CHAPTER 513 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES WAIVER (IDDW)

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CHAPTER 513 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES WAIVER (IDDW)

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BACKGROUND

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible, and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

This chapter sets forth the BMS requirements for payment of services provided to eligible West Virginia Medicaid members under the Waiver Program for persons with Intellectual and/or Developmental Disabilities (IDD). These members may or may not be eligible for other Medicaid services.

This waiver is administered by the West Virginia Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and *Chapter 9 of the West Virginia Code.* This program was previously referred to as the Mental Retardation and Developmental Disabilities (MR/DD) Waiver Program.

PROGRAM DESCRIPTION

The IDD Waiver (IDDW) Program is West Virginia's home and community-based services program for individuals with intellectual and/or developmental disabilities. It is administered by BMS pursuant to a Medicaid waiver option approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for the IDDW Program. The IDDW Program is a program that reimburses for services to instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible. The IDDW Program provides services based on a person's annual functional assessment and assigned

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individualized budget in natural settings, homes, and communities where the person resides, works, and shops.

All services, except Participant-Directed Goods and Services are available through the Traditional Service Option offered by IDDW providers state-wide. Each person must purchase Service Coordinator services through the Traditional Option. For more information refer to *Section 513.9.1 Traditional Services Option*.

Six services are available through the Participant-Directed Option to persons who are eligible and who choose to direct part or all of the 6 services available through this option. These 6 services (Person-Centered Supports (Family and Unlicensed Residential), Respite (In-Home and Out-of-Home), Transportation and Goods and Services are described more fully later in this chapter. For more information refer to *Section 513.9.2 Participant-Directed Services Option*. There is one Participant-Directed Financial Management Services available to assist persons with self-directing these services: *Personal Options* Model. Persons may choose all of their services through the Traditional Option or the person may choose to mix Traditional Option services and Participant-Directed Option Services. Persons who choose to mix services must first purchase those Traditional services that may not be participant-directed, including Service Coordination, before cashing out their remaining budget to purchase one or all of the 6 Participant-Directed services available. Some limitations apply to cashing out the remaining budget which is fully described in that section.

All required documentation forms are available on the Bureau for Medical Services website: http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/Pages/Policy-and-Forms.aspx

PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

513.1 BUREAU FOR MEDICAL SERVICES (BMS) CONTRACTUAL RELATIONSHIPS

The Bureau for Medical Services (BMS) contracts with a Utilization Management Contractor (UMC). The UMC acts as an agent of BMS and administers the operation of the IDDW Program. The UMC processes initial eligibility determination packets and conducts the annual functional assessment to establish re-determination of medical eligibility and to calculate individualized budgets. The UMC conducts education for IDDW providers, persons, advocacy groups, and DHHR. The UMC provides a framework and a process for the purchase of waiver services based on individualized budgets. At times, the UMC, in collaboration with BMS, will provide answers to policy questions which will serve as policy clarifications. These policy clarifications will be posted on the BMS IDDW website located at http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/IDDProviderinfo/Pages/default.aspx under Policy Clarifications.

The UMC provides authorization for services that are based on the person's assessed needs and provides authorization information to the claims payer. BMS contracts with IDDW providers for the provision of services for persons.

BMS contracts with a Medical Eligibility Contracted Agent (MECA) to determine initial and re-determination eligibility of prospective and active persons and to recruit and train licensed psychologists

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to participate in the Independent Psychologist Network. The UMC and the MECA work together to process initial applications and re-determination packets.

BMS contracts with a Fiscal/ Employer Agent (F/EA) to administer the *Personal Options* Financial Management Services (FMS) program. The F/EA acts as a subagent of BMS for the purpose of performing employer and payroll functions for persons wishing to self-direct some of their services through the *Personal Options* FMS.

BMS also contracts with licensed IDDW providers who wish to participate in the West Virginia Medicaid Program.

Please refer to the Intellectual/Developmental Disabilities Waiver Program website for UMC, MECA and *Personal Options* contact information.

513.2 PROVIDER ENROLLMENT AND RESPONSIBILITIES

In addition to provider enrollment requirements in *Chapter 300, Provider Participation Requirements*, IDDW Program providers must meet all the requirements listed below.

- Receive a Certificate of Need (CON) approval from the West Virginia Health Care Authority through the full length CON process or through the Summary Review process. Note that, in order to contract with extended professionals to provide Dietary Therapy, Occupational Therapy, Physical Therapy, and/or Speech Therapy services, the applicable service(s) must be included on the provider agency's CON.
- Obtain and maintain a behavioral health license through the DHHR Office of Health Facility Licensure and Certification (OHFLAC).
- Meet and maintain all BMS enrollment requirements including a valid provider agreement on file that is signed by the IDDW provider and BMS, as well as a valid Medicaid enrollment agreement.
- Ensure that a person or agency staff are not discharged, discriminated, or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process that involves the IDDW provider.
- Ensure that a person is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services the person needs to another provider(s) and is agreed upon by the person and/or their legal representative and the receiving provider(s).
- Meet and maintain the standards established by the Secretary of the U. S. Department of Health and Human Services (DHHS), and all applicable state and federal laws governing the provision of these services.
- Ensure that services are delivered and documentation meets regulatory and professional standards before the claim is submitted.
- Ensure that all required documentation is maintained at the agency on behalf of the State of West Virginia and accessible for state and federal audits.
- Begin the mandatory IDDW Program training for all agency staff on the first day of employment and document all mandatory training on the Certificate of Training Form (WV-BMS-IDD-06).
- Ensure that all agency staff providing direct care services are fully trained in the proper care of the person to whom they will be providing services prior to billing for services. Health and Safety training may be conducted by personnel deemed qualified by Interdisciplinary Team (IDT)

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members and documented on the IPP. Fully trained agency staff must be available until newly hired agency staff or Qualified Support Workers are fully trained.

- Ensure that specific goals based on assessments and designed to maintain the optional adaptive functioning of the individual, are implemented. Goals shall have related measurable objectives, have an expected achievement date, and, when appropriate, outcomes for discharge.
- Hire and retain a qualified workforce.
- Subcontract with licensed individual or group practices of the behavioral health profession as defined by the Office of Health Facility and Licensure, if contracting occurs.
- Maintain evidence of implementing a utilization review and quality improvement process which includes verification that services have been provided and the quality of those services meets the standards of the IDDW Program and all other applicable licensing and certification bodies.
- Provide an assigned agency IDDW Contact Person whose duties include:
    - Review of Home and Day Services visits to assure compliance with Waiver policy (Service Coordination provider agencies only);
    - Oversight of agency staff implementing the IPPs of all persons in the IDDW Program; and
    - Communicating with BMS and the UMC.
- Implement the IDDW Quality Improvement System as further defined under *Section 513.2.3 Quality Improvement System*.
- Provide each person with maximum choice of IDDW services within their individualized budgets available in each of the Service Delivery Models and a choice of Service Delivery Models.
- Employ or contract with extended professional agency staff who meet all the training and credentialing requirements listed under this section and its subparts, as well as the individual service definitions of this chapter.
- Maintain a record of the training verification or recertification on each agency staff.
- Participate in quarterly training sessions and routine conference calls provided by the UMC.
- Ensure that all residential sites (leased or rented by the IDDW provider) provide a safe environment for the persons and agency staff.
- Assist the person receiving services in securing safe housing.
- Provide appropriate auxiliary aids and services when necessary to ensure effective communication with persons and/or legal representatives when natural or other supports are not available. This includes the use of qualified sign language interpreters, documents in Braille or large print, audio recordings, etc.
- Comply with all American with Disabilities Act (ADA) requirements if applicable.
- Comply with all Social Security Administration (SSA) requirements for serving as a representative payee, if applicable, including maintaining documentation for a minimum of two years. For additional information, go to: http://www.socialsecurity.gov/kc/rp_fundsrecords.htm
- Maintain written policies and procedures to avoid conflict of interest (if agency is providing Service Coordination and other services) must include at a minimum:
    - Education of Service Coordinators on general Conflict of Interest/Professional Ethics with verification;
    - Annual signed Conflict of Interest Statements for all Service Coordinators and the agency director;
    - Process for investigating reports on conflict of interest complaints;
    - Process for reporting to BMS; and
    - Process for complaint to professional licensing boards for ethics violations.

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All agency staff, except contracted extended professional staff, having direct contact with persons who receive services must meet the qualifications listed below.

- Approved Criminal Background checks as defined in *Section 513.2.1* below.
- Are not listed on the list of excluded individuals maintained by the Office of the Inspector General as defined in *Section 513.2.1* below.
- Be over the age of 18.
- Have the ability to perform the tasks.
- Documentation of competency-based training initially and annually as mandated by OHFLAC and the IDDW manual. For all trainings but CPR/First Aid (which expire as indicated by the date on the card), annually is defined as within the month the training expires. These trainings include:
    - Training on treatment policies and procedures, including confidentiality training;
    - Training on rights of persons who receive services;
    - Training on Emergency Procedures, such as Crisis Intervention and restraints upon hire and thereafter only if deemed necessary by the IDT based on the assessed needs of the person who receives services;
    - Training on Emergency Care to include person-specific Crisis Plans and Emergency Disaster Plans;
    - Training on Infectious Disease Control;
    - Documented training on First Aid by a certified trainer from an approved agency listed on the BMS IDDW website (http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/IDDProviderinfo/Pages/Training.aspx) to include always having current First Aid certification upon hire and as indicated per expiration date on the card;
    - Documented training in Cardiopulmonary resuscitation (CPR) by an approved agency listed on the BMS IDDW website (http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/IDDProviderinfo/Pages/Training.aspx) to include always having current CPR certification upon hire and as indicated per expiration date on the card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the persons supported by the agency staff);
    - Training on Person-specific needs (including health, behavioral health other needs);
    - Training on Direct-Care Ethics for Direct Support Professionals (Day-Habilitation, Person-Centered Support, Respite, and Supported Employment staff) only;
    - Training on Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation, including injuries of unknown origin; and
    - Completion of the facilitated WV APBS Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview.
- Documentation must include training topic, date, the beginning time of the training, the ending time of the training, the location of the training, the signature of the instructor, and the signature of the trainee. Internet training must include the person's name, the name of the internet provider, and a certificate of completion or other documentation showing successful completion. All documented evidence of training for all staff persons who deliver IDDW services must be kept on file and available upon request.

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- Prior to using an internet provider for training purposes, the name, web address, and course names must be submitted to the UMC for review. The UMC will respond in writing whether the training meets training criteria.
- Qualifications must be verified initially as current and updated as required.
- Agency staff who function as Approved Medication Assistive Personnel (AMAP) must have high school diplomas or the equivalent and be certified AMAPs.
- Service Coordinators are also required to receive initial and annual training in Conflict Free Service Coordination.
- Any staff person who provides transportation services must have a valid driver's license, proof of current vehicle insurance and registration. In addition, any staff person who provides transportation services must abide by local, state, and federal laws regarding vehicle licensing, registration, and inspections upon hire and checked annually thereafter.
- Though not a requirement, ***BMS strongly urges providers to obtain an Approved Protective Services Record Check and consider the results.*** Please see the form at Bureau for Children and Families: http://www.wvdhhr.org/bcf/provider_resources/.

Conflicts of Interest

Conflicts of interest and self-referral are prohibited. Conflict of interest is when the Service Coordinator, who represents the person who receives services, has competing interests (the same provider agency), takes action on behalf of the person who receives services, or influences the Freedom of Choice of the person who receives services. This action is a benefit to the Service Coordinator and the provider agency; therefore, it is a conflict of interest. Failure to abide by this Conflict of Interest policy will result in the loss of provider certification for a period of one year and all current people being served will be transferred to other Service Coordination agencies. Any Service Coordinator working for a provider agency that has self-referred a person who receives services or has influenced the Freedom of Choice of a person who receives services (transfer) must not bill Service Coordination for the month this activity is conducted and will be referred to their professional licensing board for a violation of ethics.

513.2.1 Criminal Background Checks

513.2.1.1 Pre-Screening

All direct access personnel will be prescreened for negative findings by way of an internet search of registries and licensure databases through the Department's designated website, WV Clearance for Access: Registry & Employment Screening (WV CARES).

"Direct access personnel" is defined as an individual who has direct access by virtue of ownership, employment, engagement, or agreement with a covered provider or covered contractor. Direct access personnel does not include volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations or similar services for the covered provider.

If the applicant has a negative finding on any required registry or licensure database, the applicant will be notified, in writing, of such finding. Any applicant with a negative finding on any required registry or licensure database is not eligible to be employed.

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Negative findings that would disqualify an applicant in the WV CARES Rule:

1. State or federal health and social services program-related crimes;
2. Patient abuse or neglect;
3. Health care fraud;
4. Felony drug crimes;
5. Crimes against care-dependent or vulnerable individuals;
6. Felony crimes against the person; and
7. Felony crimes against property.

513.2.1.2 Fingerprinting

If the applicant does not have a negative finding in the prescreening process, and the entity or independent health contractor, if applicable, is considering the applicant for employment, the applicant must submit to fingerprinting for a state and federal criminal history record information check and may be employed as a provisional employee not to exceed 60 days subject to the provisions of this policy.

Applicants considered for hire must be notified by the hiring entity that their fingerprints will be retained by the State Police Criminal Identification Bureau and the Federal Bureau of Investigation to allow for updates of criminal history record information according to applicable standards, rules, regulations, or laws.

513.2.1.3 Employment Fitness Determination

After an applicant's fingerprints have been compared with the state and federal criminal history record information, the State Police shall notify WV CARES of the results for the purpose of making an employment fitness determination.

If the review of the criminal history record information reveals the applicant does not have a disqualifying offense, the applicant will receive a fitness determination of "eligible" and may be employed.

If the review of the criminal history record information reveals a conviction of a disqualifying offense, the applicant will receive a fitness determination of "not eligible" and may not be employed, unless a variance has been requested or granted.

The hiring entity will receive written notice of the employment fitness determination. Although fitness determination is provided, no criminal history record information will be disseminated to the applicant or hiring entity.

A copy of the applicant's fitness determination must be maintained in the applicant's personnel file.

513.2.1.4 Provisional Employees

Provisional basis employment for no more than 60 days may occur when:

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1. An applicant does not have a negative finding on a required registry or licensure database and the employment fitness determination is pending the criminal history record information; or
2. An applicant has requested a variance of the employment fitness determination and a decision is pending.

All provisional employees shall receive direct on-site supervision by the hiring entity until an eligible fitness determination is received.

The provisional employee, pending the employment fitness determination, must affirm, in a signed statement, that he or she has not committed a disqualifying offense, and acknowledge that a disqualifying offense shall constitute good cause for termination. Provisional employees who have requested a variance shall not be required to sign such a statement.

513.2.1.5 Variance

The applicant, or the hiring entity on the applicant's behalf, may file a written request for a variance of the fitness determination with WV CARES within 30 days of notification of an ineligible fitness determination.

A variance may be granted if mitigating circumstances surrounding the negative finding or disqualifying offense is provided, and it is determined that the individual will not pose a danger or threat to residents or their property.

Mitigating circumstances may include:

1. The passage of time;
2. Extenuating circumstances such as the applicant's age at the time of conviction, substance abuse, or mental health issues;
3. A demonstration of rehabilitation such as character references, employment history, education, and training; and
4. The relevancy of the particular disqualifying information with respect to the type of employment sought.

The applicant and the hiring entity will receive written notification of the variance decision within 60 days of receipt of the request.

513.2.1.6 Appeals

If the applicant believes that his or her criminal history record information within the State of West Virginia is incorrect or incomplete, he or she may challenge the accuracy of such information by writing to the State Police for a personal review.

If the applicant believes that his or her criminal history record information from outside the State of West Virginia is incorrect or incomplete, he or she may appeal the accuracy of such information by contacting the Federal Bureau of Investigation for instructions.

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If the purported discrepancies are at the charge or final disposition level, the applicant must address this with the court or arresting agency that submitted the record to the State Police.

The applicant shall not be employed during the appeal process.

513.2.1.7 Responsibility of the Hiring Entity

Monthly registry rechecks – The WV CARES system will provide monthly rechecks of all current employees against the required registries. The hiring entity will receive notification of any potential negative findings. The hiring entity is required to research each finding to determine whether or not the potential match is a negative finding for the employee. The hiring entity must maintain documentation establishing no negative findings for current employees. NOTE: This includes the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) check.

513.2.1.8 Record Retention

Documents related to the background checks for all direct access personnel must be maintained by the hiring entity for the duration of their employment. These documents include:

1. Documents establishing that an applicant has no negative findings on registries and licensure databases.
2. The employee's eligible employment fitness determination;
3. Any variance granted by the Secretary, if applicable; and
4. For provisional employees, the hiring entity shall maintain documentation that establishes that the individual meets the qualifications for provisional employment.

Failure of the hiring entity to maintain state and federal background check documentation that all direct access personnel are eligible to work, or employing an applicant or engaging an independent contractor who is ineligible to work may subject the hiring entity to civil money penalties.

513.2.1.9 Change in Employment

If an individual applies for employment at another long term care provider, the applicant is not required to submit to fingerprinting and a criminal background check if:

1. The individual previously submitted to fingerprinting and a full state and federal criminal background check as required by this policy;
2. The prior criminal background check confirmed that the individual did not have a disqualifying offense;
3. The individual received prior approval from the Secretary to work for or with the health care facility or independent health contractor, if applicable; and
4. No new criminal activity that constitutes a disqualifying offense has been reported.

The WV CARES system retains all fitness determinations made for individuals.

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513.2.2 Office Criteria

IDDW Service providers must designate and staff at least one physical office within West Virginia. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

A. An agency office site can serve no more than eight contiguous counties in WV as designated in the application. (IDDW providers wishing to make changes in the approved counties they serve **must** make the request in writing to the UMC). The UMC will make a determination on the request and inform the provider in writing. No changes in counties served can be made unless approved by the UMC. Changes can only be made annually unless it is a request for a provider to expand their service area by BMS.
B. Meet ADA requirements for physical accessibility. (Refer to 28 CFR 36, as amended) including but not limited to:
   - Maintains an unobstructed pedestrian passage in the hallways, offices, lobbies, bathrooms, entrance and exits
   - The entrance and exit has accessible handicapped curbs, sidewalks and/or ramps
   - The restrooms have call lights and grab bars for convenience
   - A telephone is accessible
   - Drinking fountains and/or water made available as needed
C. Be readily identifiable to the public.
D. Maintain a primary telephone number that is listed with the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone.)
E. Maintain an agency secure Health Insurance Portability and Accountability Act (HIPAA) compliant e-mail address for communication with BMS and the UMC for all staff.
F. Do not use personally identifiable information in the subject line of a secure email.
G. Personal electronic devices are prohibited when using personally identifiable information.
H. Referencing people receiving IDDW Services on social media is strictly prohibited.
I. At a minimum, must have access to a computer, fax, email address, scanner, and internet.
J. Utilize any database system, software, etc., compatible with/approved and/or mandated by BMS.
K. Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.
L. Contain space for securely maintaining program and personnel records. (Refer to *Chapter 100, General Administration and Information*, and *Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
M. Maintain a 24-hour contact method (Personal Attendant Agencies only).
N. Any authentication method for electronic and stamped signatures must meet the following basic requirements:
   - Unique to the person using it
   - Capable of verification
   - Under the sole control of the person using it, and
   - Linked to the data in such a manner that if the data is changed, the signature is invalidated.

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513.2.3 Quality Improvement System (QIS)

BMS is responsible for building and maintaining the IDDW's Quality Improvement System (QIS). The IDDW provider and the *Personal Options* vendor are responsible for participating in all activities related to the QIS. The IDDW's QIS is used by BMS and the UMC as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for persons receiving services, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies.

The Quality Improvement System (QIS) is designed to:

1. Collect the data necessary to provide evidence that the CMS Quality Assurances are being met; and,
2. Ensure the active involvement of interested parties in the quality improvement process.

513.2.3.1 Centers for Medicare and Medicaid Services (CMS) Quality Assurances

The CMS mandates the IDDW Program guarantee the following Quality Assurances:

1. **IDDW Administration and Oversight:** The State Medicaid agency is actively involved in the oversight of the IDDW, and is ultimately responsible for all facets of the IDDW Program;
2. **Level of Care:** Persons enrolled in the IDDW have needs consistent with an institutional level of care;
3. **Provider Qualifications:** IDDW providers are qualified to deliver services/supports;
4. **Service Plan:** A person has a service plan that is appropriate to their needs and preference and receive the services/supports specified in the service plan;
5. **Health and Welfare:** A person's health and welfare are safeguarded; and
6. **Financial Accountability:** Claims for IDDW services are paid according to state payment methodologies specified in the approved waiver.

Data is collected and analyzed for all the Quality Assurances and sub-assurances based on West Virginia's Quality Performance Indicators, as approved by CMS. The primary sources of discovery include IDDW provider reviews, Incident Management Reports, complaints and/or grievances of persons who receive services or their legal representatives, OHFLAC reviews, abuse and neglect reports, administrative reports, oversight of delegated administrative functions and interested party input.

513.2.3.2 Quality Improvement Advisory (QIA) Council

The QIA Council is the focal point of stakeholder input for the IDDW Program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The role of the QIA Council is to advise and assist BMS and the UMC staff in program planning, development and evaluation consistent with its stated purpose. In this role, the QIA Council uses the IDDW Performance Indicators as a guide to:

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- Recommend policy changes;
- Recommend Program priorities and quality initiatives;
- Monitor and evaluate policy changes;
- Monitor and evaluate the implementation of Waiver priorities and quality initiatives; and
- Serve as a liaison between the Waiver and interested parties; and
- Establish committees and work groups consistent with its purpose and guidelines.

The Council membership is comprised of: persons who formerly utilized IDDW services of the IDDW Program, persons who currently are utilizing IDDW services (or their legal representatives), service providers, advocates and other allies of people with intellectual and/or developmental disabilities.

513.2.3.3 IDDW Provider Reviews

The primary means of monitoring the quality of the IDDW services is through provider reviews conducted by OHFLAC and the UMC as determined by BMS by a defined cycle.

The UMC performs on-site and desk documentation provider reviews, staff interviews, telephone satisfaction surveys with persons who receive services/legal representatives, and day program visits to validate certification documentation and address CMS quality assurance standards. Targeted on-site IDDW provider reviews and/or desk reviews may by conducted by OHFLAC and/or the UMC in follow up to Incident Management Reports, complaint data, Plan of Correction, etc.

Upon completion of each provider review, the UMC conducts a face-to-face exit summation with staff as chosen by the provider to attend. Within two weeks of the exit summation, the UMC will make available to the provider a draft exit report and a Plan of Correction to be completed by the IDDW provider. If potential disallowances are identified, the IDDW provider will have 30 days from receipt of the draft exit report to send any necessary information/documentation, comments related to disallowances, and the completed Plan of Correction back to the UMC. If a Plan of Correction is not submitted within the 30-day comment period, BMS may place a hold on payments for services. After the 30 day comment period has ended, BMS will review the draft report and any comments submitted by the IDDW provider and issue a final report to the IDDW provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of IDDW services. A cover letter to the IDDW provider's Executive Director will outline the following options to effectuate repayment:

- Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or
- Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment; or
- A recovery schedule of up to a 12 month period, through monthly payments or the placement of a lien against future payments.

If the IDDW provider disagrees with the final report, the IDDW provider may request a document/desk review may be requested within 30 days of receipt of the final report pursuant to the procedures in *Chapter 100, General Administration and Information* of the West Virginia Medicaid Provider Manual. The IDDW provider must still complete the written repayment arrangement within 30 days of receipt of the

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final report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed, and set forth in detail the items in contention. **The letter must be addressed to:**

Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the UMC review, then the IDDW provider will receive a final letter and a final report from BMS.

Reviews of participant-directed services are included in *Section 513.9.2 for Personal Options*.

For information relating to additional audits that may be conducted for services contained in this chapter please see *Chapter 800, Program Integrity* of the BMS Provider Manual that identifies other State/Federal auditing bodies and related procedures.

513.2.3.4 Plan of Correction

In addition to the draft exit report sent to the IDDW providers, the UMC will also send a draft Plan of Correction (POC) electronically. IDDW providers are required to complete the POC and electronically submit a POC to the UMC for approval within 30 calendar days of receipt of the draft POC from the UMC. BMS may place a hold on claims if an approved POC is not received by the UMC within the specified time frame. The POC must include:

1. How the deficient practice for the persons cited in the deficiency will be corrected;
2. What system will be put into place to prevent recurrence of the deficient practice;
3. How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
4. The date the Plan of Correction will be completed; and
5. Any provider-specific training requests related to the deficiencies.

513.2.3.5 Training and Technical Assistance

The UMC develops and conducts training for IDDW providers and other interested parties as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

513.2.3.6 Self-Reviews

The UMC prepares and disseminates electronically an IDDW Self-Review Tool which primarily measures the CMS Quality Assurances. This self-review tool allows providers to incorporate into their Quality Assurance and Improvement processes a method to ensure quality services occur and CMS Quality Assurances are met. IDDW providers must use the approved format for submitting self-reviews so that

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data related to the CMS quality assurance standards can be tracked and analyzed. Failure to submit the self-reviews may jeopardize the future status of the IDDW provider as a West Virginia Medicaid provider.

IDDW providers are required to conduct self-reviews, complete an affidavit attesting to the accuracy of the self-review, and submit to the UMC via electronic format annually. The reporting periods will be based on the quarter during which the provider's on-site review takes place on alternate years and will be communicated to providers via email.

513.2.3.7 Utilization Guidelines for IDDW

Each agency must put into place a set of Utilization Guidelines (UG) to ensure that each person who receives IDDW services receives the appropriate services and supports at the right time, in the right amount, and for as long as the services are needed. UG is a person-centered process that starts with person-centered planning. The purpose of UG is to monitor claims submission and ensure that services provided are in compliance with the IDDW Manual and existing authorizations, and to ensure that the services requested and utilized for the person who receives services are within the person's annual individualized budget.

Agencies providing services must have UG in place that tracks units of services utilized/billed. It is the expectation that each agency be able to report units used and units still available at the IDT meetings (if not earlier). This is not only necessary for transfer/authorization purposes, but is also necessary for IDTs to make good decisions about purchasing services. Each agency is to have and adhere to a UG policy. With the exception of Crisis Services, agencies must receive prior-authorization for each service provided, as outlined under *Section 513.22, Prior Authorizations* and specified in each service definition under "Prior Authorization."

The internal policy of each agency must minimally address the following:

- Staff training;
- Provider education on how services will be delivered throughout the service year. This education should minimally include the following:
    - Tentative schedule of the person who receives services (daily, weekly, monthly)
    - Units of service authorized
    - Averages of usage (daily/monthly)
    - Individualized training (as needed)
    - Requirements and limitations of the particular service provided
- Empowering and educating persons and families so that they are able to make informed choices about their services and supports;
- Assessing needs of the person receiving services:
    - Service requests are based on identified need for the coming service year, therefore additional units may not be requested for contingency purposes;
- Choosing services based on the person's assessed needs and within the annual individualized budget;
- Monitoring service utilization throughout the service year;
- Monitoring the needs of the person receiving services and updating services as needed;
- Delivering services based on:

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- Assessed need and within the individualized budget;
- Agreement by the IDT;
- IDDW service caps and limitations;
- Documentation on the person's IPP; and
- The person's individualized Waiver budget

513.3 STAFF QUALIFICATIONS AND TRAINING REQUIREMENTS

All staff must be trained to provide IDDW services in a culturally and linguistically appropriate manner.

513.3.1 Behavior Support Professional (BSP) Agency Staff Qualifications

513.3.1.1 Behavior Support Professional I (BSP I) Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*, BSP I agency staff providing BSP services must meet the standard listed below.

- At a minimum have a Bachelor of Arts (BA) or Bachelor of Science (BS) degree in human services field or a Board of Regents degree, one year professional experience in the I/DD field, completion of the WV APBS facilitated three hour Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview, and completion of an approved WVAPBS curriculum.

Exception: Those meeting all of the above requirements except the one year experience will be considered qualified only if clinical supervision is provided by a Behavior Support Professional. Clinical supervision must involve review of clinical activities, review of case notes, and review of habilitation program for a minimum of six months. Monthly verification of supervisory activities is required.

Note: New hires of individual agencies that have not completed an approved WVAPBS curriculum must successfully do so within the first six months of employment and be under ongoing clinical supervision by a Behavior Support Professional.

513.3.1.2 Behavior Support Professional II (BSP II) Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*, BSP II agency staff providing BSP services must meet at least one of the standards listed below.

- Be a Board Certified Behavior Analyst (BCBA) - Master's degree or Board Certified Behavior Analyst Doctoral Level (BCBA-D) – Doctoral degree and completion of either the WVAPBS facilitated Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview, three years professional experience working with individuals with IDD; or
- Have a Master of Arts (MA) or Master of Science (MS) degree, completion of an approved WVAPBS curriculum, completion of either the WVAPBS facilitated Overview of Positive Behavior

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Support or the WVUCED Positive Behavior Direct Care Overview and three years professional experience working with individuals with IDD; or

- Have a Bachelor of Arts (BA), Bachelor of Science (BS) degree, Board of Regents degree or BCaBA credential and completion of the WVAPBS curriculum, completion of either the WVAPBS Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview, three years positive curriculum experience working with individuals with IDD and have a PBS Endorsement by a recognized APBS Network or a PBS Board of Review.

For IPP services the BSP I and II must also meet those requirements listed in *Section 513.8*.

In order to qualify to train others using an approved curriculum, an individual must meet one of the following three criteria:

- Be the developer of an approved training as indicated on the submitted application; or
- Be able to provide documentation that certifies completion of an approved training course (though not necessarily the course for which they are the trainer); or
- Be a Board Certified Behavior Analyst or Assistant and have documentation certifying completion of the facilitated Overview of Positive Behavior Support.

513.3.2 Crisis Services Agency Staff Qualifications

Must meet all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*.

513.3.3 Dietary Therapist Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*, agency staff providing dietary care services must be a licensed Dietitian in the State of WV.

If the Dietitian is not agency staff, but is contracted by the IDDW provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Dietitian only needs to be licensed to practice in the State of WV.

513.3.4 Facility-Based Day Habilitation Agency Staff Qualifications

Must meet all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*.

513.3.5 Job Development Agency Staff Qualifications

Must meet all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*.

513.3.6 Occupational Therapist Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*, agency staff providing occupational therapy services must be a Licensed Occupational Therapist in the State of WV.

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If the Occupational Therapist is not agency staff, but is contracted by the IDDW provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Occupational Therapist only needs to be licensed to practice in the State of WV.

513.3.7 Person-Centered Support Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*.

513.3.8 Physical Therapist Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*, agency staff providing physical therapy services must be a Licensed Physical Therapist in the State of WV.

If the Physical Therapist is not agency staff, but is contracted by the IDDW provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Physical Therapist only needs to be licensed to practice in the State of WV.

513.3.9 Pre-Vocational Agency Staff Qualifications

Must meet all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*.

513.3.10 Qualified Support Workers (QSW) Qualifications (*Personal Options* Only)

All Qualified Support Workers must meet the qualifications listed in this section and its subparts. For all training listed below but CPR/First Aid (which expire as indicated by the date on the card), annually is defined as within the month the training expires.

- Must be 18 years of age or over;
- Have the ability to perform the participant-specific required tasks;
- Have documentation of initial and renewal of training requirements:
  - Documented training on Emergency Procedures, such as Crisis Intervention and restraints upon hire and annually thereafter;
  - Documented training on Emergency Care such as a Crisis Plan, Emergency Worker Back-up Plan and Emergency Disaster Plan upon hire and on an as needed basis thereafter;
  - Documented training on Infectious Disease Control upon hire and annually thereafter;
  - Documented training on First Aid by a certified trainer from an approved agency listed on the BMS IDDW website (http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/IDDProviderinfo/Pages/Training.aspx) to include always having current First Aid Certification upon hire and as indicated per expiration date on the card;
  - Documented training in Cardiopulmonary resuscitation (CPR) by an approved agency listed on the BMS IDDW website (http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/IDDW/IDDProviderinfo/Pages/Training.aspx) to include always having current CPR certification upon hire and as

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indicated per expiration date on the card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the persons supported by the QSW);
  - Documented training on Person-specific needs (including special needs, health and behavioral health needs) upon hire and on an as needed basis thereafter; and
  - Documented training in Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation upon hire and annually thereafter.
- Qualifications must be verified initially upon hire as current and updated as necessary.
- The QSW may be responsible for the certain costs, i.e. CPR and First Aid certifications, criminal background checks through WV CARES.

Any Qualified Support Worker who provides transportation services must have a valid driver's license, proof of current vehicle insurance and registration in addition to abiding by local, state, and federal laws regarding vehicle licensing, registration and inspections upon hire and checked annually thereafter.

NOTE: All direct access personnel employed by the individual receiving services through the *Personal Options* program must adhere to all of the standards and requirements in *Section 513.2.1 Criminal Background Checks and its subparts*.

513.3.11 Respite Agency Staff Qualifications

Must meet all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*.

513.3.12 Service Coordination Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*, agency staff providing Service Coordination services must meet one of the following requirements listed below.

- Four year degree in a human service field and one or more years' experience in the IDD field.
- Four year degree in a human service field and less than one year of experience in the IDD field. (Restrictions - must be under the supervision of the Service Coordinator Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for 6 months. This must be verified by supervisory documentation once per month).
- Four year degree in a non-human service field and one year experience in the IDD field. (Restrictions - must be under the supervision of the Service Coordinator Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for 6 months. This must be verified by supervisory documentation once per month).
- No degree or 2 year degree and is a Licensed Social Worker grandfathered in by the West Virginia Board of Social Worker Examiners due to experience in the IDD field. (Restrictions - none)
- Registered Nurses with a two year RN degree employed prior to October 1, 2011.

513.3.13 Skilled Nursing Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*, agency staff providing skilled nursing services must be a Licensed Practical Nurse in the State of WV or a licensed Registered

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Nurse in the State of WV. The nursing license must include a CPR/First Aid component or the nurse must have a separate and current CPR/First Aid card.

For IPP services the RN must also meet those requirements listed in *Section 513.8*.

513.3.14 Speech Therapist Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in *Sections 513.2-513.2.1*, agency staff providing speech therapy must be a licensed Speech Therapist in the State of WV.

If the Speech Therapist is not agency staff, but contracted by the IDDW provider to provide services in their specialty and is also enrolled as a WV Medicaid provider, either individually or as part of a group, then the Speech Therapist only needs to be licensed to practice in the State of WV.

513.3.15 Stand-By Intervention Agency Staff Qualifications

Must meet all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*.

513.3.16 Supported Employment Agency Staff Qualifications

Must meet all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*.

513.3.17 Transportation Services Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*, agency staff providing transportation services must have a valid driver's license, proof of current vehicle insurance and registration.

Staff must also abide by local, state, and federal laws regarding vehicle licensing, registration, and inspections upon hire and checked annually thereafter.

513.4 REPORTING REQUIREMENTS

Anyone providing IDDW services who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 64 Series 11), West Virginia State Code§ 9-6-1, § 9-6-9, and § 49-6A-2 to report the incident to the local DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office or by calling 1-800-352-6513, 7 days a week, 24 hours day. A Child Protective Services (CPS) or an Adult Protective Services (APS) Worker may be assigned to investigate the suspected or alleged abuse.

The IDDW provider must also report suspected incidence of abuse and neglect to OHFLAC. OHFLAC may be contacted at telephone at (304) 558-0050 or reports may be faxed to (304) 558-2515. OHFLAC may assist with referring the report to the proper authorities.

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IDDW providers must utilize the West Virginia Incident Management System to track the types of incidents listed below.

- **Simple Incidents -** any unusual event occurring to a person that needs to be recorded and investigated for risk management or quality improvement purposes. Examples would be a minor assault by another person with injury resulting; seizures in an individual not prone to seizures; injuries of unknown origin; high rates of uncharacteristic self-injurious behavior with no significant negative outcome; suicidal threats or gestures without significant injury; medication error with minimal or no negative outcome; etc.
- **Critical Incidents -** those incidents with a high likelihood of producing real or potential harm to the health and well-being of the person or persons served but not involving abuse or neglect.
- **Abuse, Neglect and Exploitation Incidents -** those incidents which meet the following definitions of abuse, neglect, or exploitation:
    - Abuse means any physical motion or action (hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs. It includes use of corporal punishment as well as the use of any restrictive intrusive procedure to control inappropriate behavior for purposes of punishment.
    - Abuse also includes psychological abuse which means humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.
    - Abuse also includes verbal abuse which means use of oral, written, or gestured language by which abuse occurs. This includes demeaning and derogatory terms to describe persons with disabilities. Verbal abuse includes, but is not limited to yelling or using demeaning, derogatory, vulgar, profane or threatening language; threatening tones in speaking; teasing, pestering, molesting, deriding, harassing, mimicking or humiliating a person in any way; and making sexual innuendo.
    - Neglect means a negligent act or pattern of actions or events that caused or may have caused injury or death to person, or may have placed a person at risk of injury or death that was committed by an individual responsible for providing services. Neglect includes, but is not limited to a pattern of failure to establish or carry out a person's individualized program plan or treatment plan that placed or may have placed a person at risk of injury or death; a pattern of failure to provide adequate nutrition, clothing or health care; failure to provide a safe environment; and failure to maintain sufficient, appropriately trained staff.
    - Exploitation means the unlawful expenditure or willful dissipation of the funds or assets owned or paid to or for the benefit of an incapacitated individual.

The IDDW provider is responsible for tracking incidents and taking appropriate action on an individual and systemic basis in order to prevent harm to the health and safety of the individuals served. All incidents must be entered into the WV IMS within 48 hours of the occurrence of the incident or of when the IDDW provider becomes aware of the incident. The IDDW provider must also comply with any other reporting required for mandatory reporters or as part of their behavioral health license.

Incidents pertaining to persons who direct services through the *Personal Options* FMS Model are also required to be reported through the WV IMS and the appropriate Protective Services entity.

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The Service Coordination provider must submit a Mortality Notification (WV-BMS-IDD-11) to the UMC within seven days from the date of death and to OHFLAC within 24 hours of the death of the person or when the IDDW provider becomes aware of the person's death.

The Service Coordination provider must notify the UMC in writing, if they are forced to exceed the maximum case load cap due to staff vacancy. The Service Coordination provider must address the following in writing within 48 hours of exceeding their caseload cap:

- The number of persons per each Service Coordinator whose case load exceeds 30 persons (e.g. Service Coordinator Name, # of persons)
- The agency plan, including time lines for hiring and training new Service Coordinators
- The agency's back-up plan to cover emergencies that occur due to exceeding the maximum case load cap.

The Service Coordinator is responsible for submitting and maintaining accurate and current data in the UMC's web portal including name, address, telephone numbers, Service Coordination provider, legal representative name, and contact information, etc. of all individuals served.

The Service Coordinator is required to notify the UMC of a person's transfer to another Service Coordination provider or if the person chooses another service delivery system within 2 working days. The Service Coordinator must transfer the person in the UMC's web portal by the effective date of the transfer.

- The transferring agency is responsible for the notification by submitting the Person Transfer/Discharge Form (WV-BMS-IDD-10). This form must include the last date of service provided.
- Lack of notification of the transfer will affect the prior authorization for service or registration of services to the correct service provider(s) and subsequent payment of claims for services.

513.5 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

General Requirements

- IDDW Program provider agencies must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information*; and *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual. This can be found at the BMS Web Site (www.dhhr.wv.gov/bms).
- IDDW Program provider agencies must comply with all other documentation requirements of this chapter.
- All required documentation must be maintained by the IDDW provider for at least 5 years in the person's file subject to review by authorized BMS personnel or contracted agents. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or 5 years whichever is greater.
- All required documentation and records must be available upon request by BMS or federal monitors, or contracted agents for auditing and/or medical review purposes.

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- Failure to maintain all required documentation and in the manner required by BMS, may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.

Specific Requirements

IDDW Program provider agencies must maintain a specific record for all services received by the person served, including but not limited to:

- Each IDDW provider who provides Service Coordination services is required to maintain all required IDDW documentation on behalf of the State of West Virginia and for state and federal monitors.
- All IDDW Program forms as applicable to the policy requirement or service code requirement.
- Agencies that wish to computerize any of the forms may do so, however once the automated IPP becomes available through CareConnection® it must be utilized by all agencies. All basic components must be included and the name/number indicated on the form (refer to *Chapter 300, Provider Participation Requirements,* for a description of general requirements for Medicaid record retention and documentation). This can be found on the BMS website (www.dhhr.wv.gov/bms).
- All providers of Waiver services must maintain service progress notes, behavioral data collection, and/or attendance records to substantiate that services billed by the IDDW Program provider agency were provided on the dates listed and were for the actual amount of time and number of units claimed. Specific documentation requirements are detailed under *Section 513.9 Description of Service Options and its subparts as* well as each service definition in this Chapter.
- Day to day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for said service. Monitoring and review of services as related to the IPP or monthly summary (visit) are to be maintained in the Service Coordination provider record. In the course of monitoring of the IPP and services, the Service Coordinator may review or request specific day to day documentation. All documentation provided must meet the criteria for documentation as indicated in the policy manual such as date, actual time of service and number of units claimed.
- Required on-site documentation may be maintained in an electronic format as long as the documentation is accessible to individuals who may need to access it. In addition to all documentation required by other state agencies (OHFLAC), the IDDW provider must disseminate this information to the person who receives services when they reside in their natural family home. The IDDW provider must ensure that the following is maintained in the person's home when the person resides in an Unlicensed Residential or Licensed Group Home setting:
    - Personal demographic/emergency contact information. If community activities are planned, a copy will be taken in a sealed envelope for emergency use only.
    - Current complete IPP including current psychological, social, and physical evaluations (if applicable), current Behavior Support plan, activity schedule, Crisis Plan, IHP, and IEP. The IPP must be attached in the UMC's web portal prior to the UMC making decisions on requests for prior authorization for IDDW services.
    - Current doctor's orders for every medication administered at that site, even if the person self-administers.
    - Current daily direct support documentation, task analysis and/or staff notes.

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  - Current Medication Administration Records (MARs).
  - Copies of other pertinent medical or evaluative information relevant to treatment.
- Electronic health record and electronic signature requirements described in *Chapter 100, General Administration and Information* of the BMS Provider Manual.

ELIGIBILITY AND ENROLLMENT

513.6 APPLICANT ELIGIBILITY AND ENROLLMENT PROCESS

In order for an applicant to be found eligible for the IDDW Program, they must:

- Meet medical eligibility;
- Meet financial eligibility;
- Be at least three years of age;
- Be a resident of West Virginia, and be able to provide proof of residency upon application; and
- Have chosen Home and Community-Based Services over services in an institutional setting (Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Enrollment in the IDDW Program is dependent upon the availability of a funded IDDW slot.

The applicant must have a written determination that they meet medical eligibility criteria. Initial medical eligibility is determined by the Medical Eligibility Contracted Agent (MECA) through review of an Independent Psychological Evaluation (IPE) report completed by a member of the Independent Psychologist Network (IPN); which may include: background information, mental status examination, a measure of intelligence, adaptive behavior, achievement and any other documentation deemed appropriate.

If an IDDW slot is available, then the applicant must establish financial eligibility before being enrolled in the IDDW Program. If a slot is not available, the applicant is placed on a waitlist. When a slot becomes available, then the applicant is informed and must establish financial eligibility before being enrolled on the IDDW Program.

513.6.1 Application Process

Each new applicant must follow the eligibility process listed below for both medical eligibility and financial eligibility. An applicant first has medical eligibility determined and then has financial eligibility determined when a funded slot is available.

513.6.1.1 Initial Eligibility Determination Process

An applicant may obtain an application form (WV-BMS-IDD-1) from licensed Behavioral Health Centers, IDDW providers, local/county DHHR Offices, Aging and Disability Resource Centers (ADRC), the Department's Utilization Management Contractor (UMC)) and on the IDDW website. Completed applications must be submitted to the UMC (information is located on the application).

Upon receipt of the WV-BMS-IDD-1, the UMC time and date stamps the application.

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The UMC contacts the applicant within 3 business days upon receipt of the WV-BMS-IDD-1 and provides a list of Independent Psychologists (IP) in the Independent Psychologist Network (IPN) trained by the MECA who are available within the applicant's geographical area. The applicant chooses a psychologist in the IPN and contacts the IP to schedule the appointment within 14 days.

Psychologists in the IPN are identified and placed on a list following documented training by the MECA. The IP is responsible for completing an Independent Psychological Evaluation (IPE) and uploading it to the required internet site within 60 days of the receipt date of the IPN Response Form. The evaluation includes assessments which support the diagnostic considerations offered and relevant measures of adaptive behavior.

The IPE is utilized by the MECA to make a medical eligibility determination.

The MECA makes a final medical eligibility determination within 30 days of receipt of the completed IPE that utilizes the current MECS-approved diagnostic system. A written decision is mailed to the applicant and/or their legal representative by the UMC.

If an applicant is denied medical eligibility by the MECA, a funded IDDW slot is available, and financial eligibility is established, then the applicant is enrolled into the Waiver program. If a slot is not available, then the applicant will be placed on a waitlist until a funded slot allocation is available and financial eligibility is established.

If an applicant is determined not to be medically eligible by the MECA, a written Notice of Decision, a Request for Medicaid Fair Hearing form and a copy of the IPE is mailed by certified mail by the UMC to the applicant or their legal representative. This denial of medical eligibility may be appealed by the applicant or their legal representative through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 days of receipt of the Notice of Decision. The Notice of Decision letter also allows the applicant or their legal representative to request a second medical evaluation.

The second medical evaluation is completed within 60 days by a different member of the IPN at the expense of BMS. If an applicant is determined to be medically eligible, a slot is available, and financial eligibility is established, then the applicant is enrolled into the Waiver program. If a slot is not available, then the applicant will be placed on a waitlist until a funded slot is available and financial eligibility is established.

If the applicant is again determined not to be medically eligible based on the second medical evaluation, then the applicant or their legal guardian will receive a written Notice of Decision, a Request for Medicaid Fair Hearing form and a copy of the second IPE by certified mail by the UMC. This second denial of medical eligibility may be appealed through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 days of receipt of the Notice of Decision and a Medicaid Fair Hearing will be scheduled.

The applicant or legal representative may request a pre-hearing conference at any time prior to the Medicaid Fair Hearing. At the pre-hearing conference, the applicant and/or their legal representative and

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a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the denial.

The applicant shall have the right to access their IPE used by the MECA in making the eligibility decision and copies shall be provided free of charge by BMS.

If the denial of initial medical eligibility is reversed by the Hearing Officer, the applicant will be placed on the waitlist based on the date of the Hearing Officer's decision. When a slot is available, the applicant will be enrolled on the program once financial eligibility is established.

Any applicant denied medical eligibility may re-apply to the IDDW Program at any time.

The applicant's right to a medical eligibility determination within 90 days may be forfeited if the applicant fails to schedule and keep a timely appointment or does not submit follow up information needed to complete the IPE to the IP within a reasonable timeframe specified by the IP. Examples of follow up documentation requested by the IP may include, but may not be limited to:

- Individualized Education Program (IEP) plan for school aged children;
- Birth to Three assessments;
- Medical records to support the presence of a severe related condition; and
- Any other additional documentation deemed necessary by the IP to complete the IPE.

513.6.2 Initial Medical Eligibility

To be medically eligible, the applicant must require the level of care and services provided in an ICF/IID as evidenced by required evaluations and other information requested by the IP or the MECA and corroborated by narrative descriptions of functioning and reported history. An ICF/IID provides services in an institutional setting for persons with intellectual disability or a related condition. An ICF/IID provides monitoring, supervision, training, and supports.

Evaluations of the applicant must demonstrate:

- A need for intensive instruction, services, assistance, and supervision in order to learn new skills, maintain current level of skills, and/or increase independence in activities of daily living; and
- A need for the same level of care and services that is provided in an ICF/IID.

The MECA determines the qualification for an ICF/IID level of care (medical eligibility) based on the IPE that verifies that the applicant has intellectual disability with concurrent substantial deficits manifested prior to age 22 **or** a related condition which constitutes a severe and chronic disability with concurrent substantial deficits manifested prior to age 22. For the IDDW Program, individuals must meet criteria for medical eligibility not only by test scores, but also narrative descriptions contained in the documentation.

In order to be eligible to receive IDDW Program Services, an applicant must meet the medical eligibility criteria in each of the following categories:

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- Diagnosis;
- Functionality;
- Need for active treatment; and
- Requirement of ICF/IID Level of Care.

513.6.2.1 Diagnosis

The applicant must have a diagnosis of intellectual disability with concurrent substantial deficits manifested prior to age 22 **or** a related condition which constitutes a severe and chronic disability with concurrent substantial deficits manifested prior to age 22.

Examples of related conditions which may, if severe and chronic in nature, may make an individual eligible for the IDDW Program include but are not limited to, the following:

- Autism;
- Traumatic brain injury;
- Cerebral Palsy;
- Spina Bifida; and
- Any condition, other than mental illness, found to be closely related to intellectual disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires services similar to those required for persons with intellectual disabilities.

Additionally, the applicant who has a diagnosis of intellectual disability or a severe related condition with associated concurrent adaptive deficits must meet the following requirements:

- Likely to continue indefinitely; and,
- Must have the presence of at least 3 substantial deficits out of the 6 identified major life areas listed under *Section 513.6.2.2 Functionality*.

513.6.2.2 Functionality

The applicant must have substantial deficits in at least three of the six identified major life areas listed below:

- Self-care;
- Receptive or expressive language (communication);
- Learning (functional academics);
- Mobility;
- Self-direction; and,
- Capacity for independent living which includes the following six sub-domains: home living, social skills, employment, health and safety, community and leisure activities. At a minimum, three of these sub-domains must be substantially limited to meet the criteria in this major life area.

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Substantial deficits are defined as standardized scores of three standard deviations below the mean or less than one percentile when derived from a normative sample that represents the general population of the United States, or the average range or equal to or below the 75 percentile when derived from ID normative populations when intellectual disability has been diagnosed and the scores are derived from a standardized measure of adaptive behavior. The scores submitted must be obtained from using an appropriate standardized test for measuring adaptive behavior that is administered and scored by an individual properly trained and credentialed to administer the test. The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological report, the IEP, Occupational Therapy evaluation, etc. if requested by the IP for review.

513.6.2.3 Active Treatment

Documentation must support that the applicant would benefit from continuous active treatment. Active treatment includes aggressive consistent implementation of a program of specialized and generic training, treatment, health services, and related services. Active treatment does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program.

513.6.3 Initial Financial Eligibility

Upon notification that an IDDW slot is available, the applicant, or legal representative must make an application for financial eligibility at a local/county DHHR office. See the *Income Maintenance Manual* for further details.

An applicant for IDDW services who does not currently participate in a full-coverage Medicaid group and receives a Medicaid card completes the application form, DFA-1, with an Economic Services Worker (ESW) who processes the application, makes a financial eligibility decision, and notifies the applicant through written form (Economic Services Notification Letter – ESNL-A). **The Notice of Decision Letter for medical eligibility for the IDDW Program must be presented to the ESW before financial eligibility can be determined.**

An applicant for IDDW services, who participates in a full-coverage Medicaid group such as an SSI or Deemed SSI, completes an abbreviated application form, the DFA-LTC-5 which evaluates annuities, trusts, and/or potential transfers of resources in relation to financial eligibility for the additional IDDW services. The ESW also provides written verification (ESNL-A) of financial application to the person and/or their legal representative.

When approved financially by the ESW, the ESW will process the assistance group in the data system, Recipient Automated Payment and Information Data System (RAPIDS), which will facilitate triggers to BMS in order for payment for eligible medical services to occur to eligible Medicaid providers.

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513.6.3.1 Determination of Initial Financial Eligibility

The applicant must meet the following financial eligibility criteria:

INCOME

The applicant's monthly income may not exceed 300% of the current maximum monthly Supplemental Security Income (SSI) payment for a single individual. Applicants who are found to be financially eligible will receive a letter (ESNL-A) from DHHR. The maximum monthly SSI payment may be found by contacting the local county DHHR office or local Social Security Administration office.

- Only the applicant's personal income is considered for determination.
- The parent's or spouse's income is not considered for determining financial eligibility.
- An applicant does not have to be SSI eligible to become eligible for the IDDW Program.

ASSETS

- An individual's assets, excluding residence, furnishings, and personal vehicle (owned and registered in person's name) may not exceed $2,000.
- The parent's assets are not considered for determining financial eligibility.

513.6.4 Slot Allocation Referral and Selection Process

Provided a funded IDDW slot is available, the allocation process is based on:

- The chronological order by date of the UMC's receipt of the fully completed initial application (WV-BMS I/DD-1) which includes approval of eligibility from the MECA or
- The date of a fair hearing decision if medical eligibility is established as a result of a Medicaid Fair Hearing.

Once an IDDW slot is available, the enrollee will receive an informational packet up to 90 days prior to the slot being awarded. A Freedom of Choice form (WV-BMS-I/DD-2) on which the enrollee must indicate the wish to receive Home and Community Based services as opposed to services in an ICF/IID, his/her chosen Service Delivery Model (Traditional or Traditional and Participant-Directed) as well as the chosen Service Coordination provider will be included and must be returned to the UMC within 30 days of receipt of the informational packet.

The enrollee must access IDDW services within 180 days when the funded slot becomes available or the enrollee will be discharged from the program.

Upon receipt of the complete and signed Freedom of Choice form, the UMC will refer the person who receives services to his/her chosen Service Coordination (SC) provider and if indicated, Personal Options Financial Management Service (FMS). The SC provider may reject the referral only if:

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1. It appears to have been received in error;
2. The SC provider is at maximum service capacity and unable to accept referrals until additional Service Coordinators are hired; or
3. The SC provider is unable to meet the referred person's medical and/or behavioral needs.

Service Coordination providers that reject referrals due to service capacity or inability to meet medical or behavioral needs may not receive future referrals until the capacity/service issues are resolved.

Before an allocated slot can be accessed by the applicant and their chosen IDDW provider, proof of financial eligibility (ESNL-A) obtained from the WV DHHR during the financial eligibility determination must be presented to the IDDW provider.

513.6.5 Eligibility Effective Date

The initial effective date of a Medicaid Card for an applicant who has not previously acquired one is the **latest** of the following two dates (provided the person has a slot allocation):

- The date of initial medical eligibility which is established by the MECA **or**
- The date on which the applicant was approved for financial eligibility at a local/county DHHR office. The applicant will receive a letter from DHHR (ESNL-A) stating the date the applicant is financially eligible for the program.

513.7 ANNUAL RE-DETERMINATION OF ELIGIBILITY PROCESS

In order for a person to be re-determined eligible, the person must continue to meet all eligibility criteria (both medical and financial) and continue to have deficits in at least 3 of the 6 identified major life areas, as previously defined.

513.7.1 Annual Re-determination of Medical Eligibility

In accordance with federal law, re-determination of medical eligibility must be completed at least annually. The anchor date of the person's medical re-determination is the anniversary date of the first month after the initial medical eligibility was established by the MECA.

At a minimum, annual redetermination of eligibility will include one annual functional assessment which includes standardized measures of adaptive behavior in the six major life areas completed by the UMC and the results provided to the MECA. The MECA will determine medical eligibility annually based on this assessment of functioning as defined in *Section 513.6.2.2 Functionality*.

The UMC will conduct the functional assessment up to 90 days prior to each person's anchor date. At the time of the annual functional assessment by the UMC, each person or legal representative must complete the Freedom of Choice Form (WV-BMS-IDD-2) indicating their choice of level of care settings, Service Coordination agency and Service Delivery Models. If the person has a legal representative that did not attend the Annual Functional Assessment and complete the Freedom of Choice Form (WV-BMS-IDD-2), then it is the responsibility of the Service Coordinator to obtain the

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signature of the Legal Representative prior to or at the Annual IPP. If determined medically eligible, the person and Service Coordination provider will also receive the individual budget allocation that was calculated by the UMC based upon the person's assessed needs.

If a person is determined not to be medically eligible a written Notice of Decision, a Request for Hearing form and the results of the functional assessment are sent by certified mail by the UMC to the person or their legal representative. The person's Service Coordinator is also notified by the UMC. The denial of medical eligibility may be appealed through the Medicaid Fair Hearing process if the Request for Hearing form is submitted by the person or their legal representative to the Board of Review within 90 days of receipt of the Notice of Decision. The Notice of Decision letter also allows the person or their legal representative to request a second medical evaluation.

If the person chooses to have a second medical evaluation they must begin the process by selecting a member of the IPN within fifteen days of the Notice of Decision from the Bureau for Medical Services. Further, the person receiving services must have an evaluation completed within sixty days of selection of an IPN member.

If the person receiving services fails to meet the timeframes, the Bureau will proceed with scheduling a hearing on the Notice of Decision which prompted the request for a second medical evaluation.

If the person's medical eligibility is terminated and the person or legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted within 13 days of the person or their legal representative's receipt of the Notice of Decision.

If the person is determined to be medically eligible as a result of a Medicaid Fair Hearing, then services will continue if the person or their legal representative requested this within 13 days of the receipt of the Notice of Decision Letter. If services were terminated due to the person or their legal representative not requesting their continuance within 13 days of the receipt of the Notice of Decision letter, then services will begin again on the date of the Hearing Officer's decision of reversal.

At any time prior to the Medicaid Fair Hearing, the person, or legal representative may request a pre-hearing conference. At the pre-hearing conference, the person and/or their legal representative, the UMC and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination. For additional information on appealing medical eligibility refer to *Section 513.25.4 Appeals*.

513.7.2 Annual Re-determination of Financial Eligibility

All persons utilizing IDDW services persons, except for Supplemental Security Income (SSI) recipients, must have financial eligibility re-determined annually by their local or county DHHR. Persons who are found financially eligible will receive documentation from the DHHR (ESNL-A) which the person needs to present to their Service Coordination provider. The person must provide their Notice of Decision letter re-establishing their medical eligibility to the DHHR before financial eligibility can be established.

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A person's income and assets are evaluated using the same criteria used during the initial financial eligibility determination.

POLICY

513.8 INDIVIDUAL PROGRAM PLAN (IPP)

Central to the services that a person receives through the IDDW Program is the person's IPP. Developing the IPP is the process by which the person is assisted by the Interdisciplinary Team which consists of their legal representative (when applicable), their advocate (when applicable) other natural supports the person who is receiving services chooses to invite, as well as attendees required by the IDDW Program policy manual. This team meets to decide what needs to be done, by whom, when and how and to document the decisions made by this planning team. The content of the IPP must be guided by the person's needs, wishes, desires, and goals but based upon assessed needs and each person's individualized budget. If a person has had a documented change in need since the annual functional assessment was conducted, then a Critical Juncture should occur immediately to discuss the need for additional services. If no change in need has occurred, then only services that can be purchased within the budget will be authorized and all other service needs must be covered by natural or unpaid supports or from programs other than the IDDW. All IPP meetings should be scheduled at a time and location that takes into consideration the schedule and availability of the person receiving services and the other persons of the team.

The person who receives services must attend the IPP. If the person who receives services has a legal representative, the legal representative must attend the IPP in person or by teleconferencing in extenuating circumstances.

Individual Program Planning includes the Initial IPP which must be developed within 7 days of intake/admission to a new provider agency, the annual IPP, and subsequent reviews or revisions of the IPP, Critical Juncture, Transfer, and Discharge IPPs. Any activity that occurs prior to the meeting or after the meeting is **not** considered Individual Program Planning. Activities conducted before or after the meeting may meet the criteria for Service Coordination activities.

All IPPs must be uploaded into the UMC web portal and disseminated to all team members within 14 days and must minimally include:

- All components in the WV-BMS-IDD-05
  - Cover/Demographics
  - Meeting Minutes
  - Circle of Support/Goals and Dreams
  - Summary of Assessment and Evaluation Results
  - Medications
  - Individual Service Plan
    - IDDW Services
    - Non-IDDW Services and Natural Supports
  - Individual Habilitation Plan and Task Analysis if the person receives formal training

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- Tentative Weekly Schedule
- Signature Sheet (and rationale for disagreement if necessary)
- Behavior Support Plan or Protocol, if applicable, with signatures of developer and person/legal representative (must indicate consent by person/legal representative)
    - Dates that plan was approved and, initiated will be reviewed. If the plan includes restrictive measures, then approval by the IDDW Provider's Human Rights Committee must be attached. HRC must monitor plans with adverse procedures at least annually.
- Crisis Plan to include Emergency Disaster Plans
- Individual Spending Plan if person receiving services is self-directing any of the Participant-Directed Services available

A Crisis Plan must be completed for each person receiving services. This shall be considered an attachment and part of the person's IPP. A Crisis Plan must be personalized and address any foreseeable issues which might put the person's health, safety, or well-being in jeopardy. A Crisis Plan should incorporate the level of supports which would likely be required for unforeseen circumstances. A Crisis Plan should minimally cover the following events:

- No call/no show of support staff
- Primary caregiver becomes unavailable or unable to provide continued support
- Weather-related/environmental issues (transportation, inability to get to scheduled location, etc.)
- Disaster-related issues (flood, fire, etc.)
- Health/medical issues (medication administration, serious allergies, seizure protocol, if applicable, etc.)
- Termination from or reduction of IDDW services
- Bed bug infestations, including relocation plan and financially responsible party
- Any other person-specific issues

The IPP serves as documentation of the IDT team meeting. A team member's signature on the IPP constitutes participation in the team meeting; however a progress note is still required to document the team member's participation in the meeting. Team meeting minutes must be maintained with the IPP to expand discussion of the meeting, record critical issues from the meeting, and identify the active participation of each IDT member. The IPP must include the signature of all persons who attended and should indicate agreement/disagreement with the IPP, date of the meeting and the total time spent in the meeting for each team member. The person receiving services or their legal representative must agree with the plan for it to be considered a valid IPP. A copy of the IPP is maintained in all participating provider agency records and distributed to all team persons within 14 days of the date of the IDT team meeting by the Service Coordinator. The IPP must be uploaded into the UMC's web portal prior to any services being prior authorized.

In extenuating circumstances (i.e. legal representative living out of state or inclement weather), IDT members may participate by teleconferencing. Team members who attend by teleconference may not bill for the time spent in the IDT and the Service Coordinator must note on the signature sheet that they attended by phone. If the legal representative attends by telephone, the Service Coordinator must obtain their signature within 10 days. When a person who receives services has been admitted to a Crisis Site,

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then the Service Coordinator may attend and bill for their services while conducting the IPP over the telephone.

An IPP includes the completed IPP (WV-BMS-IDD-5) and the following attachments: Crisis Response Plan, Behavior Support Plan/Protocols (if applicable), tentative weekly schedule, budgeted cost of planned services, spending plans if the person self-directs eligible services, and meeting minutes.

The IPP must be developed on an annual basis. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, however the time between reviews shall not exceed 180 days. The IPP must be updated at Critical Juncture meetings to include IDT recommendations.

The IPP must reflect all services, programs and supports, both unpaid and paid. If the person also accesses Personal Care, Private Duty Nursing, Home Health or Hospice, for example, the IPP must reflect how and when these programs are used and attach a daily/weekly schedule to reflect all of these services. At no time can programs duplicate times or services.

All Medley Class Members must have IDT meetings every quarter, but the Medley Advocate may choose to only attend the six-month and the annual IDT.

MEDICAID CANNOT REIMBURSE FOR SERVICES RENDERED WHEN THE IPP HAS EXPIRED, HAS NOT BEEN REVIEWED WITHIN REQUIRED TIMELINES, AND/OR DOES NOT INCLUDE REQUIRED SIGNATURES OR SERVICES.

513.8.1 The Interdisciplinary Team (IDT)

The Interdisciplinary Team participates in the IDT meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support outline of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan within the person's individualized budget. Any services that cannot be purchased within budget must be supported from unpaid or natural supports or services from another program other than the IDDW. IDT meetings should be held in a location that is convenient to the person. All direct support services must be purchased first before professional services. This is to ensure the health and safety of the person receiving services. The direct care support services must be purchased in the following order of importance: all types of Person-Centered Supports, Facility-Based Day Habilitation, Pre-Vocational, Job Development, Supported Employment, Electronic Monitoring, LPN services and Respite services.

At a minimum, the IDT consists of:

- The person who receives services;
- Their legal representative as applicable;
- The person's Service Coordinator;
- Representatives of all IDDW providers that provide services to the individual; and
- A Medley Advocate if the person is a Medley Class Member.

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Other persons of the IDT may be included, as necessary, to develop a comprehensive IPP and assist the individual. Such persons may include:

- Natural supports the person chooses to invite;
- Professionals, such a Behavior Support Professional (BSP), Registered Nurse (RN) or Licensed Practical Nurse (LPN), Physical Therapist, Occupational Therapist, Speech Therapist, Registered Dietician, etc.;
- Direct service workers, such as Day Services providers, Person-Centered Support Workers and Respite workers;
- Service providers from other systems such as the local education agency/public schools, Division of Rehabilitation Services (DRS), or Birth to Three (provided that no duplication of service exists);
- Family Based Care Specialist (when person resides in a Specialized Family Care Home); and
- Advocate (when applicable).

All members of the IDT must sign the IPP signature sheet and indicate their participation in the meeting and should sign indicating agreement or disagreement with the IPP.

If the person or their legal representative is in disagreement with the IPP, then the IPP is not valid.

The Service Coordinator assumes the role of facilitator and coordinator for the meeting; however, the team is directed by the person or their legal representative utilizing a person-centered approach to planning.

513.8.1.1 Seven Day IDT Meeting

This meeting is mandatory when a person receives an IDDW slot. This is the initial meeting that occurs within the first seven calendar days of admission/intake by a new provider agency and must include IDDW services as well as other support services a person needs to live successfully in the community. This IPP document must reflect a full range of planned services: Medicaid, non-Medicaid, and natural supports. This meeting must be documented on the Initial IPP (WV-BMS-IDD-4) by the person's Service Coordinator. If services can be finalized at this meeting and a full range of planned services are documented, then the Thirty Day IDT meeting will not be necessary.

513.8.1.2 Thirty Day IDT Meeting

The Initial IPP must be finalized within 30 days. The resulting IPP (WV-BMS-IDD-5) completed by the Service Coordinator identifies the comprehensive array of services necessary to fully support the person who receives IDDW services. This document must be reviewed annually and at least every 180 days.

513.8.1.3 Transfer/Discharge IDT Meeting

This meeting is held when a person transfers from one IDDW provider to another, chooses a different service delivery model or when the person no longer meets medical or financial eligibility. The transfer-from agency is responsible for coordinating the meeting and documenting the transfer. The person or their legal representative, as well as the transfer-to agency, must agree to the transfer. The transfer-from agency must send the resulting IPP to the transfer-to agency within 14 calendar days. The transfer-from

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agency must also submit a transfer via the UMC's web portal and attach Transfer/Discharge Form (WV-BMS-IDD-10) to the UMC within seven calendar days. If the resulting IPP is found to be not valid because necessary team members did not attend or necessary services were not addressed during the transfer, then the authorizations may be rolled back to the transfer-from agency until a valid IPP is held.

When a person transfers from one residential provider to another or from one day setting to another, a seven day IDT meeting must occur to outline the services and supports the person needs to successfully access the new setting and services. A thirty day IDT must occur to finalize these services. The Service Coordinator must submit request for authorizations for the new residential or day services provider in the UMC's web portal by the effective date of the transfer.

A person may choose to direct the available Participant-Directed services at any time through *Personal Options* by completing a Freedom of Choice Form (WV-BMS-IDD-2). The Service Coordinator will enter the information into the UMC's web portal within two business days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be participant-directed will be referred to the *Personal Options vendor* and a participant-direct budget will be developed while all Traditional Services will remain with the IDDW provider(s).

A person may choose to stop directing the Participant-directed services at any time by completing a Freedom of Choice Form (WV-BMS-IDD-2). The Service Coordinator will enter the information into the UMC's web portal within two business days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were participant-directed will be referred to the chosen Traditional Service agency and a Traditional Service budget will be developed.

513.8.1.4 Critical Juncture IDT Meeting

This meeting is held as soon as possible when there is a significant change in the person's assessed needs and/or planned services. A Critical Juncture may be the result of a change in the person's medical/physical status, behavioral status, or availability of natural supports. The IPP must be updated to include IDT recommendations, minutes, and signatures of all IDT members indicating their attendance and agreement or disagreement.

A face-to-face meeting must be held under any of the following circumstances:

- All team members do not agree with services or service mix;
- A new goal will be implemented for the person;
- The team is discussing implementation of a Positive Behavior Support plan, where one was not previously required;
- The person changes residential setting (example: moves from Natural Family to a Licensed Group Home or an Unlicensed Residential Home);
- The person who lives in an Unlicensed Residential Home, Licensed Group Home or Specialized Family Care Home moves to a different location;
- The person goes into crisis placement;
- The person has a change in legal representative status;
- The primary caregiver changes or passes away;
- The person elects to change Service Delivery Model;

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- The person receives a new service not previously received.

513.8.1.5 Annual, Quarterly, and Six-Month IDT Meetings

The IDT must meet up to 30 days prior to the person's annual anchor date to develop the IPP. The effective date of the annual IPP will remain the annual anchor date even if the IPP was held 30 days earlier. The anchor date sets the clock for scheduling all subsequent IPPs. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, however the time between reviews shall not exceed 180 days. The IPP must be reviewed at Critical Juncture meetings. Medley Class Members are required to have IDT meetings every quarter, however, the Medley Advocate may choose to only attend the Annual and Six-Month IDT meetings.

513.9 DESCRIPTION OF SERVICE OPTIONS

Two service options are offered in the IDDW:

1. Traditional Service Option
2. Participant-Directed Service Option (as provided by the *Personal Options* Financial Management Service)

A person who receives services may choose either Service Option at any time by completing a Freedom of Choice Form (WV-BMS-IDD-2). The Service Coordinator will enter the information into the CareConnection® within two business days of receipt and schedule a Critical Juncture IDT meeting.

At this meeting, the IDT will discuss the transition from one Service Option to the other, including timelines and services. If the person who receives services is transitioning from the Traditional Service Option to the Participant-Directed Service Option, a participant-directed budget will be developed while all other services will remain with the IDDW provider(s). If the person who receives services is transitioning from the Participant-Directed Service Option to the Traditional Service Option, services that were participant-directed will be referred to the chosen Traditional service agency.

513.9.1 Traditional Service Option

The Traditional Service Option is available to every person who receives IDDW services.

If the person who receives services chooses this Service Option, all services accessed will be done so through an IDDW provider after being determined necessary, appropriate, and within the assessed budget. The IDDW provider has employer authority as well as fiscal responsibility for the services listed on the service plan of the person who receives services. These services are provided in natural settings where the person who receives services resides and participates in community activities.

Since not all services mentioned may be participant-directed, the full array of services is available to those who choose the Participant-Directed Service Option via the Traditional Service Option. It is required that Service Coordination be accessed through the Traditional Service Option by all persons who receive services.

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The following services are available via the Traditional Service Option:

- Behavior Support Professional
- Crisis Services
- Electronic Monitoring
- Environmental Accessibility Adaptations
- Extended Professional Services
    - Dietary Therapy
    - Occupational Therapy
    - Physical Therapy
    - Speech Therapy
- Facility Based Day Habilitation
- Job Development
- Person Centered Support
- Pre-vocational Services
- Respite
- Service Coordination
- Skilled Nursing
    - Registered Nursing Services
    - Licensed Practical Nursing Services
- Supported Employment
- Transportation

When a person who receives services accesses all services via the Traditional Service Option, the assessed budget is utilized to access services. Based on assessments, the IDT identifies needed services and addresses those on the IPP. Service limits based on the age and residential setting of the person who receives services may not be exceeded.

For example, the IDT of an adult who lives at home with his/her parents has determined that he/she needs 4 hours of Home-Based Person-Centered Support, 4,000 units of Traditional Transportation: Miles, and 365 units of Respite. The budget supports this amount of service.

Once the team determines the array of services within the individualized budget, the Service Coordinator documents on the IPP (WV-BMS-IDD-5) and requests the units agreed upon in the UMC web portal.

The hourly wage of agency staff employed by an IDDW provider is determined by the agency that employs the staff person, and must comply with all local, state, and federal employment requirements. All agency staff hired by an IDDW provider must meet the requirements listed in the applicable Agency Staff Qualifications in *Section 513.3*.

If receiving all services via the Traditional Services Option, the IDDW provider is the Common Law Employer, or employer of record, of the agency staff hired.

As the Common Law Employer, the IDDW provider is responsible to:

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- Recruit and hire agency staff;
- Provide required training to agency staff, including training on needs specific to the person who receives services;
- Determine agency staff work schedule and how and when agency staff should perform the required tasks;
- Determine agency staff daily activities;
- Evaluate agency staff performance;
- Maintain and process agency staff payroll;
- Maintain documentation in a secure location and ensure employee confidentiality; and
- Discharge agency staff, when necessary.

With regard to the provision of Traditional Options services, the UMC is responsible for:

- Conduct agency satisfaction surveys with a sample of persons who receives services and their representatives (when applicable), and receive and analyze the survey results and report them to BMS annually; and
- Conduct provider reviews on a defined cycle using an approved review protocol based on IDDW requirements.

513.9.2 Participant-Directed Service Option

The Participant-Directed Service Delivery Model is available to every person who receives IDDW services except for those living in OHFLAC licensed residential settings.

If the person who receives services chooses this Service Option, he/she has the opportunity to exercise choice and control over the participant-directed services they choose and the individuals and organizations who provide them (employer authority); and/or how the portion of their individualized budget associated with participant-directed services (i.e., their participant-directed budget) is spent (budget authority). The participant-directed services over which persons who receive services have the opportunity to exercise choice and control are Family/Home-Based Person-Centered Support, Unlicensed Residential Person-Centered Support, In-Home Respite, Out-of-Home Respite, Participant Directed Goods and Services, and Transportation. (Note that Participant-Directed Goods and Services and Transportation can only be participant-directed if at least one of either a Person-Centered Support and/or a Respite service is also participant-directed.)

Since only the six services mentioned above may be participant-directed, the full array of services is not available to those who choose the Participant-Directed Service Option via the Traditional Service Option. It is required that Service Coordination be accessed through the Traditional Service Option by all persons who receive services.

The maximum amount of a participant-directed budget is the equivalent monetary value of Person-Centered Support service units, Respite service units, Participant-Directed Goods and Services, and Transportation service units available, based on the age, residential setting, needs of the person who receives services, and units available. When a person who receives services is accessing Person-Centered Support, Respite, Participant-Directed Goods and Services, and/or Transportation services,

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whether via the Traditional or Participant-Directed Service Option, the total dollar amount of the services must be added together and may not exceed the service limits in both Service Options combined. All services purchased must be within the individualized budget.

For example, the IDT of an adult who lives at home with his/her parents has determined that he/she needs four hours of Home-Based Person-Centered Support. The budget supports this amount. This leaves the monetary equivalent of two hours of Family/Home-Based Person-Centered Support: *Personal Options* that is transferred into the participant-directed budget. This same adult's IDT also determines that he/she needs 4,000 units of Traditional Transportation: Miles and the budget supports this amount. This leaves the monetary equivalent of 2,000 miles of Transportation: *Personal Options* that is transferred into the participant-directed budget. The same adult's IDT also determines that he/she needs one hour of In-Home Respite and the budget supports this amount. The IDT determines that all Respite needs will be met via the Participant-Directed Service Delivery Model, therefore the monetary equivalent of one hour of Respite: *Personal Options* is transferred to the participant-directed budget.

Once all of the equivalent monies are transferred into the participant-directed budget, the person who receives services and/or their legal/non-legal representative, along with their *Personal Options* Resource Consultant, create a spending plan. At this time, the person who receives services and/or their legal/non-legal representative choose the types of services, the amount of services, and the wages of the member's employees within the parameters of the entire participant-directed budget.

The hourly wage of Qualified Support Workers employed by a person who receives IDDW services may not exceed the Medicaid rate minus all mandatory deductions. All Qualified Support Workers hired by the person who receives services must meet the requirements listed under *Section 513.3.10 Qualified Support Workers Staff Qualifications (Personal Options Only)*.

Persons who choose to participant-direct their IDDW services will do so with the support of a Financial Management Service (FMS) called *Personal Options.* If utilizing *Personal Options,* the person who receives services is the Common Law Employer, or employer of record, of the Qualified Support Workers hired.

To assist with functions related to being the Common Law Employer, the person who receives services may appoint a representative. A representative may not be a paid employee providing *Personal Options* IDDW services to the person who receives services.

As the Common Law Employer, the person who receives services is responsible to:

- Elect the participant-directed option;
- Work with their Resource Consultant (RC) to become oriented and enrolled in the Participant-Directed Service Delivery Model, enroll Qualified Support Worker(s), develop a spending plan for the participant-directed budget, and create an emergency Qualified Support Worker back-up plan to ensure staffing, as needed;
- Recruit and hire their Qualified Support Workers;
- Provide required training to Qualified Support Worker(s), including training on needs specific to the person who receives services;

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- Determine Qualified Support Worker(s)' work schedule and how and when the Qualified Support Workers should perform the required tasks;
- Determine Qualified Support Worker(s)' daily activities;
- Evaluate Qualified Support Worker(s)' performance;
- Review, sign, and submit Qualified Support Worker(s)' timesheets to the *Personal Options* FMS;
- Maintain documentation in a secure location and ensure employee confidentiality;
- Discharge Qualified Support Worker(s), when necessary; and
- Notify the SC of any changes in service need.

The *Personal Options* FMS acts as the fiscal/employer agent to the person who receives services, and is therefore responsible to:

1. Assist Common Law Employers exercising budget authority;
2. Act as a neutral bank, receiving and disbursing public funds, tracking and reporting on the budget funds (received, disbursed and any balances) of the person who receives services;
3. Monitor spending of budget funds in accordance with approved spending plans;
4. Submit claims to the state's claim processing agent on behalf of the person who receives services/employer;
5. Process and pay invoices for transportation in the member's approved participant-directed spending plan;
6. Assist persons who receive services in exercising employer authority;
7. Assist the person who receives services in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the USCIS Form I-9 for each support service worker the person who receives services employs);
8. Assist in submitting criminal background checks of prospective Qualified Support Worker(s);
9. Collect and process Qualified Support Worker(s) timesheets;
10. Operate a payroll service, (including withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums);
11. Distribute payroll checks on behalf of the person who receives services;
12. Execute simplified Medicaid provider agreements on behalf of the Medicaid agency;
13. Provide orientation/skills training to persons who receive services about their responsibilities when they function as the employer of record of their Qualified Support Worker(s);
14. Provide ongoing information and assistance to Common Law Employers; and
15. Monitor and report data pertaining to quality and utilization of the *Personal Options* FMS as required to BMS.

The *Personal Options* FMS is not the Common Law Employer of the Qualified Support Worker(s) of the persons who receive services. Rather, the *Personal Options* FMS assists the person who receives services/Common Law Employer in performing all that is required of an employer for wages paid on their behalf and all that is required of the payer for requirements of back-up withholding, as applicable. The *Personal Options* FMS operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and Medicaid program rules, as required.

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Personal Options makes available Information and Assistance (I&A) services to Common Law Employers to support their use of participant-directed services and to perform effectively as the Common Law Employer of their Qualified Support Workers. I&A provided by the *Personal Options* FMS include:

- Common Law Employer orientation sessions once the person who receives services chooses to use participant-directed services and enrolls with Personal Options;
- Skills training to assist Common Law Employers to effectively use participant-directed services and the FMS and perform the required tasks of an employer of record of Qualified Support Workers. Common Law Employer orientation provides information on:
    - The roles, responsibilities of, and potential liabilities for each of the interested parties related to the delivery and receipt of participant-directed services (i.e., Common Law Employer, *Personal Options*, UMC, SC, BMS),
    - How to use *Personal Options*,
    - How to effectively perform as a Common Law Employer of their Qualified Support Workers,
    - How to ensure that the Common Law Employer is meeting Medicaid and *Personal Options* requirements, and,
    - How a person who receives services would stop using participant-directed services and begin to receive traditional services, if they so desire.

The *Personal Options* FMS provides Information & Assistance (I&A) supports to persons who receive services and their representatives (when applicable) who wish to function as Common Law Employers. Educational materials are provided to interested parties on the roles and responsibilities of the *Personal Options* FMS, as well as the roles and responsibilities of others, such as persons who receive services, their representative, Qualified Support Worker(s), and BMS. The materials also address what is required of the person who receives services in order to be a Common Law Employer, and provide a venue through which a person who receives services may enroll in the Participant-Directed Service Delivery Model. The *Personal Options* FMS also makes available materials to persons who receive services and their representatives (when applicable), to implement and support their use of participant-directed services and performing as employer of record.

If the Participant-Directed Service Delivery Model is selected by the person who receives services, the, *Personal Options* FMS, rather than the Service Coordinator, provides I & A service that includes:

1. Providing or linking Common Law Employers with program materials in a format that they can use and understand;
2. Providing and assisting with the completion of enrollment packets for Common Law Employers;
3. Providing and assisting the Common Law Employer with employment packets;
4. Discussing and/or helping determine the participant-directed budget with the Common Law Employer;
5. Presenting the Common Law Employer with the *Personal Options* FMS' role in regards to payment for services;
6. Assisting Common Law Employers with determining participant-directed budget expenditures (hiring);
7. Assisting with the development of an individualized spending plan based upon the annual participant-directed budget;

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8. Making available to the person who receives services/representative a process for voicing complaints/grievances pertaining to the *Personal Options* FMS' performance;
9. Providing additional oversight to the Common Law Employer as requested or needed;
10. Monitoring and reporting information about the utilization of the participant- directed budget to the person who receives services, representative, SC, and BMS; and
11. Explaining all costs/fees associated with participant-directing to the person who receives services.

With regard to the provision of participant-directed services, the UMC is responsible for:

- Distribute the *Personal Options* FMS satisfaction survey, developed by BMS, to persons who participant-direct their services or their representatives (when applicable) and receive and analyze the survey results and report them to BMS annually; and
- Conduct *Personal Options* FMS performance reviews on a defined cycle using a review protocol based on the *Personal Options* FMS requirements.

513.10 BEHAVIOR SUPPORT PROFESSIONAL SERVICES

513.10.1 Behavior Support Professional I and II (Traditional Option)

Behavior Support Professional (BSP) services are provided to persons with assessed need, as identified on the annual functional assessment, for adaptive skills training. For persons who require adaptive skills training, the BSP performs the following activities:

- Develops training plans that include person-specific aspects and methods of intervention or instruction;
- Provides training to staff persons who will implement the training plans on aspects and methods of intervention (i.e., family, Person-Centered Support, Facility-Based Day Habilitation, Supported Employment, and Crisis Direct Support Professionals);
- Provides training for Direct Support Professionals who provide Respite services if applicable for respite-relevant training objectives or health/safety training objectives only;
- Evaluates/monitors the effectiveness of the training plans through analysis of programming results that occurs at least monthly;
- Follows-up once training plans have been implemented to observe progress/regression; and
- Revises training plans as needed.

In addition, this service may also be utilized to address assessed and identified maladaptive behaviors that require informal or formal intervention. For persons who require Positive Behavior Support in order to manage maladaptive behaviors, the BSP performs the following activities:

- Completes a Functional Assessment to identify targeted maladaptive behaviors;
- Creates Positive Behavior Support Plans to meet Association for Positive Behavior Support standards of practice;

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- Provides training to staff persons who will implement the Plan (i.e. family, Person-Centered Support, Facility-Based Day Habilitation, Supported Employment, Crisis, and Respite Direct Support Professionals);
- Evaluates/monitors the effectiveness of the Positive Behavior Support plan through analysis of programming results that occurs at least monthly;
- Follows-up once Plan has been implemented to observe progress/regression; and
- Revises the Plan as needed.

The BSP may also perform the following functions:

- Develop the task analysis portion of the IHP/ISP and person-specific strategy or methodology for development of habilitation plans; Develop Interactive Guidelines or Behavior Protocols for individuals who do not require a formal Positive Behavior Support Plan; Collaborate with BSP(s) from other agency(s) to ensure that Positive Behavior Support strategies are consistently applied across all environments;
- Facilitate person-centered planning as a component of the Positive Behavior Support plan;
- Present proposed restrictive measures to the IDDW provider's Human Rights Committee if no other professional is presenting the same information regarding the person;
- Attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by UMC if requested by the person who receives services or their legal representative;
- Evaluate environment(s) for implementation of the ISP which creates the optimal environment for habilitation plans, when clinically indicated and beneficial to the person who receives services;
- Assist persons who receive services in selecting the most suitable environment for their habilitation needs;
- Provide on-site training to the support staff in behavior/crisis situations;
- Consult via telephone during behavioral crisis situations only;
- Developing/update the behavioral crisis section of the crisis plan;
- Verify data compiled by Direct Support Professionals for accuracy; and
- Attend and contribute to Futures Planning sessions, including Planning Alternative Tomorrows with Hope (PATHs) and Making Action Plans (MAPs).

Procedure Code: T2021-HN Level I
T2025-HO Level II

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the person's individualized budget.

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Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home, a licensed group home, any Unlicensed Residential Home, a licensed day program facility, pre-vocational site, crisis sites, public community locations and a person's supported work site.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include all of the items listed below:

- Person's Name
- Service Code
- Date of service
- Start time
- Stop time
- Total time spent
- Analysis of the data collected or problem identified
- Clinical outcome of the service provided
- Plan of intervention as the result of the analysis
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The amount of service must be identified on the IPP.
- The maximum annual units of BSP services cannot exceed 768 units/192 hours per IPP year.
- Staff persons providing BSP services may not live in the home of the person receiving services.
- If the assigned BSP is unavailable due to an emergency or illness another BSP or TC, may provide services in their absence.
- BSP Level I services may only be provided by a staff person who meets the criteria in *Sections 513.2 - 513.2.1,* and *Section 513.3.1.1 Behavior Support Professional I (BSP I) Agency Staff Qualification Requirements*.
- BSP Level II services may only be provided by a staff person who meets the criteria in *Sections 513.2 - 513.2.1,* and *Section 513.3.1.2 Behavior Support Professional II (BSP II) Agency Staff Qualification Requirements*.
- Direct care services provided by the BSP must be billed utilizing the appropriate direct care service code.
- BSP services may not be billed for traveling to complete BSP activities.
- BSP services cannot be billed for completing administrative activities to include these listed below.
    - Human Resources activities such as staff supervision, monitoring, and scheduling.
    - Routine review of a person's file for quality assurance purposes.
    - Staff meetings for groups or individuals.
    - Monitoring of a licensed group home (fire drills, hot water heater temperature checks, etc.).

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- Filing, collating, writing notes to staff.
- Phone calls to staff.
- Observing staff while training individuals without a clinical reason.
- Administering assessments not warranted or requested by the person or their legal representative.
- Making plans for a parent for a weekend visit.
- Working in the home with providing direct care staff coverage.
- Sitting in the waiting room for a doctor or medical appointment.
- Conducting a home visit routinely and without justification—only Service Coordinators are required to make monthly home visits.

513.10.2 Behavior Support Professional I and II, Individual Program Planning (Traditional Option)

This is a service that allows the BSP to attend a person's IDT meeting to present assessments or evaluations completed for purpose of integrating recommendations, training goals and intervention strategies into the person's IPP.

Individual Program Planning is the process by which the person and their IDT develop a plan based on a person-centered philosophy. The BSP participates in the IDT meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan.

Procedure Code: T2024-HI Level I
T2025-HI Level II

Service Units: Unit = Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual function assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home, a licensed group home, any Unlicensed Residential Home, a licensed day program facility or pre-vocational center, crisis sites and public community locations. The meeting cannot begin at one location and then continue at another location.

Documentation: Documentation must include signature, date of service and the total time spent at the meeting on the person's IPP and a separate progress note must also be completed.

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.

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- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual combined units of BSP IPP Planning (both BSP I and BSP II) cannot exceed four Events per person's annual IPP year.
- BSP may attend all planning meetings, either face-to-face or by teleconference, but in order to bill the IPP code, the professional must be physically present for the duration of IPP meeting. IPP cannot be billed for preparation prior or follow-up performed after the IPP meeting.
- Staff providing BSP services may not be an individual who lives in residence of the person receiving services.

513.11 CRISIS SERVICES

513.11.1 Crisis Services (Traditional Option)

The goal of this service is to respond to a crisis immediately, assess and stabilize the situation as quickly as possible. Crisis services provided by awake and alert staff are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive Behavior Support planning, interventions, strategies and direct care. Except in emergent situations, this service requires prior authorization. This service has a 2:1 ratio (agency staff to person ratio). The additional agency staff person is available for assurance of health and safety in the respective setting. Crisis services include formal training, informal training and Positive Behavior Support.

Procedure Code: T2017 2:1 ratio

Service Units: Unit = I5 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on specific assessed needs as identified on the annual functional assessment, and services must be within the person's individualized budget.

Under emergent circumstances which place the person's or others' health and safety at risk, Crisis Services may be immediately implemented without prior authorization up to a maximum of 72 hours.

Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home, a licensed Group Home, an Unlicensed Residential Home and public community locations.

Documentation: A detailed progress note is required. If the Direct Support Service Log (WV-BMS-IDD-07) is used, the service log and progress note must both be completed by all agency staff providing this service. Documentation must include all the items listed below.

- Person's Name
- Service code
- Date
- Start time
- Stop time

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- Summary of the crisis service interventions
- Total time spent
- Signature of agency staff

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Crisis Services cannot exceed 1,344 units/336 hours per IPP year.
- This service may be billed concurrently with Service Coordination, BSP, and Transportation.
- This service may not be billed concurrently with Person-Centered Support, Facility-Based Day Habilitation, LPN, Respite, Pre-vocational, Job Development, and Supported Employment.
- The ratio of agency staff to person receiving services is 2:1 for this service.
- Direct Support Professionals providing Crisis Services may not live in in the home of the person who receives services.
- This service is not intended for use as emergency response for ongoing behavioral challenges.

513.12 EXTENDED PROFESSIONAL SERVICES

513.12.1 Dietary Therapy (Traditional Option)

Dietary Services are provided directly to the person by an agency staff that is a licensed, registered dietitian and may include:

- Nutritional assessment and therapy for diseases that have a nutrition component;
- Preventive health and diet assessment;
- Weight management therapy;
- Design of menus;
- Screening;
- Assessments;
- Planning and reporting;
- Direct therapeutic intervention;
- Consultation or demonstration of techniques with other service providers and family persons; and
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the person or legal representative.

Direct care services provided by the dietary therapist must be billed utilizing the appropriate direct care service code.

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Procedure Code: 97802-AE 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home, a licensed group home, an Unlicensed Residential Home, a licensed day program facility or pre-vocational center, crisis sites and public community locations.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include all the items listed below.

- Person's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Dietary Therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Physical Therapy and Occupational Therapy.
- The ratio of agency staff to person receiving services is 1:1 for this service.
- Agency staff providing Dietary Therapy services may not be an individual who lives in the person's home.

513.12.2 Occupational Therapy (Traditional Option)

Occupational Therapy is provided directly to the person by an agency staff that is a licensed/certified occupational therapist and may include:

- Evaluation and training services in the areas of gross and fine motor function;
- Self-care; sensory and perceptual motor function;

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- Screening; assessments;
- Planning and reporting;
- Direct therapeutic intervention;
- Design, fabrication, training and assistance with adaptive aids and devices;
- Consultation or demonstration of techniques with other service providers and family members; and
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the person or legal representative.

The scope and nature of these services differ from Occupational Therapy services furnished under the State Plan. Occupational Therapy services provided under the Waiver are for chronic conditions and maintenance while the Occupational Therapy services furnished under the State Plan are short-term and restorative in nature.

Direct care services provided by the occupational therapist must be billed utilizing the appropriate direct care service code.

Procedure Code: 97530-GO 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home, a licensed group home, any Unlicensed Residential Home, a licensed day program facility or pre-vocational center, crisis sites and public community locations.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include all of the following items.

- Person's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.

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- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Occupational Therapy may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Physical Therapy and Dietary Therapy.
- The ratio of agency staff to person receiving services is 1:1 for this service.
- Agency staff providing Occupational Therapy services may not be an individual who lives in the person's home.
- Agency staff providing Occupational Therapy services may not bill for administrative activities.

513.12.3 Physical Therapy (Traditional Option)

Physical Therapy is provided directly to the person by an agency staff that is a licensed physical therapist and may include:

- Screening and assessments;
- Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone;
- Activities of daily living;
- Planning and reporting;
- Direct therapeutic intervention;
- Training and assistance with adaptive aids and devices;
- Consultation or demonstration of techniques with other service providers and family persons; and
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the person or their legal representative.

The scope and nature of these services differ from Physical Therapy services furnished under the State Plan. Physical Therapy services provided under the IDDW are for chronic conditions and maintenance while the Physical Therapy services furnished under the State Plan are short-term and restorative in nature.

Direct care services provided by the physical therapist must be billed utilizing the appropriate direct care service code.

Procedure Code: 97530-GP 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home, a licensed Group Home, an Unlicensed Residential Home, a licensed day program facility or pre-vocational center, crisis sites and public community locations.

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Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include all of the following items.

- Person's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Physical Therapy may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: Occupational Therapy and Dietary Therapy.
- The ratio of agency staff to person receiving services is 1:1 for this service.
- Agency staff providing Physical Therapy services may not be an individual who lives in the person's home.
- Agency staff providing Physical Therapy services may not bill for administrative activities.

513.12.4 Speech Therapy (Traditional Option)

Speech Therapy is provided directly to the person by an agency staff that is a licensed speech pathologist and may include:

- Screening and assessments;
- Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids;
- Language stimulation and correction of defects in voice, articulation, rate and rhythm;
- Design, fabrication, training and assistance with adaptive aids and devices;
- Consultation or demonstration of techniques with other service providers and family persons; and
- Attending and participating in IDT meetings and the annual assessment of functioning eligibility conducted by the UMC if requested by the person or their legal representative.

The scope and nature of these services differ from Speech Therapy services furnished under the State Plan. Speech Therapy services provided under the Waiver are for chronic conditions and maintenance

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while the Speech Therapy services furnished under the State Plan are short- term and restorative in nature.

Direct care services provided by the speech therapist must be billed utilizing the appropriate direct care service code.

Procedure Code: 92507-GN 1:1 ratio

Service Units: Unit = 1 Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home, a licensed group home, an Unlicensed Residential Home, a licensed day program facility or pre-vocational site, crisis sites and public community locations.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include all of the following items.

- Person's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 96 units/96 events per person's annual IPP year for persons below age 24.
- 48 units/48 events per person's annual IPP year for persons age 24 and over.
- The ratio of agency staff to person receiving services is 1:1 for this service.
- Agency staff providing Speech Therapy services may not be an individual who lives in the person's home.
- Agency staff may not bill Speech Therapy services for completing administrative activities.

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513.13 ELECTRONIC MONITORING

513.13.1 Electronic Monitoring (Traditional Option)

Electronic Monitoring services include the provision of oversight and monitoring within the residential setting through off-site electronic surveillance. Also included is the provision of designated IDDW agency stand-by intervention staff prepared for prompt engagement with the person(s) and/or immediate deployment to the residential setting. The use of this service must be designed and implemented to ensure the need for independence and privacy of the person in their own home/apartment. All of the following requirements must be met.

- This service is only to be utilized when there is no paid staff in the person's home.
- This service may be installed in residential settings in which residing adult persons, their legal representatives (if applicable) and their IDT teams request such surveillance and monitoring in place of paid staff.
- All electronic monitoring systems or companies used or contracted by the IDDW provider meet the standards set by Bureau for Medical Services (BMS) and must be pre- approved by the BMS before providing any services and approved annual thereafter.
- The IDDW provider must have written policies and procedures approved by BMS that define emergency situations and details how remote and stand-by staff will respond to each (Ex. Fire, prolonged power outage, medical crisis, stranger in the home, violence between persons, any situation that appears to threaten the health and welfare of the person).
- The electronic monitoring system or company must receive notification of smoke/heat activation at each person's home.
- The electronic monitoring system or company must have 2-way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of the persons in each home, including emergency situations when the participant may not be able to use the telephone.
- The electronic monitoring system or company must allow the monitoring base staff to have visual (video) oversight of areas in the person's home deemed necessary by the IDT.
- At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of persons at the remote living site.
- The monitoring base staff will assess any urgent situation at a person's living site and call 911 emergency personal first if that is deemed necessary, then call the stand-by staff.
- The monitoring base staff will stay engaged with the participant(s) at the living site during an urgent situation until the stand-by staff or emergency personnel arrive.
- Any person wishing to access this service must first be assessed using the identified Risk Assessment and approved by the IDDW provider's Human Rights Committee (HRC) to ensure that the person's health and welfare would not be harmed by accessing this service. The approval of the HRC must be documented and attached to the person's IPP.
- After the approval of the HRC is obtained, the person and their legal representative (if applicable) and the IDT must give informed consent and document the approval of such support in place of on-site staff or natural supports on the person's IPP.
    - The person, their legal representative and all IDT persons are made aware of both the benefits and the risks of the operating parameters and limitations. Benefits may

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include increased independence and privacy and risks may include not having on-site staff in case of an emergency.

- The Service Coordinator conducts a home visit that includes a programmatic review of the system as well as a drill at seven days of implementation, again at 14 days and at least quarterly thereafter. The drill will consist of testing the equipment and response time.
- The Service Coordinator reviews the continued usage of this service at every home visit and during every IPP and makes the IDT aware of any problems or concerns encountered with the use of this system, all of which is documented on the IPP.
- The number of persons served by one stand-by intervention staff for on-site response is determined by the IDT and based upon the assessed needs of the persons being served in specifically identified locations.
- The IDDW provider has stand-by intervention staff who meet the following standards:
    - Responds by being at the person's residential living site within 20 minutes or less from the time an incident is identified by the remote staff and the stand-by staff acknowledges receipt of the notification by the remote staff. The IDT has the authority to set a shorter response time based on the individual person's need.
    - Assists the person in the home as needed to ensure the urgent need/issue that generated a response has been resolved.
    - Each time an emergency response is generated, an incident report must be submitted to the West Virginia Incident Management System by the IDDW provider.

Procedure Code: S5161-U1 1:1 ratio
S5161-U2 1:2 ratio
S5161-U3 1:3 ratio
S5161-U4 1:4 ratio

Service Units: Unit = 1 Hour

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in the adult person's family residence, a licensed Group Home and in an Unlicensed Residential Home.

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to people over the age of 18.
- The electronic monitoring/surveillance to person ratios for this service are 1:1, 1:2, 1:3 and 1:4 and authorizations will be based on the number of IDDW persons residing within the residence.

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- The maximum annual units of Electronic Monitoring for individuals who live in Licensed Group Homes or Unlicensed Residential Homes is 23,360 units per IPP year and this is in combination with all other types of direct care services (Person-Centered Support, Facility-Based Day Habilitation, Pre-Vocational, Supported Employment, Job Development, Crisis and LPN services).
- The maximum annual units of Electronic Monitoring for individuals who live in Natural Family homes is 11,680 units per IPP year and this is in combination with all other types of direct care services (Person-Centered Support, Facility-Based Day Habilitation, Pre-Vocational, Supported Employment, Job Development, Crisis and LPN services).
- Only electronic monitoring/surveillance systems approved by BMS will be used.
- The person will not be charged for installation costs related to video and/or audio equipment.
- The electronic monitoring/surveillance system may not be used in Specialized Family Care Homes.
- The electronic monitoring/surveillance system may not be used to monitor direct care staff.
- The electronic monitoring/surveillance system serves as a replacement for direct care staff, thus no other direct care service may not be billed at the same for the person receiving services or for any other people receiving IDDW services residing in the home.

513.14 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

513.14.1 Environmental Accessibility Adaptations Home (Traditional Option)

Environmental Accessibility Adaptations-Home (EAA-Home) are physical adaptations to the private residence of the person or the person's family home which maximize the person's physical accessibility to the home and within the home. EAA-Home must be documented in the person's IPP and must include the specific item requested. Additionally, these adaptations enable the person to function with greater independence in the home. This service is used only after all other funding sources have been exhausted.

All EAA requests must be submitted by the Service Coordination provider to the UMC for approval. If approved, the Service Coordination provider is responsible for ensuring the adaptation to the home is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation including dated and itemized receipts of the completed adaptation must be maintained by the Service Coordination provider.

Procedure Code: S5165

Service Units: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home or an Unlicensed Residential Home.

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Documentation: IDDW provider must maintain all of the following documentation in the person's file.

- The original Request for Environmental Accessibility Adaptations form (WV-BMS-IDD-08).
- Any assessments detailing the need for the EAA.
- The person's IPP which details the need for the EAA, and indicates the IDT approved the request.
- Proof of purchase including any receipts or invoices pertinent to the EAA.
- Verification by the IDDW provider that the approved EAA was completed as approved.

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- EAA-Home is not intended to replace the person's, person's family or landlord's responsibility for routine maintenance and upkeep of the home. These include but are not limited to cleaning, painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and heating, plumbing, electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service.
- Adaptations made to rental residences or to Specialized Family Care Homes must be portable.
- $1000 available per person's annual IPP year in combination with Environmental Accessibility Adaptations - Vehicle and/or Participant-Directed Goods and Services.
- The Service Coordination agency must not pay EAA funds to the person, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.14.2 Environmental Accessibility Adaptations Vehicle (Traditional Option)

Environmental Accessibility Adaptations-Vehicle (EAA-Vehicle) are physical adaptations to the vehicle including paying for accessibility adaptations to a vehicle that is the person's primary mode of transportation. EAA-Vehicle is documented on the person's IPP and must include the specific item requested. The purpose of this service is to maximize the person's accessibility to the vehicle only.

All EAA requests must be submitted by the Service Coordination provider to the UMC for approval. If approved, the Service Coordination provider is responsible for ensuring the adaptation to the vehicle is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation including dated and itemized receipts of the completed adaptation must be maintained by the Service Coordination provider.

Procedure Code: T2039

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Service Unit: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided to a vehicle owned or leased by the person or the person's family. The vehicle must be the person's primary means of transportation and the adaptations are to maximize the person's accessibility to the vehicle.

Documentation: IDDW provider must maintain all of the following documentation in the person's file.

- The original Request for Environmental Accessibility Adaptations form (WV-BMS-IDD-08).
- Any assessments detailing the need for the EAA.
- The person's IPP which details the need for the EAA, and indicates the IDT approved the request.
- Proof of purchase, including any receipts or invoices pertinent to the EAA.
- Verification by the IDDW provider that the approved EAA was completed as approved.

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- $1000 available per person's annual IPP year in combination with Environmentally Accessibility Adaptations - Home and/or Participant-Directed Goods and Services.
- This service may not be used for adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual.
- This service may not be used to purchase or lease a vehicle.
- This service may not be used to adapt a vehicle owned or leased by a paid provider of IDDW services.
- This service may not be used for regularly scheduled upkeep, maintenance and repairs of a vehicle except upkeep and maintenance of the modifications.
- The Service Coordination agency must not pay EAA funds to the person, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.15 DAY SERVICES

513.15.1 Facility-Based Day Habilitation (Traditional Option)

Facility-Based Day Habilitation is a structured program that use meaningful and productive activities designed to promote the acquisition of skills or maintenance of skills for the person outside the residential home. The services must be provided by awake and alert staff and based on assessment, be person-centered/goal oriented, and be meaningful/productive activities that are guided by the person's strengths,

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needs, wishes, desires, and goals. This service will only be available for three years following the implementation date of this manual. It is expected that after this service ends that transition to Pre-Vocational services, Job Development services, Supported Employment services, or Person-Centered Services will occur for persons receiving services.

Facility-Based Day Habilitation activities in the plan must be developed exclusively to address the habilitation and support needs of the person. Activities must consist of programs of instruction/training developed and evaluated by a Behavior Support Professional. Supervision, assistance, and specialist services are provided under the direct supervision of a Day Program supervisor.

Facility-Based Day Habilitation activities must be based at the licensed site, but the person may access community services and activities from the licensed site.

Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.

Facility-Based Day Habilitation Program services include, but are not limited to:

- Development of self-care skills;
- Use of community services and businesses;
- Emergency skills training;
- Mobility skills training;
- Nutritional skills training;
- Social skills training;
- Communication and speech instruction (prescribed by a Speech Language Pathologist ;)
- Therapy objectives (prescribed by Physical Therapist, Occupational Therapist, etc.)
- Interpersonal skills instruction;
- Functional academic training such as recognizing emergency and other public signs, independent money management skills, etc.
- Citizenship, rights and responsibilities, self-advocacy, voting training;
- Self-administration of medication training;
- Independent living skills training;
- Training the individual to follow directions and carry out assigned duties;

Facility-based Day Habilitation staff may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC and IDT meetings if requested by the person or their legal representative.

Procedure Code: T2021-U5 1:1-2 ratio
T2021-U6 1:3-4 ratio
T2021-U7 1:5-6 ratio

Service Unit: Unit = 15 minutes

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Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in a licensed IDD Facility-based Day Program facility.

Documentation: Documentation must be completed on a Direct Support Service Log (WV-BMS-IDD-7) to include the information listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the agency staff should complete the accompanying Direct Care Progress Note to detail the issue. As training is always provided in this setting, the agency staff must also complete the task analysis.

- Person's Name
- Service code including modifier to indicate staff to person ratio
- Date of service
- Start time
- Stop time
- Total time spent
- Task Analysis
- Transportation log (if applicable)
- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Facility-Based Day Habilitation cannot exceed 6.240 units/1560 hours (Average 6 hours/day) per person's IPP year. When the person accesses other direct care services, these units are counted toward the daily cap of all direct care services (all other types of Person-Centered Supported, other Day Services, LPN, Crisis Intervention and Electronic Monitoring).
- This service may not be billed concurrently with any other direct care services.
- Agency staff to person ratios for this service are 1:1-2, 1:3-4, and 1:5-6.
- Agency staff providing Facility-Based Day Habilitation services may not be an individual who lives in the person's home.
- Only persons 18 years of age and over may access this service.

513.15.2 Pre-Vocational (Traditional Option)

Pre-vocational services are designed to create a path to integrated community-based employment for which an individual is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. These services should enable each person who receives services to attain the highest level

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of work in a setting matched to the individual's strengths, interests, priorities, and abilities. Services are expected to occur over a two-year period, with integrated employment at a competitive wage being the specific outcome. It is expected that after two years, transition to Supported Employment will take place.

Pre-vocational activities in the plan must be developed exclusively to address the habilitation and support needs of the person. Activities must consist of programs of instruction/training developed and evaluated by a Behavior Support Professional. Supervision, assistance, and specialist services are provided under the direct supervision of a Day Program supervisor.

Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.

Pre-vocational Services include, but are not limited to, such concepts as:

- Attendance;
- Task completion;
- Problem solving;
- Interpersonal relations;
- Safety;
- Appropriate attitudes and work habits, such as socially appropriate behaviors on the worksite;
- Adjusting to production and performance standards of the workplace;
- Following directions;
- Compliance in workplace rules or procedures; and
- Appropriate use of work-related facilities, such as restrooms, cafeterias/lunchrooms, and break areas.

Persons receiving pre-vocational services must have employment-related goals on the IPP and general habilitation activities must be designed to support such employment goals.

Pre-vocational Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative.

Procedure Code: T2021-U1 1:1-2 ratio
T2021-U2 1:3-4 ratio
T2021-U3 1:5-6 ratio

Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services.

Site of Service: This service may be provided in a licensed IDD Facility-Based Day Program facility and community settings. Pre-vocational services are not delivered in an integrated work setting through Supported Employment.

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Documentation: Documentation must be completed on a Direct Support Service Log (WV-BMS-IDD-7) to include the information listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation, or other issues the staff person should complete the accompanying Direct Support Progress Note to detail the issue. As training is always provided in this setting, the staff person must also complete the task analysis.

- Name of the person who receives services
- Service code including modifier to indicate ratio of staff person to person who receives services
- Date of service
- Start time
- Stop time
- Total time spent
- Task Analysis
- Transportation log (if applicable)
- Signature of the staff person

Limitations/Caps:

- The amount of service is limited by the individualized budget of the person who receives services.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Pre-vocational services cannot exceed 6,240 units/1,560 hours (average 6 hours/weekday) per IPP year. This is in combination with all other direct care services (PCS, other Day Services, LPN, Crisis Intervention and Electronic Monitoring).
- After two years of access, a transition from this service to Job Development or Supported Employment must occur.
- This service may not be billed concurrently with any other direct support services.
- The ratios of staff persons to person who receives services are 1:1-2, 1:3-4, and 1:5-6 for this service.
- Direct Support Professionals providing Pre-vocational services may not live in the home of the person who receives services.
- The amount of Pre-vocational services must be identified on the IPP.
- Only persons 18 years of age and over may access this service.
- Only BSPs or Registered Nurses (RN) may bill for providing training to Pre-vocational staff.

513.15.3 Job Development (Traditional Option)

Job Development services are designed for analysis, situational assessments and supports in either acquiring or maintaining competitive employment. These services should enable each person who receives services to attain and maintain employment at the highest level of work in a setting matched to the individual's strengths, interests, priorities, and abilities. Services are expected to occur over a two-year period, with attaining and maintaining integrated employment at a competitive wage being the

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specific outcome. It is expected that on or before two years, transition to Supported Employment will take place or Job Development Services will cease.

Job Development Services must be supervised by a Supported Employment Services supervisor or a BSP. In addition to the standard training requirements, paraprofessionals providing job development must have documented training or experience in implementation of Supported Employment plans of instruction.

Meals provided as part of this service shall not constitute a full nutritional regimen of 3 meals per day.

Job Development Services include, but are not limited to, such concepts as:

- Planned visits and meetings with prospective employers to facilitate job acquisition;
- Negotiating job duties and employer expectations;
- Analyzing work duties expected by the employer;
- Creating, modifying, or customizing a community-based job so that it may be successfully performed by the person who receives services;
- Assessment in integrated employment settings to evaluate task management and job skill requirements;
- Assessment of personal interactions with co-workers and the public; and
- Supports to assist a person who receives services in developing a business plan and obtaining funding to start his/her own business.

Persons receiving job development services must have employment-related goals on the IPP and general habilitation activities must be designed to support such employment goals.

Job Development Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative.

Procedure Code: T1019-HB 1:1 ratio

Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services.

Site of Service: This service may be provided in a licensed IDD Facility-Based Day Program facility, community settings, and/or integrated employment setting.

Documentation: Documentation must be completed on a Direct Support Service Log (WV-BMS-IDD-7) to include the information listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation, or other issues the staff person should complete the accompanying Direct Support Progress Note to detail the issue. As training is always provided in this setting, the staff person must also complete the task analysis.

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- Name of the person who receives services
- Service code including modifier to indicate ratio of staff person to person who receives services
- Date of service
- Start time
- Stop time
- Total time spent
- Task Analysis
- Transportation log (if applicable)
- Signature of the staff person

Limitations/Caps:

- The amount of service is limited by the individualized budget of the person who receives services.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Job Development services cannot exceed 6,240 units/1,560 hours (average 6 hours/weekday) per IPP year. This is in combination with all other direct care services (PCS, other Day Services, LPN, Crisis Intervention and Electronic Monitoring).
- This service may not be billed concurrently with any other direct support services.
- The ratios of staff persons to person who receives services are 1:1
- Direct Support Professionals providing Job Development services may not live in the home of the person who receives services.
- The amount of Job Development services must be identified on the IPP.
- Only persons 18 years of age and over may access this service.
- Only BSPs or Registered Nurses (RN) may bill for providing training to Job Development staff.

513.15.4 Supported Employment (Traditional Option)

Supported Employment Services provided by awake and alert staff are services that enable individuals to engage in paid, competitive employment, in integrated community settings. The services are for individuals who have barriers to obtaining employment due to the nature and complexity of their disabilities. The services are designed to assist individuals for whom competitive employment at or above the minimum wage is unlikely without such support and services and need ongoing support based upon the person's level of need. Supported Employment services include, but are not limited to:

- Vocational counseling (Example: Discussion of the person's on-the-job work activities);
- On-the-job training in work and work-related skills;
- Accommodation of work performance task;
- Supervision and monitoring by a job coach;
- Intervention to replace inappropriate work behaviors with adaptive work skills and behaviors;
- Retraining as jobs change or job tasks change;

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- Training in skills essential to obtain and retain employment, such as the effective use of community resources;
- Transportation to and from job sites when other forms of transportation are unavailable or inaccessible.

Natural work setting supports are to be considered prior to the utilization of Supported Employment.

Supported Employment Services must be supervised by a Supported Employment Services supervisor or a BSP. In addition to the standard training requirements, paraprofessionals providing supported employment must have documented training or experience in implementation of Supported Employment plans of instruction.

Persons providing supported employment services may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by UMC if requested by the person or their legal representative.

Documentation is maintained in the file of each person receiving this service that a referral was made to a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) before this service was provided.

Procedure Code: T2019 1:1 ratio
T2019-HQ 1:2-4 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in an integrated community work setting.

Documentation: Documentation must include all of the following items.

- Person's Name
- Service code including modifier to indicate staff to person ratio
- Date of service
- Start time
- Stop time
- Total time spent
- Task Analysis
- Transportation log (if applicable)
- Signature of the agency staff

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Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- Agency staff providing Supported Employment services may not be an individual who lives in the person's home.
- The maximum annual units of supported employment cannot exceed 8,320 units/2080 hours per person's annual IPP year. This is in combination with all other direct care services (PCS, other Day Services, LPN, Crisis Intervention and Electronic Monitoring).
- This service may not be billed concurrently with any other direct care services.
- Group services for this service have an agency staff to person ratio of 1:2-4.
- Up to 48 units/12 hours of Supported Employment services every 3 months per person may be billed, if necessary, for the purpose of training in person-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only BSPs or RNs may bill for providing training to Supported Employment staff.

513.16 GOODS AND SERVICES

513.16.1 Goods and Services (Participant-Directed Option, *Personal Options* Model)

Participant-Directed Goods and Services (PDGS) are services, equipment or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that address an identified need in the IPP and meet the following requirements:

- An item or service that would decrease the need for other Medicaid services and/or promote full inclusion in the community and/or increase person's safety in the home environment.
- The person does not have the funds to purchase the item or service or the item or service is not available through another source.
- This service cannot be accessed as a means of reimbursement for items or services that have already been obtained and not been pre-approved by the *Personal Options* F/EA
- Participant-directed Goods and Services are purchased from the participant-directed budget.
- PDGS item(s) requested must be supported by an assessed need identified on the annual functional assessment and the item(s) requested must be specifically documented in the IPP.
- PDGS item(s) must be pre-approved by the UMC and purchase must be documented by receipts or other documentation of the goods or services from the established business or otherwise qualified entity or individual.
- The need must be documented on the Annual IPP unless it is a new need which must be documented on a Critical Juncture IPP.
    - NOTE: All services must be based on assessed need and within a person's individualized budget. If the need was documented on the Annual IPP, but not incorporated into the budget at that time and the person is over budget, then modifications of the services

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already purchased must occur before this authorization will be approved. If this is a new need, then it should be presented as a need to exceed the budget based on a new need.

Procedure Code: T2021-SC

Service Unit: Unit = $1.00

Prior Authorization: Prior authorizations are based on assessed need and services must be within the person's individualized participant-directed budget.

Site of Service: The goods or services are routinely provided at the person's residence or to the person as they participate in community activities.

Documentation:

- The specific item(s) must be documented in the IPP.
- Goods and Services must be purchased from an established business or otherwise qualified entity or individual and must be documented by a dated and itemized receipt or other documentation.

Limitations/Caps:

- The amount of service is limited by the person's individualized participant-directed budget and spending plan.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 1000 units ($1,000) per person's IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home.
- The *Personal Options* vendor must not pay PDGS funds to the person, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the PDGS service.
- To access Participant-directed Goods and Services the person must also access at least 1 other type of participant-directed service during the budget year—i.e. PCS or Respite.
- The following represents non-permissible Goods and Services:
    - Goods, services or supports covered by the State Plan, Medicare, other third- parties, including education, home-based schooling and vocational services;
    - Goods, services and supports available through another source;
    - Goods, services or supports provided to or benefiting persons other than the person receiving services;
    - Room and board;
    - Personal items and services not related to the qualifying disability;
    - Gifts forworkers/family/friends, payments to someone to serve as a representative,
    - Clothing, food and beverages;
    - Electronic entertainment equipment;
    - Utility payments;
    - Swimming pools, hot tubs and spas;

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- Costs associated with travel;
- Household furnishings such as comforters, linens, drapes and furniture
- Vehicle expenses including routine maintenance and repairs, insurance, running boards and gas money;
- Medications, vitamins and herbal supplements;
- Illegal drugs or alcohol;
- Experimental or investigational treatments
- Printers;
- Monthly internet service;
- Yard work;
- Household cleaning supplies;
- Home maintenance;
- Pet care;
- Respite services;
- Spa services;
- Education;
- Personal hygiene items;
- Fences;
- Car seats/strollers not specifically adaptive for the person;
- Day care; and
- Discretionary cash.

513.17 PERSON-CENTERED SUPPORT

There are five types of Person-Centered Support services available under the Traditional Option, each of which is described in detail in its specific section, below. The five types are:

- Family Person-Centered Support*
- Home-Based Person-Centered Support
- Licensed Group Home Person-Centered Support
- Unlicensed Residential Person-Centered Support*
- Crisis Site Person-Centered Support

* denotes that these services may be participant-directed through the *Personal Options* Model

513.17.1 Family Person-Centered Support

513.17.1.1 Family Person-Centered Support (Traditional Option)

Family Person-Centered Support (PCS) is provided **only by** family members or Specialized Family Care Providers living in the home with the person who receives services. Family Person-Centered Support (PCS) is provided by awake and alert Direct Support Professionals and consists of individually tailored training and/or support activities that enable the person who receives services to live and inclusively participate in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person who receives services to have greater independence and personal choice, and to allow for maximum inclusion into their community.

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Family PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living.

Family PCS services must be assessment based and outlined on the IPP. Activities must allow the person who receives services to reside and participate in the most integrated setting appropriate to their needs.

Family PCS services may include training specific to the person who receives services, attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC.

Direct Support Professionals providing Family PCS must be a family member living in the home of the person who receives services or a certified Specialized Family Care Provider providing this service in a certified Specialized Family Care Home. For the purposes of providing Family PCS services, family members include: biological/adoptive parents or step-parents, biological/adoptive adult siblings or step-siblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/-uncles only. Spouses of persons who receive services are excluded from providing services.

Procedure Code: S5125-U5 1:1 ratio
S5125-U6 1:2 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified in the annual functional assessment and services must be within the individualized budget of the person who receives services.

Site of Service: This service may be provided in the family residence of the person who receives services, a Specialized Family Care Home, and/or in the local public community.

Documentation: Documentation must be completed on the Direct Support Service Log (WV-BMS-IDD 07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Direct Support Progress Note to detail the issue. If training was provided, the staff person must also complete the task analysis. The Direct Support Service Log must include all of the following items.

- Name of the person who receives services
- Service Coordination provider name

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- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to person ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff person

Limitations/Caps:

- The amount of service is limited by the individualized budget of the person who receives services.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Family PCS services cannot exceed 7,320 units/1,830 hours (based upon average of 5 hours per day) per IPP year for natural family/Specialized Family Care Home settings for persons under age 18. This is in combination with the following direct support services: all other types of PCS and Crisis Intervention.
- The maximum annual units of Family PCS services cannot exceed 11,680 units/2,920 hours (based upon average of 8 hours per day) per IPP year for natural family/Specialized Family Care Home settings for persons aged 18 and older. This is in combination with the following direct support services: all other types of PCS, LPN, Crisis Intervention, and Electronic Monitoring.
- All direct support services cannot exceed an average of 12 hours per day on days when Facility-Based Day Habilitation, Job Development, Pre-vocational, and/or Supported Employment services are provided.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff persons to persons who receive services are 1:1 and 1:2 for this service.
- The amount of Family PCS provided must be identified on the IPP.
- Family PCS is not available while the person who receives services is hospitalized in a Medicaid certified hospital except for persons who live in a Specialized Family Care Home when behavioral needs of the person who receives services arise due to the temporary to change in environment.
- Family PCS is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.
- Family PCS cannot replace the routine care, and supervision which is expected to be provided by a parent or a Specialized Family Care Provider who provides care for a foster child or adult.
- Family PCS may not substitute for federally mandated educational services.
- Spouses are excluded from providing Family PCS services.

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513.17.1.2 Family Person-Centered Support (Personal Options Model*)*

Family/Home-Based Person-Centered Support (PCS): *Personal Options* is provided by awake and alert staff and consists of individually tailored training and/or support activities that enable the person who receives services to live and inclusively participate in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Family PCS: *Personal Options* services are available to persons living in the following types of residential settings: the family home of the person who receives services and Specialized Family Care Homes.

Family PCS: *Personal Options* may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction;
- Capacity for Independent Living.

Family PCS: *Personal Options* services must be assessment based and outlined on the person's spending plan. Activities must allow the person who receives services to reside and participate in the most integrated setting appropriate to their needs.

Family/Home-Based PCS: *Personal Options* services may include training specific to the person who receives services. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is permitted if requested by the person who receives services or their legal representative.

Procedure Code: S5125-UA 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the individualized budget of the person who receives services.

Site of Service: This service may be provided in the family residence of the person who receives services, a Specialized Family Care Home, and/or in the local public community. This service may not be provided in the staff person's home unless it is also the home of the person who receives services.

Documentation: The staff person must document the hours provided per day to the person. The documentation must be specific to the service and must include:

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- Name of the person who receives services
- Month of Service
- Year of Service
- Day of Service
- Total time spent
- Transportation Log including beginning location (from), end location (to) and total number of miles for the trip
- Signature of the staff person and the person who receives services and representative (when applicable)

If a Behavior Support Professional is involved in training plans carried out by the staff person, documentation is completed through those training plans per the IPP. This documentation must be maintained by the person who receives services/employer and provided to the BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the individualized participant-directed budget and spending plan.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Family PCS: *Personal Options* services are limited to the equivalent monetary value of 7,320 units/1,830 hours (based upon average of 5 hours per day) of Traditional Family PCS per IPP year for persons under age 18 when transferring funds from the annual budget allocation to the Participant-Directed budget. This is in combination with the following direct support services: all other types of PCS and Crisis Intervention.
- The maximum annual units of Family PCS: *Personal Options* services are limited to the equivalent monetary value of 11,680 units/2,920 hours (based upon average of 8 hours per day) of Traditional Family PCS per IPP year for persons aged 18 and older when transferring funds from the annual budget allocation to the Participant-Directed budget. This is in combination with the following direct support services: all other types of PCS, LPN, Crisis Intervention, and Electronic Monitoring.
- All direct support services cannot exceed the equivalent monetary value of an average of 12 hours per day on days when Facility-Based Day Habilitation, Job Development, Pre-vocational, and/or Supported Employment services are provided.
- The equivalent monetary value for Respite services cannot be used to access additional Family PCS: *Personal Options* services; however if additional Respite units are needed, the equivalent monetary value of Family PCS: *Personal Options* services may be used to access additional Respite services.
- This service may not be billed concurrently with any other direct support service.
- The ratio of staff person to person who receives services is 1:1 for this service.
- Family PCS: *Personal Options* is not available while the person who receives services is hospitalized in a Medicaid certified hospital except for persons who live in a Specialized Family

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Care Home when the behavioral needs of the person arise due to the temporary to change in environment.

- Family PCS: *Personal Options* is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.
- Family PCS: *Personal Options* cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor person or a Specialized Family Care Provider caring for a minor child. The IDT must make every effort to meet the assessed needs as identified on the annual functional assessment, of the person who receives services through natural supports.
- Family PCS: *Personal Options* may not substitute for federally mandated educational services.
- A person's representative may not be a paid employee providing *Personal Options* IDDW services to the person.
- Spouses are excluded from providing Family PCS: *Personal Options* services.

513.17.2 Home-Based Agency Person-Centered Support (Traditional Option)

Home-Based Agency Person-Centered Support (PCS) is provided in the home of the person who receives services, in a Specialized Family Care Home, and/or in the local public community by Agency Direct Support Professionals who **do not live in the home with the person.** Home-Based Agency PCS is provided by awake and alert Direct Support Professionals and consists of individually tailored training and/or support activities that enable the person who receives services to live and inclusively participate in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person who receives services to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Home-Based Agency PCS services may be used to assist with the acquisition, retention, and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living.

Staff persons administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

Home-Based Agency PCS services must be assessment based and outlined on the IPP. Activities must allow the person who receives services to reside and participate in the most integrated setting appropriate to their needs and within their individualized budget.

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Home-Based Agency PCS services may include training specific to the person who receives services.

Home-Based Agency PCS Direct Support Professionals may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the person who receives services are not compromised.

Home-Based Agency PCS Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative.

Procedure Code: S5125-U7 1:1 ratio
S5125-U8 1:2 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided.
Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services.

Site of Service: This service may be provided in the family residence of the person who receives services, a Specialized Family Care Home, and/or in the local public community. This service may not be provided in a Direct Support Professional's home.

Documentation: Documentation must be completed on the Direct Support Service Log (WV-BMS-IDD 07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Direct Support Progress Note to detail the issue. If training was provided, the staff person must also complete the task analysis.

The Direct Support Service Log must include all of the following items.

- Name of the person who receives services
- Service Coordination provider name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to person ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff person

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Limitations/Caps:

- The amount of service is limited by the individualized budget of the person who receives services.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Home-Based Agency PCS services cannot exceed 7,300 units/1,830 hours (based upon average of 5 hours per day) per IPP year for natural family/Specialized Family Care Home settings for persons under age 18. This is in combination with the following direct support services: all other types of PCS and Crisis Intervention.
- The maximum annual units of Home-Based Agency PCS services cannot exceed 11,680 units/2,920 hours (based upon average of 8 hours per day) per IPP year for natural family/Specialized Family Care Home settings for persons aged 18 and older. This is in combination with the following direct support services: all other types of PCS, LPN, Crisis Intervention, and Electronic Monitoring.
- All direct support services cannot exceed an average of 12 hours per day on days when Facility-Based Day Habilitation, Job Development, Pre-vocational, and/or Supported Employment services are provided.
- This service may not be billed concurrently with any other direct support service.
- The ratios of staff persons to person who receives services are 1:1 and 1:2 for this service.
- The amount of Home-Based Agency PCS provided must be identified on the IPP.
- Direct Support Professionals providing Home-Based Agency PCS services may not live in the home of the person who receives services.
- Home-Based Agency PCS is not available while the person who receives services is hospitalized in a Medicaid-certified hospital, except for persons who live in an Unlicensed Residential Home, Licensed Group Home or Specialized Family Care Home when behavioral needs of the person who receives services arise due to the temporary to change in environment.
- Home-Based Agency PCS is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.
- Home-Based Agency PCS services cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor child or Specialized Family Care Provider who provides care for a minor child. The IDT must make every effort to meet the assessed needs as identified on the annual functional assessment, of the person who receives services through natural supports.
- Home-Based Agency PCS may not substitute for federally mandated educational services.
- The following family members are excluded from providing services in an Unlicensed Residential Home: parents, step-parents, grandparents, step-grandparents, siblings, step-siblings, aunts/uncles, and cousins.
- Spouses are excluded from providing PCS: Agency services.

513.17.3 Licensed Group Home Person-Centered Support (Traditional Option)

Licensed Group Home Person-Centered Support (PCS) is provided to adults aged 18 and older who live in a site licensed by the Office of Health and Health Facility Licensure and Certification (OHFLAC) by

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awake and alert Direct Support Professionals and consists of individually tailored training and/or support activities that enable the person who receives services to live and inclusively participate in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person who receives services to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Licensed Group Home PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living.

Staff persons administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

Licensed Group Home PCS services must be assessment based and outlined on the IPP. Activities must allow the person who receives services to reside and participate in the most integrated setting appropriate to their needs.

Licensed Group Home PCS services may include training specific to the person who receives services. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is permitted if requested by the person who receives services or their legal representative.

Licensed Group Home PCS Direct Support Professionals may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the person who receives services are not compromised.

Licensed Group Home PCS Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative.

Procedure Code: S5125-U1 1:1 ratio
S5125-U2 1:2 ratio
S5125-U3 1:3 ratio
S5125-U4 1:4 ratio

Service Units: Unit = 15 minutes

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Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services.

Site of Service: This service may be provided in a group home licensed by OHFLAC and/or in the local public community.

Documentation: Documentation must be completed on the Direct Support Service Log (WV-BMS-IDD 07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Direct Support Progress Note to detail the issue. If training was provided, the staff person must also complete the task analysis. The Direct Support Service Log must include all of the following items.

- Name of the person who receives services
- Service Coordination provider name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to person ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff person

Limitations/Caps:

- The amount of service is limited by the individualized budget of the person who receives services.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to adults aged 18 and older.
- The maximum annual units of Licensed Group Home PCS services cannot exceed 35,040 units/8,760 hours (based upon average of 24 hours per day) per IPP year. This is in combination with the following direct support services: all other types of PCS, LPN, Crisis Intervention, Facility-Based Day Habilitation, Pre-vocational, Job Development, Supported Employment, and Electronic Monitoring.
- All requests for more than an average of 12 hours per day of 1:1 services require BMS approval. Approval of this level of service will be based on demonstration of assessed need not a particular residential placement.
- This service may not be billed concurrently with any other direct care service.

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- The ratios of staff persons to persons who receive services are 1:1, 1:2, 1:3, and 1:4 for this service.
- The amount of Licensed Group Home PCS provided must be identified on the IPP.
- Licensed Group Home PCS is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.

513.17.4 Unlicensed Residential Person-Centered Support

513.17.4.1 Unlicensed Residential Person-Centered Support (Traditional Option)

Unlicensed Residential Person-Centered Support (PCS) is provided to adults aged 18 and older in an Unlicensed Residential Home (formerly known as Intensively Supported Setting or ISS) and/or in the local public community. Unlicensed Residential PCS is provided by awake and alert Direct Support Professionals who **do not live in the home with the person** and consists of individually tailored training and/or support activities that enable the person who receives services to live and inclusively participate in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person who receives services to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Unlicensed Residential PCS may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living.

Staff persons administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED).

Unlicensed Residential PCS services must be assessment based and outlined on the IPP. Activities must allow the person who receives services to reside and participate in the most integrated setting appropriate to their needs and within their individualized budget.

Unlicensed Residential PCS services may include training specific to the person who receives services. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is permitted if requested by the person who receives services or their legal representative.

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Unlicensed Residential PCS Direct Support Professionals may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the person who receives services are not compromised.

Unlicensed Residential PCS Direct Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative.

Direct Support Professionals providing Unlicensed Residential PCS cannot be a family member of the person who receives services. For the purposes of providing Unlicensed Residential PCS services, family members include: biological/adoptive parents or step-parents, biological/adoptive adult siblings or step-siblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/-uncles only. Spouses of persons who receive services are excluded from providing services.

Procedure Code: S5125-HI 1:1 ratio
S5125-UN 1:2 ratio
S5125-UP 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services.

Site of Service: This service may be provided in an Unlicensed Residential Home and/or in the local public community.

Documentation: Documentation must be completed on the Direct Support Service Log (WV-BMS-IDD 07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Direct Support Progress Note to detail the issue. If training was provided, the staff person must also complete the task analysis. The Direct Support Service Log must include all of the following items.

- Name of the person who receives services
- Service Coordination provider name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to person ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided

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- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff person

Limitations/Caps:

- The amount of service is limited by the individualized budget of the person who receives services.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to adults aged 18 and older.
- The maximum annual units of Unlicensed Residential PCS services cannot exceed 35,040 units/8,760 hours (based upon average of 24 hours per day) per IPP year. This is in combination with the following direct support services: all other types of PCS, LPN, Crisis Intervention, Facility-Based Day Habilitation, Pre-vocational, Job Development, Supported Employment, and Electronic Monitoring.
- All requests for more than an average of 12 hours per day of 1:1 services require BMS approval. Approval of this level of service will be based on demonstration of assessed need not on a particular residential setting.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff persons to persons who receive services are 1:1, 1:2, and 1:3 for this service.
- The amount of Unlicensed Residential PCS provided must be identified on the IPP.
- Unlicensed Residential PCS is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.
- This service is limited to no more than 3 individuals per setting; note that, other than siblings, individuals must be non-related.
- Unlicensed Residential PCS cannot be provided in a setting owned or leased by an IDDW provider.

513.17.4.2 Unlicensed Residential Person-Centered Support (Personal Options Model*)*

Unlicensed Residential Person-Centered Support (PCS): *Personal Options* is provided to adults aged 18 and older in an Unlicensed Residential Home and/or in the local public community. Unlicensed Residential PCS: *Personal Options* is provided by awake and alert staff who **do not live in the home with the person** and consists of individually tailored training and/or support activities that enable the person who receives services to live and inclusively participate in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person who receives services to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Unlicensed Residential PCS: *Personal Options* may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

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- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for Independent Living.

Unlicensed Residential PCS: *Personal Options* services must be assessment based and outlined on the IPP. Activities must allow the person who receives services to reside and participate in the most integrated setting appropriate to their needs.

Unlicensed Residential PCS: *Personal Options* services may include training specific to the person who receives services. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is permitted if requested by the person who receives services or their legal representative.

Unlicensed Residential PCS: *Personal Options* staff may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the person who receives services are not compromised.

Unlicensed Residential PCS: *Personal Options* staff may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the person who receives services or their legal representative.

Staff providing Unlicensed Residential PCS: *Personal Options* cannot be a family member of the person who receives services. For the purposes of providing Unlicensed Residential PCS services, family members include: biological/adoptive parents or step-parents, biological/adoptive adult siblings or step-siblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/-uncles only. Spouses of persons who receive services are excluded from providing services.

Procedure Code: S5125-UC 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services.

Site of Service: This service may be provided in an Unlicensed Residential Home and/or in the local public community.

Documentation: The staff person must document the hours provided per day to the person. The documentation must be specific to the service and must include:

- Name of the person who receives services
- Month of Service

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- Year of Service
- Day of Service
- Total time spent
- Transportation Log including beginning location (from), end location (to) and total number of miles for the trip
- Signature of the staff person and the person who receives services and representative (when applicable)

If a Behavior Support Professional is involved in training plans carried out by the staff person, documentation is completed through those training plans per the IPP. This documentation must be maintained by the person who receives services/employer and provided to the BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the individualized participant-directed budget and spending plan.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to adults aged 18 and older.
- The maximum annual units of Unlicensed Residential PCS: *Personal Options* services cannot exceed 35,040 units/8,760 hours (based upon average of 24 hours per day) per IPP year. This is in combination with the following direct support services: all other types of PCS, LPN, Crisis Intervention, Facility-Based Day Habilitation, Pre-vocational, Job Development, Supported Employment, and Electronic Monitoring.
- All direct support services cannot exceed the equivalent monetary value of an average of 12 hours per day on days when Facility-Based Day Habilitation, Job Development, Pre-vocational, and/or Supported Employment services are provided.
- All requests for more than an average of 12 hours per day of 1:1 services require BMS approval. Approval of this level of service will be based on demonstration of assessed need.
- This service may not be billed concurrently with any other direct care service.
- The ratio of staff person to person who receives services is 1:1 for this service.
- The amount of Unlicensed Residential PCS: *Personal Options* provided must be identified on the IPP.
- Unlicensed Residential PCS: *Personal Options* is not available while the person who receives services is hospitalized in a Medicaid certified hospital.
- Unlicensed Residential PCS: *Personal Options* is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.
- This service is limited to no more than 3 individuals per setting; note that, other than siblings, individuals must be non-related.
- Unlicensed Residential PCS: *Personal Options* cannot be provided in a setting owned or leased by an IDDW provider.

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513.17.5 Crisis Site Person-Centered Support (Traditional Option)

Crisis Site Person-Centered Support services provided by awake and alert Direct Support Professionals are specifically designed to provide temporary substitute care for an individual who is in need of an alternative residential setting due to behavioral needs or lack of supports. Training programs on the IPP may be implemented by Direct Support Professionals while the person who receives services is at the Crisis Site.

The services are to be utilized only in licensed crisis sites and used on a short-term basis not to exceed a maximum stay of 30 days per admission without prior authorization from the UMC. During a service year, the duration of a Crisis Site stay may not exceed a total of 180 days and prior authorization will only be provided for 30 days or fewer at a time.

Crisis Site services usually occur after a Critical Juncture in treatment and must be approved by the IDT. If Crisis Site services are utilized due to an emergent need there must be a plan to transition the person who receives services back into the community developed at the time of admission by the Service Coordinator and the length of stay in the Crisis Site may not exceed 30 days per admission.

Crisis Site facilities are listed on the IDDW Provider Reference Guide. Service Coordinators must contact individual sites to determine availability for admission.

The referral packet to the Crisis Site must include the IPP that identifies the services to be provided and assessments as appropriate. The Service Coordinator must submit form IDD-12 to the UMC within 72 hours

Direct Support Professionals may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the person who receives services are not compromised.

Procedure Code: T1005-U7 1:1 ratio
T1005-U8 1:2 ratio
T1005-U9 1:3 ratio

Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on specific assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services.

Under emergent circumstances which place the health and safety of the person who receives services at risk, this service may be immediately implemented without prior authorization up to a maximum of 72 hours.

Site of Service: This service may only be provided in sites that are licensed by the Office of Health Facility and Licensure as Crisis Sites.

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Documentation: Documentation must be completed on the Direct Support Service Log (WV-BMS-IDD-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the staff person should complete the accompanying Direct Support Progress Note to detail the issue. The Direct Support Service Log must include all of the following items.

- Name of the person who receives services
- Service Coordination provider name
- Month of service
- Year of service
- Day of service
- Service code including modifier to indicate staff to person ratio
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff person

Limitations/Caps:

- The amount of service is limited by the individualized budget of the person who receives services.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- Prior authorization will only be provided for up to 2,880 units/720 hours (based upon an average of 24 hours per day for 30 days) at a time.
- The maximum annual units of Crisis Site services may not exceed 17,280 units/4,032 hours (based upon an average of 24 hours per day for 180 days) per IPP year. This is in combination with the following direct support services: *PCS, Day Services, LPN, Crisis Intervention and Electronic Monitoring*.
- An equivalent reduction in other authorized Direct Support Professional services must be made in UMC's web portal to off-set the number of units of Crisis Site services requested.
- Form IDD-12 must be submitted by the Service Coordinator to the UMC within 72 hours of admission.
- The ratios of staff persons to person who receives services are 1:1, 1:2, and 1:3 for this service.
- This service may not be billed concurrently with any other direct support service.
- Crisis Site services must be prior authorized by the UMC. Under emergent circumstances which place the health and safety of the person who receives services or others at risk, Crisis Site services may be immediately implemented without prior authorization up to a maximum of 72 hours.

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513.18 RESPITE

There are two types of Respite services available under the Traditional Option, each of which is described in detail in its specific section, below. Not all forms of respite are paid services. Anytime the primary caregiver can get a break from providing care, then this a form of respite. The two types are:

- In-Home Respite*
- Out-of-Home Respite*

* Denotes that this service may be participant-directed through the *Personal Options* Model.

513.18.1 In-Home Respite

513.18.1.1 In-Home Respite (Traditional Option)

In-Home Respite services provided by awake and alert Direct Support Professionals are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent person who receives services. Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the person, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the person is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver. In-Home Respite services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing In-Home Respite services may participate in person-centered planning.

In-Home Respite services may be used to:

- Allow the primary care giver to have planned time from the caretaker role;
- Provide assistance to the primary caregiver in crisis and emergency situations;
- Ensure the physical and/or emotional well-being of the primary caregiver by temporarily relieving them of the responsibility of providing care; and
- Support the person who receives services while the primary caregiver works outside the home.

Direct Support Professionals providing In-Home Respite services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the person who receives services or their legal representative.

Procedure Code: T1005-UA 1:1 ratio
T1005-UB 1:2 ratio

Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulation. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services.

Site of Service: This service may be provided in the family residence of the person who receives services, a Specialized Family Care Home where the person who receives services resides, a licensed day program facility and public community locations.

Documentation: Documentation must be completed on the Direct Support Service Log (WV-BMS-IDD-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Direct Support Progress Note to detail the issue. The Direct Support Service Log must include all of the following items.

- Name of the person who receives services
- Service Coordination provider name
- Month of Service
- Year of Service
- Day of Service
- Service code including modifier to indicate ratio of staff to person who receives services
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff person

Limitations/Caps:

- The amount of service is limited by the individualized budget of the person who receives services.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of In-Home Respite service may not exceed 3,650 units/912 hours (based upon average of 2.5 hours/ day) per IPP year. This is in combination with the following direct support services: Out-of-Home Respite, In-Home Respite: *Personal Options,* and Out-of-Home Respite: *Personal Options*.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff person to person who receives services are 1:1 and 1:2 for this service.
- The amount of In-Home Respite must be identified on the IPP.
- Direct Support Professionals providing In-Home Respite services may not live in the home of the person who receives services.
- In-Home Respite is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities located either within or outside of a medical hospital.

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- In-Home Respite services are not available to persons living in Unlicensed Residential Home or Licensed Group Home settings.
- In-Home Respite services may not be provided by a spouse of a person who receives services or any other individual living in the home of the person who receives services.
- In-Home Respite services are not to replace natural supports, and cannot be provided by biological or adoptive parents or step-parents.
- In-Home Respite services may not be provided in an ICF/IID facility.

513.18.1.2 In-Home Respite (Personal Options Model*)*

In-Home Respite: *Personal Options* services provided by awake and alert staff are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. Not all forms of respite are paid services. Anytime the primary caregiver can get a break from providing care, then this a form of respite. The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent person who receives services. In-Home Respite: *Personal Options* services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing In-Home Respite: *Personal Options* services may participate in person-centered planning.

In-Home Respite: *Personal Options* services may be used to:

- Allow the primary caregiver to have planned time from the caretaker role;
- Provide assistance to the primary caregiver in crisis and emergency situations;
- Ensure the physical and/or emotional well-being of the primary caregiver by temporarily relieving them of the responsibility of providing care; and
- Support the person who receives services while the primary caregiver works outside the home.

Staff providing In-Home Respite: *Personal Options* services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the person who receives services or their legal representative.

Procedure Code: T1005-UD 1:1 ratio

Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services. The annual budget for participant-directed services is determined following the purchase of Traditional services.

Site of Service: This service may be provided in the family residence of the person who receives services, a Specialized Family Care Home where the person who receives services resides, a licensed day program facility or pre-vocational center and/or public community locations.

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulation. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

Documentation: The staff person must document the hours provided per day to the person who receives services. The documentation must be specific to the service and must include:

- Name of the person who receives services
- Month of service
- Year of service
- Day of service
- Total time spent
- Transportation Log (when applicable) including beginning location (from), end location
- (to) and total number of miles for the trip
- Signature of the staff person and the person who receives services and representative (when applicable)

If a Behavior Support Professional is involved in training plans carried out by the Respite staff person, documentation is completed through those training plans per the IPP. This documentation must be maintained by the person who receives services/employer and provided to the BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the individualized participant-directed budget and spending plan.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of In-Home Respite*: Personal Options* services are limited to the equivalent monetary value of 3,650 units/912 hours (based upon average of 2.5 hour per day) per IPP year. This is in combination with the following direct support services: Out-of-Home Respite, In-Home Respite, and Out-of-Home Respite: *Personal Options*.
- This service may not be billed concurrently with any other direct support service.
- The ratio of staff person to person who receives services is 1:1 for this service.
- The amount of In-Home Respite: *Personal Options* must be identified on the IPP.
- In-Home Respite service units may not be transferred to Person-Centered Support services of any kind.
- Staff providing In-Home Respite: *Personal Options* may not live in the home of the person who receives services or within the Specialized Family Care Home where the person who receives services resides.
- In-Home Respite: *Personal Options* is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities located either within or outside of a medical hospital.
- In-Home Respite: *Personal Options* services are not available to persons living in Unlicensed Residential Home or Licensed Group Home settings.
- In-Home Respite: *Personal Options* services may not be provided by a spouse of a person who receives services or any other individual living in the home of the person who receives services.

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- In-Home Respite: *Personal Options* services are not to replace natural supports, and cannot be provided by biological or adoptive parents or step-parents.
- In-Home Respite: *Personal Options* services may not be provided in an ICF/IID facility.

513.18.2 Out-of-Home Respite

513.18.2.1 Out-of-Home Respite (Traditional Option)

Out-of-Home Respite services are provided out of the home where the individual resides and are provided by awake and alert Direct Support Professionals are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. Not all forms of respite are paid services. Anytime the primary caregiver can get a break from providing care, then this a form of respite. The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent person who receives services. Out-of-Home Respite services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing Out-of-Home Respite services may participate in person-centered planning.

Out-of-Home Respite services may be used to:

- Allow the primary caregiver to have planned time from the caretaker role;
- Provide assistance to the primary caregiver in crisis and emergency situations;
- Ensure the physical and/or emotional well-being of the primary caregiver by temporarily relieving them of the responsibility of providing care; and
- Support the person who receives services while the primary caregiver works outside the home.

Direct Support Professionals providing Out-of-Home Respite services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the person who receives services or their legal representative.

Procedure Code: T1005-U1 1:1 ratio
T1005-U5 1:2 ratio
T1005-U6 1:3 ratio

Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided.
Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services.

Site of Service: This service may be provided in a Specialized Family Care Home in which the person who receives services **does not** reside and/or public community locations.

Documentation: Documentation must be completed on the Direct Support Service Log (WV-BMS-IDD-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen

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circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Direct Support Progress Note to detail the issue. The Direct Support Service Log must include all of the following items.

- Name of the person who receives services
- Service Coordination provider name
- Month of Service
- Year of Service
- Day of Service
- Service code including modifier to indicate ratio of staff to person who receives services
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff person

Limitations/Caps:

- The amount of service is limited by the individualized budget of the person who receives services.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Out-of-Home Respite service may not exceed 3,650 units/912 hours (based upon average of 2.5 hours/ day). This is in combination with the following direct support services: In-Home Respite, In-Home Respite: *Personal Options,* and Out-of-Home Respite: *Personal Options*.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff person to person who receives services are 1:1, 1:2, and 1:3 for this service.
- The amount of Out-of-Home Respite must be identified on the IPP.
- Direct Support Professionals providing Out-of-Home Respite services may not live in the home of the person who receives services.
- Out-of-Home Respite is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities located either within or outside of a medical hospital.
- Out-of-Home Respite services are not available to persons living in an Unlicensed Residential Home or Licensed Group Home settings.
- Out-of-Home Respite services may not be provided by a spouse of a person who receives services or any other individual living in the home of the person who receives services.
- Out-of-Home Respite services are not to replace natural supports, and cannot be provided by biological or adoptive parents or step-parents.
- Out-of-Home Respite services may not be provided in an ICF/IID facility.

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513.18.2.2 Out-of-Home Respite (Personal Options Model*)*

Out-of-Home Respite: *Personal Options* services provided out of the home where the person resides by awake and alert staff are specifically designed to provide temporary substitute care normally provided by a family member or a Specialized Family Care Provider. Not all forms of respite are paid services. Anytime the primary caregiver can get a break from providing care, then this a form of respite. The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent person who receives services. Out-of-Home Respite: *Personal Options* services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing Out-of-Home Respite: *Personal Options* services may participate in person-centered planning.

Out-of-Home Respite: *Personal Options* services may be used to:

- Allow the primary caregiver to have planned time from the caretaker role;
- Provide assistance to the primary caregiver in crisis and emergency situations;
- Ensure the physical and/or emotional well-being of the primary caregiver by temporarily relieving them of the responsibility of providing care; and
- Support the person who receives services while the primary caregiver works outside the home.

Staff providing Out-of-Home Respite: *Personal Options* services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the person who receives services or their legal representative.

Procedure Code: T1005-UC 1:1 ratio

Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the person who receives services. The annual budget for participant-directed services is determined following the purchase of Traditional services.

Site of Service: This service may be provided in a Specialized Family Care Home in which the person who receives services **does not** reside and/or public community locations.

Documentation: The staff person must document the hours provided per day to the person who receives services. The documentation must be specific to the service and must include:

- Name of the person who receives services
- Month of service
- Year of service
- Day of service
- Total time spent
- Transportation Log (when applicable) including beginning location (from), end location

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- (to) and total number of miles for the trip
- Signature of the staff person and the person who receives services and representative (when applicable)

If a Behavior Support Professional is involved in training plans carried out by the Respite staff person, documentation is completed through those training plans per the IPP. This documentation must be maintained by the person who receives services/employer and provided to the BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the individualized participant-directed budget and spending plan.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Out-of-Home Respite: Personal Options services are limited to the equivalent monetary value of Traditional Respite of 3,650 units/912 hours (based upon average of 2.5 hour per day) per IPP year when transferring funds from the annual budget allocation to the Participant-Directed budget. This is in combination with the following direct support services: Out-of-Home Respite, In-Home Respite, and In-Home Respite: Personal Options.
- This service may not be billed concurrently with any other direct support service.
- The ratio of staff person to person who receives services is 1:1 for this service.
- The amount of Out-of-Home Respite: Personal Options must be identified on the IPP.
- In-Home Respite service units may not be transferred to Person-Centered Support services of any kind.
- Staff providing Out-of-Home Respite: Personal Options may not live in the home of the person who receives services or within the Specialized Family Care Home where the person who receives services resides.
- Out-of-Home Respite: Personal Options is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities located either within or outside of a medical hospital.
- Out-of-Home Respite: Personal Options services are not available to persons living in an Unlicensed Residential Home or Licensed Group Home settings.
- Out-of-Home Respite: Personal Options services may not be provided by a spouse of a person who receives services or any other individual living in the home of the person who receives services.
- Out-of-Home Respite: Personal Options services are not to replace natural supports, and cannot be provided by biological or adoptive parents or step-parents.
- Out-of-Home Respite: Personal Options services may not be provided in an ICF/IID facility.

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513.19 SERVICE COORDINATION

513.19.1 Service Coordination (Traditional Option)

Service Coordination services establish, along with the person, a life-long, person-centered, goal-oriented process for coordinating the supports (both natural and paid), range of services, instruction and assistance needed by persons with developmental disabilities. It is designed to ensure accessibility, accountability and continuity of support and services. This service also ensures that the maximum potential and productivity of a person is utilized in making meaningful choices with regard to their life and their inclusion in the community. All IDDW services purchased, however, just be within their annual individualized budget.

Once the person/legal representative has chosen a Service Coordination provider from the available IDDW providers, the agency assigns a Service Coordinator to the person. The person/legal representative may request the assignment of a specific Service Coordinator (SC) and when possible the agency honors the request. The person/legal representative may choose to transfer to a different SC provider at any time and for any reason.

The Service Coordinator must, at a minimum, perform the following activities listed below.

- Assist the person and/or legal representative with re-determination of financial eligibility as required at the DHHR office in the county where the person lives.
- Verify financial eligibility during monthly home visits.
- Begin the discharge process and provide linkage to services appropriate to the level of need when a person is found to be ineligible for IDDW Services during annual eligibility or financial redetermination.
- Provide oral and written information about the IDDW provider agency's rights and grievance procedures for persons served by the agency.
- Assist with procurement of all services that are appropriate and necessary for each person within and beyond the scope of the IDDW Program including annual medical and other evaluations as applicable to the person.
- Act as an advocate for the person. The IDDW Program must not be substituted for entitlement programs funded under other Federal public laws such as Special Education under P.L.99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers). Therefore, it is necessary for the Service Coordinator to advocate with these systems to obtain the required and appropriate services.
- Provide education, linkage and referral to community resources,
- Promote a valuable and meaningful social role for the person in the community while recognizing the person's unique cultural and personal value system.
- Interface with the UMC on behalf of the person in regard to the assessment process, purchase of services and budget process. Activities may include linkage, negotiation of services, submission of information, coordination of choice of appropriate assessment respondents on behalf of the person, education and coordination of the most appropriate assessment setting that best meets the person's needs.

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- Communicate with other service providers on the IDT to allow for continuity of services and payment of services.
- Coordinate necessary evaluations to be utilized as a basis of need and recommendation for services in the development of the IPP.
- Notify IDT persons at least 30 days in advance of meeting.
- Support the person as necessary to convene and conduct IDT meetings.
- Documenting that all services, both paid and unpaid, from any and all programs also be documented on the IPP.
- Providing schedules of all programs used by the person to ensure that times and tasks do not overlap or duplicate.
- Coordinate the development of IPPs at least annually. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, but shall not exceed 180 days.
- Access the necessary resources detailed in the IPP, make referrals to qualified service providers and resources, and monitor that service providers implement the instructional, behavioral and service objectives of the IPP.
- Disseminate copies of all IPPs to the IDT persons and Participant-Directed service Option providers (if applicable) within 14 days of the IDT meeting.
- Upload the ISP,the Demographic/cover sheet and signature page into the UMC's web portal within 14 days of the IDT meeting. NOTE: No services will be prior authorized until the current IPP is loaded into the web portal.
- Upload into the UMC's web portal any additional documentation requested by BMS or the UMC.
- Disseminate copies of the budget sheet from the IDDW CareConnection® website, once finalized.
- Monitor to ensure that the person's health and safety needs are addressed.
- Comply with reporting requirements of the WV IMS for persons on their caseload.
- Personally meet monthly with the person and their paid or natural supports that are present with the person the time of the visit at the person's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented and that the person continues to be financially eligible. The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the Service Coordinator Home/Day Visit Form (WV-BMS- IDD-03).
- Personally meet at least every other month with the person and their support staff at the person's facility-based day program or pre-vocational center (if applicable). The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the Service Coordinator Home/Day Visit Form (WV-BMS-IDD-03).
- Provide planning and coordination before, during and after crises, including notifying the UMC if a person is admitted to a crisis site or state institution.
- Process Freedom of Choice forms (WV-BMS-IDD-2) in the UMC's web portal within two business days any time a person requests a change of Service Delivery Models.
- Coordinate Transfer/Discharge meetings to ensure the linkage to a new service provider or service delivery model and access to services when transferring services from one provider

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agency to another or to another type of service delivery model. Coordination efforts must continue until the transfer of services is finalized.
- Travel as necessary to complete Service Coordination activities related to the IPP.
- Provide information and assistance regarding participant-directed services during annual IPP meetings and upon request by the person or legal representative.
- Inform the person of their rights at least annually.
- Attend and participate in the annual functional assessment for eligibility conducted by UMC.
- Present person's proposed restrictive measures to the IDDW provider agency's Human Rights Committee (HRC) if no other professional is presenting the same information.
- Monitor any restrictive measures approved by the HRC to ensure the measures are implemented properly and reviewed at least annually by the HRC and by the IDT at every IDT meeting.
- Attend and contribute to Futures Planning sessions, including PATHs and MAPs.

Procedure Code: T1016-HI 1:1 ratio

Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in any setting that allows the Service Coordinator to complete all necessary duties for the person.

Documentation: A detailed progress note or evaluation report for each service is required, including when any type of IDT meeting is held. Documentation must include all of the following items.

- Person's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Type of contact (phone, face-to-face, written)
- Detailed summary of the service provided
- Clinical outcome and/or result of the service provided
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 872 units/218 hours per person's annual IPP year.

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- Up to 4 units of Service Coordination per month per person served may be billed to review services provided in order to verify the person receives services as indicated on the IPP.
- Service Coordinators may not provide services for more than 30 people, inclusive of non-IDDW persons served by the agency.
- A person may only have one Service Coordinator assigned at one time. In the event of a transfer from one Service Coordination provider to another Service Coordination provider, the "transfer-from" Service Coordination may have up to 30 days after the effective date of the transfer to complete an agency discharge summary or other documentation related to the transfer.
- Agency staff providing Service Coordination services may not be an individual who lives in the person's home.
- Only one Service Coordinator may bill for this service during an IDT meeting.
- Service Coordination cannot be billed for activities that are an integral component of another covered Medicaid service.
- Service Coordination cannot be billed for activities integral to the administration of foster care programs.
- Service Coordination cannot be billed for activities required of representative payees. Example: writing checks, maintaining bank account, paying the electric bill, compiling a report for Social Security, etc. (Linkage to the payee on behalf of the person is an acceptable Service Coordination activity).
- Service Coordination cannot be billed for Human Resources activities. Example: calling direct care staff to see if they can work with the person, interviewing, etc.
- Service Coordination cannot be billed for evaluation a person's IPP implementation by means of review of "billing or billing documentation" or other auditing activities. (The
- Service Coordinator may not function as a billing person/auditor. The Service Coordinator may review/monitor implemented services.)
- Service Coordination cannot be billed for leaving voice mail messages.
- Service Coordination cannot be billed for sitting in a waiting room with a person.
- Service Coordination cannot be billed for activities that should be performed by a home manager. Example: fire drills, checking hot water tanks, etc.
- Service Coordination cannot be billed for clinical supervision.
- Service Coordination cannot be billed for administrative activities such as filing.
- Service Coordination cannot be billed for Utilization Management activities.
- Service Coordination cannot be billed for activities that are performed outside of West Virginia unless the Service Coordinator is accompanying the person to a WV Medicaid reimbursable service
- Service Coordination cannot be billed for activities not related to the person.
- Service Coordination cannot be billed for training Agency Staff and Qualified Support Workers.
- Service Coordination cannot be billed for developing goals for a person.
- Service Coordination cannot be billed for the entire calendar month if a home visit did not occur within that calendar month.
- Direct care services provided by the Service Coordinator must be billed utilizing the appropriate direct care service code.

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513.20 SKILLED NURSING

513.20.1 Skilled Nursing Licensed Practical Nurse (Traditional Option)

Licensed Practical Nursing (LPN) services listed in the service plan must be within the scope of West Virginia's Nurse Practice Act, ordered by a physician and are provided by a LPN under the supervision and monitoring of a RN actively licensed to practice in the State. LPN services are available to people who are aged 21 or older, as children with significant medical issues can access Private Duty Nursing via the Medicaid State Plan. This service can only be used for activities that require a nurse to complete according to the WV Nurse Practice Act. Nursing services that must be provided by an awake and alert LPN include but are not limited to:

- Verifying and documenting physician orders if only RNs or LPNs are administering medication (no AMAPS are administering medications);
- Reviewing and verifying physician orders are current, properly documented and communicated to direct care staff and others per IDDW provider policy;
- Direct nursing care including medication/treatment administration;
- Review of Medication Administration Records (MARs), medication storage and documentation (when no AMAPs are administering medication);
- Review scheduled medical appointments before occurrence and communicate this information to others per IDDW provider policy;
- Facilitate procurement of and monitoring of medical equipment;
- Train persons on individualized medical and health needs, such as wound-care, medically necessary diets, etc.

Note: If these services are provided by an RN then the LPN code must be billed for reimbursement.

The Request for Nursing Service (WV-BMS-IDD-09) must be submitted to the UMC for prior authorization and must include a detailed list and schedule of all LPN activities that will be provided. Any activities that are not within the scope of LPN duties according to the Nurse Practice Act must be billed as Person-Centered Support or Respite.

The LPN may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by UMC at the request of the person or their legal representative.

Procedure Code: T1003-U4 1:1 ratio
T1003-U3 1:2 ratio
T1003-U2 1:3 ratio

Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment and services must be within the person's individualized budget.

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Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home, a Licensed Group Home, an Unlicensed Residential Home, a licensed day program facility or pre-vocational center, crisis sites and public community locations.

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is only available for adults aged 21 and older.
- This service can only be used for activities that require a nurse to complete according to the WV Nurse Practice Act.
- The maximum annual units of LPN services cannot exceed 2,920 units/730 hours (based upon an average of 2 hours per day) per person's annual IPP year. Under extraordinary circumstances documented on WV-BMS-IDD-09, the LPN units may be approved up to 11,680 units/2920 hours (average 8 hours/day) per person's annual IPP year or the monetary equivalent of 8 hours of 1:1 LPN service when alternate LPN service ratios are used. This is in combination with all other direct care services (PCS, Day Services, Crisis Intervention and Electronic Monitoring).
- All LPN services provided must be within the scope of practice for Licensed Practical Nurses. If a LPN provides a service that is not within the scope of the WV Nurse Practice Act (such as taking vital signs, providing personal hygiene, comfort, nutrition, ambulation and environmental safety and protection), it will be considered a PCS or Respite service and must be billed as such.
- This service may not be billed concurrently with any other direct care services.
- Agency staff to person ratio codes are 1:1, 1:2 and 1:3.
- Staff persons providing Skilled Nursing LPN services may not be an individual who lives in the person's home.
- LPN services may not be billed for completing administrative activities, including:
    - Attempting phone calls when the line is busy or leaving a message.
    - Nursing assessments required by the IDDW provider but not the IDD Waiver manual.
    - Waiting at a physician's office.
    - Conducting group training on general medical topics.
    - Orientation training that is not person-specific.
    - Reviewing incident reports.
    - Travel.

Documentation: A detailed progress note for each service is required. Documentation must include all of the following items.

- Person's Name
- Service code including modifier to indicate staff to person ratio
- Date of service
- Start time
- Stop time
- Total time spent

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- Detailed summary of the service provided
- Signature and credentials of the agency staff

513.20.2 Skilled Nursing Licensed Registered Nurse (Traditional Option)

Registered Nurse (RN) services listed in the service plan are within the scope of the West Virginia Nurse Practice Act, ordered by a physician and are provided by a licensed RN licensed to practice in the State. RN Skilled Nursing services are services which only a licensed RN can perform. The service must be provided by a RN under the direction of a physician. The RN may perform clinical supervision of LPN and AMAP staff.

RN Skilled Nursing Services are restricted to those nursing services that are outside the scope and practice of a LPN. If the RN provides a Skilled Nursing service that is within the scope of practice for a LPN, the RN must utilize the LPN code.

The RN may also bill for training of staff in the person's home, Unlicensed Residential Home, licensed Group Home and licensed day program settings on the person's specific medical needs and related interventions as recommended by the person's treatment team.

The RN may attend and participate in the IPP and the annual functional assessment for eligibility conducted by UMC based upon the person or their legal representative's request.

Direct care services provided by the RN must be billed utilizing the appropriate direct care service code.

The RN may bill to complete assessments if a person's medical need warrant an individualized assessment.

The RN must complete a summary of services provided if necessitated by a change in the person's medical needs, such as Emergency Room visits, medication changes, diagnostic changes, new treatments recommended by physician, etc.

The RN may bill to consult with LPNs who are providing direct care when an urgent, person-specific medical need arises.

Procedure Code: T1002-HI 1:1 ratio

Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home, a licensed Group Home, an Unlicensed Residential Home, a licensed day program facility or pre-vocational center, crisis sites and public community locations.

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Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 480 units/120 hours per person's annual IPP year.
- The agency staff to person ratio for this service is 1:1.
- If the RN provides a skilled nursing service that is within the scope of practice for a LPN, the RN must utilize the LPN code/rate.
- Agency staff providing Skilled Nursing RN services may not be an individual who lives in the person's home.
- RN services may only be billed 30 days prior to discharge for a person or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/IID or another WV waiver program for planning purposes.
- RN services may not be billed for completing administrative activities including these listed below.
    - Attempting phone calls when the line is busy or leaving a message.
    - Nursing assessments required by the IDDW provider but not the IDDW manual.
    - Waiting at a physician's office.
    - Reading LPN notes.
    - Conducting group training on general medical topics.
    - Orientation training that is not person-specific.
    - Reviewing incident reports.
    - Assessing LPN competency and providing support.
    - Travel.

513.20.3 Skilled Nursing Licensed Registered Nurse, Individual Program Planning (Traditional Option)

This is a service that allows the RN to attend a person's IDT meeting in person or by video-conferencing to present assessments or evaluations completed for the purpose of integrating recommendations, training goals and intervention strategies into the person's IPP.

Individual Program Planning is the process by which the person and their IDT develop a plan based on a person-centered philosophy. The RN participates in the IDT meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan.

Procedure Code: T2024-TD 1:1 ratio

Service Units: Unit = Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment and services must be within the person's individualized budget.

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Site of Service: This service may be provided in the person's family residence, a Specialized Family Care Home, a licensed Group Home, an Unlicensed Residential Home, a licensed day program facility or pre-vocational center, crisis sites and public community locations. The meeting cannot begin at one location and then be continued at another.

Documentation: Documentation must include signature, date of service and the total time spent at the meeting on the person's IPP and a separate progress note must also be completed.

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 4 Events per person's annual IPP year.
- Professional must attend all planning meetings, either face-to-face or by teleconference, but in order to bill the IPP Planning code, the professional must be physically present for the duration of IPP meeting. IPP cannot be billed for preparation prior or follow-up performed after the IPP meeting.
- Staff providing Skilled Nursing RN IPP services may not be an individual who lives in the person's home.
- Only one RN may bill for this service during an IDT meeting.

513.21 TRANSPORTATION

Persons who receive IDDW services are required to access Non-Emergency Medical Transportation (NEMT) for non-IDDW Medicaid services, including doctor appointments. Transportation via the NEMT vendor, currently Medical Transportation Management, can be arranged by calling 1-844-549-8353 or by going to https://wv.mtm-inc.net/mp.

513.21.1 Transportation Miles (Traditional Option)

Transportation: Miles services are provided to the IDDW person for trips to and from the person's home, licensed IDD Facility-based Day Habilitation Program, Pre-vocational centers, Job Development activities or Supported Employment activities, or to the site of a planned activity or service which is addressed on the IPP and based on assessed need identified on the annual functional assessment.

This service may be billed concurrently with Person-Centered Support Services, Respite, LPN, RN, Supported Employment and all Day Services.

Procedure Code: A0160-U1

Service Units: Unit = 1 mile

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Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be billed to and from any activity or service outlined in the person's IPP and based on assessed need.

Documentation: Agency staff must complete the transportation log section of the Direct Support Documentation Form (WV-BMS-IDD-07) to include all of the following items.

- Person's Name
- Service code
- Date of service
- "From" location (Specific Site: example person's home)
- "To" location (Specific Site: example Beckley Walmart)
- Purpose of trip
- Total number of miles per trip
- Beginning and ending odometer reading

The person's IPP must specify the number of miles per service (ex. Up to 100 miles per month shall be used for transporting the person to and from his job location).

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Transportation: Miles cannot exceed 9,600 miles per person's annual IPP year (based on average of 800 miles per month).
- Person must be present in vehicle if mileage is billed. If more than one person is present in the vehicle, then the total mileage will be divided between the number of persons present in vehicle.
- Must be related to a specific activity or service based on an assessed need as identified on the annual function assessment and documented in the IPP.
- May utilized up to 30 miles beyond the West Virginia border by persons living in a WV county bordering another state.

513.21.2 Transportation Miles (Participant-Directed Option, *Personal Options* Model)

Transportation: Miles services are provided to the IDDW person for trips to and from the person's home, licensed IDD Facility-based Day Habilitation Program, Pre-Vocational, Job Development activities or Supported Employment activities, or to a community-based planned activity or service which is based on assessed need. This service may be billed concurrently with Person-Centered Support Services:

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Personal Options option or Respite: *Personal Options* option. The number of miles per service must be included on the person's IPP.

Procedure Code: A0160-U3

Service Units: Unit = 1 mile

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the person's individualized participant-directed budget. The annual budget for participant-directed services is determined following the purchase of Traditional Services.

Site of Service: This service may be billed to and from any activity or service outlined on the person's IPP and based on assessed need.

Documentation: The person's spending plan must specify the number of miles to be provided and Qualified Support Workers must document the provision of transportation on a transportation log that includes:

- Person's Name
- Date of Service
- "From" location (Specific Site: example person's home)
- "To" location (Specific Site: example Beckley Walmart)
- Purpose of trip
- Total number of miles for the trip
- Beginning and ending odometer reading

Limitations/Caps:

- The amount of service is limited by the person's individualized participant-directed budget and spending plan.
- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The program representative may not be billed to provide transportation services.
- The maximum annual units of Transportation Miles: *Personal Options* services are limited to the equivalent monetary value of Traditional Transportation Miles of 9,600 units (based upon average of 800 miles per month) per IPP year when transferring funds from the annual budget allocation to the Participant-Directed budget.
- The amount of transportation provided to a person directing their transportation services must be identified on the spending plan.
- Person must be present in vehicle if mileage is billed. If more than 1 person is present in the vehicle, then the total mileage will be divided between the number of persons present in vehicle.
- Must be related to an assessed need identified on the annual functional assessment and documented in the IPP.

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- May be within 30 miles of the West Virginia border when the person is a resident of a county bordering the state of West Virginia.

513.21.3 Transportation Trips (Traditional Option)

Transportation services are provided to the IDDW person in the IDDW provider's mini-van or mini-bus for trips to and from the person's home, licensed Facility-based Day Habilitation Program, Pre-Vocational Center, Job Development activities or Supported Employment site or to the site of a planned activity or service which is addressed on the IPP and based on assessed need.

The agency mini-bus or mini-van must have proof of current vehicle insurance and registration inside the vehicle in addition to abiding by local, state and federal laws regarding vehicle licensing, registration and inspections.

Agency passenger mini-bus or mini-van must have had the original capacity to transport more than 6 passengers but less than 16 passengers.

Procedure Code: A0120-HI

Service Units: Unit = 1 Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the person's individualized budget.

Site of Service: This service may be billed to and from any activity or service outlined on the person's IPP and based on assessed need as identified on the annual functional assessment.

Documentation: Agency staff must complete the transportation log section of the Direct Support Documentation Form (WV-BMS-IDD-07) to include all of the following items.

- Person's Name
- Service code
- Date of service
- "From" location (Specific Site: example person's home)
- "To" location (Specific Site: example Beckley Walmart)
- Purpose of trip
- Total number of miles for the trip
- Beginning and ending odometer reading

The person's IPP must specify the number of trips per service (ex. Up to 20 trips per month shall be used for transporting the person to and from his job location).

Limitations/Caps:

- The amount of service is limited by the person's individualized budget.

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- If a person has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum units of Transportation Trips cannot exceed 2 one-way trips per day or 520 trips annually.
- Person must be present in Agency-owned mini-van or mini-bus if trips are billed.
- A trip must be related to a specific activity or service based on an assessed need identified on the annual functional assessment and documented in the IPP.
- A trip may be billed concurrently with Person-Centered Support Services, Respite and any Day Services.

513.22 PRIOR AUTHORIZATIONS

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the Provider Manual.

In order to receive payment from BMS, a provider must comply with all prior authorization requirements. BMS in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met**.** All services provided within the IDDW Program must be authorized with the UMC. Services requiring prior authorization (refer to *Section 513.5 Documentation and Record Retention Requirements* as well as each service definition in this Chapter) must be submitted to the UMC within 10 working days of the IDT meeting at which the services were chosen. The Service Coordinator is responsible for ensuring that all prior authorizations for all chosen IDDW providers are forwarded to the UMC.

513.23 BILLING PROCEDURES

Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement the amount of time documented in minutes must be totaled and divided by the minutes in a unit of service to arrive at the number of units billed. After arriving at the number of billable units, billing must take place on the last date in the service range. Billing cannot be rounded more than once within a calendar month. **The billing period cannot overlap calendar months.**

- Medicaid is the payer of last resort. IDDW Program providers must bill all third party liabilities such as a person's private insurance for those services that are covered by both private insurance and the Medicaid waiver program prior to billing Medicaid. Medicaid is considered a secondary insurance to an individual's private insurance. The Service Coordinator must inform the person, their family and/or legal representative of this requirement.
- Claims will not be honored for services (inclusive of service code definitions) provided outside of the scope of Chapter 513 IDDW policy manual or outside of the scope of federal regulations.

513.24 PAYMENTS AND PAYMENT LIMITATIONS

IDDW providers must comply with the payment and billing procedures and requirements described in *Chapter 600, Reimbursement Methodologies* of the Provider Manual.

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When a person is an inpatient in a West Virginia medical hospital and the person's behavioral needs require additional support staff, then the person may receive Person-Centered Support services on a short-term basis. The services provided by PCS may not duplicate services provided by the medical hospital.

IDDW services may not be billed while an individual is receiving services as an inpatient in an ICF/IID facility, a state institution, nursing facility, rehabilitation facility, psychiatric facility, or as a person of another other waiver program.

Reimbursement via the Resource Based Relative Value Scale (RBRVS) is described in *Chapter 600, Reimbursement Methodologies*. CPT codes referenced in this manual are reimbursed by using the Resource Based Relative Scale (RBRVS). RBRVS rates are subject to change on an annual basis. It is also necessary to include a location code for CPT codes.

513.25 RIGHTS AND RESPONSIBILITIES OF PERSONS RECEIVING SERVICES/LEGAL REPRESENTATIVES

513.25.1 Rights

The person retains all rights afforded to them under the law and the list below is intended to be limited to their rights as a person participating in the IDDW Program. Each person is informed of these rights by their IDDW provider Service Coordination agency upon enrollment and at least annually thereafter.

- Persons and/or their legal representatives have the right to choose between home and community-based services as an alternative to institutional care and a choice of Service Delivery Models by the UMC through the completion of a Freedom of Choice form (WV- BMS-IDD-2) upon enrollment in the program and at least annually thereafter.
- Persons and/or their legal representatives have a choice of IDDW providers.
- Persons and/or their legal representatives have a choice of Service Delivery Models.
- Persons and/or their legal representatives have the right to address dissatisfaction with services through the IDDW provider's grievance procedure.
- Persons directing their services through Personal *Options* will also have the right to address dissatisfaction regarding Financial Management Services. The *Personal Options* Vendor must have a procedure for responding to and tracking person complaints.
- Persons or their legal representatives have the right to access the Medicaid Fair Hearing process consistent with state and federal law.
- Persons have the right to be free from abuse, neglect and financial exploitation.
- Persons and/or their legal representatives have the right to be notified and attend any and all of their IDT meetings, including Critical Juncture meetings.
- Persons and/or their legal representatives have the right to choose who they wish to attend their IDT meetings, in addition to those attendees required by regulations.
- Persons and/or their legal representatives have the right to obtain advocacy if they choose to do so.

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- Persons and/or their legal representatives have the right to file a complaint with the UMC regarding the results of their functional assessment.
- Persons and/or their legal representatives have the right to have all assessments, evaluations, medical treatments, budgets and IPPs explained to them in a format they can understand, even if they have a legal representative making the final decisions in regard to their health care.
- Persons and/or their legal representative have the right to make decisions regarding their services.
- Persons have the right to receive reasonable accommodations afforded to them under the ADA.

513.25.2 Responsibilities

The person and/or their legal representative (if applicable) have the following responsibilities:

- To be present during IDT meetings. In extremely extenuating circumstances, the legal representative or other team persons may participate by teleconferencing if they do not bill for the time spent in the IDT. The person **must** be present if they do not have a legal representative;
- To understand that this is an optional program and that not all needs may be able to be met through the services available within this program and a person's annual individualized budget.
- To participate and supply correct information in the annual assessments for determination of medical eligibility and individualized budget;
- To purchase services within their annual individualized budget or utilize natural or unpaid supports for services unable to be purchased;
- To participate in re-determination of financial eligibility at their local DHHR as required;
- To comply with all IDDW policies including monthly home visits by the Service Coordinator;
- To implement the portions of the IPP for which they have accepted responsibility; and
- To maintain a safe home environment for all service providers; and
- To provide their Service Coordinator with income information so financial eligibility can be monitored; and
- To notify their Service Coordinator immediately if the person's living arrangements change, the person's needs change, the person is hospitalized or if the person needs to have a Critical Juncture meeting.

Failure to comply with these responsibilities may jeopardize the person's continuation of IDDW services.

513.25.3 Grievances/Complaints

Persons have a right to obtain oral and written information on the agency's rights and grievance policies. If a person or their legal representative is dissatisfied with the quantity of services or the provider of service, it is recommended that they follow the IDDW provider agency's grievance process. If the issue is not resolved at this level, the person or legal representative may file a formal complaint with the UMC.

If a person or their legal representative is dissatisfied with the content of the annual functional assessment, they must notify the UMC within 60 days of assessment date. The Assessment Data Modification Request (WV-BMS-IDD-13) form must be fully completed and must cite the items in

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question. The UMC reviews the items in question and gives a written response which may include adjustments or revisions to the assessment findings and/or budget amount.

The IDT must purchase services within the budget allocated by the UMC. If, after purchasing services within the allocated budget, the IDT wishes to modify services based on a documented change in need, then a Critical Juncture must be held, the WV-BMS-IDD-13 completed, and the Service Coordinator must contact the UMC to request additional services. If negotiation is unsuccessful, the Service Coordinator may request a Second Level Negotiation with the UMC and BMS will review the request for the additional services. The person and/or their legal representative may by-pass the First and Second Level Negotiations with the UMC and request a Medicaid Fair Hearing on the denial of the additional amount of services. At no time is the amount of the annual individualized budget a matter that may be taken before the Board of Review through a Medicaid Fair Hearing. The individualized budget is assigned based on the annual functional assessment and the structured interview. The process and mathematical formulas that are used to derive the individualized budget amounts are a matter of policy and thus, are not subject to the purview of the Board of Review.

513.25.4 Appeals

If a person is determined not to be medically eligible, a written Notice of Decision, a Request for Hearing form and the results of the functional assessment are sent by certified mail by the UMC to the person or their legal representative. A notice is also sent to the person's Service Coordinator. The termination may be appealed through the Medicaid Fair Hearing process if the Request for Hearing form is submitted to the Board of Review within 90 days of receipt of the Notice of Decision. The person or their legal representative may also request a second medical evaluation.

The second medical evaluation must be completed within 60 days by a person of the IPN. If the person or legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted within 13 days of the person or their legal representative's receipt of the Notice of Decision. If the Request for Hearing form is not submitted within 13 days of the person or legal representative's receipt of the Notice of Decision, reimbursement for all IDDW services will cease.

The Service Coordinator, upon notification of the eligibility decision, must begin the discharge process by arranging for a Transfer/Discharge IDT meeting to develop a "back-up" plan for transition because reimbursement for IDDW services will cease on the 13th day after receipt of the written Notice of Decision letter if the person or their legal guardian does not submit a Request for Hearing form or a request for a second psychological evaluation in the required time frame.

If the person is again denied medical eligibility based on the second medical evaluation, the person or the legal representative will receive a written Notice of Decision, a Request for a Fair Hearing Form and a copy of the second functional assessment/evaluation by certified mail from the UMC. The person's Service Coordinator will also receive a notice. The person or their legal representative may appeal this decision through the Medicaid Fair Hearing process if the Request for Hearing form is submitted to the Board of Review within 90 days of receipt of the Notice of Decision.

A pre-hearing conference may be requested by the person or their legal representative any time prior to the Medicaid Fair Hearing and the UMC will schedule. At the pre-hearing conference, the person and/or

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their legal representative and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination.

If the denial of medical eligibility is upheld by the hearing officer, services that were continued during the appeal process must cease on the date of the hearing decision. If the person is eligible financially for Medicaid services without the IDDW Program, other services may be available for the individual. If the termination based on medical eligibility is reversed by the Hearing Officer, the individual's services will continue with no interruption.

The person and/or their legal representative shall have the right to access their IPE used by the MECA in making the eligibility decision and copies shall be provided free of charge.

513.26 DISCHARGE

A person may be discharged from the IDDW Program for a reason outlined below. The Service Coordinator must complete and submit to the UMC a copy of the Person Transfer/Discharge Form (WV-BMS-IDD-10) within seven days to the UMC.

- A person's income or assets exceed the limits specified in *Section 513.6.3.1* of this chapter. The county DHHR office must be contacted, in addition to the UMC, any time an individual's income or assets exceed the limits.
    - The county DHHR office closes the Medicaid file upon notification of the increase in income or assets and notifies the individual and the UMC of termination of the Medicaid card. The Service Coordinator is responsible for monitoring the person's assets and is also the responsible party for reporting when the person's income or assets exceed the limits specified in *Section 513.6.3.1* of this Chapter. The Service Coordinator may request information from the person or the person's payee or person's legal representative to ensure that financial eligibility is not "lost" throughout the year due to excessive assets or other reasons.
- The annual functional assessment which is used by the MECA to determine a person's medical eligibility demonstrates that they are no longer medically eligible for the IDDW Program. The UMC notifies the person or their legal representative and the person's Service Coordinator of termination of services and of their right to appeal as outlined in *Section 513.25.4 Appeals*.
- A person or their legal representative voluntarily terminates Waiver services by signing the Transfer/Discharge form (WV-BMS-IDD-10). The Service Coordinator must convene the IDT in the development of the IPP to transition the person to the new services when applicable.
- A person becomes deceased. The Service Coordinator must complete and submit the Notification of Person Death (WV-BMS-IDD-11) and notify OHFLAC within 24 hours and submit the completed form to the UMC within seven days.
- A person or their legal representative fails to comply with all IDDW policies including monthly home visits by Service Coordinator, participation in required assessments, IDT meetings and IPP development, and then the person may be discharged from the IDDW Program following consultation and approval from the UMC.

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- A person does not access or utilize at least one direct care IDDW Service each month. If the person or their legal representative signed a Transfer/Discharge Form (WV-BMS-IDD-10), then it is effective on the date of signature and this rule does not apply.

The Service Coordinator must transfer/discharge the person in the CareConnection® by the effective date of the valid transfer/discharge.

IDDW providers are prohibited from discharging, discriminating or retaliating in any way against a person and/or their legal representative who has been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process involving the IDDW provider.

IDDW Service Coordination providers may not discharge a person if the person chooses to self-direct part of their services through either of the Participant-Directed service options.

513.27 TRANSFER

The person has the right to transfer Service Coordination and other services from the existing provider to another chosen provider at any time for any reason. Transfers must be addressed on the IPP and approved by the person or their legal representative and a representative from the receiving provider as evidenced by their signature on the IPP signature sheet. During the transition from one provider to another, the IPP must be developed and must specifically address the responsibilities and associated time frames of the "transfer-from" and the "transfer- to" providers. The Service Coordinator must complete and submit the Person Transfer/Discharge Form (WV-BMS-IDD-10) within 7 days to the UMC. If a transfer IPP is found not to be valid then, the authorizations for services may be rolled back to the transfer-from provider until a valid IPP is held.

An IDDW provider may not terminate services unless a viable IPP is in place that effectively transfers needed services from one IDDW provider to another provider and is agreed upon by the person and/or their legal representative and the receiving provider. Providers are prohibited from discriminating in any way against a person or legal representative wishing to transfer services to another provider agency.

513.28 SERVICE LIMITATIONS AND SERVICE EXCLUSIONS

Services governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the Provider Manual and *Section 513.8 Individual Program Plan* of this chapter. Reimbursement for services is made pursuant to *Chapter 600, Reimbursement Methodologies,* however, the following limitations also apply to the requirements for payment of services that are appropriate and necessary for IDDW Program Services described in this chapter.

- IDDW services are made available with the following limitations:
  - All persons must live in West Virginia;
  - All IDDW regulations and policies must be followed in the provision of the services. This includes the requirement that all IDDW providers be licensed in the State of West Virginia and enrolled in the West Virginia Medicaid Program;
  - The services provided must conform with the stated goals and objectives on the person's IPP; and

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  - Individual service and limitations described in this manual must be followed.
- IDDW services may be provided within 30 miles of the West Virginia border to persons residing in a county bordering another state.
- In addition to the non-covered services listed in *Chapter 100, General Administration and Information*, of the West Virginia Medicaid Provider Manual, BMS will not pay for the following services:
  - The IDDW Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973;
  - Public school services, including children who are home-schooled, receive home-bound instruction, and children who are eligible for public school services but are not enrolled;
  - Person-Centered Support Services payments may not be made for room and board or the cost of facility maintenance and upkeep;
  - Birth-to-Three services paid for by Title C of Individuals with Disabilities Education Act (IDEA) for children enrolled in the IDDW Program; and
  - IDDW services may not be provided concurrently unless otherwise indicated in the service definition. For example Person-Centered Support services may not be provided concurrently with the individual's Facility-Based Day Habilitation Program, Pre-Vocational, School-based services, Crisis services, Supported Employment services, Job Development, LPN Services, or Respite Care services.
- Reimbursement for IDDW services cannot be made for Service provided outside a valid IPP;
- To be considered valid, the IPP must be current (dated within the past year and reviewed with last 6 months by IDT), signed by all required IDT members and include all provided services. The following are considered reasons for invalid IPP:
  - Services provided when eligibility has not been established;
  - Services provided when there is no IPP;
  - Services provided without supporting documentation;
  - Services provided by unqualified staff; and
  - Services provided outside the scope of a defined service.

513.29 HOW TO OBTAIN INFORMATION

Please refer to the Intellectual/Developmental Disabilities Waiver Program website for Program contact information.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Activities of Daily Living (ADLs): Activities usually performed in the course of a normal day in an individual's life, such as eating, dressing, bathing and personal hygiene, mobility, and toileting.

Agency Staff: Staff or contracted extended professional staff employed by an IDDW provider to provide services to persons in the IDDW Program through the Traditional Option.

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Aging and Disability Resource Centers (ADRCs): The state agency sponsored by the West Virginia Bureau of Senior Services who have a wide-ranging list of resources available for informational purposes. These services and supports can help the person remain at home and active in the community by providing a comprehensive assessment of the person's needs and empower the person to make informed choices and decisions regarding long-term care.

Annual "Anchor" Date: The annual date by which the person's medical eligibility must be recertified and is determined by the anniversary date that is the first day of the month following the date when initial medical eligibility was established by the Medical Eligibility Contracted Agent (MECA). This date will also serve as the annual IPP date.

Approved Medication Assistive Personnel (AMAP): An unlicensed staff person who meets the eligibility requirements to become an AMAP, has successfully completed the required training and competency testing and has been deemed competent by the RN to administer medications to residents in the covered facilities in accordance with AMAP policy located at http://ohflac.wv.gov/Programs/AM.html.

Board of Review: The agency under the West Virginia DHHR and the Office of Inspector General that provides impartial hearings to persons who are aggrieved by an adverse action including denial of eligibility, eligibility terminations or denial of a covered benefit or service.

Circle of Support: A group of people with an interest in the person who offer either evaluation, planning, advocacy, or support to the person on an ongoing basis.

Common Law Employer: The entity that is viewed by the IRS, United States Customs and Immigration Service, state tax and labor departments as the employer. In the *Personal Options* FMS Model, the person is the Common Law Employer.

Critical Juncture: Any time that there is a significant event or change in the person's life that requires a meeting of the Interdisciplinary Team (IDT). The occurrence may require that a service needs to be decreased, increased or changed. A Critical Juncture constitutes a change in the person's needs such as behavioral, mental health or physical health, service/service units, support, setting, or a crisis.

Days: Calendar days unless otherwise specified.

Developmental Disability: Persons with related conditions who have a severe, chronic disability that meets all of the following conditions: It is attributable to cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. It is manifested before the person reaches age 22; it is likely to continue indefinitely; it results in substantial functional limitations in 3 or more of the following areas of major life activity:

1. Self-care,
2. Understanding and use of language,
3. Learning,
4. Mobility,

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5. Self-direction, and,
6. Capacity for independent living. (Refer to the Code of Federal Regulations 42 CFR 435.1010).

Direct Care Services: Person-Centered Support, Respite, Facility-based Day Habilitation, Pre-Vocational, Job Development, Crisis Intervention, Supported Employment and LPN services available through the IDDW Program.

Extended Professional Staff: WV Licensed Dietitians, Occupational Therapists, Physical Therapists and Speech Therapists who are enrolled Medicaid providers who contract with an IDDW provider to provide services in their specialty.

Financial Management Service (FMS): A general term applied to a service/function that assists a person to:

a. manage and direct the distribution of funds contained in the participant-directed budget;
b. facilitate the employment of staff by the person by performing as the person's agent such employer responsibilities as verifying worker qualifications, processing payroll, withholding and filing federal, state, and local taxes, and making tax payments to appropriate tax authorities; and,
c. performing fiscal accounting and making expenditure reports to the participant and/or their legal representative. In the IDDW *Personal Options* is the Model of Financial Management Services.

Human Services Field Degree: Four year degree from accredited college or university in one of the following fields: Psychology; Criminal Justice; Board of Regents; Recreational Therapy; Political Science; Nursing; Sociology; Social Work; Counseling; Teacher Education; Behavioral Health; Liberal Arts or other degree approved by the West Virginia Board of Social Work Examiners.

Incident: any unusual event occurring to a person that needs to be recorded and investigated for risk management or Quality Improvement purposes.

Independent Psychologist (IP): A West Virginia licensed psychologist who is a WV Medicaid Provider who performs comprehensive psychological evaluations independent of IDDW providers and who is a person of the Independent Psychologist Network trained by the Medical Eligibility Contracted Agent (MECA).

Independent Psychological Evaluation (IPE): An evaluation completed by a psychologist of the Independent Psychologist Network which includes background information, behavioral observations, documentation that addresses the 6 major life areas, developmental history, mental status examination, diagnosis and prognosis.

Independent Psychologist Network (IPN): West Virginia licensed psychologists who are enrolled West Virginia Medicaid Providers and have completed the required IPN Training provided by the Medical Eligibility Contracted Agent (MECA) training and agreed to complete the IPE as defined.

Individual Education Program (IEP): The legal document that defines an individual's special education program and includes the disability under which the individual qualifies for Special Education Services, the services the school will provide, the individual's yearly goals and objectives and any accommodations that must be made to assist in the individual's learning.

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Individual Program Plan (IPP): The required document outlining activities that primarily focus on the establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by persons of the IDDW Program. It is designed to ensure accessibility, accountability, and continuity of support and services. The content of the IPP must be guided by the person's needs, wishes, desires and goals but based on the person's assessed needs.

Individual Program Planning: The process by which the person is assisted by a team consisting of their legal representative (when applicable), their advocate (when applicable) other natural supports the person chooses to invite as well as attendees required by the IDDW Program policy manual who meet to decide what needs to be done, by whom, when and how and to document the decisions made by this planning team. The purpose of IPP planning is to identify and address a person's assessed needs.

Intellectual Disabilities and Developmental Disabilities Waiver (IDDW) Program: The program formerly referred to as the MR/DD Waiver Program funded by the Center for Medicare and Medicaid and administered by the Bureau for Medical Services. This program offers a comprehensive scope of services and supports to eligible IDDW Program persons. Authorized services, if applicable, must be rendered by enrolled IDDW providers within the scope of their licenses and in accordance with all state and federal requirements. BMS also contracts with an UMC to perform waiver operations including annual functional assessment for eligibility and budget determinations for active program persons, prior authorization of services, and quality assurance/improvement functions. BMS contracts with a MECA to assess and determine initial medical eligibility for program applicants as well as review and approve annual re-determination of eligibility for waiver services. BMS contracts with a Claims Agent to process Medicaid claims. BMS also contracts with one Fiscal Employer Agent (F/EA) known as *Personal Options* to provide Financial Management Services to waiver persons who choose to direct their own services through the participant-directed service options. *Personal Options* also provides Information and Referral services to persons choosing that Participant-Directed Option. The Office of Health Facility Licensure and Certification (OHFLAC) provides monitoring and supervision of persons' health and welfare through oversight of IDDW providers.

Intellectual Disabilities and Developmental Disabilities Waiver (IDDW) Provider: An agency that has been granted a Certificate of Need (CON) from the West Virginia Health Care Authority or an exemption from the CON Summary Review Committee and is licensed by OHFLAC to provide behavioral health services and is an enrolled West Virginia Medicaid provider.

Intellectual Disability: A condition which is usually permanent and originates prior to the age of 18. This condition results in significantly below average intellectual functioning as measured on standardized tests of intelligence (IQ of 70 or below) along with concurrent impairments in age appropriate adaptive functioning. Causes of mental retardation (intellectual disabilities) may vary and degree of intellectual impairment can range from mild to profound. (See DSM-IV for further explanation.)

Interdisciplinary Team (IDT): The person, Service Coordinator and when applicable, the legal representative and/or professionals, paraprofessionals, and others who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the individual's needs and design appropriate services and specialized programs responsive to those needs. The IDT meetings are guided by the person's needs, wishes, desires, and goals.

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Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID): An institution for persons with mental retardation (intellectual disabilities) that provides, in a protected residential setting, ongoing evaluation, planning, 24 hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability as defined in 42 CFR 435.1010.

Legal Representative: The parent of a minor child or a court appointed legal guardian for an adult or child or anyone with the legal standing to make decisions for the person.

Licensed Home: A residential setting that is owned, leased and/or operated by an IDDW provider and licensed by Office of Health Facility and Licensure.

Making Action Plans (MAPS): A person-centered planning tool that uses a graphic process to tell the story of a person's milestones, help others get to know them, and begin it build a plan to move in the direction of their dreams.

Medicaid Fair Hearing: The formal process by which a person or applicant may appeal a decision if the individual feels aggrieved by an adverse action that is consistent with state and federal law, including eligibility denials, eligibility terminations or when denied a covered benefit or service. This process is conducted by an impartial Board of Review Hearing Officer.

Medical Eligibility Contracted Agency (MECA): The contracted agent of BMS responsible for the determination of medical eligibility for IDDW applicants, annual redeterminations of continued eligibility for persons and recruiting and training licensed psychologists for participation in the IPN.

Medication Administration Record (MAR): The report that serves as a legal record of the drugs administered to a person by a nurse or other healthcare professional, such as an Approved Medication Assistive Personnel (AMAP).

Medley Advocate: Employees of the designated Medley Advocacy Agency who advocate for the inclusion of services appropriate to the individual and for services consistent with the principles of least restrictive alternative and the person's choice.

Medley Class Member: Individuals with a diagnosis of mental retardation (intellectual disabilities) who were institutionalized prior to the age of 23 in a West Virginia state institution i.e. Weston State Hospital, William Sharpe Hospital, Huntington State Hospital, Mildred Bateman Hospital, Colin- Anderson Center, Greenbrier Center, Spencer State Hospital, Lain State Hospital or Hope Mont State Hospital for at least 30 days and whose birth date is on or after April 1, 1956.

Natural Supports: Family, friends, neighbors or anyone who provides a service to a person but is not reimbursed. Normal parenting activities such as transporting a child to school, church or to visit relatives or caring for a child who is absent from school due to illness are considered natural supports.

Non-legal Representative: A person freely appointed by the person or their legal representative to assist the person or their legal representative with the responsibilities of participant direction, including exercising budget authority and employer authority.

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Office of Health Facility Licensure and Certification (OHFLAC): The state agency that inspects and licenses IDDW providers to assure the health and safety of IDDW persons. Licensed entities include but are not limited to behavioral health providers, IDDW providers, facility-based day programs, group homes, supported employment facilities, and Service Coordination agencies.

Participant-Directed Services: Six services (Person-Centered Supports (Family and Unlicensed Residential), Respite (In-Home and Out-of-Home), Transportation and Goods & Services) that an IDDW person not living in a licensed setting may choose to self-direct. The person may determine what mix of personal assistance supports and services work best for them within their individualized budget.

Person: The individual Medicaid member receiving Intellectual/Developmental Disability Waiver (IDDW) services.

Person's Family Residence: A residence where the person has a 911 address and lives with at least one biological, adoptive, natural, or other family person.

***Personal Options* Financial Management Services Model:** The Fiscal/Employer Agent (F/EA) Financial Management Service that is a contracted subagent of BMS that assists the person and/or their legal/non-legal representative with exercising employer and budget authority by assisting with the hiring of person's Qualified Support Workers and completing payroll functions. The F/EA also provides Information and Assistance (I&A) to persons choosing to direct the available services.

Planning Alternative Tomorrows with Hope (PATHS): A results oriented creative planning tool which starts in the future and works backwards to an outcome of first (beginning) steps that are possible and positive.

Pre-hearing Conference: A meeting requested by the applicant or person and/or legal representative to review the information submitted for the medical eligibility determination and the basis for the denial/ termination. A Medicaid Fair Hearing pre-hearing conference may be requested any time prior to a Medicaid Fair Hearing.

Professional Experience: A position that requires a minimum of a Bachelor's degree or a professional license, such as an LPN.

Public Community Location: Any community setting open to the general public such as libraries, banks, stores, post offices, etc. Facility-Based Day and Pre-Vocational sites are not considered Public Community Locations.

Public Education Services: School services for students through the end of the school year when the student turns 21 years of age or the student has met graduation requirements for a standard high school diploma as defined by the Individuals with Disabilities Education Act (IDEA) and WV policy 2419.

Qualified Support Worker (QSW): Direct care workers employed by the self-directing person who provide person-centered support services, respite services or transportation services to the person through one of the Participant-Directed Options.

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Resource Consultant: A representative from the Fiscal/Employer Agent's Financial Management Service who assists the person and/or their legal/non-legal representative who choose this Participant-Directed Option with the responsibilities of self-direction; developing a plan and budget to meet their needs; providing information and resources to help hire, train and manage employees; provides resources to assist the person with locating staff,; providing information and resources to help purchase goods and services; helping to complete required paperwork for this service option; and helping the person select a representative to assist them, as needed.

Safe Environment: A place where people feel secure; where they are not at risk of being subject to harm, abuse, neglect or exploitation; and where they have the freedom to make choices without fear of recourse.

Specialized Family Care Provider (SFCP): An individual who operates a foster-care home which has received certification through the WVDHHR Specialized Family Care Program. Both the home and the individual providing services are certified by a Specialized Family Care Family Based Care Specialist.

Stand-by Staff: Agency staff that are on stand-by status to replace Electronic Monitoring and On-Site Surveillance within 20 minutes or less of notification by base monitoring staff.

Traditional Services: Home and community-based services that help persons of the IDDW Program maintain their independence and determine for themselves what mix of personal assistance supports and services work best for them.

Unlicensed Residential Home: A residential home setting that is not licensed by the Office of Health Facility and Licensure with one to 3 adults living in the home. The person's name is either on the lease or the person pays rent. No biological, adoptive, or other family persons reside in the home setting with the person or work in the home. An exception would be when siblings who are also IDDW persons reside in a setting without any other family persons.

Utilization Management Contractor (UMC): The contracted agent of BMS responsible for processing initial applications, investigating complaints, assessing waiver persons' needs, functionality and supports and determining an individualized budget. The UMC also provides education for persons, their families, their workers, and IDDW providers. The UMC is authorized to grant prior authorization for services provided to West Virginia Medicaid persons. The UMC utilizes nationally recognized medical appropriateness criteria established and approved by BMS for medical necessity reviews. The UMC interfaces with the claims management system to ensure that purchased services are properly reimbursed.

West Virginia Incident Management System (WV IMS): A web-based program used by IDDW providers and *Personal Options* staff to report simple and critical abuse, neglect, and exploitation incidences to the UMC and BMS.

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CHAPTER 513 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES WAIVER (IDDW)

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter			TBD

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