WEST VIRGINIA
Department of
Health & Human Resources
Bureau for Medical Services

Innovative Resource Group d/b/a
APS Healthcare

TBI Waiver Program Manual Training for Providers

April 10, 2012

TBI Waiver Agenda

Program Description

Provider Agency Certification

Incident Management

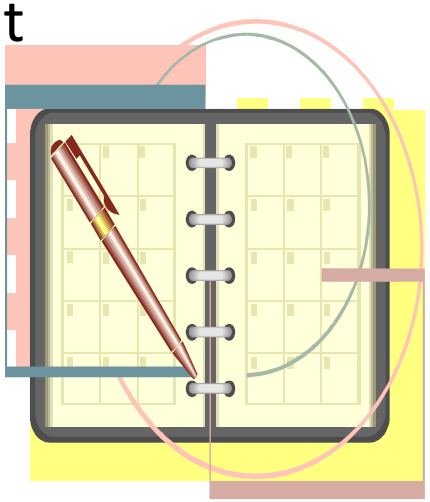
Member Eligibility

Member Enrollment

Member Assessment

Service Plan Development

Covered Services



TBI Waiver Agenda

Member Rights and Responsibilities

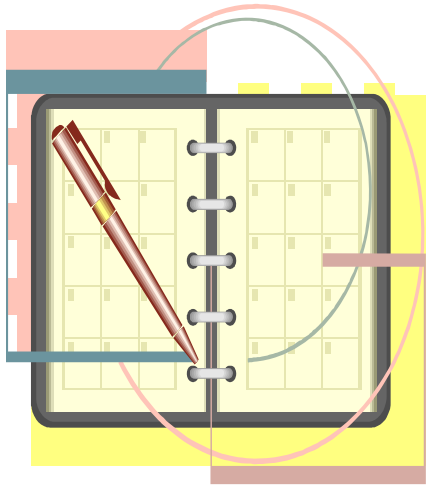
Member Grievances

Transfers

Discontinuation of Services

Dual Provision (TBI and PC)

Excluded Services and Non-reimbursable Services



Program Description

Program Description

The TBI Waiver Program is a long-term care alternative which provides services that enable individuals to live at home rather than receiving nursing facility care

The program provides home and community-based services to WV residents who are medically and financially eligible

Program Description

The goals and objectives of this program are focused on providing services that are

Person-centered

Promote choice

Independence

Participant-directed

Respect

Dignity

Community integration

Program Description

All members are offered and have a right to freedom of choice of providers for services

All members may choose from either the Traditional (Agency) Model or the Participant-Directed Model known as Personal Options for Service Delivery

Program Description

BMS has contracted with APS Healthcare to serve as the Administrative Services Organization for the TBI Waiver Services Program

APS Healthcare is responsible for day-to-day operations and oversight of the TBI Waiver Program including conducting the medical evaluations and determining medical eligibility for applicants and members of the program

Program Description

As with all Waiver programs, Medicaid establishes policies and approves processes and forms

APS Healthcare is responsible for monitoring the quality of TBI Waiver services and implementing and evaluating quality improvement strategies

Program Description

The primary mechanism for involving stakeholders in the TBI Waiver's quality improvement initiative is the establishment of the Quality Improvement (QI) Advisory Council

The QI Council will be comprised of members , legal representatives, Waiver providers, advocates and other interested stakeholders

Provider Agency Certification 512.3

Provider Agency Certification

TBI Waiver provider agencies must be certified by APS Healthcare, Inc.

Initial Enrollment for Aged and Disabled and I/DD Waiver providers, Personal Care Providers and LBHC providers occurring through an application process and enrollment with Molina

Provider Agency Certification

An agency may provide one or more of the TBI Waiver services

Case Management

Personal Attendant Services
(Direct care support and transportation)

Cognitive Rehabilitation Therapy

Provider Agency Certification

As of March 2012

17 Enrolled Providers

Covering **40** + Counties

15 Case Management Agencies

14 Personal Attendant Services Agencies

4 LBHC- CRT

Provider Agency Certification

Certified TBI Waiver Case Management and Personal Attendant Service Provider Agencies must meet and maintain the fifteen (15) requirements listed at 512.3

Personal Attendant Agencies in addition must have a written policy and procedure for maintaining 24 hour contact availability

Agencies providing Cognitive Rehabilitation Therapy must also maintain a current behavioral health provider license with OHFLAC

Provider Agency Certification

Office Criteria

512.3.1

Each designated office must meet the criteria listed

Must designate and staff at least one physical office within West Virginia

Office site can serve no more than eight contiguous counties

Provider Agency Certification

New Location/Satellite Office

APS Healthcare must be notified **PRIOR** to the move.

APS Healthcare will schedule an onsite review of the new location

Medicaid services cannot be provided from any site not certified by APS Healthcare

Provider Agency Certification

Certified Enrolled Agency must continue to:

Employ adequate, qualified, and appropriately trained personnel

Provide services based on each member's assessed needs

Maintain records

Provider Agency Certification

Certified Enrolled Agency must continue to:

Furnish information to BMS, or designee, as requested

Maintain a current list of members receiving TBI Waiver services

Licensed Behavioral Health Centers must maintain current licensure with OHFLAC

Provider Agency Certification

Records Requirement

512.3.3

Member Records

Personnel Records

Provider Agency Certification

Certification Reviews

512.3.4

Required to submit evidence every 12 months documenting continued compliance

Evidence must be attested to by an appropriate official

Provisional certification may apply if all the appropriate documentation is not received within 30 days of the expiration of current certification

Provider Agency Certification

Onsite Reviews

To **validate** certification documentation

Record selection will include a statewide representative sample

Targeted onsite certification reviews

Provider Agency Certification

Onsite Reviews

Completed reports will be made available within 30 days of the review.

Provider must respond to any corrective action within 30 days

Provider Agency Certification

Staff Requirements

512.3.5

Personal Attendant Service Staff:

- Not the spouse of the TBI Waiver member
- At least 18 years of age or older
- Complete competency based training before providing services

Provider Agency Certification

Annual Staff Training

513.5.1

CPR, First Aid, OLSHA, Abuse, Neglect, Exploitation and HIPAA training must be kept current

Provider Agency Certification

Training Documentation

512.3.5.2

Documentation must include:

- Training topic
- Date
- Beginning and ending time
- Location of training
- Signature of instructor
- Signature of trainee

Provider Agency Certification

Internet Training

Obtain Prior Approval:

How: Instructions for Internet-Based Training Approval

Form: Request for Approval of Internet-Based Training

Documentation in Personnel file must include:

- Employee's name
- Name of internet provider/trainer
- Certificate

Provider Agency Certification

Staff Requirements

Case Manager Qualifications

512.3.6

Cognitive Rehabilitation Therapist Qualifications

512.3.7

Provider Agency Certification

Criminal Investigation of Background Checks and Restrictions

OIG Exclusion List

Topic 512.3.8

Provider Agency Certification

Voluntary Agency Closure

512.4

Involuntary Agency Closure

512.5

Additional Sanctions

512.6

Incident Management
512.7

Incident Management

Incident Management

Agencies shall have policies and procedures for thoroughly reviewing, investigating and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve

Incident Management

During this time of transition, TBI Waiver Providers will not be issued a user account for the West Virginia Incident Management System (WVIMS)

Until a user account is issued, TBI Waiver Providers will use a paper reporting system

The Incident Report Form will be located on the APS Healthcare web site

Incident Management

Classification of Incidents

Incidents shall be classified by the provider as one of the following:

- Abuse, Neglect or Exploitation
- Critical Incidents
- Simple Incidents

Incident Management

Documentation and Investigation Procedures

Provider must document all incidents (critical, simple and abuse, neglect, exploitation)

Provider must report all incidents involving abuse, neglect and/ or exploitation to Adult Protective Services

Provider must also investigate allegations of abuse, neglect, and exploitation

Incident Management

Documentation and Investigation Procedures

Provider must fax to APS Healthcare the Incident Report for any incident involving a TBI Waiver member within 24 hours of the provider learning of the incident

Incident Reports are accepted by fax only to APS Healthcare, Inc. Fax number is: 866-607-9903

Incident Management

Tracking and Reporting

Provider must:

Review and analyze incident reports to identify health and safety trends

Incorporate into its Quality Management Plan the identified health and safety concerns and remediation strategies

Complete and send to APS Healthcare the Agency Monthly Incident Tracking Report

Member Eligibility
512.8

Member Eligibility

Applicants must meet all of the eight criterion listed under topic 512.8 of the TBI Waiver Manual to be eligible for the program.

APS Healthcare is responsible for:

- evaluating medical eligibility,
- conducting assessments
- determining if medical eligibility requirements for the TBI waiver program are met (initial and re-evaluation)

Member Eligibility

Initial Medical Evaluation: Process

Medical Necessity Evaluation Request Form is received

Completed MNER –assessment scheduled

Incomplete MNER- returned for additional information

APS Healthcare Staff completes the assessments (WV PAS and the Rancho Levels of Cognitive Functioning)

Member Eligibility

Notification Process

Letters of medical eligibility determination are sent to applicant, legal representative and referent

Service Delivery Model Selection Form

Service Selection Forms (enrolled Case Management and Personal Attendant Services agencies)

Member Eligibility

Medical Re-evaluation Process

APS Healthcare will schedule an annual re-evaluation of the member's medical eligibility screening

APS Healthcare conducts the assessments

APS Healthcare evaluates the findings to determine continuance of medical eligibility

Member Eligibility

Notification Process

Notice of Approved Continued Medical Eligibility is sent to the member, and/or legal representative, the Case Management Agency and PPL (if applicable)

Potential Denial letter is sent if the member does not meet medical eligibility sent to the member, and/or legal representative, the Case Management Agency and PPL (if applicable)

Member Eligibility

Notification Process

Final Denial Letter sent if the review of the supplemental information determines that there is still no medical eligibility

Final Denial Letter sent to the member, and/or legal representative, the Case Management Agency and PPL (if applicable)

Member Eligibility

Financial Eligibility

512.8.2

Selected Case Management Agency must make initial contact within 3 business days of receipt of notification

Initial contact may be either face to face or telephone with the applicant

Submit the required DHS-2 form to the county DHHR

Member Enrollment
512.9
Member Assessment
512.10
Service Plan Development
512.11

Member Enrollment

Member Enrollment Process

Occurs once an applicant has been found medically and financially eligible

Case Manager completes a Member Enrollment Request Form and sends to APS Healthcare

APS Healthcare will provide a Confirmation Notice to the Case Management and Personal Attendant agencies and PPL (if applicable)

Member Enrollment

No Medicaid reimbursed TBI Waiver services can be provided until the Member Confirmation Notice is received

The Case Management Agency must maintain a copy of the Member Enrollment Request Form and the Member Enrollment Confirmation Notice in the member file

The Personal Attendant Service provider agency (and LBHC if providing Cognitive Rehabilitation Therapy) must maintain a copy of the Member Enrollment Confirmation Notice in the member file

Member Assessment

Member Assessment Process

Why: Comprehensive information concerning each member's preferences and personal goals, needs and abilities, health status and other available supports is gathered and used in developing a service plan

How: Case Manager completes the Member Assessment

Time Frames: 7 days to complete the initial Member Assessment once Member Enrollment is complete

Member Assessment

Member Assessment Process

A new member Assessment must be completed:

- when a member's needs change
- at six (6) month intervals

Case Managers must share changes in a member's assessment with all service providers listed on the members Service Plan

Service Plan Development

Service Plan Development Process

Why: Each member's plan comprehensively addresses his or her identified need for TBI Waiver Services, health care and other services in accordance with his or her expressed personal preferences and goals

How: Case Manager is responsible for development of the Service Plan in collaboration with the member and/or their legal representative

Service Plan Development

Service Plan Development Process

Time Frames: The Service Plan meeting must be scheduled within 7 calendar days of the Member Assessment

The Service Plan must be completed within 14 days of the completed Member Assessment

Form: Service Plan and instructions are located on the APS Healthcare web site

Service Plan Development

Six Month and On-going

Six month Service Plan and Annual Service Plan Development

Who: Mandatory for the member and/or their legal representative, the Case Manager and the Personal Attendant Service provider agency

Service Plan Development

Interim Service Plan Development

Why: To begin services immediately to address and health and safety concerns

Who: Case Management Agency

Form: Interim Service Plan form located on the APS Healthcare website

Time frame: Plan is in effect up to 21 calendar days from the date of Member Enrollment Confirmation

Covered Services
512.12

Covered Services

Case Management

Personal Attendant Services

Direct Care support

Transportation

Cognitive Rehabilitation Therapy

Participant-Directed Goods and Services

(Personal Options only)

Covered Services
Case Management

Covered Services

Case Management Code, Unit, Limit
& Documentation Requirements
512.12.1.1

Procedure Code: T1016 UB

Service Unit: 15 minutes

Service Limit: 192 15 minute units annually

Prior Authorization Required: Yes

Rate: $ 8.50 per unit

Covered Services

Case Management

Indirect services that assist the member to obtain access to:

- Needed TBI Waiver services
- Other State Plan services
- Medical, social, education and other services

Covered Services

Case Management

Responsibilities include

Development of the Service Plan

Ongoing monitoring of the provision of services in the Service Plan

Monitoring member's continuing eligibility, health and welfare, and advocacy

Covered Services

Case Management

Responsibilities include

Coordination of services that are individually planned and arranged for members

Informing members of the Participant-Directed option

On-going Case Managements Services

Covered Services

Case Management

Documentation Requirements

All contacts with, or on the behalf of a member, must be documented within the member record

All documentation must include date and time of the contact, description of the contact and the signature of the Case Manager

Form: Case Management Monthly Contact form must be used to document contact with the member and/or their legal representative

Covered Services

Case Management

Reporting

Monthly reports must be submitted by the Case Management Agencies to APS Healthcare by the sixth business day of every month

Form: Case Management Agency Monthly Report to APS Healthcare, located on the APS Healthcare web site

Additional, required administrative and program reports as requested by either BMS or APS Healthcare

Covered Services
Personal Attendant Services

Covered Services

Personal Attendant Service (Direct Care support) Code, Unit, Limit and Documentation Requirements 512.12.2.1

Procedure Code: S5125 UB

Service Unit: 15 minutes

Service Limits: limited by the member's budget

Prior Authorization Required: Yes

Rate: $3.75 per unit

Covered Services

Personal Attendant Services

Long-term direct care and support services that are necessary in to enable a member to remain at home rather than enter a nursing facility, or to enable an individual to return home from a nursing facility

Personal Attendant Services has two components

- Direct Care Support
- Transportation

Covered Services

Personal Attendant Services

Personal Attendant Service direct care staff duties and responsibilities must be described in the member's Service Plan:

- Includes ADLs and IADLs

Personal Attendant Services agency staff and employees of Personal Options **cannot perform:**

- **Professional skilled services**
- **Any service that is not on the member's Service Plan**

Covered Services

Personal Attendant Services

Documentation Requirements

All services provided to a member must be documented on the Personal Attendant Worksheet and maintained within the member record

All documented evidence of Personal Attendant Service direct care staff qualifications shall be maintained on file by the provider agency

Covered Services
Transportation

Covered Services

Transportation Code, Unit, Limit and Documentation Requirements

512.12.2.3

Procedure Code: A0160 UB

Service Unit: 1 unit – 1 mile

Service Limit – N/A

Prior Authorization: Yes

Rate: 0.47 per mile

Covered Services

Transportation

Component of Personal Attendant Services

Provides reimbursement for direct care staff that performs:

- Essential errands for or with a member
- Community activities with a member
- Members may be transported by staff in order to gain access to services and activities as specified in the Service Plan
- Free transportation must be used first

Covered Services

Transportation

Documentation Requirements

All transportation with, or on behalf of a member must be on the member's Service Plan

Documentation must include date, miles driven, travel time, destination, purpose of travel and type of travel

Type of travel refers to essential errands or community activity

Covered Services
Cognitive Rehabilitation Therapy

Covered Services

Cognitive Rehabilitation Therapy

Code, Unit, Limit and Documentation Requirements

512.12.3.1

Procedure Code: 97532 UB

Service Unit: 15 minutes

Service Limit: 192 15 minute units annually

Prior Authorization Required: Yes

Rate: $17.43 per unit

Covered Services

Cognitive Rehabilitation Therapy

Therapy utilized for the development of cognitive skills to improve:

- Functional attention
- Memory
- Problem solving

Includes compensatory training in the context of direct one-to-one participant contact with the therapist.

Covered Services

Cognitive Rehabilitation Therapy

Documentation Requirements

All contacts with, or on behalf of a member, must be documented within the member's records

Documentation must include date and time of contact, a description of the contact and the signature of the CRT

All documented evidence of CRT staff qualifications shall be maintained on file by the provider agency

Covered Services Participant-Directed Goods and Services

Covered Services

Participant-Directed Goods and Services Code, Unit, Limit and Documentation Requirements 512.12.4.1

Procedure Code: T2028 UB

Service Unit: As specified on Service Plan

Service Limit: $1000 annually

Prior Authorization Required: No

(Personal Option only)

Covered Services

Participant-Directed Goods and Services

Equipment, services or supplies not otherwise provided through the Medicaid State Plan

Addresses an identified need in the Service Plan

Covered Services

Participant-Directed Goods and Services Documentation Requirements

Participant Directed Goods and Services receipts and other approved documentation per the PPL contract with BMS must be maintained on file with PPL

Must be in the member's Spending Plan

Member Rights and Responsibilities, 512.13
Member Grievance Process 512.14

Member Rights

At a minimum, Case Management Agencies must communicate in writing to each member and/or their legal representative rights and responsibilities

APS Healthcare will give applicants/ members at the time of their initial/re-evaluation a program handbook

TBI Waiver Program Handbook will be located on the APS Healthcare web site

Member Grievance Process

Members who are dissatisfied with the services they receive from a provider agency have a right to file a grievance

TBI Waiver provider agencies will have a written member grievance procedure

APS Healthcare will explain the grievance process to all applicants/members at the time of application/re-evaluation

Transfers
512.15
Discontinuation of Services
512.16

Transfers

Member may request to transfer to another agency at any time

Member Request to Transfer form must be completed and signed by the member and/or their legal representatives

Member Request Transfer form is in the handbook given by APS Healthcare

Member Request to Transfer form will be on APS Healthcare web site

Transfers

Process

A completed and signed Member Request to Transfer form is submitted to APS Healthcare

Transfer is coordinated by APS Healthcare

Transfer completed in 45 calendar days from the date that the member signed form is received at APS Healthcare

Transfers

Transferring Agency Responsibilities

To continue to provide services until transfer is complete

To provide the necessary documents to the receiving agency

To maintain all original documents for monitoring purposes

Transfers

Receiving Agency Responsibilities

Personal Attendant Service Agencies must meet with the member and/or legal representative within 7 business days to review the Service Plan

Case Management Agencies must conduct a Member Assessment within 7 business days of the transfer effective date

Develop the Service Plan within 7 business days of the transfer effective date

Transfers

Emergency

A request to transfer that is considered an emergency will be reviewed by APS Healthcare

APS Healthcare will expedite the request

Case Management and Personal Attendant Services Agencies must submit supporting documentation

Discontinuation of Services

Request for Discontinuation of Services form must be submitted to APS Healthcare, for any of the following reasons:

- No service provided for 180 continuous days
- Unsafe Environment
- Member No Longer desires services

The Request for Discontinuation of Services form will be located on the APS Healthcare web site

Dual Provision of TBI Waiver and Personal Care 512.7

Dual Provision TBI and PC

Approval of the provision of both TBI and PC services to an active TBI Waiver member must be approved by APS Healthcare, including the initial 60 hours

The Dual Service Provision Request form must be completed

The Dual Service Provision Request will be located on the APS Healthcare web site

Criteria listed in the manual must be met for consideration of the request

Excluded Services and Non-Reimbursable Situations 512.18

Exclusions

Medicaid will only reimburse for TBI Waiver services that are defined as required services on the member's Service Plan

Non-reimbursable services include:

- Services provided for other member (s) of the TBI Waiver member's household or to anyone who is not a TBI Waiver Program member

Exclusions

Non-reimbursable services include:

Services provided by a Case Manger Agency, Personal Attendant Service Agency or Cognitive Rehabilitation Therapy provider that are not included in the Service Plan

Services provided to an individual who is not medically and financially eligible on the date (s) that service is provided

Forms

Forms

Forms for the TBI Waiver Program will be posted at

http://apshealthcare.com/publicprograms/west_virginia/west_virginia1.htm

Please check the site over the next few months as we continue to upload forms

Wrap Up

Please complete evaluation forms for today's training

Webinar participants please fax your completed evaluation forms to APS Healthcare at

866-607-9903

Thank You