

Aged & Disabled Waiver Provider Conference Call Questions

February 18, 2014

1. Why can't policy be changed to allow LPN's to act as Case Managers since there is no skilled nursing required?

Answer: Case Management is primarily a social work position. The exception was made in policy to allow for a RN or counselor to do a social work type position.

2. Why does the Homemaker RN have to be present during the Service Planning meeting with the Case Manager?

Answer: The Service Plan is the key planning document for the member. It is the driving force and key element in the development of the Plan of Care. It is a requirement that the Homemaker RN be at the Service Planning meeting, it is not a requirement for the HM RN to be at the WVMi assessment.

3. When is Case Management going to get a rate increase?

Answer: There are no current plans to increase case management rates.

March 18, 2014

4. On the log review by the RN, can we accumulate minutes month to month to bill when we get 1 unit (15 minutes) or do the minutes need to be billed in the month that the logs were reviewed.

Answer: First we are assuming by "log" you mean the Plan of Care/worksheet. With this said, you need to bill it for the date it was reviewed. The Bureau for Medical Services is looking at possible changes in the future related to billing issues providers have reported in relation to reviewing the POC/worksheet.

5. We have had several members pass away, is someone somewhere getting these slots.

Answer: Per the Centers for Medicare & Medicaid, slots must be unduplicated in a fiscal year. Example: If a member has a slot and they only get one service before going off the program for whatever reason – that slot is gone until the next fiscal year.

6. Is there any chance of new members being opened under the Managed Enrollment?

Answer: If additional funding is allocated for the program.

7. In the past 2 years, there have been some slots opened for Waiver. Have these all been filled?

Answer: Most of them have been filled. There are still a few from the last slots that were released that are completing their financial eligibility.

8. Can you address why there are funds for Money Follows the Person which allows nursing home patients an opportunity to come home but decreases the amount of funding for Waiver which keeps people out of the nursing home in the first place?

Answer: Money Follows the Person is a federal grant with the Centers for Medicare & Medicaid. Money Follows the Person does not decrease funding for the Waiver.

9. According to policy, a felony offense prohibits a homemaker from working (in the caregiving field) if the offense was within the last 10 years. Policy also dictates that a homemaker cannot work at all (in the caregiving) field if there is a CPS/APS substantiation of maltreatment. This seems inequitable. Why should a homemaker be punished forever for an offense that carries no legal penalty but be excused after 10 years for a legal offense of the highest level?

Answer: The only offenses listed in Medicaid policy that has the 10 year limitation is felony DUI and felony drug related offenses. There is a process for individuals to apply to DHHR to request findings be removed from their DHHR Protective Services Record Check. Information on how to do this was sent out via email last week to all providers.

10. Is the Transportation Toolkit a policy, can we be cited for not following it? Or is it a guideline that the provider may use to increase efficiency and accuracy of services?

Answer: No, it is not policy. It is a guideline that provides best practices. However, there are some items in the Toolkit that refer to actual policies from the Aged & Disabled Waiver manual. Those specific were pointed out on the Transportation Toolkit Webinar held on 3/11/14. That webinar will be available in the near future on the WV Learning Center.

11. If the PAS says an individual is a LOC B, but after the CM and RN do the Member Assessment, they feel they don't even have 5 deficits, do we continue to provide services because they have been determined eligible by the WVMI PAS – or do we terminate services?

Answer: You cannot just terminate services because you think the PAS is incorrect and your assessment is correct. There are a multitude of things you can do in this situation. First, you should discuss this issue with the member. The member, if they no longer need services, can request a closure. Or if the member is not accepting the planned services, then you can request a closure due to noncompliance with the Plan of Care. If you consider it a fraudulent situation, you should complete a report with recipient fraud (304-558-1970). You can also contact the Bureau of Senior Services for technical support. And a new PAS can be completed with the provider present to assist in providing accurate and truthful information to WVMI.

12. If the PAS has determined a person is a LOC C, but after the CM and RN do the Member Assessment, it is determined that they only need LOC B services, do we give LOC C hours based on the PAS determination, or do we do LOC B hours based on our determination?

Answer: They should only be giving the person the hours they actually need regardless of LOC.

13. If we have a member who uses our transit services and needs the personal assistant/homemaker to go with the member to her non-emergency medical appointment in order to help with ambulation, toileting, transferring, etc., can we bill for the personal assistance/homemaker time? And can the Senior Center bill under transit for the mileage for non-emergency medical transportation?

Answer: Yes, you can bill for the personal assistance/homemaker time at medical appointments. Refer to DHHR for information/policy on NEMT services.

April 15, 2014

14. What is the policy on soliciting? Ex: Door to door soliciting and family/friend referrals where they give the provider an address to follow up with their family member.

Answer: There is no Medicaid policy on soliciting. Agencies can market their services in any legal manner they choose. Any harassment or intimidation of members is unacceptable and should be reported to the Bureau of Senior Services.

15. Is it ok if a member puts an "X" instead of initialing on the Plan of Care/worksheet?

Answer: Yes, they can make their own mark, but only if the member is incapable of signing their initials. If that is the case, it must be clinically documented as to why. This does not apply to every member and should only be for cases where their disability prevents them from initialing/signing

16. Is it true that if a member who is on the Managed Enrollment list is on an organ donor waiting list, that they will be moved to the top of the list? Is it also true that their spouse can work for them?

Answer: The answer is no to both questions.

17. Can a Medical Power of Attorney sign the POC/worksheet?

Answer: Only if the Medical Power of Attorney is in effect. A Medical Power of Attorney goes into effect when a person has been deemed incapacitated.

18. Does it matter who signs the paperwork if the member has Alzheimer's? Sometimes the member does but mostly it is the Medical Power of Attorney.

Answer: The member should sign if they are able. If there is a day they are unable due to disorientation, etc., then the Medical Power of Attorney can sign and it should be documented as to why.

19. What is policy if the Medical Power of Attorney is the homemaker and the Medical Power of Attorney also signs for the member?

Answer: Currently this is allowed in Traditional services but we highly recommend this is only used when there are no other options. This would require increased oversight to ensure services are being provided.

20. Why is it that per program policy, I can hire a twice convicted felon for drug related offenses occurring greater than 10 years ago but I must remove a direct care worker from providing services for a 13 year old DHHR Protective Services Record Check that amounted to nothing? Should the DHHR Record Check be amended to include allowed continued employment if the offense occurred greater than 10 years ago?

Answer: There is a process to have these removed from an individual's record if that is justified. Information regarding this process was emailed to providers on March 20, 2014.

21. Is the plan period on the Plan of Care to span a year or is it to span a 6 month period of time?

Answer: The plan period on the Plan of Care is to span a 6 month period of time. Ex. July, 2014 to December, 2014.

22. Regarding PAS extension requests made by Case Management agencies due to a PAS expiring before the re-evaluation can be conducted. Is the Bureau for Medical Services looking at WVMi and the need to reschedule appointments because their RN is unable to keep the appointment and the need to reschedule due to the member cancelling the appointment?

Answer: Yes. The reasons for all PAS's that are not conducted within 365 days are tracked and reported to the Bureau for Medical Services.

23. WVMi RN's get paid mileage to travel to Members homes, is this reimbursed by the State?

Answer: No.

24. Why do CM and HM/RN Agency's not get reimbursed for their mileage?

Answer: Transportation provides reimbursement for PA/HM direct care staff that performs essential errands for or with a member or community activities with a member. Transportation costs were considered when setting other reimbursement rates.

25. When are additional slots going to be released? What are the projected numbers to be served for your new fiscal year?

Answer: We are waiting on information regarding SFY15 budget and additional funding that could fund additional slots. The current ADW application with CMS has 5864 approved slots for SFY15. That would have to be amended with any additional funding/slots.

26. On the Plan of Care, do you need to put the day of the month? Or just the month and year?

Answer: The month and year.

27. Do you need to complete a RN Assessment (RN portion of the Member Assessment) after every hospital stay?

Answer: No, only if the members condition/needs change.

28. Regarding the 365 ADW slots released in August, 2013, how many have received their member enrollment as of today?

Answer: Most of them have been filled. This number changes day to day. This can be a lengthy process – we are currently contacting case management agencies about the importance of working diligently with individuals who select them as their case management agency to assist them in every way possible in getting their financial eligibility completed and getting them enrolled via the Bureau of Senior Services. If you have an individual who is not going to enroll due to not being financially eligible, no longer interested, etc. – you should immediately contact the Bureau of Senior Services (Barbara Paxton) at (304)558-3317 or Barbara.A.Paxton@wv.gov.

29. If we have a member who has MS and falls every day, do we have to do an incident report for each fall? (These falls do not involve injuries, the social worker is working on DME to assist with this matter. He likes to sweep his kitchen with a broom and falls out of his power chair – but does not want to stop trying to sweep).

Answer: If there is a fall with no injuries, you need to report each of these in the IMS system as a simple incident. A fall risk plan should also be developed and implemented for this member.

Updates:

1. An individual submitted a question regarding Chore services at Senior Centers. This question did not pertain to ADW services or Personal Care services. Senior Centers are allocated money that they can choose to use for chore services – but they are not required to. They can also use those funds for Lighthouse, FAIR, respite, meals, transportation, etc. Providers are prioritizing their funds for the services they feel are the most needed services.
2. Directors are no longer required to send a letter to Susan Given, Program Manager, Bureau for Medical Services for PAS extensions. An email was sent to providers regarding this on 4/1/14. As stated in the email, we ask that every effort be made to relay to members the importance of keeping the appointments that are made for them. We also ask that Case Managers refrain from asking members to cancel their appointments if they want to attend and have scheduling conflicts. There is no requirement for the Case Manager to be at the assessment. The best assistance in the re-evaluation process from a Case Manager is to ensure the MNER is completed appropriately.
3. We are currently beginning desk reviews for transportation services.

May 20, 2014

30. When a member is transferring both Case Management and Personal Assistance/Homemaker to the same agency, and the transfer date for each agency falls within two separate months such as the Personal Assistance/Homemaker transfer date is April 22 and the Case Management agency transfer date is 8 days later on May 1, can the Case Manager do the 6 month Service Plan in October instead of November so it can be done in the same month the RN is doing the Plan of Care?

Answer: Yes, it could be done in October. The key is to not go over the 6 month policy requirements. Ex. If you did it in December, you would be out of compliance with policy.

31. Why does the Personal Options give \$1000.00 yearly allowance for the purchase of goods and services such as lift chairs and wheelchair ramps and the Traditional Option does not?

Answer: This is a service offered by the Centers for Medicare and Medicaid (CMS) that is only permitted in self-directed programs. The CMS service name even defines that as Personal Directed Goods and Services.

32. In the current manual on the change log page, it lists to replace section 501.3, Criminal Investigation Background checks; the change date says 4/25/12 with the effective date being 7/1/11. How can the change date be after the effective date? Also the manual notes at the bottom of every page effective date 9/1/11, should this not be 9/1/12? In the memo dated 4/28/14 from Susan Given Program Manager, it says ADW providers will not be required to submit DHHR Protective Services Records Checks for any employee hired prior to 9/1/11, should this not be 9/1/12?

Answer: Regarding the first question about the change date of 4/25/12 for CIB's, you are correct that the change date is wrong, that is a typo. The effective date of the manual is 9/1/11. Please note, that Susan Given's memo also strongly encourages providers to continue to submit these forms and to consider the results.

33. Since each agency now establishes their own mileage cap, what is to prevent a member from transferring somewhere that allows more mileage? We had a member that was considering leaving us to get more hours with Personal Options.

Answer: Nothing can prevent a member from transferring to another agency. Members have a right to choose their health care providers. However, if there are allegations of fraud, please report the fraud and contact the Bureau of Senior Services. At the direction of Bureau for Medical Services, the Bureau of Senior Services will be doing desk audits on transportation.

34. Regarding discontinuation of services, the manual states that when no services have been provided for 180 continuous days, the discontinuation of services is required. I just want to get clarification that this includes the weekends, not just Monday through Friday?

Answer: Yes, it is counted by calendar days.

35. Are there restrictions on what type of community activities the member can do if their homemaker is also a family member?

Answer: If it is an activity that the family member would be going to anyway, then they shouldn't be billing for that. If you have specific cases that you have questions about, contact the Bureau of Senior Services for technical assistance.

36. When a person wants to apply for ADW services, why does the MNER portion of eligibility come before the financial eligibility?

Answer: Medical eligibility must be established before financial eligibility can be established.

37. If a person has gone through the whole process of medical eligibility, including submission of the MNER form and RN visit with WVMI, but ends up not financially qualified, is that person taking a slot on the Managed Enrollment List?

Answer: We aren't sure if this question was what the person who submitted it intended to ask. But to answer the question that was submitted, if a person is found medically eligible but is found not to be financially eligible, they are no longer on the Managed Enrollment List. But to also answer what we believe the question was intended to be, if a person is found medically eligible but is found not to be financially eligible, they are not taking an actual waiver slot on the program.

Program Updates:

We received a question regarding the Aging & Disability Resource Centers (ADRC's). For any questions regarding the ADRC's, please contact Jenni Sutherland at (304)558-3317 or Jenni.L.Sutherland@wv.gov

June 17, 2014

38. According to the Service Plan Addendum policy, if a member has a Service Level Change, a new Service Plan must be done. This is not in the manual. When did it become policy?

Answer: This no longer requires a new Service Plan (however you can do one if you choose to). If you choose not to do a new Service Plan, you would need to do a Service Plan Addendum.

39. Please explain the correct use of "B: on page 2 of the Service Plan. Does this look at 24 hours 7 days a week? Or just the time the PA/HM is scheduled?

Answer: Please refer to the Service Plan Instructions # 16 on the Bureau for Medical Services website at www.dhhr.wv.gov/bms The Service Plan does look at how member needs are being met 24/7. "B" indicates that the member is using both formal and informal support to meet one or more of their needs. There is an example as well on the instruction sheet.

40. I hear Case Management agencies and Homemaker agencies will be going to a new computerized system. When will this take effect? How will personnel be trained?

Answer: APS Healthcare's ADW CareConnection© is tentatively scheduled to go live during July 2014. Providers have registered their agencies and users for the system over the last year. To provide an introduction to the system, APS conducted an initial round of webinars in May, 2014, for Case Management agencies, Homemaker Agencies, and the fiscal/employer agent. An email with the schedule for monthly repeat sessions of the webinar has been sent to all providers. Prior to go live, an APS staff member will also be assigned to each provider agency to provide technical assistance and training on the system.

41. Some of my members do not have informal supports when a homemaker is not available or when an emergency arises. How do other Case Managers address this issue? What do they put on the Service Plan and what suggestions are made to the member?

Answer: Every member's situation is different and unique. Case Managers seek out resources in their members communities for informal support – such as neighbors, churches, universities, schools, etc. If a person is getting the maximum number of hours of services permitted on the program and their needs cannot be met within the parameters of this program and this in turn creates health & safety issues, alternatives may need to be considered such as assisted living, nursing home placement, etc.

July 15, 2014

42. How specific should the details be on the Plan of Care? For example, there is not enough room to list what help is needed with each piece of clothing under dressing. Also, is it o.k. to list examples on essential errands such as shopping 1-2 times per week instead of writing specific days to go grocery shopping?

Answer: There are many questions being asked. The most important thing to remember is the Plan of Care is the member's plan based on his/her needs and preferences as specified in the Service Plan. The Plan of Care should reflect those needs/preferences. To address the specific questions above – it is not required that the Plan of Care be specific to each piece of clothing under dressing. But if you feel for some reason that your direct care worker needs additional instructions for a particular member you should provide those detailed instructions which don't necessarily have to be on the Plan of Care. Regarding grocery shopping 1-2x per week. Grocery shopping should preferably be 1x per week. If a situation occurs that requires an additional grocery shopping trip in a specific week that can be documented and approved by the agency RN. You should be specific about the day of the week for essential errands. Remember this is a plan and it provides instruction/direction to your direct care worker on what tasks they are to be providing for Medicaid reimbursement and it should also be consistent with the Service Plan.

43. Question asked during the conference call: If we designate a specific day of the week for grocery shopping, Ex. Monday, and then they have to go to the doctor on that day so we need to change the grocery shopping to another day – do we just document that in the comment section?

Answer: Yes, the direct care worker and the RN must be in communication about any change that occurs, the RN must approve this change in the schedule and it must be documented in the comment section.

44. Question asked during the conference call: Can we put a specific day of the week for essential errands such as grocery shopping and then also put “or as needed”?

Answer: No, you cannot do this. The Plan of Care needs to be specific. Again, remember that this is a plan that provides instruction and direction to your direct care worker regarding specifically what they are to be doing for the member. If you put “or as needed” that essentially permits them to deviate from the member’s Plan of Care at any given time and decide when/what they are going to do on any given day.

45. I recently attended a Service Plan meeting with a Case Manager from another agency. This member had transferred their HM services and the timeframes for when my HMA RN Assessment was due and their CM Assessment and Service Plan were due were not at the same time. The Case Manager stated I needed to complete my HMA Assessment at the same time as the Service Plan to “get them together”. This would have been 3 months early for my HMA RN Assessment.

Answer: The Case Manager is incorrect. You do not have to complete the HMA Assessment at the same time as the Service Plan to “get them together”. The 6 month and annual Service Plan meeting require both the Case Manager and HM RN attend. The most recent HM RN Assessment can be used at that Service Plan meeting. The HM RN can use the RN Member Contact form at that meeting to document the meeting, changes, etc. The HM RN’s 6 month and annual HM RN Assessment may not ever match up with the Service Plan meeting.

46. If a RN while reviewing a HM worksheet finds incorrect travel information – ex., wrong mileage, travel time, whether it’s an essential errand or a community activity, how do you want us to fix this? We’ve been crossing out the incorrect information and writing in the correct information.

Answer: You should not correct/change another employee’s documentation. The personal assistant/homemaker should be correcting any mistakes they make – they can draw a line, correct and initial.

August 19, 2014

47. I understand that we are not to use PRN on our POCs. So, if we get a SP with PRN on it, do we use it so the POC matches the SP?

Answer: Yes, if the service is to be provided as needed, you can abbreviate by noting PRN but it can’t stand alone. It must be complete with frequency and day of the week. Example: 1 x week PRN on Wednesday.

48. Can payment for tolls be turned for reimbursement under mileage?

Answer: No.

49. The Homemaker calls in sick two (2) days in a week. The client would or would not receive a HM for those days, based on availability of a substitute. The client calls the next week and wants to “make-up” those hours by having the HM stay later. The client does not need the “make-up” hours for personal care, rather she wants the HM to clean her house and do other tasks for her that may or may not be identified on the POC. How do we address this with the client?

Answer: Services are provided based on the member needs and noted the POC. Once the service is missed it cannot be “made up”.

Example: If the member missed a bath on Tuesday the PA/HM cannot “make up” the missed service by giving the member two baths on Wednesday.

50. In light of the CareConnection© Program;

1. Do we still need to submit transfer requests to BoSS? Yes
2. Do we still need to get closures authorized by BoSS? Yes
3. Do Case Management Agencies still have to do monthly reports? **Yes**
4. Do we need to print out everything from CareConnection© for members chart? Yes

Answer: Yes to all four questions. All requests can be uploaded in CareConnection© , fax or mailed to BoSS. Documents can be printed from CareConnection© for the member record.

Announcement:

1. The question numbering was changed to assist in referencing duplicate questions.

2. The Service Plan and Plan of Care Webinar conducted on July 31st is now available on the On Line Learning Center at <http://www.onlinelearning.wv.gov> . A copy of the Power Point is on the BoSS web site at www.wvseniorservices@wv.gov.

4. When attaching PAS additional doc or other information into ADW CareConnection© system, neither APS, nor WVMI is not notified via the system. Please be sure to notify us by emailing ADWAdditionalInformation@WVMI.org. To efficiently process these emails, it would be most helpful if the sender minimally includes the APSID#, a summary of the document(s) attached and/or purpose for sending the information. There is no need to include clinical information or member identifying information, as we can retrieve from the CareConnection© system. This is group mailbox and will be monitored daily.”

September 16, 2014

51. Could we request APS to always put in Prior Authorization numbers from the first to the end of the month? If WVMi makes a visit 08/13/14 for re-evaluation, then when I do billing I have to bill 08/01 through 08/12 and then do another billing for 08/13 through the end of the month. This is very time consuming.

Answer:

We need additional information to answer this question. Please resubmit with an example.

52. In the Aged and Disabled Webinar about development of Service Plan and POC, it was noted that on the Service Plan that travel has to be specific to certain stores that the Member travels to or has Homemaker go to for them. It's understood that the POC is developed from the Service Plan. If we list certain stores and such but the Member request that homemaker go to a place that's not listed on the POC, then will that trip be billable?

Answer: It must be reasonable and necessary and approved by the RN as a onetime change to the POC.

53. At monitoring, we were told that POC has to be specific to the Member. Example: On POC it stated Daily on Bathing, Grooming. Homemaker did not mark daily based on Member's Request. So should the RN document Bathing and Grooming as tolerated and not daily, due to the fact that we cannot designate specific days that Member will feel like bathing and grooming?

Answer: The SP and POC must meet the members identified needs and be specific; such as every other day. The statement of "As Tolerated" would not be acceptable.

54. Is a Service Plan Addendum necessary when community activities is revised? Or just when actual times are changed?

Answer: Yes, the SP Addendum is required.

55. When a Plan of Care is completed on the computer, is it okay to type name under RN signature or does the nurse need to sign?

Answer: The document needs to have the RN signature to show he/she developed the POC and not the person typing the document. An electronic signature would be acceptable if the policy outlined in Chapter 300; section 320.4 is followed.

October 21, 2014

56. If the WVMI RN visits on 08/13/14 and we get the PAS back signed 08/13/14, then when I go to do my monthly billing thru Molina web portal, I need to bill the 08/01/14 thru 08/12/14 and then bill another separate billing for 08/13/14 thru 08/31/14. I cannot bill for the whole month 08/01/14 thru 08/31/14 because Molina says there's a Prior Auth# for 08/01/14 thru 08/12/14 & a different Prior Auth # for 08/13/14 thru 08/31/14. So what I am asking is can we always have a Prior Auth # to start at the 1st in these situations?

Answer: With the implementation of Anchor Date, and as all members are assessed and their PAS entered/completed through CareConnection©, all authorizations will start with the Anchor Date (which will be the first of a calendar month), and monthly thereafter through the end of the member's service year. The only exception to this will be if/when a Service Continuation was granted for the previous service year due to extenuating circumstances preventing timely completion of the PAS.

57. If a new PAS increases or decreases the LOC for the member when do we increase or decrease the hours?

Answer: The newly determined service level will be effective upon the member's Anchor Date. If you determine an increase in hours needs to begin immediately you should submit a request for a service level change to APS Healthcare at wvadwaiver@apshealthcare.com. Likewise, if you cannot substantiate the need for services at a higher level, those services can be decreased before the anchor date (this should be happening any way). Just because someone is authorized at a certain level, doesn't mean they have to receive those hours if they don't need them.

November 18, 2014

58. With the travel guidelines given to HMA's this year: limiting travel out of state to only medical appts: this has resulted in members having to travel over 50 miles just to shop at a Walmart in a neighboring county instead of 15 miles across state line to a Walmart. The only shopping in our county is Dollar stores. There are not shopping malls, etc that are within traveling distance except in Maryland or Virginia. (from our office about 40 miles to either) When I bring this up to the HMA – that it is a guideline, not a policy and that common sense should be used as well as going to the place that is lowest mileage I am told that they will be monitored on using the guideline and will have pay backs if they do not keep all travel within the state. Do you have any comment or amendment that could be made to the guideline?

Answer: The travel guidelines are to assist you to make decisions regarding travel that are reasonable and the guidelines are not policy. Any travel should be planned and be reasonable and necessary including considering the needs and distance. If you have a choice to travel 15 miles or 50 miles to a grocery store, the plan should be 15 miles. Choosing to travel 50 miles would be unreasonable and unnecessary.

59. Can the Service Plan Addendum be mailed to the member for signature if there is a simple change, such as, poc hrs or change in essential errands?

Answer: Yes, the CM may call the member and confirm the request and mail the SP Addendum to the member to sign and return.

Other Questions/Comments from call:

New Continuing Certification Tracking System. There were questions during the call regarding the new system. Following are some highlights:

- Data will not be imported from the old system into the new system. You will be required to enter employee information into the system again; however, you may print information from the old system to a spread sheet which will help with the data entry into the new system.
- Employees will be entered into the system one time only and you can designate at that time whether they are ADW, PC, HM or CM. Additionally, if an employee provides services for both ADW and PC, you will designate that by checking ADW and PC when you initially enter them into the system and it will track their certificates for both programs/services.
- Most recent date of training (last date) should be entered in the new system.
- Alerts for upcoming training needs will be displayed on the Preview screen.
- The old system will not be deleted and you will continue to have access to it.
- Trainings/webinars will begin soon.
- You will have at least three months to get data entered into the new system.

Service Plans and Plans of Care. How specific do we need to be on the Service Plan? Do we need to put how many times member goes to the Doctor? Yes, you should document when the member goes to the doctor. The Plan should include all regularly scheduled appointments, for example, every three months, monthly, etc. This helps the RN create the member's POC. Anything changes after the SP developed can be added to the Service Plan Addendum. Any unplanned doctor appointments need to be communicated too, for example, going to the doctor for a very bad cold.

For trips to the grocery store, you should document the day(s) of the week that the member will go shopping, not just say "1 to 2 days per week". Try to ascertain the member's preference on which days they wish to go, but if they don't care, then you should choose and put that in the Plan.

BoSS Desk Reviews. The question was asked if there was a packet that BoSS distributes to providers regarding desk reviews so that they will know what BoSS is looking for? No. BoSS reviews those items on the monitoring tool which is posted on the website.

Compatability with Windows 8. Some providers are having trouble with the Assessment not being compatible with Windows 8. The suggestion was made to be sure you have the latest version of ADOBE and Susan Given will check to see if the forms could be developed to be compatible windows 8.

December 16, 2014

60. On the POC when it comes to essential errands and community activities do we have to have on there that informal is to be used before HM is used?

Answer: The CM will determine at the SP meeting if the service is provided by informal support (friend/family) or formal support (PA/HA) and document on the SP. Only the services which require the formal support of PA/HM would be written on the members POC.

61. And does the places traveled have to have a particular day listed to travel? EXAMPLE: Wal-Mart on Mondays, Doctors per scheduled, pharmacy on Thursdays. Or may it say Wal-Mart 3xweek, pharmacy 1xweek?

Medical Cards only refill medications on a 30day bases so some clients have medication that are refilled 2-3 different days a week or a couple days throughout the month depending on the date the prescription is sent/dropped off at pharmacy.

Answer: Yes. If the member needs grocery shopping once a week the CM must first determine if the member has informal support (Sue Doe) or if they need formal support (PA/HM). The CM must determine the day of the week if the member has no preference. For example, ask the member if Mondays work?

The examples you provided are not acceptable for a complete Service Plan and any issues should be discussed and plans made at the SP meeting.

Example:

1. Wal-Mart shopping for groceries and other items every Monday in a.m.
2. Dr. John Wee every 3months (next appointment 2/24/2015 at 2pm); Informal Support (Sue Doe).
3. The CM would need to address the problems you describe regarding the pharmacy challenges. The CM must document the name of the Pharmacy and determine if this is an informal or formal support service. If this is a formal support service the CM would need to coordinate this service to be more practical and organized for planning the service. Such as asking the pharmacy if they deliver, or set up a consistent schedule for refills such as every other Monday or discuss with the member the possibility of using Wal-Mart for prescription refills since Wal-Mart is planned for every Monday.

62. Non-essential shopping, including flea markets, thrift store, yard sale. Would these go under Community Activities or would these be something which would be the informal/family responsibility? The member on whose behalf I ask leaves his apartment very infrequently but enjoys going to yard sales. I would like to include this on his plan of care but am unsure as to whether this is considered a community activity. Please advise. Thanks.

Answer: Yes. However, you need to be sure these outings are within the community. Also, be sure to use family/friends/community support first for transportation, where possible.

Other questions/comments from the call:

- a. What if member doesn't feel well or the weather is bad on the day they are scheduled to go to the grocery store?
Answer: Grocery shopping can be changed for that week, but the overall POC should still designate a specific(s) day for grocery shopping. The PA/HM should document this deviation from the POC.
- b. Is this requirement new? (Specifying a certain day for member activities).
Answer: No, this is not new. The creation of a POC is an area that needs some focus, based on the results of recent provider monitoring.
- c. What if the member cannot afford to shop at the grocery store that is closest to their home?
Answer: You would be allowed to drive a reasonable distance, past the closest grocery store, if it would be more economical for the member. Just be sure to include this in the POC.
- d. Do we need to specify a certain day for all essential errands or just for shopping and/or doctor appointments?
Answer: The POC should cover all needs – laundry, cooking, shopping, etc.

Person-Centered-Planning is based on meeting the unique needs of every member. It also assists the RN in knowing what the PA/HM is required to do for the member. It could almost be a job description for the PA/HM. Every service performed for the member should have a plan and it must be within the scope of the Program. Services provided should not be "whatever I want" from the member's perspective. Person-Centered-Planning came about actually to be sure that the member's preferences were taken into account, and also that they would know what to expect from the Program. A thorough POC and Service Plan also ensure that there is accountability in the provision of services to the member.

- e. If the provider can't fit all of their notes in the Transportation section, can they continue their notes in 'Other' on page 4?
Answer: Yes.
- f. Is it ok to put formal and informal support coding on page 4, 'Other'?
Answer: Yes. Family members may only come to town sporadically or they may work, so that would be fine.
- g. Should Community Activities be planned for specific days as well?

Answer: Yes, when possible. For example, 'Bingo at the Senior Center every Wednesday'. Also, be sure that a Community Activity involves interaction with individuals in the community. For example, going to church, going to the beauty parlor, a county fair, etc. would be considered Community Activities. Taking a drive or visiting relatives, on the other hand, are not Community Activities. Also remember, any transportation services provided on behalf of a member must have a purpose and a destination.

CMS's intent for Community Activities is to encourage integration into the community, connecting with people and places in the community so that members are not isolated and sitting home alone.

The proposed definition for a Community Location in the new ADW manual is as follows: Community Location: any community setting open to the general public such as libraries, banks, stores, post offices, etc. within a justifiable proximity to the member's geographical area.

Announcements:

A request for **Fair Hearing** must be sent to BMS per the instructions on the bottom of the Request for Fair Hearing form. Uploading a copy of the request in CareConnection© **will not** initiate a fair hearing request or alert anyone the form was attached.

A request for **Discontinuation of Services** must be submitted per policy to the Bureau of Senior Services (BoSS) with supporting documentation. The only change in this process is you now must contact Tammy Grueser RN @ 304-558-3317 ext. 137 or email to tamra.r.grueser@wv.gov to inform her of the request when you upload the request and documents in CareConnection© **instead of faxing**. Once Tammy is contacted the request will be processed as quickly as possible. If you receive a rejected request via CareConnection please see the comment section for the reason for rejection. You will need to make any corrections and re-submit your request.

If you have any questions regarding the Fair Hearing process or Requests for Discontinuation of services please contact Tammy Grueser RN @ 304-558-3317 ext. 137 or email to tamra.r.grueser@wv.gov.

Announcement:

Please contact Cathy Richardson, Transfer Coordinator at 304-558-3317 ext. 118, if you have any questions regarding member transfer.

Two reminders:

You may submit questions at any time via email at seniorservicesmedicaid@wv.gov or susan.r.silverman@wv.gov.

January 20, 2015

63. I have 3 clients who have been scheduled WVMI visits the day before their anchor date. I would like to do extensions on them. Can you tell me how to go about doing this now that the new system is in place? Is there a special form to be used and to whom it should be addressed.

Answer: When the PAS cannot be completed prior to the member's anchor date, the CMA, HMA or F/EA user may request a continuation of services until the PAS can be completed. This action is performed in ADW CareConnection®. Detailed instructions for submitting the service continuation request are provided on page 35 of the ADW CareConnection® web user manual for CMA, HMA and F/EA users and are summarized below:

The user should select Service Continuation from the Member Detail Menu to initiate the process. The user will then select the Enter new Service Continuation Request Hyperlink. The user will select a Reason for Continuation from the available drop down items:

- Member/rep cancellation,
- Member/rep refused/unavailable for visit,
- Assessment coordinator no show/cancel/illness,
- Assessment coordinator scheduling conflict/hearing,
- Inclement weather,
- Annual MNER not submitted within 45 days prior to anchor date,
- Other (if other is chosen, a comment is required).

The system will send notification to APS to review the request.

64. After reviewing of the December Q&A. We have found some of our POC's for the ADW are not as detailed on the Essential Errands and Community Activities. Should we correct the POC now or wait and do with the next visit? I'm concerned that if we are monitored we would have a payback if we don't correct these POC now.

Answer: The SP should have the day and time documented for the activity. Per # 16, bullet # 2 of the SP Instructions: **Indicate each day the activity will be provided.** Your POC should follow the SP.

1st Review the SP and use the day of the week specified, if the CM did not complete the SP he/she should contact the member to discuss what day the member prefers the activity and complete an addendum to the SP. The addendum must be signed by the member and sent to the PA/HM RN to correct the POC.

Per the POC instructions the day and time is documented for the activity. Per #1, bullet 6, of the Plan of Care instruction sheet: **Enter the day of the week services are to be provided.** Any POC out of compliance should be corrected.

65. Member has dx of confusion, dementia or Alzheimer's. Is it mandatory for a family member, an informal, the MPOA, the POA, the legal guardian, or a contact person to be present at the meetings?

Answer: Per the Cyrus court order *if the individual has identified a guardian, no home visit shall be scheduled without presence of the guardian, contact person or legal representative; and/or if the*

Evaluation Form indicates that the individual suffers from Alzheimer's, multi-infarct, senile dementia, or related condition dementia, no home visit shall be scheduled without another individual designated by the applicant present to assist the individual during the interview.

Per policy section 501.5.1.3 D. If the MNER form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition dementia; or if he/she has a guardian, contact person or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.

66. (HMer is informal or is family member) The Member resides with HMer; or the HMer resides in Member's home; or, both will be in attendance for a holiday or at the family gathering. Can the HMer document care on the POC (worksheet) & the agency bill for care which HMer provides? (even though HMer would be present and is family member or informal anyway)

Answer: No, the **Homemaker** taking the member to a family function is not a community activity and would not be billable.

Announcements:

When the ADW Claimant no longer has a medical necessity, such as in the case of someone losing a hearing regarding medical eligibility it is the Case Management Agency's responsibility to notify the DHHR Department per Chapter 17.26 of the DHHR's Income Maintenance Manual.

A list of Economic Service Worker(s) (ESW) for every county with an email address, phone and fax number is on the www.wvseniorservices.gov web site under the Documents Center and will be kept up to date by BoSS. You may have a quicker response from the ESW if you email your questions and documents instead of faxing or mailing.

The **only** MNER accepted by WVMI via fax is an Initial. Any others will be returned to the provider. The provider must upload all re-eval MNER's in CareConnection©.

Comments/questions from the January 20, 2015 call:

Question # 63: APS commented that an extension for a re-evaluation is only necessary if the actual appointment is past the Anchor Date. If the appointment is prior to the Anchor Date, no extension request is necessary. (Detailed instructions on how to request an extension in CareConnection© have been added to question #63.)

Question #64: Provider: How far back should they (Providers) go to correct a Plan of Care?

BoSS stated the following regarding creating a Plan of Care and/or Service Plan:

- The Plan of Care form with instructions was updated in April 2012.
- The Service Plan form with instructions was updated in November 2012.
- Planning training was conducted in July 2014 which gave examples of specifying the day for community activities.

- The Question & Answer document mentioned this topic in December 2014 (question #61 and in the “Other questions/comments from the call”).
- The Questions & Answer document mentions other resources for transportation in September 2011.

BoSS stated that ADW policy requires a member’s informal supports, friends/family or other resources to be utilized first for services, including transportation. If there is a reason why the alternative resource cannot be used, this must be documented on the Service Plan.

Provider: So if there is no other means of transportation (informal supports) the HM can provide and be paid for transportation?

BoSS: Yes. Refer to the July 2014 Planning Instructions regarding how to document on the Service Plan when no other alternative is available. (Page 18)

Provider: Brooke County has clients who are upset that they are being asked to specify the days they participate in certain activities, for example, what day they go to the grocery store.

BoSS: With person-centered planning, you must talk to the client and there must be a specific Plan. This provides instruction to the homemaker on what to do each day and lets the member know what to expect. Medicaid services cannot meet every need. For example: if the member’s plan indicates trips to the grocery store on Monday and Friday. The member drops a gallon of milk on Wednesday (needs to go to the grocery store), document this on the worksheet.

Provider: The instructions on BMS’s website for the POC say “as needed”.

BMS/BoSS: The Plan of Care Instructions say to be specific. Community activities are addressed here specifically and there is an example of the day of the week.

It also says above this instruction on the Plan of Care Instruction sheet, “must be specific when using PRN or as needed. Example: Vacuum Monday or as needed. This statement was to address when people were using PRN all the time. Even this statement says to give a specific day and not to use just “as needed”.

It’s obvious that things will happen that are going to require the homemaker to go outside of the Plan of Care, but those instances should be rare and there must be adequate documentation as to why it changed.

Provider: Their agency has been monitored several times and adding the specific day of the week for activities has never been brought up. The client may not want to participate in an activity every week. They’re not sure how to be specific on the POC.

Susan Given @ BMS: Monitoring is claim-specific. The issue may not come up during a monitoring visit. The decision of what services the member receives should not be left up to the HM. Some members demand to be taken places at certain times and in this instance, you can use the POC to explain to the member what services they are supposed to receive and when. The HM should not be deciding the service plan or member activities. In addition, the POC and Service Plan keeps the RN informed of what's going on with each member.

February 17, 2015

67. If a HMA has travel limitations such as a limited number of days to travel or a limited amount of miles per week, how should a Case Manager from another company address that? Should the Case Manager be telling members that there are no limits set by Medicaid? This makes it difficult for a HMA to enforce travel limitations.

Answer: The Case Manager, PA/HM RN and member will determine if a need for transportation exists at the Service Plan meeting. If the member has no other resources such as family, friends, community or NEMT (state contracted medical transportation) the transportation need will be discussed and planned. Example: Identified need for groceries and go to the post office so a day of week should be planned and both could be accomplished on the same day. (Tuesday morning (am) shop at Food Land and stop at post office.

68. If the Case Manager is not choosing a specific date for services to be done, can the HMA RN put a specific day on the POC? Example: Service Plan states mopping is "1 x per week and prn" and "F" is placed in all 5 days homemaker services are provided.

Answer: The day of the activity/service should be determined at the time of the SP meeting by the member, CM and PA/HM RN and documented on the SP. The PA/HM POC is developed from the Service Plan which should be complete and include the day of the planned activity/service.

Announcement:

New Call-in number: (877) 278-2734

PIN: 779160 (unchanged)

Please be aware that if you are not able to make it to your office, this dial-in number will work from your home or cell phone.

March 17, 2015

69. When a member gets an increase in a level of care it cannot start until the anchor date, what if it is a decrease?

Answer: *This question was answered in # 57.*

The newly determined service level will be effective upon the member's Anchor Date. If you determine an increase in hours needs to begin immediately you should submit a request for a service level change to APS Healthcare at wvadwaiver@apshealthcare.com. Likewise, if you cannot substantiate the need for services at a higher level, those services can be decreased before the anchor date (this should be happening any way). Just because someone is authorized at a certain level, doesn't mean they have to receive those hours if they don't need them.

70. A homemaker rides with a family member to take Member to the Dr. due to member being so hard to manage. Is this billable time for the homemaker if it is within the hours she works?

Answer: *Yes, the Service Plan documentation must support the need and then it must be on the members POC.*

71. When are you going to revise/update the POC to allow more space for the details you are now wanting on there? For example: it is impossible to write specific details to include medical appointment frequency with the specific MD, especially if the client has a team of 8 – 10 specialists they see throughout the year. The information cannot be currently typed in with those details and it be printed off for the homemaker/client to see.

Answer: *The specific information such as MD name, type of specialist, date and time of the apt. must be on the Service Plan (which the PA/HM RN and member should have a copy). The Case Manager is responsible for coordinating the services and if no family, neighbors, friends, or community agencies can provide this service, without charge first. The CM should utilize MTM for medical transportation.*

FYI, MTM accepts applications from PA/HM employees to become a "Volunteer Driver" and will pay the driver per mile for the travel. (www.mtm-inc.net) If the PA/HM provides the service during the POC hours for ADW the "service" time would be billable under the ADW service code S5130.

The POC should note the date and time of the appt. If the member has a different scheduled appt. monthly during the hours of service, the PA/HM RN would need to document the date and time of the appt. on the POC for that month which should follow the Service Plan.

72. Should a homemaker be scheduled working hours while their client is in dialysis?

Answer: No

73. Are homemakers permitted to purchase alcohol for their client?

Answer: BMS has no policy regarding the purchase of alcohol and/or tobacco/nicotine related products. If upon request, and the HM/PA is performing an essential errand for a member, the provider may choose to purchase alcohol and/or tobacco/nicotine related products for the eligible member. If, however, the eligible member requests a trip only for the purchase of alcohol and/or tobacco/nicotine related products, this would not qualify as an essential errand and shall be considered a non-reimbursable trip. The provider assumes all risks associated with the purchase. (This answer will be discussed during the April 21 call.)

74. The conference call questions packet, page 15 & 16 regarding Community Activities states there is a **proposed** definition for a Community Location in the new ADW manual. When will the new ADW manual be complete/finished?

Answer: The new ADW manual will be completed once the ADW renewal is approved by CMS.

75. Can you re-word the Notice of Decision letter that is mailed to the client to reflect their range of hours for their approved level? Some clients look at that letter and have great difficulty understanding why they do not get those hours every month and not looking at the “cannot exceed 93 hours per month”

Answer: Any revision to this form would have to come from APS and WVMi.

76. When a CMA or HMA completes an incident report, is a telephone notification sufficient to let the other agency know of the incident? Does each agency need to complete their own incident report?

Answer: The agency who receives the report of the incident will submit the report and report the incident to the other provider.

77. If the PA/HM is not a relative of the member, what kind of guidelines are suggested for visiting friends or relatives?

Answer: Visiting a friend or relative in their home is not considered a community activity. A community activity such as meeting friends at a local restaurant in the community for lunch would be acceptable. The member is then interacting with others in the community.

Questions/Comments from call:

Question A: Can a member visit a friend in a nursing home?

Answer: If the nursing home is in the member's community, and they participate in a group activity at the nursing home, for example, having lunch in the dining room, playing bingo, etc., then yes. If it would involve just the member and friend in the friend's room, it would not be considered a community activity. By definition, "community integration" is the provision of services which allows a person to live and participate in his/her community and the activities it offers to all citizens.

Question B: The Policy manual states that a provider has 10 calendar days to begin direct services for a new ADW member. Is this correct?

Answer: Yes, although 10 days should be treated as the maximum. We would hope that direct services could begin sooner than that.

Question C: Do providers need to revise forms that use the term "Homemaker" and replace it with "Personal Attendant"?

Answer: No. It will not be required. The forms committee will review the forms and make recommendations for changes based on the new Waiver Application approval.

Question D: Have clients on ADW been sent information on the rules governing transportation?

Answer: No. BoSS does not send information to ADW members. However, the Quality Council published the Transportation Took Kit which was intended to be a guide for providers. The rules, including limitations, regarding transportation should be explained to ADW members so that there is no confusion. The policies governing transportation have not changed since 2006, however, there has been more of an effort recently to enforce the policies that have been in place.

Question E: Can a member visit their husband/wife in a nursing home?

Answer: Again, if the nursing home is in the member's community, and if they participate in group activities at the nursing home, then yes, it would be considered a community activity. "Community integration" is the provision of services which allows a person to live and participate in his/her community and the activities it offers to all citizens.

Question F: When a provider receives an allocation (initial referral) for a new ADW member but the PAS is not attached to their record in CareConnection®, what should they do?

Answer: If you receive a member referral in CareConnection© that does not have a PAS attached, you can contact WVMI at (800) 982-6334, option 3 or APS at (866) 385-8920 and ask them to upload it to the member's record. If you have to leave a message, please provide the member's name and their APS ID number from CareConnection©.

Question G: Taylor County has no MTM transportation providers in their county. Can they utilize and bill for alternate transportation options?

Answer: Yes, if you document the fact that MTM is not represented in your county. However, you may want to encourage your homemakers to apply to become volunteer drivers for MTM. In doing so, the homemaker can bill for mileage and the provider can bill for service time.

Question H: Some members don't understand why they can only do things that are listed on their Plan of Care. And if our agency limits the member's activities, they will just transfer to another agency that will not be as strict. How do we deal with this?

Answer: Members agree to, and are expected to follow program guidelines. The ADW program, both the benefits and limitations, should be thoroughly explained to each member during the initial assessment. If a member transfers away from your agency and you become aware that the new agency is providing services outside the parameters of the ADW program and/or the member's Plan of Care, notify either Cecilia Brown or Linda Wright at the Bureau of Senior Services at (304) 558-3317 and they will follow up.

Reminder(s): Continuing Certification Report 2015

The new system will be available soon and due to the amount of additional information we are collecting, importing the employee data over to the new system is not feasible. You need to spend this time getting all employee training dates in a format that makes it easy for you to add the information for the 2014/2015 reporting period. The system is currently being piloted by five providers and the response is very positive. BoSS will contact all providers once training plans for the new Continuing Certification Reporting system is confirmed.

IMPORTANT NOTICE: Medical Necessity Evaluation Request (MNER) submitted incompletely and/or incorrectly could impact the assessment scheduling, medical eligibility and service level when the MNER data transfers over to the PAS.

Forms Committee:

The Quality Improvement Council is creating a Forms Committee to review all Medicaid forms. Anyone interested in participating on this committee should contact Cecilia Brown at (304) 558-3317 or Cecilia.a.brown@wv.gov.

April 21, 2015

78. We were monitored last week and were told that clients must go to closest grocery store for their monthly groceries. The problem is that we live in a very rural area and our closest grocery is very expensive and if our clients are forced to buy their food there then they are going to run out of food by the end of the month.

My clients should not have to go without food and many have no family and/or friends that are able to drive them to another, more affordable, grocery. I am only asking if these clients would be allowed to go to Mineral County and buy their food at Save a Lot, where they can afford to purchase more food for their minimal budget. What is the solution?

Answer: Refer to question 62, section entitled Other questions/comments from the call, part c.

79. Once again, per monitor, client is allowed one trip to pharmacy per week. Medicaid will only fill a Rx 3 days prior to last pill and when clients are taking many (about 20 or so) meds then it is IMPOSSIBLE to get all Rx's filled on the same day. There is no way we can change this and our client CANNOT go without their meds. What is the solution?

Answer: Refer to question 61, part 3 of the answer.

Further clarification from call: *Is it policy that a member can only go to the pharmacy once per week? No. The Plan of Care should consolidate trips to make the travel reasonable. For any unexpected instances, you should just document the situation in the Plan of Care. Be efficient and reasonable with travel.*

Comment 1: *Most drug stores deliver prescriptions, depending on location. Also, some medications can be delivered through the mail.*

80. As before, per our monitor, everything has to be local. How far is local? I currently have a client that lives 20 miles, one way, from town so therefore local to her is at least 40+ miles round trip. As I said before, we live in a very rural area and local to us is not local to someone from Charleston. What is the solution?

Answer: *In rural settings, it can be common practice to have to travel a distance to grocery stores, pharmacies, etc. For the member, it would be the closest location to the member. What is local for this member may be in a neighboring city (it is reasonable travel because everyone in the area must travel to the next town to grocery shop due to no stores in the area). For situations where they travel 40 miles round trip, consolidate the trips. Example: Traveling to the store on Fridays to grocery shop*

and pick up prescription at the pharmacy at the same time. The person would not need to travel every day. Please keep in mind, the member's personal care comes first.

81. According to the memo sent out July 24th by Susan Given, once the Anchor Date is established, it does not change, but I have noticed on a few people that have had a PAS extension done, the Anchor Date has changed. So is this the exception to the rule?

Answer: Yes, this is an exception to the rule. Please provide APS with an APSID to research and make sure it is not a system issue.

82. Can you reformat the current PAS evaluation so all of the member's diagnoses are visible? They do not all fit and get cut off and we don't always have a Medical Necessity Evaluation Request available to see what the MD has listed.

Answer: Users can print the PAS in landscape –or- can print in portrait orientation at 85%. Doing so will display the narrative fields when printed. The MNER should also always be available in the attach documents feature in CareConnection®. APS will explore changes to the PAS, as an enhancement at a future date.

83. Is there a Notification for potential closures? The only way I have found this out is by doing a member search for letters. Then it can be too late!

Answer: No, there is no notification to providers for a potential closure. However, users can always use the 'Search_Member' feature and input the variable of eligibility status = Member-Potential Closure.

84. How can you remove a client from the notifications on CareConnection if they are new to the program but they have chosen not to proceed with the Financial Eligibility process?

Answer: Open member detail then choose eligibility status history. You will see change status under the "action" tab. Click close on the new eligibility status and choose the reason. Note effective date and submit.

Comment: A Provider on the call doesn't have access to the "Action" tab in CareConnection®. Contact Tami Shamblin at APS at (304) 343-9663.

85. Are we required to fax a copy of our Incident Report to the other agency (HMA/CMA) or is just a phone call of the incident sufficient notification?

Answer: Communication between the Case Manager and PA/HM Agency is critical and should include any information regarding the member. Sharing a copy of the Incident Report is not required by policy

but the expectation of informing and discussing an incident with other disciplines either by fax or phone is very important.

86. If the member has a diagnosis of Alzheimer's, and there is not designated MPOA/Legal Rep., can the member sign for themselves?

Answer: If the member is still alert and oriented, then it may be possible for the member to sign for themselves. The member would need to be evaluated. If it is a relatively new diagnosis, the member could be exhibiting very few symptoms of Alzheimer's Disease and still possess the ability to make his/her own decisions. It is required that a MPOA/DPOA/legal rep sign on the member's behalf when the member has been diagnosed with Alzheimer's Disease and is undergoing the initial PAS process or the re-evaluation process with WVMi.

87. If the member has a diagnosis of Alzheimer's, can the contact person sign assessment/SCP signature pages, or does it have to be someone with legal representation?

Answer: If the member lacks capacity due to suffering with Alzheimer's Disease, then no, a contact person cannot sign the assessment/SCP signature page. These are considered medical documents and thus are held to a higher standard requiring appropriate representation and signatures.

Further clarification from call: *If member is alert and oriented and is still making decisions, then they can sign. However, if they are incapacitated, a MPOA, POA or legally appointed representative should be used. The CM should work with the family and hopefully a representative would be in place in plenty of time. If there are no family members to assist with this process, the court could appoint someone or the member's physician could appoint a health surrogate. There are many variables to consider and each one should be dealt with on a case by case basis.*

88. If the member has a diagnosis of Alzheimer's, and lives alone, and there is no one else to speak with, how do we complete CM monthly contacts?

Answer: This question involves a lot of variables. If the member lacks capacity to make decisions and have a meaningful contact with the case manager, why does the member live alone? It seems unsafe and it seems that other steps should be taken immediately to ensure the safety of the member.

IMPORTANT NOTICE: With the advent of anchor dates and the new ADW CareConnection, there has been some confusion about requesting a change in level of care when the most recent PAS delineates a need for a higher level of care than last year. For example, a person's anchor date is 3/1/15 and her PAS was completed on 2/1/15 and the new PAS necessitates a level of care D. Her level of care last year was level C. It is a health and safety risk to continue for the next month at level C when it has already been demonstrated that this person needs care at level D. Understandably, her agencies want to begin

providing care for her at the appropriate level as soon as possible. In order to be paid at the correct level, you must request a Change in Level of Care through the ADW CareConnection (Refer to section 3.9.1 of the ADW CareConnection Web User Manual; disregard documentation requirements since PAS was just completed). This is simply doing the appropriate computer screens to request that change. The paperwork that was required in the past is not associated or needed in this situation because the PAS was just done. *Information in gray highlighted area is currently incorrect. Please see answer to question 91 for the correction to the highlighted information. All other information in this note remains correct.* For more information or a walk-through on completing a request for change in level of care in this situation, please feel free to contact APS Healthcare at (304) 343-9663. APS Healthcare can also send you an electronic version of the Provider Manual for ADW CareConnection. Also, please remember that if a change in level of care is necessitated by something other than the completion of the yearly PAS, you will need to complete the entire process for Change in Level of Care including the necessary documentation.

Questions/Comments from call:

Question A: We cannot request a level of care change until a member's Anchor Date, right?

Answer: No, you can request it at any time whether it's an increase or decrease. (See above.)

May 19, 2015

Questions/Comments from call:

Questions B: Please explain to me why I need to retrain an aide who is transferring to us from another in-home care agency?

We hired an aide that had current CPR/First Aid and all of her annual trainings were current but we were told we must teach those subjects to her again. Since both our agency and her former agency are subject to the same training guidelines, I do not understand why training by her former agency could not be considered to be valid. I have looked for aide transfer instructions in the ADW and PC manuals but do not see it.

Answer: The aide in question must have received the training from a certified and nationally recognized provider for CPR/First Aid training. The following providers are certified to provide CPR/First Aid training: American Heart Association, American Red Cross, American Health and Safety Institute, American CPR and the National Safety Council. The aide must carry her card certifying that she completed the training with her and provide a copy of it to her current employer. When/if she moves to another employer, then she will be able to produce her proof of training and it will carry over to her next employer.

Question C: Related to Question 1, above, do we have to re-do the background check also?

Answer: Yes. However, when the WV CARES CIB system is activated and a background check has already been done for an employee, you will not have to request one again if the employee changes agencies.

June 16, 2015

89. On a Case Management Assessment page 4 there is a box where you check yes or no for “unsafe feelings in neighborhood”. Even though we check the appropriate box and save the assessment it will uncheck the box automatically. Also, on page 5 of the CM Assessment in the emotional assessment section it will check both yes and no boxes under “do you feel you cannot think clearly” even though we choose only one. Can this be fixed? Thanks!

Answer: This is may be an issue with the formatting of the PDF version of the form. The Bureau will evaluate this formatting issue and make any necessary corrections to the formatting. If corrections are made, an amended version will be posted to the website.

Questions/Comments from call:

Question D. When is the new Manual coming out for review?

Answer: We are reviewing the manual now so it should be released soon. It cannot be posted until we know if there will be any changes made to the Waiver by CMS.

NOTE: Questions for this call should be submitted to Susan Silverman at susan.r.silverman@wv.gov or FAX to (304) 558-5547.

July 21, 2015

90. Regarding dual services coordination, the manual reads, “...the coordination of the dual service request is the responsibility of the Case Manager. This includes the coordinating the planning meeting which includes the ADW RN, the Personal Care RN and the member....” I would like clarification as to whether the ADW case manager is required to attend the planning meeting.

Answer: Yes, the Case Manager is responsible for coordination and must attend the meeting to ensure services are not duplicated and member needs are being met.

91. Please clarify the process when a member receives a Level of Care increase during a WVMR Re-evaluation in month(s) prior to Anchor Date, in order for the homemaker agency to be reimbursed. In an April 2015 Directive Susan Silverman stated we must (request) a change in Level of Care through

CareConnection without submitting the forms. When I did this Renee at APS Healthcare told me I must withdraw this and fax a Level of Care Request.

Answer: Electronic submission via ADW CareConnection® for the LOC increase due to the Re-Evaluation will not be possible at this time. It has been found that this workaround is not compatible with the system design. When a member needs the higher level of service prior to their new anchor date as determined by the most recent PAS, please fax the Request for Service Level Change form and a brief narrative stating the reason for request to APS Healthcare at 866-212-5053. APS will process the request manually and the agency will receive fax confirmation of the result. As noted in the April 2015 FAQ, if a change in level of care is necessitated by something other than the completion of the yearly PAS, you will still need to complete the entire process for Change in Level of Care in CareConnection including the necessary documentation.

92. Pertaining to RE-writing the POC's to be more specific, is the Case Manager required to go back on each case a(nd) complete a SP Addendum? What is being completed by the Homemaker is not changing, it is only expanding, in more detail, on what it is meant when "Food" and "Medical Appointments" are listed on the SP.

Examples:

- (1) The POC might just say "Medical appointment" and to be more specific "Dr. Jones at least once a month, Dr. Smith once a month, Dr. Jane 2 times a month/medical appointments only on Wednesday's"
- (2) The POC might just say "Food" and to be more specific "Food lion on 2nd and 4th Tuesdays, Free Pantry 1st Wednesday, Aldi 1st days of the month"

Answer: The PA/HM must follow the Service Plan (SP) developed at the time of the SP meeting and should be as specific as your examples above. If you are rewriting the POC to follow the SP, an Addendum would not be needed. The SP Addendum is required only if the SP changes.

Example: The PA/HM RN notifies the CM that a member requested a change in hours. The SP Addendum would show the need for the change and confirm the change with the member to ensure compliance.

93. This concern is in reference to Q&A #72 "Should a homemaker be scheduled working hours while their client is in dialysis?" "No". The only documentation I have been able to find regarding this question is from a memo dated May 16, 2012 from Penney Hall. In it, she instructed that there was no distinction to be made between billing for homemaker services for a Member's doctor appointments and billing for homemaker services for other medical appointments for the Member. If I am not mistaken, this memo was in reference at least partly to address Provider questions about dialysis appointments.

Recently, one of our Members missed her scheduled dialysis appointment because of failure of MTM transport to arrive as confirmed. That is unacceptable for a dialysis patient.

Please refer RNs to the documentation that indicates that there has been a change in the billing process for dialysis patients since the above memo was received in May 2012.

Answer: We ran this question by Susan Given, current Program Manager at BMS and she stated that, "They could not bill for the time they are waiting for the member to get dialysis. They may want to consider using NEMT for this." So the Personal Attendant/Homemaker could transport the member to and from dialysis, but could not bill for the time waiting on the member. Also, we would encourage the member to make a complaint to MTM about the no-show driver.

IMPORTANT NOTICE: Please make sure that you check ADW CareConnection every day to see if you have new referrals. If you have new referrals, please accept or deny them as soon as possible so you don't delay a member's services. Remember, people sign up for the program because they need help and the longer it takes you to accept their referral, the longer they go without help. If you need a password reset for CareConnection, please contact APS Healthcare asap to get that reset. Their phone number is 304-343-9663. Tell the receptionist that you need a reset for ADW CareConnection. The receptionist will send you to the correct person for a reset.

Questions/Comments from call:

Question E. Does the Homemaker RN have to approve every change that varies from the Service Plan?

Answer: Yes. If there is a change to the current Service Plan, the Homemaker RN must sign off on it.

Question F. How can we find out about changes to ADW Policy?

Answer: Although BMS and BoSS try to inform all providers about important changes in ADW policy, we may not be able to communicate them all. Therefore, we would suggest that you periodically check for changes on the BMS website. All changes to Chapter 501 – ADW Policy can be found at the following link:

***[http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/bms_manuals_chapter%20501%20ADW.p
df](http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/bms_manuals_chapter%20501%20ADW.pdf) (This link is at the top of the Forms page on the BMS website.)***

Question G. How are providers notified of potential closures in CareConnection?

Answer: Currently there is no notification in CareConnection for 'potential' closures.

MTM Non-Emergency Medical Transportation

If you have a complaint regarding the service you have received from MTM, proceed to the link below to file the complaint with them.

<https://www.mtm-inc.net/west-virginia/>

To file a complaint: 1-866-436-0457. (There is also a form you can submit online.)

If your ride is late: 1-844-549-8354. (If your ride is at least 15 minutes late.)

August 18, 2015

94. Can CareConnection be modified? Our agency received Notification SDM-member transferred today. When going in the link, it lists the member's name and effective date of the transfer for both HM and CM agencies and now neither HM or CM can access the chart to see which agency the member transferred to. We are unable to fax the Service Plan etc., unless the new agency calls us to let us know where the member transferred to.

Answer: The Bureau of Senior Services emails a copy of the Transfer Notice to both the new and old agencies and to the Case Management agency. BoSS either emails it to the director of the agency or to the person within that agency that is traditionally associated with handling transfers or to both people.

95. Can a "contact us" link be added to CareConnection? It would be nice to have this available for any problems with notifications on there that we cannot "dismiss" and requires us to call various people to have them removed. Example for member hold expiration notification: it can be "viewed" but not dismissed. Going in the link then denies access to the chart because the member is closed.

Answer: Some notifications in ADW CareConnection® are dismissible; others require action on the user's part to remove the notification. For the system to dismiss the Member Hold Expiration notification, the user must perform one of three actions: update the Projected End Date and submit with a future date; submit Closure Hold Outcome and Actual Hold End Date; or move the member to Discharged status.

In the event a user continues receiving a notification they cannot act on, they can contact their assigned APS staff or call the AD Waiver department of APS Healthcare at 866-385-8920 to have the notification deleted.

96. At this time is there a plan for Family Nurse Practitioners and Physician Assistants to be able to sign off on the MNERs. If so, when will it become effective?

Answer: Yes, it should become effective when the new ADW manual is released sometime this fall.

September 15, 2015

97. Some of my referrals for the Waiver Program have gotten letters saying they are medically eligible for the Waiver Program but there is no slot available at this time and they will be notified when a slot is available but are not getting the yellow sheet to begin the financial review. However, some of my referrals are getting that yellow paper. Should everyone be getting that yellow form in their letter?

Answer: The yellow DHS-2 forms are not sent with the Initial Notice of Decision letters. Yellow DHS-2s will be sent on or near the first of each calendar month to individuals newly added to the Managed Enrollment List. If you have a question about a yellow DHS-2, please email WVADWaiver@apshealthcare.com or call and ask for an ADW support staff.

98. Once a Service Plan Addendum is completed by CM, is mailed to member for signature, then once we receive that back and submit to PA/HMA, how many days do they have to start services per the Addendum?

Answer: You can start immediately on a verbal from the CM. The CM can provide you a copy of the Addendum once it is signed.

99. Are CMgt Agencies supposed to be utilizing the Member Hold Request in Care Connection for Members admitted to NH, Members admitted for Rehab, hospital admissions and psychiatric hospital admissions and whenever Member goes out of state to visit a relative or on vacation? We have not been doing this – we didn't know – errored inadvertently.

Answer: The Member Hold feature in the Aged and Disabled Waiver CareConnection® allows for tracking of members who are not accessing Aged and Disabled Waiver services for various reasons. Please refer to page 20 of the AD Waiver CareConnection Web User Manual for instructions on how to use this feature.

Questions/Comments from the call:

Question H. An eligible person chooses a Case Management and Homemaker agency prior to enrollment, and then changes their mind and wants to transfer to different agencies. Can they transfer at any time?

Answer: Yes. One of the main focuses of the ADW program is member choice, and therefore, whenever someone chooses another agency, we will process that change.

Question I: How long does it take to get a slot after being determined medically eligible for the ADW program?

Answer: The time varies based on multiple factors. Slots are made available in each fiscal year based on available funding. However, if someone doesn't enroll within 60 days of becoming medically eligible or if someone is closed for not accessing services in 180 days, these "unduplicated" slots (meaning the slots were never used because someone never received services in the current fiscal year) could be used by the next person on the Managed Enrollment List.

Question J: Do slots stay with a particular agency? In other words, if a member at Agency A dies, or for some other reason goes off of the program, does the now open slot stay with Agency A?

Answer: No. Slots go into a "pool" and are assigned on a first come, first serve basis. They are not assigned to certain agencies.

Question K: Is there a new manual and forms?

Answer: Yes. CMS approved West Virginia's Waiver Application for the ADW program. The resulting ADW manual has been posted for a 30-day public comment period. Some forms have been revised also. Follow this link to go online to review and make comments:

<http://www.dhr.wv.gov/bms/Public%20Notices/Pages/Aged-and-Disabled-Waiver-Chapter-501-is-available-for-public-comment-until-5-p.m.,-October-15,-2015.aspx> (You may need to hold the "Ctrl" key to activate link.)

Question L: What about the 1,200 reduced slots mentioned in the ADW Application?

Answer: The Application covers a five-year period and BMS must try to estimate the number of slots based on available funding. The reason that the application predicted fewer slots each year is because the projected amount of funding for the entire 5-year period is the only funding you can mention in the application. Over a period of five years, your dollar will buy less, thereby reducing the amount of people served. At times, WV BMS receives additional funding for the ADW program and when that occurs, it raises the number of people who can be served.

Question M: When will Case Managers get an increase in pay? Minimum wage goes up and expenses go up, but Case Manager's compensation stays the same.

Answer: The Bureau of Senior Services does not set reimbursement rates. You would have to contact the Bureau for Medical Services.

Question N: Who made the decision about the new Morpho Trust background check contract?

Answer: The Bureau of Senior Services was not involved in renewing that contract. You may be able to get more information on the bid process by contacting the WV Purchasing Division at (304) 558-2306.

October 20, 2015

No call conducted in October due to ADW Manual Training.

November 17, 2015

100. We are looking to clear up a few matters concerning the mileage. If we're understanding this correctly, MTM will provide the transportation for scheduled Medicaid appointments only. We have different situations that arise where our participants need transported because they have no informal support to take them. They are medical-related but not actual pre-scheduled appointments such as blood work prior to day surgery or picking up a prescription from the doctor office. Are we still able to claim this mileage as an essential errand?

Answer: For blood work prior to surgery, your staff could take the participant, but your staff would need to sign up with MTM as a Friends and Family driver and use that mechanism to bill NEMT (non-emergency medical transportation). They would need to call the number on the form about 5 days prior to the appointment to tell MTM that they were transporting the person that day. No mileage for medical appointments or medical testing can be billed to the ADW program as per mandate from the federal government. To pick up the prescription from the doctor's office, that would be an essential errand and you can bill ADW non-medical transportation to do that.

101. If we have a participant that is to have day surgery in Clarksburg (approximately 60 miles away), will MTM take them to the surgery and then come back later and pick them up? If not and the PA takes them to the hospital for the surgery, they are not able to stay because they cannot be paid for the time. They would need to leave, drive the 60 miles home and then drive back to pick up the participant. This would be twice the mileage necessary.

Answer: You are correct for the day surgery in that the Personal Attendant can't bill for the wait time because surgery is a Medicaid facility code meaning that once the person gets back into the facility, there are staff available to take them to the bathroom, tend to any other needs they have, etc. If I were the Personal Attendant, I would go off the clock and shop around the area, buy my groceries, whatever, until I could go back and pick up my participant. In the end, if you didn't want the PA to do this, then you could have the participant use MTM. And yes, MTM would come back and get them.

Questions/Comments from the call:

Question O: Clarify the five days' notice as it pertains to being a friends and family MTM driver.

Answer: Actually, according to MTM, you do not need to give five days' notice as a friends and family driver. You can, but it is not a requirement. You can actually call the day of the trip but you still must supply all required information and receive your trip number.

Question P: What about coming home from the hospital? Can we bill NEMT for bringing the member home? Or physical therapy? Can the PA transport member?

Answer: Yes. To and from the hospital or physical therapy facility, as long as the participant is in the car.

Question Q: Is there a list of Facility vs Non-Facilities?

Answer: No, but you may contact the Bureau of Senior Services on a case-by-case basis.

Question R: Has there been a decision made about when to use the new PAL?

Answer: You may either do all assessments at once or wait until they become due. It is up to each agency.

Question S: Is the ADW Training Record Form that was handed out recently mandatory?

Answer: Yes, because it contains space for all required information.

Question T: Is it billable if a member calls to request a home visit by the RN?

Answer: Probably not. The ADW program is not providing medical care. If the participant is feeling ill, they should go to their own physician. If they feel they need more hours, then they could request a re-evaluation and you would follow policy for that request and billing.

Question U: Regarding the Care Plan, do we still need to pick a specific day for a doctor's appointment?

Answer: When the Case Manager and RN are creating the Service Plan, they should try to be as specific as possible and list purpose of outings, day(s) of the week, specific destination, frequency, etc. It may be difficult to be this specific for doctor's appointments but most other Essential Errands and Community Activities should include this detail. Any changes to the Plan due to unforeseen circumstances can be documented in the participant's file.

Question V: When will forms be fillable and savable?

Answer: We will offer both fillable pdf and WORD formats when the new forms are posted. The WORD version of the form will include a disclaimer to ensure that no changes have been made to the original content of the form.

Question W: Do you still want MTM travel recorded on the Plan of Care?

Answer: Yes, you still need to include it because part of the time will be billable. It is also part of the participants Service Plan.

Question X: When should we begin using the new ADW Training Record form? We just recently conducted some trainings in July.

Answer: You can begin using the form now, if you wish.

Question Y: On page three of the Personal Attendant Log, what do you want in the boxes that say "Time In" and "Time Out:"? The instructions are unclear as to what you want there. And also, the PA may work at different times on different days.

Answer: That was intended to be the time in and out, or the hours that it is projected that the Personal Attendant will be working, for example, Time In: 10:00 a.m. and Time Out: 1:00 p.m., if the PA will normally work three hours per day. It would be completed by the RN when they are developing the Service Plan. The request for this information came from the Medicaid Fraud Division. As you pointed out, the hours may be different on different days, so we will review the form and the instructions to see if we need to make any changes.

Question Z: Is the Personal Attendant Log going to remain the same as the form handed out at training?

Answer: In most respects, yes. There may be some formatting or other changes due to questions or comments made during the training sessions, but for the most part, it will remain the same.

Question AA: Is review time of the Personal Attendant Log billable?

Answer: Yes, because you are allowed to bill one unit for review per month.

Question BB: Do we have to wait for the Case Manager to sign off on the Personal Attendant Log?

Answer: No. Sometimes you may need to initiate services before the Case Manager can sign it.

Question CC: When someone transfers to another agency, when are reviews to be done?

Answer: If it is a Personal Attendant agency transfer, you will have to go ahead and do an initial assessment right away, but you can use the Case Management assessment that is already in place, until it needs to be done again. (It should be attached to the participant's record in CareConnection.) In addition, you do not have to be on the same schedule, but you can align them if you want to whenever the next six-month or annual assessment is due. The Service Plan meeting with the Case Manager and RN is mandatory and is done every six months.

Question DD: Can we bill for an initial assessment on a transfer?

Answer: Only if it has not been billed already. Remember, T1001 can only be billed every 300 days but T1002 can be billed once per month.

Question EE: For dental and eye appointments, can we bill that as an Essential Errand?

Answer: Yes. Medicaid does not pay for these services.

Question FF: What if someone has the flu? Can MTM pick them up that day?

Answer: There is an emergency MTM phone number (), and they may be able to provide transportation that day, however, if the Personal Attendant has signed up to be a friends and family driver, they can notify MTM that they are taking the participant, receive their trip number and take them that day.

Question GG: Regarding Community Activities and Essential Errands, can the RN make changes to the Service Plan is something changes?

Answer: Yes, there is some leniency. Just be sure to document the reason for the change.

Question HH: Is shopping at the mall a Community Activity?

Answer: Yes, within reason.

Question II: When changing to the Personal Attendant Log (PAL), do we need to do a new assessment?

Answer: Every participant needs to be "converted" to the new PAL by May 30, 2016. The switch to the new PAL can be done when the assessment would normally be due or you can do them all at once.

December 15, 2015

102. Is there a plan to fix the text boxes in the new PDF forms. In the Assessment It is very difficult to enter information when some of the text boxes will wrap text and others will not. In addition, the font size varies greatly. The problem with the word format as noted at the bottom of the SP is “any alterations of the original form will result in improper documentation and disallowance”. When can we expect the formatting issues to be corrected? Thanks.

Answer: We are currently working on these issues and hope to have them corrected A.S.A.P. The reference to alteration of the original forms is in reference to content, not necessarily the appearance of the forms.

Questions/Comments from the call

Question JJ: When do you bill for reviewing the PAL?

Answer: There is an automatic billing of one unit per month. The RN must sign the PAL to verify that it has been reviewed.

Question KK: If the RN completes the PAL, do they then just send it to the Case Manager?

Answer: The RN and Case Manager should do an initial visit together. If there is a change in between assessment dates, the RN can update the PAL and make sure the Case Manager gets a copy of it.

Question LL: If someone has a change in hours, for example, but their assessment isn't due, do we use the old forms or use the new PAL?

Answer: Until the assessment is due, use the old forms.

Comment: There were many questions regarding completing the Person Centered Assessment and Personal Attendant Log. BoSS will review and revise the instructions to make them more clear.

January 19, 2016

103. In the event that a member who is still on a previous version of the POC & Service Plan requests a schedule change or has a change in need, do we continue to use the Service Plan Addendum form until this member is transitioned onto the new forms when either their 6 month review or annual comes due?

Answer: Yes.

104. If a member that is still on the previous version of the POC & Service Plan requests a schedule change after 12/1/15, how do we proceed? Is a PAL completed to show the new schedule, even though all of this member's other paperwork is still the previous version, or do we complete a new POC on the old form until this member's next review or annual is due and they are changed over to new paperwork?

Answer: Continue to use old paperwork and the Service Plan Addendum.

105. Is this waiver log a mandatory form to be used for communication if the provider agency has a communication system already in place?

Answer: You can use the ADW Log or use your agency's form.

106. If a homemaker drives a participant to outpatient physical therapy we were told during training and in manual that it wasn't a billable service, but then Pg 15. Q & A #117 said that outpatient therapy that the homemaker can bill for service? I don't understand what other type of PT would be received other than outpatient since inpatient PT would have no need of a homemaker.

Answer: If homemaker takes a participant to outpatient physical therapy, the Personal Attendant code can be billed for the time to take the person to the appointment and to wait for them (usually they will be in the PT facility with the person in case the person needs the PA during the appointment) and then to return the participant home.

107. Also if a homemaker clocks out for 30 minutes due to physical therapy and waits off the clock for them to finish and then transports them back home do they get to add that 30 minutes back to complete designated hours for member correct?

Answer: The Personal Attendant will not clock out for 30 minutes in this case. The Personal Attendant will stay with the person and continue to assist the person as needed during the PT appointment. If the PA did clock out for 30 minutes, no, it could not be added back in to the designated hours for the participant.

108. On Forms & instructions 2nd bullet states worker must check the box if they provided service to 1 person during the service time (1 staff to 1 ADW participant at a time) but my question is that the actual form states initial? So do they want check marks or initials?

Answer: The instructions are being changed to say that the Personal Attendant will initial the box for providing services to 1 recipient at a time.

109. Pg 24 of manual states that there is 4 hours of training focusing on enhancing direct care service delivery knowledge & skills annually- Who is expected to provide this training ? can this be RN/Social Worker or approved internet trainer?

Answer: The training must come from the PA Agency RN. You can also use internet training programs that have either previously been approved by BoSS or you can request approval from BoSS to use new ones. We have a list of approved internet training providers on the BoSS website.

110. Pg 50 Documentation –all contacts except 6 month/annual with or on behalf of a person receiving ADW services must be documented using RN contact Log & maintained in the person’s record. The directions for **this log was may** utilize if needed. My question is this the required document to use for contact & not the RN progress note.

Answer: If you are doing a service for which you expect to get paid and can be paid, which are the listed services on the RN contact form (with the exception of the initial, the 6-month and the annual), then yes, you must use the RN contact form. If you have additional notation on something or something for which you don’t expect payment, feel free to use an RN progress note.

111. I saw the Extreme situation guide uploaded. Is this going to be a mandatory training?

Answer: No. It is a guide to be used in the situations prescribed in the guide.

112. One of the members asked if they drove themselves and claimed mileage themselves can the caregiver go along & get paid for their time?

Answer: If it is an appointment that the PA usually accompanies the participant on and it is necessary (the necessity for the PA’s assistance would have to be documented) for the PA to be there with the participant, then the Personal Attendant code can be billed for the time depending upon what the appointment is for. If it is for a doctor’s appointment or a medical test, then the Personal Attendant code can be billed for the time. If it is for something like dialysis or day surgery, it would be difficult to bill for any PA time because then the question becomes, what is the purpose of the Personal Attendant in this case?

113. In the past we were telling the members and caregivers if you’re out in Charleston that was considered community at that time; now it’s specifically saying reasonably close proximity to the person’s home so do I need to rephrase that so they are only to do doctor appointments separate and no other activity done that same day?

Answer: The problem becomes what transportation code is being billed? I am assuming that NEMT is being billed. If NEMT is being billed, going anywhere else in Charleston that is not on the direct route to or from the appointment will not be billable to NEMT. It could be possible to separate the mileage out to allow for an essential errand in Charleston, but you would have to document it clearly. Also, the BMS Program Manager will be checking Molina billing for NEMT against ADW non-medical transportation to assure no duplications.

114. MTM is giving so many different answers to the homemaker that it's making it unreasonable to talk to the same person in the same state regarding trips and what is allowed and not allowed. I can't get clarification for the difference between friend and family volunteer guidelines because we have had caregivers scheduled to transport and at last minute cancel work and since that trip number was given out for that worker we can't get a new trip number for MTM unless the original person cancels it out? Also they are asking the members when they call and schedule the SSN for the driver. That would be giving our members a lot of different personal information that I feel we shouldn't have to go thru to schedule an appointment, we have a lot of subs and a lot of switching caregivers for transports.

Answer: Since MTM is not a company we oversee, nor is the contract with BMS anything that we oversee, we are unable to assist with this issue. We have tried to route specific questions with participant information along to the program manager at BMS who oversees the MTM contract. If you want to provide us with the ADW participant's name and Medicaid number (by phone, not email unless you can send it to us encrypted), then we can send the information to Tammy Pritt-Jones.

115. Also there is a 20 mile limit for second leg of Dr visits? So if there is a PT appt in Gassaway and then a dr appt in Charleston seems not feasible for a limit on 2nd dr appt

Answer: Once again, this is something that would be addressed by Tammy Pritt-Jones at BMS regarding the contract with MTM. The requirement you cite is not in the ADW manual and therefore, nothing I can address or change.

116. If a member is going to the doctor using MTM can the caregiver get paid during that drive time and wait time? The caregiver's have been told by MTM that they could not?

Answer: The MTM customer service representatives cannot answer this question. This question relates specifically to the ADW manual for the state of WV. If the Personal Attendant is taking the participant to a doctor's appointment or medical test, then yes, the Personal Attendant code can be billed for the time in the car to and from the appointment and the time at the appointment or test. MTM only reimburses for NEMT which is mileage only.

117. Also I have a member that goes weekly to a psychiatric doctor and sometimes those visits last several hours. Is this considered a doctor appointment or outpatient clinic and can the additional time be added to her Plan of Care that she is missing out on? Or would this be considered same as therapy, dialysis?

Answer: The Personal Attendant code can be billed for the time to drive the participant to and from a psychiatric appointment. Once the person gets to the appointment, then I have questions. Does the PA usually go into the appointment with the participant and sit through the session? Does the PA help the person with things that are on the current Plan of Care or Personal Attendant Log while in the session? If the answer to both of those questions is yes, then yes, Personal Attendant time can be billed for the appointment. If the answers to either or both of those questions is no, then no, Personal

Attendant time cannot be billed during that appointment. And no, additional time cannot be added to her Plan of Care of Personal Attendant Log because that time was used up going to the appointment.

118. If they bill 0 mileage for any travel can they still get paid for any time?

Answer: Yes, the Personal Attendant code can be billed even if the Personal Attendant does not drive the person to the appointment (rides with the person on the MTM van) or chooses not to bill NEMT (for example, if the round trip is less than 1 miles and PA doesn't want to bother to bill NEMT).

119. Also it talks about the time frame allowed for the Case Manager to get information to Agency and the participant is 7 days? Is this business day's or calendar days?

Answer: If you look at the Glossary at the end of the policy, you will see that it states the following - days: calendar days unless otherwise specified.

120. I have a question regarding billing for personal assistant (PA) for wait time with a non-facility code verses a facility code. For example, if a participant has a scheduled outpatient procedure, does amount of wait time involved in procedure have bearing for billing or is it black and white that wait time is not paid at certain facilities. How are we to know the difference between what is a billable facility and what is not?

Answer: This is how to know – once the person gets back into the facility, is there someone there like a nurse or CNA who is paid to help people checked into that facility to the bathroom, or to get dressed or undressed if that is necessary, or with any other needs that you have written on the Plan of Care of Personal Attendant Log for that participant? Then the answer is that the Personal Attendant code cannot be billed while that person is in that facility (meaning the person is not in the waiting room for the facility). So that means that while someone is in dialysis, or in surgery, or in the ER, or in chemo or something like that, the Personal Attendant code cannot be billed.

121. To settle a difference in interpretation, please clarify what a six-month plan period is for the Service Plan. Example: If a six-month Service Plan is completed on 12/7/15:

- On Page 1 of Service Plan, would "Plan Begin Date" and "Plan End Date:" be: **December 2015 – June 2016?**

Answer: The "Plan Begin Date" would be December 2015 and the "Plan End Date" would be June 2016.

- On Page 3 of Service Plan, would "Plan Period:" also be: **December 2015 – June 2016?**

Answer: Yes. Plan period would be December 2015 to June 2016.

122. Does the Personal Attendant Agency still need to ask next doctor appointments for all doctors and add it to the PAL? Even if the PA is providing transportation through MTM or community MTM is used?

Answer: Yes. Yes.

123. Can someone fix the new forms and remove the gray shaded areas on the front? If you try to darken it when making a copy, the gray area turns into a black bar. If you do not darken it, the days of the month can barely be seen.

Answer: We will take a look at this.

124. Can someone fix the new assessment so the "Copy of the assessment was provided to the ADW participant and Personal Attendant agency: _____" is on the tail end of the CM Assessment and not in the heading of the RN Assessment? That may also fix the RN Assessment so the very last page "Copy of the assessment was provided to the ADW participant and Personal Attendant agency: _____" so it is not wasting an entire sheet of paper just for that. There is a huge space on the CM Assessment signature page (page 7) that it all could possibly be moved (back-spaced) into that gap.

Answer: We will take a look at this.

125. Is APS required to send a letter notification to participants once they schedule the PAS appointments? We are getting complaints of no letters, they are not in CC when you do a blank search under 'edit letters'.

Answer: APS sends appointment confirmation letters to people. If there is an instance when a letter was not received, simply call APS and the team leader will investigate and correct.

126. There are numerous problems with both formats on the new forms that were effective 12/1/15. When can we expect those to be corrected?

Answer: We are correcting what we can but eventually, the forms will just stay as they are even with formatting issues. If you can fix the formatting issues, you are welcome to work on the forms and send them back to us. Some of the providers have already done so. It is thanks to their hard work and to the hard work of the people in my office that we have been able to correct some of the issues. Please remember, there is nothing in policy that requires that the forms be completed electronically or typed. It is totally fine for them to be hand-written as long as they are legible.

127. Will all required caregiver training topics be on the Learning Management System soon? Abuse and Neglect was added recently and is very nice!

Answer: All of the training sessions are on the Learning Management System now. We are glad that you like the Abuse/neglect module. Thank you.

Questions/Comments from the call:

MM: If a participant transfers, what can an agency do if they cannot get a copy of the Service Plan from the previous agency?

Answer: First look to see if it is in CareConnection. If not, continue to contact the agency to request the documentation and if this doesn't work, contact the agency Director. You may also contact BoSS, and we can try to help you get it as well.

NN: Should a Case Manager go ahead and upload a Service Plan in CareConnection even if they don't have the PAL?

Answer: If the previous agency has not gotten the PAL to you in a timely manner, then yes, go ahead and upload your portion of the Service Plan while you continue to try to get a copy of the PAL.

OO: Who is responsible for uploading forms in CareConnection? Per the manual (page 45), it is the Case Manager.

Answer: Ultimately, it is the Case Manager's responsibility, however, we would hope that the Case Management agency and Personal Attendant agency will work together to be sure that all documents are uploaded into CareConnection. (Clarification issued by BMS the following day and sent out to providers via email on 1/26/16 - BMS answered that the Case Manager is responsible for uploading those documents in their entirety into CareConnection. The hope is that this system will make the "other providers" more accountable in getting the information out in a timely manner to the Case Manager. This also helps to ensure that someone (the CM) is watching to make sure all required documentation is getting into CareConnection. If you are in danger of missing a deadline because the other agency has not delivered the info, then you should go ahead and upload it. However, for example if the RN did not get pages 3 and 4 to the CM within the timeline and the CM had to go ahead and up load the Service Plan the CM should still follow up with the RN to obtain the documentation and then get it uploaded if it had not already been done and get those pages to the appropriate parties.)

PP: Please clarify who keeps the original Service Plan/PAL in their files. The Case Manager or the Personal Attendant agency RN?

Answer: The manual states that the Case Manager must have the original document in the person's file (page 41, 501.13). For several reasons, however, it may not be imperative for the Case Management agency to have the original PAL. BoSS will get clarification on this with BMS and will let everyone know the outcome. (Clarification issued by BMS the following day and sent out to providers via email on 1/26/16 - Teresa McDonough agrees that going forward, all agencies will keep their original work so RN's, it is fine for you to keep the original Personal Attendant Log (PAL) and fax it to the Case Manager to upload in CareConnection.)

QQ: We have a transfer and the Personal Attendant agency must go out to do an assessment now, but the Case Management agency doesn't go out for a couple weeks because the effective date of the Case

Management transfer isn't until the first of the next month. First, do we go ahead and do the assessment and second, do we wait to upload our new assessment?

Answer: First, you should go ahead and do your assessment and the Case Management agency will do theirs once the transfer is effective. Second, you should go ahead and upload your assessment into CareConnection so the most current information is on record.

RR: Is the Case Management agency still responsible for sending a person's documents to the new agency (for a transfer) or can the new agency get them off CareConnection?

Answer: If the documents have been uploaded into CareConnection, the new agency can get them there. However, uploading documents does not generate any sort of notification, so you should contact the new agency to let them know the documents are there.

SS: On Section IV of the Service Plan, how specific do you want us to be?

Answer: Section IV should be used for a general description of services. A much more detailed description should be given on the PAL.

TT: Back to the seven days to conduct an assessment, is that only for initial assessments?

Answer: For clarification, Section 501.12, Person-Centered Assessment (page 40), of the new manual states, "Once Enrollment has been complete with the OA, in the traditional model, the Case Manager and the RN will schedule a home visit within seven calendar days to complete the initial Person-Centered Assessment (T1001)."

Section 501.32 Transfer to Another Agency or to Personal Options - Receiving Agency Responsibilities – C. (page 59), states, "If it is a Case Management transfer, Section 1 of the Person-Centered Assessment must be conducted within seven business days of the of the transfer effective date."

UU: If the Personal Attendant is not turning in a claim for mileage, does it still need to be documented on page 4 of the Service Plan?

Answer: Yes, they still need to document mileage for Essential Errands and Community Activities as part of the PAL.

February 16, 2016

128. Do we still need to give a copy of the member user guide to those coming onto the program? It is outdated and mentions WVMI throughout.

Answer: BoSS has updated the document and it is located on the BoSS website under Document Center/Program-Specific Documents/ADW Quality Assurance Documents/ Version 3: ADW Recipient User Guide.

129. Does the provider need to be having the participants sign the same informed consent you use at the annual medical re-evals or can the provider just get their company informed consent signed?

Answer: Companies are at liberty to develop their own consent forms for their ADW participants. Companies can also use the form you reference in your question.

130. Should we continue to hand out the “Member User Guide” and ensure a signature receipt that is kept in the person’s chart?

Answer: Although it is best practice to hand out and document the receipt of the ADW Recipient User Guide, it is not required by policy. It is also very helpful if you later have to request closure due to persistent noncompliance or unsafe environment because it proves that the ADW recipient received the information.

131. One agency mailing original forms (PAL) to another agency does not make sense. It is customary for the company to keep their originals and send a copy to the other agency and the person. This practice is common with many entities such as MPOA – the person usually has the original, unless they’ve lost it, and distributes copies to agencies, MD, etc. The same with bank loans. The bank keeps all original documents. Could this be a mistake in the manual that needs corrected?

Answer: As per clarification issued on 1/26/16, each creating entity can keep their original documentation in their own records including the Service Plan.

132. Should the HMA keep a copy of the CMA initialed receipt verifying they received the PAL update? Also, can the updated PAL be used immediately or does the HMA need to use the initialed CM verification one for PA’s to complete?

Answer: The updated PAL can be used immediately and does not require the CM’s signature before it is enacted. The CM will sign it and upload the PAL update into CareConnection. Once it has been uploaded to CareConnection, the PA agency should print it out and use it as the PAL that the PA will complete. I know this means that for some period of time (hopefully short) the PA will be using the un-initialed PAL and then after the CM gets it uploaded, the PA will switch.

133. Since the med list is not part of the assessment, does this mean it does not need redone at each review (6 month and annual) and we should just keep it current as meds change? And do we need to give CMA a copy of the med list?

Answer: You would do it as part of the initial assessment with a new ADW recipient and then just keep it updated as medications change. Since it is an unofficial part of the Service Plan, you should give a copy to the CMA.

134. Is faxing transfer documents to the newly selected agency alright? The manual says to upload docs into CareConnection, but when we get the notification, the member has already transferred and we cannot access their chart to upload anything.

Answer: Yes, faxing transfer documents to the newly selected agency is acceptable.

135. How hard would it be to have a notification for potential closures (when APS unable to schedule PAS)?

Answer: At this time, changes are not planned for CareConnection but, according to APS Healthcare staff, one way to find members who are moved to Potential Closure is to Search_Member by eligibility status of "Member Potential Closure." A routine check of this will notify providers of those who are currently in that status.



136. Who uploads the PAL updates into CareConnection? Or does it need uploaded if there are changes?

Answer: Since the Case Manager in the traditional service delivery model is the last person to initial it and because the Case Manager is responsible to upload documents into CareConnection, the Case Manager will upload the PAL update into CareConnection.

137. The PAS does not have a client name on top and pages are not numbered. Easy to get mixed up. Can you add?

Answer: I am assuming you mean the PAS that you print out of CareConnection. In that case, APS Healthcare asserts that the pages are numbered. At this time, changes are not planned for CareConnection and so the client name will not be on the top of each page of the PAS.

138. On RN (person centered assessment, page 8), “Dental” is on Integumentary and should be on the GI/GU section. Can you change?

Answer: Yes. We are working on that now. Thanks for bringing it to my attention.

139. When a CM receives an updated PAL and they date it and initial it, does it need uploaded into CareConnection? Whose responsibility is it to upload (CM or Waiver RN)? And does RN need to keep that initialed copy from the CM in the HMA chart?

Answer: It is CM’s responsibility to upload the PAL update into CareConnection. Yes, RN should keep the initialed copy from the CM in the PA agency chart.

140. Can APS Healthcare accept a diagnosis from a family nurse practitioner on a Service Level Change Request?

Answer: Yes.

Questions/Comments from call

VV. When the PAL is updated and initialed by the Case Manager and uploaded into CareConnection, does the CM need to send it to the Personal Attendant agency?

Answer: The CM should notify the Personal Attendant agency that it has been updated and uploaded into CareConnection because there is no notification generated just by attaching documents.

WW. When we do PAL updates, do we have to sign on the space above the Wellness Scale (page 4)?

Answer: No. It is signed on the front where it asks if this is a change in hours, days or services.

XX. In the dark boxes above the Description of Services, can we write the day of the week above where they initial that services were completed?

Answer: Yes.

In reference to question # 90 and dual service coordination, does the ADW CM, ADW RN, and PC RN all have to attend all meetings with the participant?

Answer: Yes.

YY. And does the CM attend the Personal Care six-month and annual evaluations?

Answer: Yes.

ZZ. Regarding question # 96, where it states that for dual services, the Personal Care RN is to use the ADW assessment instead of doing their own, this makes me uncomfortable. Could that endanger the Personal Care RN’s licensure standards?

Answer: No. It would not endanger the PC RN's license to accept the assessment of another fully licensed professional (ADW RN). And yes, the PC RN will still use the ADW RN's assessment to complete the PC Plan of Care. If, for some reason, the PC RN felt that the ADW RN missed something on her/his assessment, then that should be discussed with the ADW RN and the ADW CM.

Questions for the Q & A monthly conference call may be emailed to Susan Silverman at susan.r.silverman@wv.gov.

The next Q & A call will be March 15, 2016 at 10:00 a.m.