

**I/DD Waiver Policy Clarifications—
(Policy Effective 12/1/15)**

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Approved Medication Assistive Personnel (AMAP)

Q9: Can the RN code be billed for supervision and training of AMAP staff?

A9: [12/3/15] AMAPs have been used for many years by many agencies. The RN code has not been allowed to be billed for supervision or training of AMAP staff. I/DD Waiver reimburses for specific services to be provided to an individual recipient. Supervision of AMAP/LPN staff is not a member-specific service, rather it is an agency responsibility to ensure that personnel providing services are properly monitored.

Behavior Support Professional

Q8: How does a BSP become board certified and can current BSPs be grandfathered in as BSP II?

A8: [Updated 12/17/15] A process has been in place for three months (dated 12/3/15) that allows individuals to submit their applications to have a PBS endorsement by a recognized APBS Network for PBS Board of Review. The WV APBS Network is meeting next week and have an expedited process, but have very few applications to review. Additional information can be found at: <http://wvaps.blogspot.com/>.

Some provider agencies and staff have received PBS endorsements from other states; information on PBS endorsement in other states was previously provided. Since the opportunity to become PBS endorsed has been available, BMS will not grandfather BSP staff.

Current TC/BSP staff can bill BSP I if this service is authorized for individuals who have transitioned to “new” services. BMS will allow staff who are not currently credentialed as BSP I a Period of one year to become credentialed, during which time BSP I can be billed. In addition, BSP I can be provided by staff with a non-human services degree if they were hired prior to 12/1/15.

If a BSP I qualifies for a PBS endorsement and meets all other requirements for BSP II and the budget allows, the team can request to replace BSP I with BSP II services.

BSP II cannot be provided until the clinician meets the requirements to bill that service as described in the policy manual.

Q20: According to the Quarterly Provider Training in May 2015 and the document on the BMS website, labeled “2015 Draft I/DD Waiver Comments and Responses,” a transition period of one year was documented to allow current TCs and BSPs to obtain BSP I and BSP II certification. The Policy Manual, however, indicates that the time-period is six months. Please clarify.

A20: [Updated 2/18/16] BMS will allow a transition period of one year for a Therapeutic Consultant to become certified as a Behavior Support Professional, as communicated in May 2015 and in the comments and responses document. During this time, the Therapeutic Consultant can bill BSP I, as there is no other code available. Note that this does not apply to BSP II—in order to bill BSP II, the clinician must meet the requirements as described in the policy manual.

Q28: The current policy manual says that, in order to be approved to train on a curriculum, the trainer must 1—be a BCBA, 2—be the developer of the approved course, or 3—have documentation that certifies completion of an approved training course (though not necessarily the course for which they are the trainer). What is considered an “approved training course” in option 3?

A28: [1/7/16] An “approved training course” is any curriculum that was approved by the WV APBS Network.

Q53: Can BSPs bill to develop the tentative schedule? This task is not identified in the policy manual as something that the BSP can do.

A53: [2/4/16] Yes, it is the responsibility of the BSP to develop the tentative schedule, therefore this is a billable activity.

CareConnection©

Q72: A request for prior authorization for a person new to the program was recently submitted by our agency using the “initial” option in CareConnection©. We were advised that this function should not be used and that initial requests should actually be made using the “annual” option. Is this correct?

A72: [5/5/16] Yes, this is correct. The initial feature only provides an authorization for a period of 30 days. If an authorization is needed for a 30-day period, this can be received using the “annual” option, which can later be modified to reflect the units needed for the entire service year.

Direct Care Service (Day Services, Person-Centered Support)

Q2: Given that 1:3 and 1:4 ratios are not available for Home-Based Person-Centered Support, what ratios should be billed when an individual is receiving services in the community while attending Facility-Based Day Habilitation?

A2: [12/3/15] The provider should bill the appropriate Facility-Based Day Habilitation code.

Q3: If an individual turns 18 during his/her service year, will they be eligible at that time to receive authorization for direct support services at the limits specified in the policy manual for those age 18 and older?

A3: [12/3/15] Yes, if the request is supported by the individualized budget and is clinically necessary.

Q6: If, at the Facility-Based Day Habilitation/Pre-vocational site, one staff person is working with four individuals and two of those are focused on day hab related tasks and two are focused on pre-voc related tasks, what code and what ratio does the staff person bill?

A6: [12/3/15] Under the circumstance described, the staff person would bill the 1:3-4 Facility-Based Day Habilitation code for the individuals focused on day hab tasks and 1:3-4 Pre-vocational code for individuals focused on pre-voc tasks. [Updated 5/5/16]

Q10: Is there an administrative billing code for AMAP services? The manual is unclear.

A10: [12/3/15] There is no code for AMAP, rather Person-Centered Support staff are trained to function as AMAPs also.

Q23: If an agency does not wish to integrate a Facility-Based Day Program into the community, can Person-Centered Support services be billed while individuals attend the program?

A23: [12/17/15] The allowable sites for any type of Person-Centered Support are: the residence of the individual or the local public community. The definition of local public community in the glossary section of the Policy Manual is: "Any community setting open to the general public, such as libraries, banks, stores, post offices, etc. Facility-Based Day Programs and Pre-vocational sites are not considered public community locations." As such, Person-Centered Support services cannot be provided at the former site of a Facility-Based Day Habilitation program or within the offices of an IDW provider.

Q24: Our agency wants to set up an additional company to pay individuals who will work in our office and we will bill Supported Employment. Is this acceptable?

A24: [12/17/15] The allowable sites for Job Development and Supported Employment are local public community settings and integrated employment settings. The definition of an integrated employment setting in the glossary section of the Policy Manual is: "A site where an individual receiving IDW Job Development or Supported Employment services is employed where not more than 75% of the people with the same job description are diagnosed with an intellectual or developmental disability." The provider will be required to apply this standard to the individuals employed; if 75% or

more individuals with the same job description are diagnosed with an intellectual or developmental disability, it will not be considered an integrated setting and neither Job Development nor Supported Employment may be billed under this circumstance.

Q35: BMS has indicated that the annual service limit for direct care services has been changed to 35,280 to accommodate “indirect” LPN activities. Should this number be changed to 35,376 due to leap year?

A35: [1/7/16] Yes, this limit has been changed to 35,376.

Q36: When are agencies required to stop billing for LPN travel time?

A36: [1/7/16] LPN travel may be billed for each individual until they transition to new services. Once the transition occurs, travel for LPN services can no longer be billed.

Q38: The policy manual says that providers cannot have any other responsibilities when providing 1:1 PCS services. With parent providers, does this apply to other children living in the home, caring for another family member, grandchild etc?

A38: [1/7/16] Yes. When a person is receiving 1:1 PCS services, he/she must be the only person receiving care. In the event that the person who receives I/DD Waiver services has siblings who require care at the same time, the parent may elect to have someone else provide care to the siblings while PCS Family services are provided, or can choose to have another provider deliver PCS services.

Q49: Can I/DD Waiver mileage/trips be used for transport to Facility-Based Day Habilitation facilities and/or Supported Employment sites, or must NEMT be used?

A49: [1/21/16] I/DD Waiver mileage/trips can be used for this type of transport. Individuals can access NEMT for transportation to these types of facilities if the I/DD Waiver mileage/trips authorizations are exhausted.

Q50: There have been several issues when calling the number provided to verify financial eligibility. Either the operator will not provide the requested information because they require the guardian to call, or there is no answer. The same information can be obtained via Molina’s website. Can a printed confirmation that eligibility is verified via the website be maintained in the member file instead of calling?

A50: [1/21/16] Yes, or the Service Coordinator may verify the month’s eligibility during the monthly home visit by viewing the actual Medicaid card.

Q57: Can a person who attends Facility-Based Day Habilitation or Pre-vocational be paid to perform services while FBDH or Pre-vocational is being billed?

A57: [UPDATED 3/3/16] It is not permissible for individuals who are receiving Facility-Based Day Habilitation services to receive payment while that service is being billed. For those receiving Pre-vocational or Job Development services, agencies may pay “piece-rate” or sub-minimum wage with Department of Labor approval certificate.

Q60: When an individual is receiving job coaching through the Division of Rehabilitation Services (DRS), is it required to also have that IDDW staff person bill Supported Employment, Person-Centered Support, or Respite?

A60: [3/3/16] No. Because DRS is paying an agency to provide job coaching services to the individual, it would be a duplication of services to also bill Medicaid Waiver at the same time and is thus fraudulent.

Q61: Can Occupational, Speech, and Physical Therapy be considered direct care services for individuals who live in natural family settings for the purposes of the rule that requires individuals to receive direct care services at least once every 30 days?

A61: [3/3/16] Yes, BMS has determined that individuals who receive Occupational, Speech, and/or Physical Therapy will not be subject to discharge, even if no other direct care services are provided.

Q69: If a community employer pays an I/DD Waiver member at a rate other than minimum wage (for example, “piece-rate,”), can Supported Employment be billed or must the agency bill Pre-vocational services?

A69: [4/7/16] The agency should bill Pre-vocational services in this case.

Electronic Monitoring

Q12: The Electronic Monitoring service information states that an incident report has to be entered in the IMS every time an emergency response is generated. Is there an exception to this if the response is a false alarm? If there is not an exception, is there a specific code that needs to be used in the IMS for this?

A12: [12/17/15] Even if the response is a false alarm, an incident report must still be completed in the IMS. It should be entered as a “simple” incident.

Financial Eligibility

Q68: Our local DHHR economic service worker indicated that cases for individuals who “have full coverage SSI related Medicaid with no other benefits require no maintenance” with respect to financial eligibility. For I/DD Waiver members to whom this applies, what needs to be maintained in the file?

A68: [4/7/16] Per the Income Maintenance Manual, both medical and financial eligibility must be determined annually. If county DHHRs indicate that it is not necessary to determine financial eligibility annually, please send their name and county to Pat Nisbet or Taniua Hardy for follow-up.

Q85: Does financial eligibility for I/DD Waiver members who have SSI need to be re-determined annually?

A85: Yes, they do, per Income Maintenance Manual 17.32: “.....SSI.....must complete the DFA-LTC-5 to evaluate any annuities, trusts, and/or other potential resources or transfers when determined medically eligible for I/DD and at each annual redetermination.”

Hold/Extension Requests

Q83: Section 513.26 of the I/DD Policy Manual says a person may be discharged from the program “a person does not access or utilize at least one IDDW Service each month (with the exception of Service Coordination).” So that agencies know when it is appropriate to submit a DD-12, how is the term “month” applied—every 30 days or within the calendar month?

A83: The term “month” here refers to within the calendar month. For example, if a person does not or will not receive services during the month of July, a DD-12 should be submitted identifying the reason services were not/will not be accessed and requesting an extension.

Q84: Can Service Coordination and/or Behavior Support Professional be billed while an individual is in the hospital, for purposes of discharge planning?

A84: These services cannot be billed while a person is in the hospital, or at any time when services are on hold. When a member is hospitalized, it is the responsibility of the hospital social worker to arrange for discharge planning. Note, this does not apply to when a person is in a Crisis PCS site and their status is Member Hold-Extension in CareConnection©.

Incident Management System (IMS)

Q66: If an individual self-directs their services, who is responsible for entering incidents into the IMS?

A66: [4/7/16] The Service Coordinator is responsible for ensuring that incidents are entered into the IMS, as well as for maintaining a written copy of the report in the member file. While PPL Resource Consultants have capability to enter incidents into the

IMS and follow-up with families on a monthly basis regarding reportable incidents, they will verify with the SC prior to entering an incident in order to avoid duplication.

Individual Program Plan (IPP)

Q25: What sections of the I/DD-5 are required to be uploaded to CareConnection©?

A25: [1/7/16] The entire IPP (I/DD-5) must be uploaded to CareConnection© before requesting prior authorization for services. APS and BMS must have access to the entire document in order to review when considering requests.

Q30: The ISP section of the new I/DD-5 requires that the name of the staff person be indicated in the section for provider. Is it permissible to indicate the agency in this space instead of the staff person's name for those who live in ISS and for those who attend agency day services? Frequent turnover in these particular settings would require very frequent updates to the IPP document.

A30: [1/7/16] For Licensed Group Home PCS, Unlicensed Residential PCS, Facility-Based Day Habilitation, Pre-vocational Training, Job Development, and Supported Employment, it is acceptable to indicate the name of the agency that will supply the staff. For all other services, the name of the staff person must be indicated.

Q52: Can video-conferencing such as Omnijoin or Go To Meeting be used for BSPs and RNs to attend IDT meetings?

A52: [2/4/16] These professionals can attend IDT meetings using such services; however RN IPP Planning and/or BSP IPP Planning can only be billed by the professional when he/she is physically present.

Q54: As many agencies and families are using technology more, is it permissible to send an IPP to the family by email instead of printing and mailing a hard copy? If so, how is this best documented?

A54: [2/4/16] If any IDT members prefer to receive the IPP via email, then this is permissible. All email communication that includes Protected Health Information (PHI) must be sent securely. In order to document that the email with the attachment was forwarded, a service note can be done and a copy of the email attached to that service note, which would then go into the record of the person who receives services.

Q63: When a member transitions to new services at a juncture other than the annual, can an addendum be uploaded to CareConnection© or must the entire IPP be provided?

A63: [4/7/16] If the annual IPP is not already in CareConnection®, it must be uploaded before any authorizations will be provided. In the event that the transition occurs at a critical juncture or quarterly, an addendum showing the changes to the annual IPP is sufficient. If the transition occurs at the 6 month juncture, the 6 month IPP showing the changes must be provided.

Q78: Under what circumstances may an IDT member write in “attended” on a signature page instead of agree or disagree? What is billable for the SC when trying to obtain those signatures after the meeting?

A78: [6/2/16] The SC can bill for documenting the IPP. Signatures and attendance, and if possible, agreement and/or disagreement should be obtained during the IDT meeting. In the event that a team member chooses not to provide agreement/disagreement at the meeting, the SC should send a copy of the signature sheet with the completed IPP for the team member to indicate agreement/disagreement and return. The IPP is not valid until all required signatures and indication of agreement/disagreement are obtained.

Intellectual/Developmental Disabilities (I/DD) Waiver Forms

Q42: The transportation log portion of the I/DD-7 lists the starting address under the travel column and the ending address under the travel to column. This is different from the previous I/DD-7, so it appears that the actual street address is required on the form. Is this correct? If so, how should it be documented?

A42: [1/21/16] Yes, the street address is required, and should be documented as follows:

Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	Provider/ Staff Initials
12/30/15	1234 Main St	100 Nitro Marketplace	Small Purchase	10	CM
	Dunbar	Cross Lanes			

Q62: On the I/DD-5, in the medications section, there is space for both “reason rx/dx” and “rationale for continuation,” which seems repetitive. What is the expectation for these items?

A62: [3/3/16] The “reason rx/dx” item should include the reason the medication is prescribed; to also include a “rationale for continuation” is an OHFLAC Behavioral Health regulation, and should include the reason the medication must continue to be taken at the time of the IPP. The reason the medication may be the member’s diagnosis “dx.”

Intensively Supported Settings (ISS)

Q21: Will there be any over-budget approval for individuals whose lease obligations or inability to find someone to share a home with prevent agencies from being able to provide direct support services in ratios other than 1:1?

A21: [12/17/15] These will be considered on a case-by-case basis. Service Coordinators should submit the Direct Support Living Arrangement assessment, attached, in advance of the annual IDT meeting in preparation. Agencies are encouraged to assist individuals with ensuring their living arrangement needs are met in the most cost-effective manner possible, as, unless clinical/medical necessity is demonstrated, 24-hour per day 1:1 ratios will not be approved. This may require that IDTs proactively identify alternatives to 1:1 ratios PRIOR to the annual IDT meeting.

Q22: What is the final decision on the requirement for requests for more than 12 hours, average, per day of 1:1 direct support? The Policy Manual states “all requests for more than an average of 12 hours per day of 1:1 services require BMS approval,” however, we have been directed that the Direct Support Services Living Arrangement assessment is not required if the request is under budget?

A22: [Updated 3/3/16] The Direct Support Services Living Arrangement assessment (DSS LA) must be submitted under the following circumstances:

- The individual wishes to change the current living arrangement to a setting that will result in an increase over the current cost of annual services
- A change in living arrangement will result in the **current** budget being exceeded (note, approval of a DSS LA is required prior to changing living arrangement in the demographics section in CareConnection©)
- The current living arrangement is ISS, the individual does not wish to change living arrangement, however, the request for services agreed upon will cause the budget to be exceeded
- The individual lives in a setting other than ISS and wishes to receive greater than an average of 12 hours per day of direct support services

[Updated 5/5/16] Note that, as announced at the Quarterly Provider Meeting in March 2015, prior approval is required for individuals to receive a higher level of direct support services than he/she is currently receiving. While BMS does not approve or deny a person’s choice of living setting, medical, behavioral, and/or circumstantial necessity must be demonstrated in order for a higher level of services to be approved and/or for the current assigned budget to be exceeded. **Agencies are advised against providing services prior to receiving authorization as reimbursement cannot be guaranteed.**

Q64: On the Direct Support Services Living Arrangement (DSS LA) assessment, what is the difference between “conditionally approved” and “approved as requested?” Specifically, what criteria must be met in order for BMS to “approve as requested?”

A64: [4/7/16] A DSS LA may be conditionally approved, rather than denied, if the request for new or continued requests for 24-hour per day direct support services can be approved, but not exactly as requested. For example, it may be possible for the individual to receive 24 hours of direct support service per day without exceeding the budget by utilizing different ratios than what is initially proposed. Conditionally approved means the request is approved so long as certain conditions are met. Approved as requested means the request is approved, and no additional conditions are necessary. In order for a request to be approved, medical, behavioral, or circumstantial necessity (such as owning a 1-bedroom home BEFORE March 2015 when this policy went into effect), must be demonstrated.

Q65: If an agency is temporarily unable to staff an ISS, can the individuals who live in that setting be placed in a crisis site?

A65: [4/7/16] This is not allowed. Agencies are expected to staff ISS. The purpose of crisis sites is to assist members who are experiencing behavioral crises or to assist those who live in natural family/SFCH and have lost their natural supports.

Q67: Is a modified diploma required for someone to receive 24 hour residential services as an adult?

A67: [4/7/16] No; individuals over the age of 18 are not required to have any sort of diploma in order to receive residential services.

Miscellaneous

Q4: The new policy manual says that if a home visit was not conducted, services cannot be billed during that month. If there is an approved DD-12, can services be billed?

A4: [12/3/15] Yes.

Q16: I understand that the Policy Manual will not be revised at this time. Will discussions and agreements during Policy Clarification calls be considered policy? Will Policy Clarifications be applied during Provider Reviews?

A16: [12/17/15] Yes, Policy Clarifications will be considered policy. It will be the expectation that agencies apply policy as clarified during conference calls. For Provider Reviews, clarifications will also be applied as approved policy.

Q47: The policy manual says “all required documentation must be maintained by the IDDW provider for at least five years in the person’s file subject to review by authorized BMS personnel or contracted agents” and “the provider must retain the member’s medical records for at least five years after the date of service. Any record that is disputed or under investigation must be maintained until the issue is resolved.” What records, exactly, must remain on site for five years?

A47: [1/21/16] All records pertaining to I/DD Waiver eligibility, service provision, and treatment must be maintained per the instructions in the policy manual.

Q59: Are there plans to look at rate increases for services?

A59: [3/3/16] Not at this time, unless there is an increase in legislative appropriations for this program. BMS will conduct their annual rates review in the near future.

Qualified Providers/Training

Q13: The document responding to manual public comments indicates that BMS requires the facilitated APBS Overview of PBS or the WVUCED PBS Direct Care Overview initially, with the hopes that agencies will offer annual refreshers. However, the manual indicates that an Overview is required annually. Please clarify.

A13: [12/17/15] Either the facilitated APBS Overview of PBS or the WVUCED PBS Direct Care Overview is required upon hire. It is not required to be completed annually; however, to ensure that staff are apprised of the latest developments, BMS encourages agencies to offer annual refreshers.

Q18: Is a statement, signed by staff, acceptable verification that state/local laws are adhered to by the staff for auto insurance, inspection, and registration?

A18: [12/17/16] Auto insurance can be verified by requesting a copy of the insurance card required to be maintained in all vehicles and inspection can be verified by checking the inspection sticker on the vehicle.

Q29: For newly hired staff, does the PBS Direct Care Overview have to be completed prior to staff working the person who receives services?

A29: [1/7/16] Before providing any I/DD Waiver service, all staff must meet qualification requirements, with the exception of new policy that was effective 12/1/15. Agencies have until 5/31/16 to ensure that all staff hired before that date meet new requirements. This does apply to the new requirement of either completion of the

facilitated WV APBS Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview.

Q31: Section 513.3.7 Person-Centered Support Agency Staff Qualifications, reads: “In addition to meeting all requirements for IDDW Staff in Sections 513.2-513.2.1. This gives the impression that there is additional information, though none is provided in this section. Is this a typo?

A31: [1/7/16] Yes, the statement should read: “Must meet all requirements for IDDW Staff in Sections 513.2-513.2.1.”

Q37: The manual indicates that all agency staff, except extended professional staff, having direct contact with persons who receives services must meet all of the qualifications in that section. Does this apply to janitorial, clerical, and other staff who do not provide Medicaid services to individuals?

A37: [1/7/16] No. The requirements in Section 513.2 Provider Enrollment and Responsibilities, must be met by those who provide Medicaid services to persons who receive services. WV CARES will further clarify whether staff who do not provide Medicaid services are required to receive a Criminal Background Check.

[Updated 4/7/16] Only those who provide Medicaid services are required to receive the Criminal Background Check.

[Updated 6/2/16] WV CARES has clarified that direct access means physical contact with a resident, member, beneficiary, or client of a covered provider or covered contractor, or access to their property, personally identifiable information, protected health information, or financial information. As the requirement is for all direct access personnel to undergo a background check, agencies must maintain such on all employees who fit the definition. Any employee who has received a fingerprint-based background check within the last 3 years are covered until the expiration date of those 3 years. Those who have not received a background check in the past 3 years are required to submit an application in the WV CARES system and be fingerprinted.

Q39: The manual indicates that Service Coordinators are required to comply with training requirements in sections 513.2 and 513.2.1. Does this include the training in Direct Care Ethics and completion of the facilitated WV APBS Overview or WVUCED PBS Direct Care Overview?

A39: [1/7/16] SCs are required to receive the WV APBS Overview or WVUCED PBS Direct Care Overview; however they are not required to complete the Direct Care Ethics.

Q40: Are professional staff (TCs, RNs, SCs, and BSPs) required to receive person-specific training?

A40: [1/7/16] No. These professionals can familiarize themselves by reviewing clinical documentation for the individual as appropriate.

Q56: Section 513.3 of the policy manual states: “all staff must be trained to provide IDDW services in a culturally and linguistically appropriate manner.” Since this section is separate from the training requirements in Section 513.2, please clarify who is required to receive this training.

A56: [1/7/16] All staff who provide Medicaid services to persons who receive I/DD Waiver services must receive this training.

Q58: Can I/DD Waiver trainings be completed using live interactive video feeds where the presenter and trainee(s) can see each other, interact with each other, and documents can be presented?

A58: [3/3/16] Yes, this is permissible, as long as the training is interactive as described in the question. This does not apply to CPR or First Aid training, which must be conducted face-to-face.

Q70: For purposes of the definition of Human Services degree in the policy manual, what constitutes a Liberal Arts degree?

A70: [4/7/16] At least 15 credit hours in Human Services classes are required for a degree to be considered Liberal Arts.

Q75: Please clarify the difference between the WVUCED Positive Behavior Support Direct Care Overview and the WVAPBS Overview of PBS.

A75: [5/5/16] The WVUCED Positive Behavior Support Direct Care Overview provides a basic yet thorough review of the principles and implementation of PBS and can be obtained by contacting WVUCED at cedcontact@hsc.wvu.edu. CED also offers “Train the Trainer”, which is required in order to conduct this overview. The WVAPBS Overview of PBS is a facilitated workshop that provides an introduction to Positive Behavior Support. Providers will be notified when this is offered.

[Update 6/2/16] The WVUCED Positive Behavior Support Direct Care Overview provides a basic yet thorough review of the principles and implementation of PBS and can be obtained by contacting WVUCED at cedcontact@hsc.wvu.edu. CED also offers “Train the Trainer”, which is required in order to conduct this overview. The WVAPBS Overview of PBS is a facilitated workshop that provides an introduction to Positive Behavior Support. Providers will be notified when this is offered, however, any

individual who has already received this training is qualified to train others. The training and workbooks are available to be downloaded on the WVAPBS website and Liz Bragg is the contact person for behavioral health agencies. Please contact Liz at lbragg@shsinc.org if you have trouble downloading the material or cannot locate it on the site.

Q77: Several trainings identified in the policy manual are required to be “competency-based.” How is competency expected to be demonstrated?

A77: [6/2/16] A score of 85% or higher is required on a post-test in order to demonstrate competency.

[Updated 7/7/16] Person-specific (i.e. DD-6) training is not required to be competency-based.

Q80: Can DD-6 training be conducted via telephone, as long as no billing occurs for the training?

A80: It is not appropriate for DD-6 training to occur via telephone, even if it is not billed. Face-to-face training on goals/objectives and member health/safety and behavioral issues is required to ensure that the staff person is adequately prepared to provide services. In emergency circumstances, training may be provided via telephone to ensure health and safety of the person who receives services.

Respite

Q55: Please clarify the difference between In-Home and Out-of-Home Respite.

A55: [2/4/16] In-Home Respite services are respite services that are provided in the home/community of the person who receives services or in a Specialized Family Care Home (SFCH) where the person who receives services **resides**. Out-of-Home Respite services are respite services that are provided in SFCHs where the person who receives services **DOES NOT reside**, in licensed facility-based day habilitation/pre-vocational sites, and/or public community locations. An easy way to distinguish between the two is that out-of-home respite must be provided by a Specialized Family Care Provider; in-home does not.

Q73: If a child receives home-based school services due to being medically fragile, can I/DD Waiver respite be billed during the time that the teacher or school speech therapist is in the home?

A73: [5/5/16] This is not permissible, as I/DD Waiver services and school services being provided at the same time would be considered duplicative.

Service Coordination (SC)

Q5: Can the Service Coordinator bill to complete the DD-9?

A5: [12/3/15] No, this should be completed by a Registered Nurse.

Q7: In Section 513.2 *Conflict of Interest*, the policy reads as though an agency that provides both Service Coordination and Residential Services can never refer an individual to their own company. Is this correct?

A7: [12/3/15] The intent of BMS is for the paragraph on conflict of interest at the end of Section 513.2 to be interpreted as in the paragraph below. The policy manual will be modified at the first opportunity to read:

Conflicts of Interest

Conflicts of interest and are prohibited. A conflict of interest is when the Service Coordinator who represents the person who receives services (“person”) has competing interests due to affiliation with a provider agency, combined with some other action. “Affiliated” means has either an employment, contractual or other relationship with a provider agency such that the Service Coordinator receives financial gain or potential financial gain or job security when the provider agency receives business serving IDDW clients. A Service Coordinator representing the person and being affiliated with a provider agency is not by itself a conflict. However, if a Service Coordinator affiliated with a provider agency: (1) takes action on behalf of the person they represent to obtain services for the person from the provider agency with which the Service Coordinator is affiliated while knowing of a non-affiliated, reasonable available provider agency clearly being more qualified to provide the services (regardless of whether any preference is expressed by the person or their guardian); or (2) influences the Freedom of Choice of the person by taking action on behalf of the person they represent to obtain services for the person from the company with which the Service Coordinator is affiliated with when the person or their guardian has expressed preferences to the Service Coordinator to use a different provider agency for service, then a conflict of interest occurs. Service Coordinators must always ensure any affiliation with a provider agency does not influence their actions with regard to seeking services for the person they represent. Failure to abide by this Conflict of Interest policy will result in the loss of provider IDDW certification for the provider involved in the conflict of interest for a period of one year and all current people being served by the suspended provider will be transferred to other Service Coordination agencies. Additionally, any Service Coordinator who takes improper action as described above will be referred to their professional licensing board for a potential violation of ethics. (BMS notes that whether any action is taken would be within the sole discretion of the particular licensing board and depend upon its specific ethical rules). Reports of failure to abide by this Conflict of Interest policy will be investigated by the UMC and the results of this investigation will be reported to BMS for review and possible action.

Q11: A new Service Coordination requirement is to “check with the BMS fiscal agent monthly to verify financial eligibility.” Who is the BMS fiscal agent?

A11: [12/17/15] West Virginia Medicaid Provider Services is the fiscal agent who should be contacted. Eligibility can be verified by calling 888-483-0793. This number is included on form WV-BMS-I/DD-3 Monthly/Bi-Monthly SC Visit.

Q26: The home visit form states the SC should contact the MMIS on a monthly basis to verify financial eligibility. The new manual (page 36) states: Persons who are found financially eligible will receive documentation from the DHHR (ESNL-A) which the person needs to present to their Service Coordination provider. If the SC is verifying financial eligibility monthly, are we also expected to keep the ESNL-A on file?

A26: [1/7/16] Yes.

Q27: Page 101 of the policy manual indicates that SCs cannot bill to conduct training; however page 9 says: "Health and Safety training must be conducted by RN, BSP, or Service Coordinator. When an individual does not access TC services, is it acceptable for the SC to bill to train staff on the crisis plan?"

A27: [1/7/16] Yes. In the absence of other team members who can provide training on the crisis plan, the SC may bill to do so. SCs may document on the I/DD-6 and bill Service Coordination for the task.

Q39: The manual indicates that Service Coordinators are required to comply with training requirements in sections 513.2 and 513.2.1. Does this include the training in Direct Care Ethics and completion of the facilitated WV APBS Overview or WVUCED PBS Direct Care Overview?

A39: SCs are required to receive the WV APBS Overview or WVUCED PBS Direct Care Overview; however they are not required to complete the Direct Care Ethics.

Q79: For individuals who do not have an approved extension or hold and are in out-of-state placement or attend school away from home, are monthly home visits required?

A79: Yes. A requirement of the program is that the SC verify health and safety monthly by conducting a home visit. Without an approved hold or extension, or an approved DD12 for an exception to the monthly home visit, the visit must take place.

Skilled Nursing Services

Q5: Can the Service Coordinator bill to complete the DD-9?

A5: [12/3/16] No, this should be completed by a Registered Nurse.

Q9: Can the RN code be billed for supervision and training of AMAP staff?

A9: [12/3/15] AMAPs have been used for many years by many agencies. The RN code has not been allowed to be billed for supervision or training of AMAP staff. I/DD Waiver reimburses for specific services to be provided to an individual recipient. Supervision of

AMAP/LPN staff is not a member-specific service, rather it is an agency responsibility to ensure that personnel providing services are properly monitored.

Q34: BMS has indicated that up to 240 units per year of LPN can be provided for “indirect” LPN duties and thus be billed concurrently with other direct care services. What tasks are considered “indirect?”

A34: [1/7/16] “Indirect” LPN services are those that are conducted that do not require direct contact with the person who receives services. These include, but are not limited to, scheduling doctor appointments, documenting physicians’ orders, and completing Medication Administration Records (MARs.)

Q35: BMS has indicated that the annual service limit for direct care services has been changed to 35,280 to accommodate “indirect” LPN activities. Should this number be changed to 35,376 due to leap year?

A35: [Updated 2/4/16] Yes, this limit has been changed to 35,376.

Q36: When are agencies required to stop billing for LPN travel time?

A36: [1/7/16] LPN travel may be billed for each individual until they transition to new services. Once the transition occurs, travel for LPN services can no longer be billed.

Q51: Is the I/DD-9 required to be submitted only at the Annual IPP, or must it be submitted if the team requests an increase in LPN units during the service year?

A51: [2/4/16] The I/DD-9 must be submitted each time a change in LPN need results in a request to modify for additional units of the service.

Q82: If more than one agency is requesting RN and/or LPN services for a member, does each agency need to have an RN fill out a DD-9 or is one sufficient to cover requests for both agencies?

A82: One DD-9 can be submitted, however, how each facility will use the requested units must be specified.

Transportation

Q14: During transport in an agency-owned vehicle, if an agency is billing Person-Centered Support for one member and providing natural support for another, how should the agency document the natural support? Will BMS hold the agency accountable for having to attend to the person to whom natural support is being provided?

A14: [12/17/15] If an agency is transporting an individual in an agency-owned vehicle, “natural support” is not being provided, as the agency is being reimbursed. IDTs are responsible for identifying the level of support that an individual needs, including the level needed when transported in an agency vehicle. If the IDT determines that the individual does not require Person-Centered Support during transport, documentation on the transportation log of form WV-BMS-I/DD-7 would be completed.

Q15: Section 513.21 Transportation, of the Policy Manual, says “persons who receive IDDW services are required to access Non-Emergency Medical Transportation (NEMT) for non-IDDW Medicaid services, including doctor appointments.” Does this mean that someone absolutely cannot bill I/DD Waiver for mileage to doctor appointments, or is it just a suggestion that NEMT is available since some people say they don’t have enough miles?

A15: [12/17/15] CMS has indicated that I/DD Waiver services, including mileage, cannot duplicate state plan services. As such, NEMT must be utilized when I/DD Waiver services are not being provided and for non-emergency visits that result in Medicaid transportation being utilized.

Q17: Do the Transportation Services Agency Staff requirements apply to staff who bill mileage only?

A17: [12/17/15] These requirements apply to staff who bill mileage as well as those who bill trips.

Q18: Is a statement, signed by staff, acceptable verification that state/local laws are adhered to by the staff for auto insurance, inspection, and registration?

A18: [12/17/15] Auto insurance can be verified by requesting a copy of the insurance card required to be maintained in all vehicles and inspection can be verified by checking the inspection sticker on the vehicle and recording the date of inspection. In addition, the agency may choose to have staff sign a statement indicating that he/she agrees to comply with all state/local laws associated with operating a motor vehicle. If the vehicle is licensed/inspected in a state other than WV, the owner is required to comply with all of the licensing state’s associated laws. For vehicles that are not licensed in WV, the agency can document so in the personnel file, specify the licensing state’s inspection/other requirements, and document the date compliance was verified by the agency. The frequency agencies verify requirements will depend on the specific state requirements, which should also be documented.

Q19: Concerning the Transportation Trips service, if a person is transported from a day program setting to eat and go bowling, then is transported back to the day program, is this considered one trip?

A19: [Updated 2/18/16] A trip is defined as one outing. From the previous policy manual (applicable to current policy): Member starts from his/her home, goes to the post office, travels to a store, and travels to a restaurant and returns home is one (1) trip. Facility Based Programming: Member starts from his/her home, goes to the facility based day program and stays for six (6) hours. This is one (1) trip. Member leaves the day program facility at the end of the day and returns home. This is one (1) trip.

Q32: Who must access NEMT?

A32: [Updated 3/3/16] Once a person transitions to new services, he/she must access NEMT for all non-I/DD Waiver Medicaid services.

Q33: Can I/DD Waiver mileage be billed for transport to/from I/DD Waiver physical, occupational, dietary, and/or speech therapy?

A33: [1/7/16] Yes.

Q36: When are agencies required to stop billing for LPN travel time?

A36: [1/7/16] LPN travel may be billed for each individual until they transition to new services. Once the transition occurs, travel for LPN services can no longer be billed.

Q41: In Section 513.21.3 Transportation Trips, the third bullet indicates that the service limit is 520 trips annually; however in the WV I/DD Waiver Services, Units, Rates and Limitations sheet, the limit is 730. Which one is correct?

A41: [Updated 2/4/16] The policy manual is correct; the units on the Services, Units, Rates and Limitations sheet is an error and has been corrected. **Please note, however, that, though the policy manual indicates that there is a 2 trips per day limit, this will not apply—only the annual limit of 520 will apply.**

Q43: Can parent providers enroll as NEMT providers?

A43: [1/21/16] Yes, they can receive gas mileage reimbursement (GMR) for transporting their child, family member, or friends. To do so, the individual must call MTM prior to a scheduled appointment at 1-844-549-8353. During this call, MTM will request information required to verify that the person being transported is Medicaid eligible. Upon eligibility verification, the caller is provided with a trip number and access information to obtain required forms. The individual providing transportation must take the required documents to the appointment for the medical provider to sign, verifying that the appointment was attended; the transporter then sends the completed form to MTM for processing. On the first trip, and annually thereafter, MTM requires the transporter to provide verification of current driver's license, and vehicle insurance and

registration prior to receiving reimbursement. Trips must be arranged at least 5 business days before the appointment.

Q44: Families have reported that there is a 6-8 week delay in receiving GMR. Why is there such a delay, and is it anticipated that this delay will be reduced in the future?

A44: [1/21/16] MTM usually processes complete trip forms within 11 business days or receipt. Delays may be caused by incomplete forms or driver credentials not having been received.

Q45: Can MTM vehicles accommodate wheelchairs? If not, can I/DD Waiver mileage be billed for transport?

A45: [1/21/16] Yes, MTM has contracted transportation providers that can accommodate wheelchair transports. The individual must indicate that they need wheelchair transport when scheduling the trip. MTM is required to verify the wheelchair transport Level of Need (LON) with the requesting individual's physician.

Q46: Who should bill to schedule transportation with MTM?

A46: [1/21/16] The LPN or the SC can bill to schedule transport with MTM. For natural family settings, the parent may wish to schedule the transportation.

Q48: Can I/DD Waiver mileage/trips be billed for transportation to the Emergency Room or urgent care facilities, or must NEMT be utilized?

A48: [1/21/16] NEMT **cannot** be utilized for trips to the Emergency Room, as ER trips are considered emergent in nature. If necessary, an ambulance may be called or I/DD Waiver mileage can be used. For transport to urgent care facilities, MTM may be able to arrange transport via their urgent request protocol, or I/DD Waiver mileage may be used.

Q49: Can I/DD Waiver mileage/trips be used for transport to Facility-Based Day Habilitation facilities and/or Supported Employment sites, or must NEMT be used?

A49: [1/21/16] I/DD Waiver mileage/trips can be used for this type of transport. Individuals can access NEMT for transportation to these types of facilities if the I/DD Waiver mileage/trips authorizations are exhausted.

Q74: The DD7s that were distributed (transportation log) says "starting address" and "end address" but the manual says "Transportation Log including beginning location (from) and end location (to). Is either acceptable?

A74: [5/5/16] When completing the transportation log “from” and “to” portions, staff should be as specific as possible. In most cases, indicating the address would be best practice; however on occasion the exact physical address would be acceptable. For example, for transportation from the individual’s home to the local library, the individual’s street address should be provided as the “from” address, but the exact address of the local library may not be available. In that case, it would be acceptable to indicate “Marmet Public Library on Rt 60 in Marmet.”

WV CARES

Q1: When will providers be required to utilize the WV CARES system for conducting CIBs and monthly OIG checks?

A1: [12/3/15] WV CARES is an independent program operated by BMS. The manager of this program has indicated that trainings will be offered in January or February 2016. Until that time, providers should continue to conduct CIBs and OIG checks utilizing the current procedure. Providers will be notified of the training dates and locations when they are received.

Q37: The manual indicates that all agency staff, except extended professional staff, having direct contact with persons who receives services must meet all of the qualifications in that section. Does this apply to janitorial, clerical, and other staff who do not provide Medicaid services to individuals?

A37: [1/7/16] No. The requirements in Section 513.2 Provider Enrollment and Responsibilities, must be met by those who provide Medicaid services to persons who receive services. WV CARES will further clarify whether staff who do not provide Medicaid services are required to receive a Criminal Background Check.

Q71: If an agency does not have capability to provide supervision while someone is provisionally employed and awaiting results from WV CARES, can an Intellicorp check be used instead?

A71: [4/7/16] Yes, this is permissible.

Q76: What date is used to determine when the next background check through WVCARES is due?

A76: [5/5/16] As an existing CIB expires, the employee should be entered into the WVCARES. All CIBs expire within 3 years of completion, so an individual’s entry into WVCARES will be required within 3 years of their original CIB. Once an employee is entered and determined fit for employment, the next WVCARES check will be due within 5 years.

Q81: What is the process for securing a background check via WV CARES when fingerprints are rejected due to lack of clarity?

A81: The process for rejections is as follows:

- If fingerprints have been rejected twice for a state background check, both “hard cards” must be provided to WV CARES, who will then initiate a name-based search and will submit the “hard cards” for manual processing to the FBI.
- If fingerprints have been rejected twice for a federal background check, WV CARES will initiate a name search with the FBI. No additional information is needed from the agency.