficiency (“Responsible Party”), and by WHEN (“Date Due”).
- Your POC must not only address HOW, WHO and WHEN each Deficiency will be corrected, but must also address overall systemic issues to prevent the Deficiency from reoccurring, i.e., Quality Assurance (QA). Your description of your QA must include specifics about your self-auditing processes, such as HOW OFTEN you will self-audit, WHO will do it, and WHAT FORMS will be used.
- Corrective actions should be incorporated into your agency’s Quality Assurance/Quality Improvement policies and procedures.
- You may send your POC response electronically to [George.Perrault@state.nm.us](mailto:George.Perrault@state.nm.us), by fax (505-841-5815), or by postal mail.
- Do not send supporting documentation to QMB until after your POC has been approved by QMB.
- QMB will notify you if your POC has been “Approved” or “Denied”.
- Whether your POC is “Approved” or “Denied”, you have a maximum of 45 business days to correct all survey Deficiencies from the date of receipt of your Survey Report. If your POC is “Denied” it must be revised and resubmitted ASAP, as the 45 working day limit is in effect. Providers whose revised POC is denied will be referred to the IRC.
- The POC must be completed on the official QMB Survey Report and Plan of Correction Form, unless approved in advance by the POC Coordinator.
- The following Deficiencies must be corrected within the deadlines below (after receipt of your Survey Report):
  - CCHS and EAR: 10 working days
  - Medication errors: 10 working days
  - IMS system/training: 20 working days
  - ISP related documentation: 30 working days
  - DDSD Training 45 working days
- If you have questions about the POC process, call the QMB POC Coordinator, George Perrault at 505-222-8624 for assistance.
- For Technical Assistance (TA) in developing or implementing your POC, contact your local DDSD Regional Office.
- Once your POC has been approved by QMB, the POC may not be altered or the dates changed.
- Requests for an extension or modification of your POC (post approval) must be made in writing and submitted to the POC Coordinator at QMB, and are approved on a case-by-case basis.
- When submitting supporting documentation, organize your documents by Tag #s, and annotate or label each document using Individual #s.
- Do not submit original documents, hard copies or scanned and electronically submitted copies are fine. Originals must be maintained in the agency/client file(s) as per DDSD Standards.
- Failure to submit, complete or implement your POC within the required timeframes will result in a referral to the IRC and the possible imposition of a \$200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

**Attachment B**

**QMB Scope and Severity Matrix of survey results**

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 Certification.

			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:**

Key to Scope scale:

**Isolated:**

A deficiency that is limited to 1% to 15% of the sample, usually impacting no more than one or two 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 must be referred to the Internal Review Committee for review and possible actions or sanctions.

Key to Severity scale:

**Low Impact Severity: (Blue)**

Low level findings have no or minimal potential for harm to an individual. Providers that have no findings above a “C” level may receive a “Quality” Certification approval rating from QMB.

Medium Impact Severity: (Tan)

Medium level findings have a potential for harm to an individual. Providers that have no findings above a “F” level and/or no more than two F level findings and no F level Conditions of Participation may receive a “Merit” Certification approval rating from QMB.

High Impact Severity: (Green or Yellow)

High level findings are when harm to an individual has occurred. Providers that have no findings above “I” level may only receive a “Standard” Approval rating from QMB and will be referred to the IRC.

High Impact Severity: (Yellow)

“J, K, and L” Level findings:

This is a finding of Immediate Jeopardy. If a provider is found to have “I” level findings or higher, with an outcome of Immediate Jeopardy, including repeat findings or Conditions of Participation they will be referred to the Internal Review Committee.

## Attachment C

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

### Introduction:

Throughout the 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.

To informally dispute a finding the provider must request in writing an Informal Reconsideration of the Finding (IRF) to the QMB Deputy Bureau Chief **within 10 working days** of receipt of the final report.

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>) and must specify in detail the request for reconsideration and why the finding is inaccurate. **The IRF request must include all supporting documentation or evidence that was not previously reviewed during the survey process.**

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

- The request for an IRF and all supporting evidence must be received in 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 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 Scope and Severity of a finding.
- 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 Quality Approval Rating and the length of their DDS 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 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 successfully reconsidered, it will be noted and will be removed or modified from the report. 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.

### **Administrative Review Process:**

If a Provider desires to challenge the decision of the IRF committee they may request an Administrative Review by the DHI and DDS Director. The Request must be made in writing to the QMB Bureau Chief and received within 5 days of notification from the IRF decision.

### **Regarding IRC Sanctions:**

The Informal Reconsideration of the Finding process is a separate process specific to QMB Survey Findings and should not be confused with any process associated with IRC Sanctions.

If a Provider desires to Dispute or Appeal an IRC Sanction that is a separate and different process. Providers may choose the Informal Dispute Resolution Process or the Formal Medicaid Fair Hearing Process to dispute or appeal IRC sanctions, please refer to the DOH Sanction policy and section 39 of the provider contract agreement.

**Agency:** A New Vision Case Management, Inc. - Metro  
**Program:** Developmental Disabilities Waiver  
**Service:** Case Management  
**Monitoring Type:** Routine  
**Date of Survey:** August 4 – 10, 2009

Statute	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 all supplemental plans specific to the individual, and the most current completed Health</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 19 individuals.</p> <p>Review of the Agency individual case files revealed the following items were missing, incomplete, and/or not current:</p> <ul style="list-style-type: none"> <li>• Teaching &amp; Support Strategies (#7 &amp; 16)</li> <li>• Speech Therapy Plan (#4 &amp; 6)</li> <li>• Physical Therapy Plan (#6 &amp; 17)</li> <li>• Physical Therapy Evaluation (#6)</li> <li>• <b>Health Care Plans</b> <ul style="list-style-type: none"> <li>◦ Risk for Aspiration (#6)</li> <li>◦ Seizures (#7)</li> <li>◦ Healthcare Maintenance (#7)</li> <li>◦ Use of Psychotropic Medication (#7)</li> </ul> </li> <li>• <b>Crisis Plans</b> <ul style="list-style-type: none"> <li>◦ Allergies               <ul style="list-style-type: none"> <li>◦ Individual #6 - As indicated by the Individual Specific Training Section of the ISP a crisis plan is required.</li> </ul> </li> <li>◦ Aspiration               <ul style="list-style-type: none"> <li>◦ Individual #6 - As indicated by the Individual Specific Training Section of the ISP a crisis plan is required.</li> </ul> </li> </ul> </li> </ul>		

<p>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>	<ul style="list-style-type: none"> <li>◦ Seizures <ul style="list-style-type: none"> <li>◦ Individual #7 - As indicated by the Individual Specific Training Section of the ISP a crisis plan is required.</li> </ul> </li> <li>• Health Assessment Tool (#7)</li> <li>• Medication Administration Assessment Tool (#7)</li> <li>• <b>Dental Exam</b> <ul style="list-style-type: none"> <li>◦ As indicated by the documentation reviewed, last exam was completed on 1/1/2009. No evidence of exam found. (Individual #7)</li> </ul> </li> <li>• <b>Auditory Exam</b> <ul style="list-style-type: none"> <li>◦ As indicated by the documentation reviewed, last exam was completed on 8/1/2006. No evidence of exam found. (Individual #7)</li> </ul> </li> <li>• <b>Vision Exam</b> <ul style="list-style-type: none"> <li>◦ As indicated by the documentation review, exam was to be completed annually. No evidence of exam found. (Individual #6)</li> <li>◦ As indicated by the documentation reviewed, exam was completed on 12/17/2008. No evidence of exam found. (Individual #13)</li> </ul> </li> <li>• <b>Pap</b> <ul style="list-style-type: none"> <li>◦ As indicated by the Annual History &amp; Physical exam a pap smear exam was to be completed every 5 years. No evidence of exam found. (Individual #2)</li> <li>◦ As indicated by the Annual History &amp; Physical exam a pap smear exam was to be completed annually. No evidence of exam found. (Individual #8)</li> </ul> </li> </ul>		
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	<ul style="list-style-type: none"><li>• <b>Cholesterol &amp; Blood Glucose</b><ul style="list-style-type: none"><li>◦ As indicated by the documentation reviewed, lab work was ordered on 3/5/2009. No evidence found to verify visit was completed (Individual #1)</li><li>◦ As indicated by the documentation reviewed, lab work was ordered on 10/13/2000. No evidence found to verify visit was completed. (Individual #13)</li></ul></li><li>• <b>Blood Levels</b><ul style="list-style-type: none"><li>◦ As indicated by the documentation reviewed, lab work was ordered on 3/5/2009. No evidence found to verify visit was completed. (Individual #1)</li><li>◦ As indicated by the documentation reviewed, lab work was ordered on 7/9/2009. No evidence found to verify visit was completed (Individual #7)</li><li>◦ As indicated by the documentation reviewed, lab work was ordered on 10/13/2008. No evidence found to verify visit was completed (Individual #13)</li></ul></li><li>• Guardianship Documentation (#16)</li></ul>		
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<b>Tag # 1A29 Complaints / Grievances</b>	<b>Scope and Severity Rating: A</b>		
<p><b>NMAC 7.26.3.6</b>  A. These regulations set out rights that the department expects all providers of services to individuals with developmental disabilities to respect. These regulations are intended to complement the department's Client Complaint Procedures (7 NMAC 26.4) [now 7.26.4 NMAC].</p> <p><b>NMAC 7.26.3.13 Client Complaint Procedure Available.</b> A complainant may initiate a complaint as provided in the client complaint procedure to resolve complaints alleging that a service provider has violated a client's rights as described in Section 10 [now 7.26.3.10 NMAC]. The department will enforce remedies for substantiated complaints of violation of a client's rights as provided in client complaint procedure. [09/12/94; 01/15/97; Recompiled 10/31/01]</p> <p><b>NMAC 7.26.4.13 Complaint Process:</b>  <b>A. (2).</b> The service provider's complaint or grievance procedure shall provide, at a minimum, that: <b>(a)</b> the client is notified of the service provider's complaint or grievance procedure</p>	<p>Based on record review, the Agency failed to provide documentation that the complaint procedure had been made available to individuals or their legal guardians for 2 of 19 individuals.</p> <ul style="list-style-type: none"> <li>Grievance/ Complaint Procedure (#7 &amp;16)</li> </ul>		
<b>Tag #1A40 - Provider Requirement</b>	<b>Scope &amp; Severity Rating: C</b>		

Accreditation			
<p><b>NMAC 7.26.6.6 OBJECTIVE:</b></p> <p>A. These regulations are being promulgated to promote and assure the provision of quality services to persons with developmental disabilities residing in community agencies.</p> <p>B. These regulations are being promulgated as part of a quality assurance initiative requiring all community agencies providing services to persons with developmental disabilities and contracting with the developmental disabilities division to be accredited by the commission on accreditation of rehabilitation facilities (CARF).</p> <p><b>7.26.6.14 CARF STANDARDS MANUAL FOR ORGANIZATIONS SERVING PEOPLE WITH DEVELOPMENTAL DISABILITIES:</b> Community agencies governed by these regulations are required to meet applicable provisions of the most current edition of the “CARF Standards Manual for Organizations Serving People with Disabilities”. Sections of the CARF standards may be waived by the Department when deemed not applicable to the services provided by the community agency.</p> <p><b>Long Term Services Division Policy - Accreditation of Long Term Services Division Funded Providers eff. August 30, 2004</b></p> <p><b>A. Mandate for Accreditation</b></p> <p>The Department of Health, Long Term Services Division (hereafter referred to as the Division) will contract only with agencies/organizations accredited in compliance with this policy.</p> <p>1. Within eighteen (18) months of an initial contract or change in exemption status as defined in this policy, the contractor must provide the Division with written verification of accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and</p>	<p>Based on observation and interview, the Agency failed to obtain the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Quality and Leadership in Supports for People with Disabilities (The Council) accreditation or the applicable waiver from the Developmental Disability Support Division.</p> <p>When #50 was asked if the Agency had evidence of current CARF accreditation or a waiver from DDSD the following was reported:</p> <p>#50 stated, “Our CARF accreditation expired in 2008 and I submitted on August 20, 2008 a letter to Kathleen Linnehan (DDSD Metro Regional Director) requesting a waiver from ongoing CARF surveys, due to the high cost of the CARF process. I have not heard from Kathleen Linnehan or anyone at DDSD.”</p>		

Leadership in Supports for People with Disabilities (The Council).

2. Except as provided in this policy, the Division may terminate its contract with a contractor that fails to maintain an accreditation status of at least one year, regardless of any appeal process available from CARF or the Council.

Tag #4C02 Scope of Services	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 II. SCOPE OF CASE MANAGEMENT SERVICES:</b> Case Management shall include, but is not limited to, the following services:</p> <p><b>K.</b> Inform the individual of his or her rights and responsibilities at least annually, and promote informed decision-making;</p>	<p>Based on record review, the Agency failed to maintain documentation indicating they had informed the individual of his or her rights and responsibilities at least annually for 2 of 19 individuals.</p> <p>No evidence of the following was found:</p> <ul style="list-style-type: none"> <li>◦ Rights &amp; Responsibilities (#7 &amp; 16)</li> </ul>		

Tag # 4C12 (CoP) - Monitoring & Eval. of Serv.	Scope and Severity Rating: D		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 III. CASE MANAGEMENT SERVICE REQUIREMENTS</b></p> <p><b>J. Case Manager Monitoring and Evaluation of Service Delivery</b></p> <p>(1) The Case Manager shall use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual as specified in the ISP.</p> <p>(2) Monitoring and evaluation activities shall include, but not be limited to:</p> <p>(a) Face-To-Face Contact: A minimum of twelve (12) face-to-face contact visits annually (1 per month) is required to occur between the Case Manager and the individual served as described in the ISP; an exception is that children may receive a minimum of four visits per year;</p> <p>(b) Jackson Class members require two (2) face-to-face contacts per month, one of which occurs at a location in which the individual spends the majority of the day (i.e., place of employment, habilitation program) and one at the person's residence;</p> <p>(c) For non-Jackson Class members who receive Community Living Services, at least every other month, one of the face-to-face visits shall occur in the individual's residence;</p> <p>(d) For adults who are not Jackson Class members and who do not receive Community Living Services, at least one face-to-face visit per quarter shall be in his or her home;</p> <p>(e) If concerns regarding the health or safety of the individual are documented during monitoring or assessment activities, the Case Manager shall immediately notify appropriate supervisory personnel within the Provider Agency and document the concern. If the reported remedied by the Provider Agency within a reasonable,</p>	<p>Based on record review, the Agency failed to use a formal ongoing monitoring process that provides for the evaluation of quality, effectiveness, and appropriateness of services and supports provided to the individual for 1 of 19 individuals.</p> <p>Record review of Agency files found face-to-face visits were not alternating between community sites and residence sites as required by standard for the following individuals:</p> <p>Individual #1 (Non-Jackson) No site visit was noted between 01/2009 &amp; 06/2009.</p> <ul style="list-style-type: none"> <li>• 06/19/09 – 10:00am 11:30am– Home Visit</li> <li>• 05/14/09 – 1:15pm - 2:45pm – Home Visit</li> <li>• 04/09/09 -12:30pm - 2:00pm – Home Visit</li> <li>• 03/17/09 – 3:00pm - 5:00pm – Home Visit</li> <li>• 02/05/09 – 3:00pm - 5:00pm – Home Visit</li> <li>• 01/09/09 – 12:00pm – 1:45pm – Home Visit</li> <li>• 01/09/09 – 12:00pm – 1:45pm - Home Visit</li> </ul>		

mutually agreed period of time, the concern shall be reported in writing to the respective DDSD Regional Office and/or the Division of Health Improvement (DHI) as appropriate to the nature of the concern. Unless the nature of the concern is urgent, no more than fifteen (15) working days shall be allowed for remediation or development of an acceptable plan of remediation. This does not preclude the Case Managers' obligation to report abuse, neglect or exploitation as required by New Mexico Statute.

(f) Service monitoring for children: When a parent chooses fewer than twelve (12) annual units of case management, the Case Manager will inform the parent of the parent's responsibility for the monitoring and evaluation activities during the months he or she does not receive case management services,

(g) It is appropriate to conduct face-to-face visits with the individual both during the time the individual is receiving a service and during times the individual is not receiving a service. The preferences of the individual shall be taken into consideration when scheduling a visit. Visits may be scheduled in advance or be unannounced visits depending on the nature of the need in monitoring service delivery for the individual.

(h) Communication with IDT members: Case Managers shall facilitate and maintain communication with the individual or his or her representative, other IDT members, providers and other relevant parties to ensure the individual receives maximum benefit of his or her services. Case Managers need to ensure that any needed adjustments to the service plan are made, where indicated. Concerns identified through communication with teams that are not remedied within a reasonable period of time shall be reported in writing to the respective regional office and/or the Division of Health Improvements, as appropriate to the concerns.

Tag # 4C15 - QA Requirements – Code of Ethics	Scope and Severity Rating: A		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <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>(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>	<p>Based on record review, the Agency failed to provide documentation that the individual and/or guardian was provided the Case Management Code of Ethics for 2 of 19 individuals.</p> <p>The following items were not found, incomplete and/or not current:</p> <ul style="list-style-type: none"> <li>• Case Manager Code of Ethics (#7 &amp; 16)</li> </ul>		

Tag # 4C16 (CoP) - Req. for Reports & Distribution of Doc.	Scope and Severity Rating: E		
<p>Developmental Disabilities (DD) Waiver Service Standards effective 4/1/2007</p> <p><b>CHAPTER 4 IV. CASE MANAGEMENT PROVIDER AGENCY REQUIREMENTS</b></p> <p><b>D. Case Manager Requirements for Reports and Distribution of Documents</b></p> <p>(1) Case Managers will provide reports and data as specified/requested by DDS within the required time frames.</p> <p><b>(2) Case Managers shall provide copies of the ISP to the Provider Agencies listed in the budget, and the individual and guardian (if applicable) within 14 days of ISP approval;</b></p> <p>(3) Case Managers shall provide copies of the ISP to the respective DDS Regional Offices within 14 days of ISP approval.</p> <p>(4) Copies of the ISP given to providers, the individual and guardians shall include any related ISP minutes, provider strategies, individual specific training required, client rights and responsibilities, and revisions, if applicable.</p> <p>(5) At times, recommendations for further evaluations, screenings, diagnostics and/or treatments may be made to the IDT Members by various healthcare staff, consultants, various audit tools, the Supports and Assessments for Feeding and Eating (SAFE) Clinic, Transdisciplinary Evaluation and Support Clinic (TEASC) or other experts:</p> <p>(a) The IDT Members shall discuss these recommendations and a determination made if the IDT Members agree with the recommendations.</p> <p>(b) If the IDT Members concur with the recommendation, the ISP is required to be revised and follow-up shall be completed and documented in progress reports and, if applicable, in a revision to relevant therapy plans.</p> <p>(c) If the IDT Members, in their professional judgment, do not agree with the</p>	<p>Based on record review, the Agency failed to ensure that reports and ISP's meet required timelines and include the required contents 5 of 19 individuals.</p> <p>Evidence of the following quarterly/bi-annual reports were not found:</p> <ul style="list-style-type: none"> <li>• <b>Community Living (Supported Living) Quarterly Reports</b> <ul style="list-style-type: none"> <li>◦ Individual #10 - None found for 06/2008 – 06/2009</li> </ul> </li> <li>• <b>Community Living (Family Living) Quarterly Reports</b> <ul style="list-style-type: none"> <li>◦ Individual #4 - None found for 07/2008 – 03/2009</li> <li>◦ Individual #7 - None found for 07/2008 – 03/2009</li> </ul> </li> <li>• <b>Community Inclusion (Adult Habilitation) Quarterly Reports</b> <ul style="list-style-type: none"> <li>◦ Individual #14 - None found for 10/2008 - 12/2008</li> </ul> </li> <li>• <b>Behavior Consultation Quarterly Reports</b> <ul style="list-style-type: none"> <li>◦ Individual #7 - None found for 07/2008 – 09/2008.</li> </ul> </li> <li>• <b>Speech/Language Therapy Bi-Annual Reports</b> <ul style="list-style-type: none"> <li>◦ Individual #16 - None found for 08/2008 – 08/2009</li> </ul> </li> </ul>		

<p>recommendation, the reasons for this shall be clearly documented in the Decision Justification document and filed by the Case Manager with the healthcare provider or consultant report/document in which the recommendation was made.</p> <p>(d) A copy of the Decision Justification document shall also be given to the residential provider (if any) and the guardian.</p> <p>(6) The individual's name and the date are required to be included on all pages of documents. All documents shall also include the signature of the author on the last page.</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 19 of 19 individuals. Progress notes and billing records supported billing activities for the months of April, May and June 2009.