Date:	February 7, 2019
To:	Twila Rutter, General Manager
Provider:	Interim Healthcare (New Mexico Healthcare Services, LLC)
Address:	2300 North Main St., Suite 19, Hilltop Plaza
State/Zip:	Clovis, New Mexico 88101
E-mail Address:	twila.rutter@interimhh.com
CC:	Jim Bullard, Board Chair
E-Mail Address:	jim.bullard@interimhh.com
Region:	Southeast
Survey Date:	January 11 - 15, 2019
Program Surveyed:	Medically Fragile Waiver
Services Surveyed:	Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA and Respite PDN (*Note: There were no individuals receiving any services, therefore an administrative review was conducted.)*
Survey Type:	Routine
Team Leader:	Yolanda J. Herrera, RN, Nurse Healthcare Surveyor, Division of Health Improvement / Quality Management Bureau
Team Members:	Crystal Lopez-Beck, BA, Deputy Bureau Chief, Division of Health Division of Health Improvement / Quality Management Bureau and Iris Clevenger, RN, BSN, MA, CCM, Medically Fragile Waiver Program Manager, Developmental Disability Supports Division/Clinical Services Bureau

Dear Ms. T. Rutter:

The Division of Health Improvement/Quality Management Bureau (DHI/QMB) 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 Medically Fragile 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.

Plan of Correction:

The attached Report of Findings identifies the deficiencies found during your agency's compliance review. You are required to complete and implement a Plan of Correction (POC). Your agency has a total of 45 business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction) from the receipt of this letter. During the exit interview of your on-site survey Attachment A on the Plan of Correction Process was provided to you. Please refer to Attachment A for specific instruction on completing your Plan of Correction. At a minimum, your Plan of Correction should address the following for each Tag cited:

Corrective Action:

- How is the deficiency going to be corrected? (i.e., obtained documents, retrain staff, individuals and/or staff no longer in service, void/adjusts completed, etc.) This can be specific to each deficiency cited or if possible an overall correction, i.e. all documents will be requested and filed as appropriate.

On-going Quality Assurance/Quality Improvement Processes:

- What is going to be done? (i.e., file reviews, periodic check with checklist, etc.)
- How many individuals is this going to effect? (i.e., percentage of individuals reviewed, number of files reviewed, etc.)
- How often will this be completed? (i.e., weekly, monthly, quarterly, etc.)
- Who is responsible? (responsible position)
- What steps will be taken if issues are found? (i.e., retraining, requesting documents, filing RORA, etc.)

Submission of your 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)*.

Within 10 business days of receipt of this letter your agency Plan of Correction must be submitted to the parties below:

1. **Quality Management Bureau, Attention: Amanda Castaneda, Plan of Correction Coordinator 1170 North Solano Suite D Las Cruces, New Mexico 88001**

2. **Developmental Disabilities Supports Division Regional Office for region of service surveyed**

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

Failure to submit your POC within the allotted 10 business days or complete and implement your Plan of Correction within the total 45 business days allowed may result in the imposition of a $200 per day Civil Monetary Penalty until it is received, completed and/or implemented.

Billing Deficiencies:

If you have deficiencies noted in this report of findings under the *Service Domain: Medicaid Billing/Reimbursement*, you must complete a Void/Adjust claims or remit the identified overpayment via a check within 30 calendar days of the date of this letter to HSD/OIG/PIU, *though this is not the preferred method of payment*. If you choose to pay via check, please include a copy of this letter with the payment. Make the check payable to the New Mexico Human Services Department and mail to:

Attention: *Lisa Medina-Lujan*
HSD/OIG/Program Integrity Unit
1474 Rodeo Road
Santa Fe, New Mexico 87505

If you have questions and would like to speak with someone at HSD/OIG/PIU, please contact:

Lisa Medina-Lujan (Lisa.medina-lujan@state.nm.us)
OR
Jennifer Goble (Jennifer.goble2@state.nm.us)

Please be advised that there is a one-week lag period for applying payments received by check to Voided/Adjusted claims. During this lag period, your other claim payments may be applied to the amount you owe even though you have sent a

refund, reducing your payment amount. For this reason, we recommend that you allow the system to recover the overpayment instead of sending in a check.

Request for Informal Reconsideration of Findings (IRF):
If you disagree with a finding of deficient practice, you have 10 business 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 total business days (10 business days to submit your POC for approval and 35 days to implement your *approved* Plan of Correction). 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, Amanda Castaneda, at (575) 373-5716 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,

Yolanda J. Herrera, RN

Yolanda J. Herrera, RN
Nurse Healthcare Surveyor / Team Lead
Division of Health Improvement
Quality Management Bureau

Survey Process Employed:

Administrative Review Start Date:	January 11, 2019
Contact:	**Interim Healthcare (New Mexico Healthcare Services, LLC)** Twila Rutter, General Manager **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Deputy Bureau Chief
On-site Entrance Conference Date:	January 15, 2019
Present:	**Interim Healthcare (New Mexico Healthcare Services, LLC)** Twila Rutter, General Manager **DOH/DHI/QMB** Yolanda J. Herrera, RN, Nurse Healthcare Surveyor / Team Lead Crystal Lopez-Beck, BA, Deputy Bureau Chief
Exit Conference Date:	January 15, 2019
Present:	**Interim Healthcare (New Mexico Healthcare Services, LLC)** Twila Rutter, General Manager Rakel Nussbaumer, RN, Director of Healthcare Services **DOH/DHI/QMB** Crystal Lopez-Beck, BA, Deputy Bureau Chief / Team Lead Yolanda J. Herrera, RN, Nurse Healthcare Surveyor **DDSD/ Clinical Services Bureau** Iris Clevenger, RN, BSN, MA, CCM, Medically Fragile Waiver Program Manager, Developmental Disability Supports Division/Clinical Services Bureau (via phone)
Administrative Locations Visited :	Number: 1
Private Duty Nursing Records Reviewed	Number: 2
Administrative Personnel Interviewed	Number: 3

Administrative Files Reviewed:

- Medicaid Billing/Reimbursement Records for all Services Provided
- Accreditation Records
- Internal Incident Management Reports and System Process
- Agency Policy and Procedure to include, but not limited to:
    - Transportation of individuals served.
    - Employee Tuberculosis Testing.
    - Rights and Responsibilities and Grievance Procedure.
    - Transition/discharges/termination of individuals served.
    - Procedures for disaster planning and emergency preparedness and evacuation of individuals served.
    - Response to individual's medical emergency situations.

    - Record Storage for maintaining individual's files.
    - Supervision of HHAs, LPNs, RNs and verification process to ensure competency.
- Case Files
- Quality Assurance / Improvement Plan
- Personnel Files – including nursing and subcontracted staff
- Staff Training Records, including staff training hours, competency and interviews with staff
- Caregiver Criminal History Screening Records
- Consolidated Online Registry/Employee Abuse Registry
- Cardiopulmonary Resuscitation (CPR) for Home Health Aides
- Licensure/Certification for Nursing

CC Distribution List: DOH - Division of Health Improvement
DOH - Developmental Disabilities Supports Division
DOH - Office of Internal Audit
HSD - Medical Assistance Division
MFEAD – NM Attorney General

Attachment A

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

Introduction:
After a QMB Compliance Survey, your QMB Report of Findings will be sent to you via e-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 deficiencies and non-compliance.

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

Agencies must fully implement their approved Plan of Correction within 45 business days (10 business days to submit your POC for approval and 35 days to implement your approved Plan of Correction) from the date they receive the QMB Report of Findings (Providers who fail to complete a POC within the 45 business days allowed will be referred to the IRC for possible actions or sanctions.)

If you have questions about the Plan of Correction process, call the Plan of Correction Coordinator at 575-373-5716 or email at AmandaE.Castaneda@state.nm.us. Requests for technical assistance must be requested through your Regional DDSD Office.

The POC process cannot resolve disputes regarding findings. 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) business days of receiving your report. 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.

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 must address the six required Center for Medicare and Medicaid Services (CMS) core elements to address each deficiency cited in the Report of Findings:

1. How the specific and realistic corrective action will be accomplished for individuals found to have been affected by the deficient practice.
2. How the agency will identify other individuals who have the potential to be affected by the same deficient practice, and how the agency will act to protect individuals in similar situations.
3. What QA measures will be put into place or systemic changes made to ensure that the deficient practice will not recur
4. Indicate how the agency plans to monitor its performance to make sure that solutions are sustained. The agency must develop a QA plan for ensuring that correction is achieved and sustained. This QA plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the agency quality assurance system; and
5. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State.
6. The POC must be signed and dated by the agency director or other authorized official.

The following details should be considered when developing your Plan of Correction:

- Details about how and when Consumer, Personnel and Residential files are audited by Agency personnel to ensure they contain required documents;
- Information about how Medication Administration Records are reviewed to verify they contain all required information before they are distributed, as they are being used, and after they are completed;
- Your processes for ensuring that all staff are trained in Core Competencies, Abuse, Neglect and Exploitation Reporting, and Individual-Specific service requirements, etc.;
- How accuracy in Billing/Reimbursement documentation is assured;
- How health, safety is assured;
- For Case Management Providers, how Individual Specific Plans 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 indicators; and,
- Details about Quality Targets in various areas, current status, analyses about why targets were not met, and remedies implemented.

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) for each finding. Be sure the date is **realistic** in the amount of time your Agency will need to correct the deficiency; not to exceed 45 total business 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.

Initial Submission of the Plan of Correction Requirements

1. The 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. For questions about the POC process, call the POC Coordinator, Amanda E Castaneda at (575) 373-5716 email at AmandaE.Castaneda@state.nm.us for assistance.
3. For Technical Assistance (TA) in developing or implementing your POC, contact your Regional DDSD Office.
4. Submit your POC to Amanda E. Castaneda, POC Coordinator in any of the following ways:
    a. Electronically at AmandaE.Castaneda@state.nm.us *(preferred method)*
    b. Fax to (575) 528-5019, or
    c. Mail to POC Coordinator, 1170 N. Solano Suite D, Las Cruces, NM 88001
5. Do not submit supporting documentation (evidence of compliance) to QMB until after your POC has been approved by the QMB.
6. QMB will notify you when your POC has been "approved" or "denied."
    a. During this time, 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-business 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 when your POC has been approved by QMB and a final deadline for completion of your POC.
    e. Please note that all POC correspondence will be sent electronically unless otherwise requested.
7. Failure to submit your POC within 10 business 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.

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. It is preferred that you submit your documents via USPS or other carrier (scanned and saved to CD/DVD disc, flash drive, etc.). If the documents do not contain protected Health information (PHI) the preferred method is that you submit your documents electronically (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; Please provide copies or scanned electronic files for evidence. 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. When billing deficiencies are cited, you must provide documentation to justify billing and/or void and adjust forms submitted to Xerox State Healthcare, LLC for the deficiencies cited in the Report of Findings. In addition to this, we ask that you submit:
    a. Evidence of an internal audit of billing/reimbursement conducted for a sample of individuals and timeframes of your choosing to verify POC implementation;
    b. Copies of "void and adjust" forms submitted to Xerox State Healthcare, LLC to correct all unjustified units identified and submitted for payment during your internal audit.

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, 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.

Attachment C

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 surveyors have clarified issues and/or requested missing information before completing the review through the use of the signed/dated "Document Request," or "Administrative Needs," etc. forms. 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 received in writing to the QMB Deputy Bureau Chief **within 10 business days** of receipt of the final Report of Findings.
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: https://nmhealth.org/about/dhi/cbp/irf/
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.
5. If you have questions about the IRF process, email the IRF Chairperson, Crystal Lopez-Beck at crystal.lopez-beck@state.nm.us for assistance.

The following limitations apply to the IRF process:
- The written request for an IRF and all supporting evidence must be received within 10 business 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 DHI/QMB determination of compliance or the length of their DDSD provider contract.

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

The IRF Committee will review the request, 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: **Interim Healthcare (New Mexico Healthcare Services, LLC) - Southeast Region**
Program: Medically Fragile Waiver
Services: Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA and Respite PDN
Survey Type: Routine
Survey Dates: **January 11 - 15, 2019**

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Administrative Requirements:			
TAG # MF04 **General Provider Requirements**			
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 01/01/2011 **GENERAL PROVIDER REQUIREMENTS** I. Provider Requirements A. The Medicaid Medically Fragile Home and Community Based Services Waiver requires providers to meet any pertinent laws, regulations, rules, policies and interpretive memoranda published by the New Mexico Department of Health (DOH) and HSD. B. All providers must be currently enrolled as a MFW provider through the Developmental Disabilities' Supports Division (DDSD) Provider Enrollment Unit process. Reference: http://nmhealth.org/ddsd/providerinformation/ProviderEnrollmentApplicationPage.htm C. All providers must follow the DOH/Division of Health Improvement (DHI) Statewide Incident Management System Policies and Procedures. D. All provider agencies that enter into a contractual relationship with DOH to provide MFW services shall comply with all applicable regulation, policies and standards.	Based on record review and interview, the Agency did not develop, implement and/or update written policies and procedures that comply with all DDSD requirements. **Review of the Agency's policies & procedures found no evidence of the following:** • Transportation of individuals served. **When surveyor asked if the agency had a policy and procedure for transportation, the following was reported:** • #203 stated, "None of our staff do but I'm still looking for a policy specific to staff not transporting individuals."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

Reference: http://dhi.health.state.nm.us/ E. Provider Agency Report of Changes in Operations: 1. The provider agency shall notify the DOH in writing of any changes in the disclosures required in this section within ten (10) calendar days. This notice shall include information and documentation regarding such changes as the following: any change in the mailing address of the provider agency, and any change in executive director, administrator and classification of any services provided. F. Program Flexibility: 1. If the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects conflicts with these standards, then prior written approval from the DOH shall be obtained. Such approval shall provide for the terms and conditions under which the waiver of specific standard(s) is/are granted. The applicant or provider agency is required to submit a written request and attach substantiating evidence supporting the request to DOH. DOH will only approve requests that remain consistent with the current federally approved MFW application. G. Continuous Quality Management System: 1. On an annual basis, MFW provider agencies shall update and implement the request, the agency will submit a summary of each year's quality improvement activities and resolutions to the MFW Program Manager. H. The provider agency is required to develop and implement written policies and			

procedures that maintain and protect the physical and mental health of individuals and that comply with all DDSD policies and procedures and all relevant New Mexico statutes, rules and standards. These policies and procedures shall be reviewed at least every three years and updated as needed. I. Appropriate planning shall take place with all Interdisciplinary Team (IDT) members, Medicaid SALUD provider, other waiver providers and school services to facilitate a smooth transition from the MFW program. The participant's individual choices shall be given consideration when possible. DOH policies must be adhered to during this process as per the provider's contract. J. All provider agencies, in addition to requirements under each specific service standard, shall at a minimum develop, implement and maintain at the designated provider agency main office, documentation of policies and procedures for the following: 1. Coordination with other provider agency staff serving individuals receiving MFW services that delineates the specific roles of each agency staff. 2. Response to the individual emergency medical situations, including staff training for emergency response and on-call systems as indicated. 3. Agency protocols for disaster planning and emergency preparedness.			

TAG #MF 1A28 Incident Mgt. System			
NMAC 7.1.13.10 INCIDENT MANAGEMENT SYSTEM REQUIREMENTS: **A. General:** All licensed health care facilities and community based service providers shall establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. The licensed health care facility or community based service provider shall ensure that the incident management system policies and procedures requires all employees to be competently trained to respond to, report, and document incidents in a timely and accurate manner. **B. Training Curriculum:** The licensed health care facility and community based service provider shall provide all employees and volunteers with a written training curriculum on incident policies and procedures for identification, and timely reporting of abuse, neglect, misappropriation of consumers' property, and where applicable to community based service providers, unexpected deaths or other reportable incidents, within thirty (30) days of the employees' initial employment, and by annual review not to exceed twelve (12) month intervals. The training curriculum may include computer-based training. Periodic reviews shall include, at a minimum, review of the written training curriculum and site-specific issues pertaining to the licensed health care facilities or community based service provider's facility. Training shall be conducted in a language that is understood by the employee and volunteer. C. **Incident Management System Training Curriculum Requirements:** **(1)** The licensed health care facility and community based service provider shall conduct training, or designate a knowledgeable	Based on record review and interview, the Agency did not establish and maintain an incident management system, which emphasizes the principles of prevention and staff involvement. **During on-site survey, the following was found:** • No evidence of the Agency's Policy and Procedure for employee training and reporting Abuse, Neglect, Exploitation. **When surveyors asked if the agency had a policy and procedure for training and reporting Abuse, Neglect, Exploitation, the following was reported:** • #203 stated, "I'm not able to locate the policy and procedure for Abuse, Neglect, Exploitation, but upon hire every employee is trained and annually."	**Provider:** **State your Plan of Correction for the deficiencies cited in this tag here** *(How is the deficiency going to be corrected? This can be specific to each deficiency cited or if possible an overall correction?)*: → **Provider:** **Enter your ongoing Quality Assurance/Quality Improvement processes as it related to this tag number here** *(What is going to be done? How many individuals is this going to affect? How often will this be completed? Who is responsible? What steps will be taken if issues are found?)*: →	

representative to conduct training, in accordance with the written training curriculum that includes but is not limited to: **(a)** An overview of the potential risk of abuse, neglect, misappropriation of consumers' property; **(b)** Informational procedures for properly filing the division's incident management report form; **(c)** Specific instructions of the employees' legal responsibility to report an incident of abuse, neglect and misappropriation of consumers' property. **(d)** Specific instructions on how to respond to abuse, neglect, misappropriation of consumers' property; **(e)** Emergency action procedures to be followed in the event of an alleged incident or knowledge of abuse, neglect, misappropriation of consumers' property; and **(f)** Where applicable to employees of community based service providers, informational procedures for properly filing the division's incident management report form for unexpected deaths or other reportable incidents.			

Statute	Deficiency	Agency Plan of Correction, On-going QA/QI and Responsible Party	Date Due
Medicaid Billing/Reimbursement:			
Tag # MF 1A12 All Services Reimbursement	**N/A Agency had no clients.**		
New Mexico Department of Health Developmental Disabilities Supports Division Medically Fragile Wavier (MFW) effective 1/01/2011 **Private Duty Nursing IV. <u>REIMBURSEMENT</u>** Each provider of a service is responsible for providing clinical documentation that identifies the DSP's role in all components of the provision of home care: including assessment information, care planning, intervention, communications and care coordination and evaluation. There must be justification in each participant's medical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of care. Services must be reflected in the ISP that is coordinated with the participant/participant's representative, other caregivers as applicable, and authorized by the approved budget. All services provided, claimed and billed must have documented justification supporting medical necessity and be covered by the MFW. A. Payment for PDN services through the Medicaid waiver is considered payment in full. B. PDN services must abide by all Federal, State and HSD and DOH policies and procedures regarding billable and non-billable items. C. Billed services must not exceed the capped dollar amount for LOC. D. PDN services are a Medicaid benefit for children birth to 21 years, through the children's EPSDT program. E. The Medicaid benefit is the payer of last resort. Payment for the PDN services should not be requested until all other third-party and			

community resources have been explored and/or exhausted. F. PDN services are a MFW benefit for the 21 year and older enrolled participant. The MFW benefit is the payer of last resort. Payment for waiver services should not be requested or authorized until all other third-party and community resources have been explored and/or exhausted. G. Reimbursement for PDN services will be based on the current rate allowed for services. H. The HH Agency must follow all current billing requirements by the HSD and DOH for PDN services. I. Service providers have the responsibility to review and assure that the information on the MAD 046 form for their services is current. If providers identify an error, they will contact the CM or a supervisor of the case. 1. The private duty nurse may ride in the vehicle with the participant for the purpose of oversight, support or monitoring during transportation. The private duty nurse may not operate the vehicle for the purpose of transporting the participant. J. The MFW Program does not consider the following to be professional PDN duties and will not authorize payment for: 1. Performing errands for the participant/participant representative or family that is not program specific. 2. "Friendly visiting," meaning visiting with the participant outside of PDN work scheduled. 3. Financial brokerage services, handling of participant finances or preparation of legal documents. 4. Time spent on paperwork or travel that is administrative for the provider. 5. Transportation of participants. 6. Pick up and/or delivery of commodities.			

7. Other non-Medicaid reimbursable activities. **Home Health Aide (HHA) <u>IV. REIMBURSEMENT:</u>** Each provider of a service is responsible for providing clinical documentation that identifies direct care professional (DCP) roles in all components of the provision of home care, including assessment information, care planning, intervention, communications and care coordination and evaluation. There must be justification in each participant's clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant's representative and other caregivers as applicable. All services provided, claimed and billed must have documented justification supporting medical necessity and be covered by the MFW and authorized by the approved budget. A. Payment for HHA services through the Medicaid Waiver is considered payment in full. B. The HHA services must abide by all Federal, State, HSD and DOH policies and procedures regarding billable and non-billable items. C. The billed services must not exceed capped dollar amount for LOC. D. The HHA services are a Medicaid benefit for children birth to 21 years though the children's EPSDT program. E. The Medicaid benefit is the payer of last resort. Payments for HHA services should not be requested until all other third party and community resources have been explored and/or exhausted. F. Reimbursement for HHA services will be based on the current rate allowed for the service. G. The HH Agency must follow all current billing requirements by the HSD and the DOH for HHA			

services. H. Providers of service have the responsibility to review and assure that the information of the MAD 046 for their services is current. If the provider identifies an error, they will contact the CM or a supervisor at the case management agency immediately to have the error corrected. 1. The HHA may ride in the vehicle with the participant for the purpose of oversight during transportation. The HHA will accompany the participant for the purpose of monitoring or support during transportation. This means the HHA may not operate the vehicle for purpose of transporting the participant. I. The MFW Program does not consider the following to be professional HHA duties and will not authorize payment for: 1. Performing errands for the participant/participant's representative or family that is not program specific. 2. "Friendly visiting", meaning visits with the participant outside of work scheduled. 3. Financial brokerage services, handling of participant finances or preparation of legal documents. 4. Time spent on paperwork or travel that is administrative for the provider. 5. Transportation of participants. 6. Pick up and/or delivery of commodities. 7. Other non-Medicaid reimbursable activities. **RESPITE CARE: IV <u>REIMBURSEMENT</u>** Each provider agency of a service is responsible for developing clinical documentation that identifies the direct support professionals' role in all components of the provision of home care, including assessment information, care planning, intervention, communications and care coordination and evaluation. There must be justification in each participant's clinical record supporting medical			

necessity for the care and for the approved Level of Care that will also include frequency and duration of the care. All services must be reflected in the ISP that is coordinated with the participant/participant representative, other caregivers as applicable. All services provided, claimed, and billed must have documentation justification supporting medical necessity and be covered by the MFW and authorized by the approved budget. A. Payment for respite services through the MFW is considered payment in full. B. The respite services must abide by all Federal, State and Human Services Department (HSD) and DOH policies and procedures regarding billable and non-billable items. C. All billed services must not exceed the capped dollar amount for respite services. D. Reimbursement for respite services will be based on the current rate allowed for the services. E. The agency must follow all current billing requirements by the HSD and DOH for respite services. F. Service providers have the responsibility to review and assure that the information on the MAS 046 form is current. If the provider identifies an error, he/she will contact the CM or a supervisor at the case management agency immediately to have the error corrected.			

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

Date: February 20, 2019

To: Twila Rutter, General Manager
Provider: Interim Healthcare (New Mexico Healthcare Services, LLC)
Address: 2300 North Main St., Suite 19, Hilltop Plaza
State/Zip: Clovis, New Mexico 88101

E-mail Address: twila.rutter@interimhh.com

CC: Jim Bullard, Board Chair
E-Mail Address: jim.bullard@interimhh.com

Region: Southeast
Survey Date: January 11 - 15, 2019
Program Surveyed: Medically Fragile Waiver

Services Surveyed: Home Health Aide (HHA), Private Duty Nursing (PDN), Respite HHA and Respite PDN (*Note: There were no individuals receiving any services, therefore an administrative review was conducted.)*

Survey Type: Routine

Dear Ms. T. Rutter:

The Division of Health Improvement/Quality Management Bureau has received, reviewed and approved the supporting documents you submitted for your Plan of Correction. The documents you provided verified that all previously cited survey Deficiencies have been corrected.

The Plan of Correction process is now complete.

Furthermore, your agency is now determined to be in Compliance with all Conditions of Participation.

To maintain ongoing compliance with standards and regulations, continue to use the Quality Assurance (self-auditing) processes you described in your Plan of Correction.

Consistent use these Quality Assurance processes will enable you to identify and promptly respond to problems, enhance your service delivery, and result in fewer deficiencies cited in future QMB surveys.

Thank you for your cooperation with the Plan of Correction process, for striving to come into compliance with standards and regulations, and for helping to provide the health, safety and personal growth of the people you serve.

Sincerely,

Amanda Castañeda

Amanda Castañeda
Plan of Correction Coordinator
Quality Management Bureau/DHI

Q.19.3.MedFrag.43455875.1.RTN.09.19.051