CHAPTER 513–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR I/DD WAIVER SERVICES
CHANGE LOG

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CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR I/DD WAIVER SERVICES

INTRODUCTION

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 Mental Retardation and/or Developmental Disabilities. These members may or may not be eligible for other Medicaid services.

The policies and procedures set forth herein are regulations governing the provision of services under the Mental Retardation and/or Developmental Disabilities Waiver of the Medicaid Program Administered by the DHHR under the provisions of Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code. This program is hereafter referred to as the Intellectual Disabilities and Developmental Disabilities (I/DD) Waiver Program.

All services, except Participant-Directed Goods and Services are available through the Traditional Service Option offered by I/DD Waiver providers state-wide. Each member must purchase service coordinator services through the Traditional Option. For more detailed information on the Traditional Service Option, see section 513.9.1.

Four services are available through the Participant-Directed Option to members who are eligible and who choose to direct part or all of the four services available through this option. These four services (Person-Centered Supports, Respite, Transportation and Goods and Services) are described more fully in section 513.9.2. There are two Participant-Directed Financial Management Services available to assist members with self-directing these services: Agency with Choice Model and *Personal Options* Model. Members may choose all of their services

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through the Traditional Option or the member may choose to mix Traditional Option services and Participant-Directed Option Services. Members who choose to do this must first purchase those Traditional services that may not be self directed, including service coordination, before cashing out their remaining budget to purchase one or all of the four Participant-Directed services available.

All required documentation forms are available on the Bureau for Medical Services website: http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/default.aspx

513.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to *Common Chapter 200, Acronyms and Definitions,* of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of the services in the I/DD Waiver Program described in 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.

Administrative Service Organization (ASO): the contracted agent of BMS responsible for processing initial applications, investigating complaints, assessing waiver members' needs, functionality and supports and determining an individualized budget. The ASO also provides education for members, their families, their workers and I/DD Waiver providers. The ASO interfaces with the claims management system to ensure that purchased services are properly reimbursed.

Agency with Choice (AwC) Service Financial Management Service Agency: an agency who meets all the qualifications of an I/DD Waiver provider and is approved as an Agency with Choice by BMS to assist members and/or their legal/non-legal representatives with directing participant-directed services.

Agency Staff: staff employed or contracted by an I/DD Waiver provider to provide services to members in the I/DD Waiver program through both the Traditional Option and the Agency with Choice Option.

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 member remain at home and active in the community by providing a comprehensive assessment of the member's needs and empower the member to make informed choices and decisions regarding long-term care.

Annual "Anchor" Date: the annual date by which the member'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.

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Approved Medication Assistive Personnel (AMAP): an **unlicensed** staff member 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 to WV State Code 16-5O and Legislative Rule 64CSR60.

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

CareConnection®: a HIPAA compliant software system that couples technology with clinical practice to offer an effective, efficient platform for ASO services.

Circle of Support: a group of people with an interest in the member who offer either evaluation, planning, advocacy, or support to the member 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 AwC FMS Model, the I/DD Waiver provider is the Common Law Employer and in the *Personal Options* FMS Model, the member is the Common Law Employer.

Co-Employer: the relationship between a member and an I/DD Waiver provider who is a certified Agency with Choice (AwC) provider in which the member and the AwC provider share in the responsibility of hiring, training, scheduling, supervising and dismissing the member's agency staff while the AwC provider is fully responsible for all payroll functions, including determining wages and benefits of agency staff.

Critical Juncture: any time that there is a significant event or change in the member'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 member'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 mental retardation 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

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age 22; it is likely to continue indefinitely; it results in substantial functional limitations in three or more of the following areas of major life activity:

(1) Self-care,
(2) Understanding and use of language,
(3) Learning,
(4) Mobility,
(5) Self-direction, and,
(6) Capacity for independent living. (Refer to Code of Federal Regulations 42 CFR 435.1010).

Direct Care Services: Person-Centered Support, Respite, Facility-based Day Habilitation, Crisis, Supported Employment and LPN (when LPN services are provided for more than two hours per day) services available through the I/DD Waiver program.

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

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

a) manage and direct the distribution of funds contained in the participant-directed budget;
b) facilitate the employment of staff by the member by performing as the member'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 I/DD Waiver, both Agency with Choice (AwC) and *Personal Options* are models 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 member 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 I/DD Waiver providers and who is a member of the Independent Psychologist Network trained by the Medical Eligibility Contracted Agent (MECA).

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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 six 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 Plan (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.

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 members of the I/DD Waiver Program. It is designed to ensure accessibility, accountability, and continuity of support and services. The content of the IPP must be guided by the member's needs, wishes, desires and goals but based on the member's assessed needs.

Individual Program Planning: the process by which the member is assisted by a team consisting of their legal representative (when applicable), their advocate (when applicable) other natural supports the member chooses to invite as well as attendees required by the I/DD Waiver 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 member's assessed needs.

Intellectual Disabilities and Developmental Disabilities (I/DD) Waiver 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 I/DD Waiver program members. Authorized services, if applicable, must be rendered by enrolled I/DD Waiver providers within the scope of their licenses and in accordance with all state and federal requirements. BMS also contracts with an ASO to perform waiver operations including annual functional assessment for eligibility and budget determinations for active program members, 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 any qualified Agency with Choice (AwC) and with one Fiscal Employer Agent (F/EA) known as *Personal Options* to provide Financial Management Services to waiver members who choose to direct their own services through the participant-directed service options. *Personal Options* also provides Information and Referral services to members choosing that Participant-Directed Option. The Office of Health Facility

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Licensure and Certification (OHFLAC) provides monitoring and supervision of members' health and welfare through oversight of I/DD Waiver providers.

Intellectual Disabilities and Developmental Disabilities (I/DD) Waiver 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.

Intensively Supported Setting (ISS): a residential home setting that is not licensed by the Office of Health Facility and Licensure with one to three people living in the home. The member's name is either on the lease or the member pays rent. No biological, adoptive or other family members or natural supports reside in the home setting with the member.

Interdisciplinary Team (IDT): the member, 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 member's needs, wishes, desires, and goals.

Intermediate Care Facility for Persons with Mental Retardation (ICF/MR): an institution for persons with mental retardation 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 435.1009.

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 member.

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

Managing Employer: the member or their legal representative who use the AwC FMS model to direct some of their services by controlling the work being performed by sharing in the responsibility of hiring, training, scheduling, supervising and dismissing the member's agency staff, but not determining wages or benefits.

Medicaid Fair Hearing: the formal process by which a member 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): means the contracted agent of BMS responsible for the determination of medical eligibility for I/DD Waiver applicants, annual redeterminations of continued eligibility for members and recruiting and training licensed psychologists for participation in the IPN.

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Medication Administration Record (MAR): is the report that serves as a legal record of the drugs administered to a member 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 member's choice.

Medley Class Member: Individuals with a diagnosis of mental retardation 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, Lakin State Hospital or Hopemont State Hospital for at least 30 days and whose birth date is on or after April 1, 1956.

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

Mental Retardation (Intellectual Disability): is defined as 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 disability) may vary and degree of intellectual impairment can range from mild to profound. (See DSM-IV for further explanation.)

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 member and/or their legal/non-legal representative with exercising employer and budget authority by assisting with the hiring of member's Qualified Support Workers and completing payroll functions. The F/EA also provides Information and Assistance (I&A) to members choosing to direct the available services.

Natural Supports: Family, friends, neighbors or anyone who provides a service to a member but is not reimbursed.

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

Office of Health Facility Licensure and Certification (OHFLAC): the state agency that inspects and licenses I/DD Waiver providers to assure the health and safety of I/DD Waiver members. Licensed entities include but are not limited to behavioral health providers, I/DD Waiver providers, facility-based day programs, group homes, supported employment facilities and service coordination agencies.

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Participant-Directed Services: Four services (Person-Centered Supports, Respite, Transportation and Goods & Services) that an I/DD Waiver member not living in a licensed setting may choose to self-direct. The member may determine what mix of personal assistance supports and services work best for them.

Pre-hearing Conference: a meeting requested by the applicant or member 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.

Public Education Services: school services for students through the end of the school year when the student turns twenty-one (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: direct care workers employed by the self-directing member who provide person-centered support services, respite services or transportation services to the member through one of the Participant-Directed Options.

Resource Consultant: a representative from the Fiscal/Employer Agent's Financial Management Service who assists the member 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 member 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 member 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.

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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 members of the I/DD Waiver program maintain their independence and determine for themselves what mix of personal assistance supports and services work best for them.

West Virginia Incident Management System (WV IMS): a web-based program used by I/DD Waiver providers, AwC providers and *Personal Options* staff to report simple, critical and abuse, neglect and exploitation incidents to the ASO and BMS.

513.2 PROGRAM DESCRIPTION

The I/DD Waiver 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 (CMS), the federal agency responsible for the I/DD Waiver Program. The I/DD Waiver 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 I/DD Waiver Program provides services in natural settings, homes and communities where the member resides, works and shops.

513.2.1 Bureau for Medical Services Contractual Relationships

The Bureau for Medical Services (BMS) contracts with an Administrative Services Organization (ASO). The ASO acts as an agent of BMS and administers the operation of the I/DD Waiver Program. The ASO processes initial eligibility determination packets and conducts the annual functional assessment to establish re-determination of medical eligibility. The ASO conducts education for I/DD Waiver providers, members, advocacy groups, and DHHR. The ASO provides a framework and a process for the purchase of waiver services.

The ASO provides authorization for services that are based on the member's assessed needs and provides service registration information to the claims payer. BMS contracts with I/DD Waiver providers for the provision of services for members.

BMS contracts with a Medical Eligibility Contracted Agent (MECA) to determine initial and re-determination eligibility of prospective and active members and to recruit and train licensed psychologists to participate in the Independent Psychologist Network. The ASO 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 is as a subagent of BMS for the purpose of performing employer and payroll functions for members wishing to self direct some of their services through the *Personal Options* FMS..

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BMS also contracts with licensed I/DD Waiver providers who wish to participate in the West Virginia Medicaid Program. This includes an additional certification with I/DD Waiver providers who wish to provide the Participant-Directed Agency with Choice Financial Management Service Option.

A contact list for the ASO, MECA and *Personal Options* is located in Section 513.14.

513.2.2 Traditional and Agency with Choice Provider Enrollment and Responsibilities

In addition to provider enrollment requirements in *Chapter 300, Provider Participation Requirements*, I/DD Waiver 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.
- Obtain and maintain a behavioral health license through OHFLAC.
- Meet and maintain all BMS enrollment requirements including a valid provider agreement on file that is signed by the I/DD Waiver provider and BMS as well as a valid Medicaid enrollment agreement.
- Ensure that a member 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 I/DD Waiver provider.
- Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services the member needs to another provider(s) and is agreed upon by the member 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 I/DD Waiver 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-I/DD-06).
- Ensure that all agency staff providing direct care services are fully trained in the proper care of the member to whom they will be providing services prior to billing for services. Fully trained agency staff must be available until newly hired Agency Staff or Qualified Support Workers are fully trained.
- Hires and retains a qualified workforce.

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- Subcontracts with licensed individuals 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 I/DD Waiver Program and all other applicable licensing and certification bodies.
- Provide an assigned agency I/DD Waiver Contact Person whose duties include:
    - Review of Home and Day Program visits to assure compliance with Waiver policy (service coordination provider agencies only);
    - Oversight of agency staff implementing the IPPs of all members in the I/DD Waiver Program; and
    - Communicating with BMS and the ASO.
- Implement the I/DD Waiver Quality Improvement System as further defined in Section 513.2.4.
- Provide each member with maximum choice of I/DD Waiver services within their individualized budgets available in each of the service delivery options.
- Employ or contract with agency staff who meet all the training and credentialing requirements listed under Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 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 ASO.
- Ensure that all residential sites (leased or rented by the I/DD Waiver provider) provide a safe environment for the members and agency staff.
- Provide appropriate auxiliary aids and services when necessary to ensure effective communication with members 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.
- Complies with all American with Disabilities Act (ADA) requirements if applicable.

513.2.2.1 Additional Qualifications for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

All agency staff, except contracted extended professional staff, having direct contact with members must meet the qualifications listed below.

- Approved Criminal Investigation Background (CIB) checks as defined in Section 513.2.2.1.1.
- Approved Protective Services Record Check as defined in Section 513.2.2.1.2
- Are not on the list of excluded individuals maintained by the Office of the Inspector General as defined in Section 513.2.2.1.3.
- Be over the age of 18.
- Have the ability to perform the tasks.

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- Documentation of training initially and annually as mandated by OHFLAC including:
  - Training on treatment policies and procedures, including confidentiality training;
  - Training on Consumer Rights;
  - Training on Emergency Procedures, such as Crisis Intervention and restraints;
  - Training on Emergency Care to include Crisis Plans or Emergency Disaster Plans;
  - Training on Infectious Disease Control;
  - Documented training on First Aid by a certified trainer from the American Heart Association (AHA) or the American Red Cross (ARC) to include always having current First Aid certification upon hire and as indicated per expiration date on the AHA or ARC card;
  - Documented training in Cardiopulmonary resuscitation (CPR) by a certified trainer from the American Heart Association (AHA) or the American Red Cross (ARC) to include always having current CPR certification upon hire and as indicated per expiration date on the AHA or ARC card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the Agency Staff);
  - Training on the Heimlich maneuver;
  - Training on Member-specific needs (including special needs, health and behavioral health needs); and
  - Training on Recognition of, Documentation of and Reporting of suspected Abuse/Neglect and Exploitation, including injuries of unknown origin.
- Qualifications must be verified initially as current and updated as necessary.
- Agency staff who function as Approved Medication Assistive Personnel (AMAP) must have high school diplomas or the equivalent and be certified AMAPs.

513.2.2.1.1 Criminal Investigation Background Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

All I/DD Waiver provider agency staff, except contracted extended professional staff, having direct contact with members must, at a minimum, have results from a state level CIB check which includes fingerprints. This check must be conducted initially and again every three years. If the current or prospective employee has lived out of state within the last five years, the agency must conduct an additional federal background check utilizing fingerprints through the National Crime Information Database (NCID) also upon hire. I/DD Waiver providers may do an on-line preliminary check and use these results for a period of three months while waiting for state and/or federal fingerprint results to be received. Providers may only use on-line companies to complete these checks that meet OHFLAC standards. I/DD Waiver provider must contact OHFLAC at (304) 558-0050 to verify that a company meets these standards. An individual who is providing services or is employed by an I/DD Waiver provider cannot be considered to provide services nor can be employed if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;

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- Child/adult abuse or neglect;
- Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the licensed I/DD Waiver provider before placing an individual in a position to provide services to the member.

If aware of recent convictions or change in status of an agency staff member providing I/DD Waiver services, the I/DD Waiver provider must take appropriate action, including notification to the BMS I/DD Program Manager.

513.2.2.1.2 Protective Services Record Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

All I/DD Waiver provider agency staff hired after January 1, 2009, except for contracted Extended Professional Staff, having direct contact with members must have a WVDHHR Protective Services Record Checks. These must be initiated on each individual upon hire and the results must be considered by the I/DD Waiver provider before continuing employment. The Authorization and Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the DHHR Bureau for Children and Families, Division of Children and Adult Services or at www.wvdhhr.org/bcf. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of the date the form is submitted to BCF for processing must be in the Agency Staff's personnel file.

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513.2.2.1.3 Office of the Inspector General (OIG) Medicaid Exclusion List Check for Traditional Option Agency Staff and Participant-Directed Option Agency with Choice Model Staff

The Office of the Inspector General (OIG) Medicaid Exclusion List must be checked by the I/DD Waiver provider for every agency staff who provides Medicaid services prior to employment and monthly. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.gov/. A form may be printed from this website to verify that the check occurred.

513.2.3 Reporting Requirements

Anyone providing services to an I/DD Waiver member 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, seven 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 I/DD Waiver 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.

I/DD 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 member that needs to be recorded and investigated for risk management or quality improvement purposes. Examples would be a minor assault by another member 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.

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- 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 member'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 I/DD Waiver 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 members. All incidents must be entered into the WV IMS within 48 hours of the occurrence of the incident or of when the I/DD Waiver provider becomes aware of the incident. The I/DD Waiver provider must also comply with any other reporting required for mandatory reporters or as part of their behavioral health license.

Incidents pertaining to members 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. Details regarding the reporting requirements for these self-directing members are available in Section

The Service Coordination provider must submit a Mortality Notification (WV-BMS-I/DD-11) to the ASO within seven days from the date of death and to OHFLAC within 24 hours of the death of the member or when the I/DD Waiver provider becomes aware of the member's death.

The Service Coordination provider must notify the ASO 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:

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- The number of members per each Service Coordinator whose case load exceeds 20 members (e.g. Service Coordinator Name, # of members).
- 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 member data in the ASO's CareConnection® including name, address, telephone numbers, Service Coordination provider, status of financial eligibility, legal representative name and contact information, etc.

The Service Coordinator is required to notify the ASO of a member's transfer to another Service Coordination provider or if the member chooses another service delivery system within two working days. The Service Coordinator must transfer the member in the CareConnection® by the effective date of the transfer.

- The transferring agency is responsible for the notification by submitting the Member Transfer/Discharge Form (WV-BMS-I/DD-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.

513.2.4 Quality Improvement System

BMS is responsible for building and maintaining the I/DD Waiver's Quality Improvement System (QIS). The I/DD Waiver provider is responsible for participating in all activities related to the QIS. The I/DD Waiver's QIS is used by BMS and the ASO 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 member outcomes, 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 six CMS Quality Assurances are being met; and,
2) Ensure the active involvement of interested parties in the quality improvement process.

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513.2.4.1 Centers for Medicare and Medicaid Quality Assurances (CMS)

The CMS mandates the I/DD Waiver program guarantee the following six Quality Assurances:

1) **I/DD Waiver Administration and Oversight:** The State Medicaid agency is actively involved in the oversight of the I/DD Waiver, and is ultimately responsible for all facets of the I/DD Waiver program;
2) **Level of Care:** Persons enrolled in the I/DD Waiver have needs consistent with an institutional level of care;
3) **Provider qualifications:** I/DD Waiver providers are qualified to deliver services/supports;
4) **Service Plan:** Members have 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:** Members' health and welfare are safeguarded; and
6) **Financial Accountability:** Claims for I/DD Waiver services are paid according to state payment methodologies specified in the approved waiver.

Data is collected and analyzed for all six Quality Assurances and sub-assurances based on West Virginia's Quality Performance Indicators, as approved by CMS. The primary sources of discovery include I/DD Waiver provider reviews, incident management reports, member complaints/grievances, OHFLAC reviews, abuse and neglect reports, administrative reports, oversight of delegated administrative functions and interested party input.

513.2.4.2 I/DD Waiver Provider Reviews

The primary means of monitoring the quality of the I/DD Waiver services is through provider reviews conducted by the OHFLAC and the ASO as determined by BMS by a defined cycle.

The ASO performs on-site and desk documentation provider reviews, face-to-face member/legal representative and staff interviews, home visits and day program visits to validate certification documentation and address CMS quality assurance standards. Targeted on-site I/DD Waiver provider reviews and/or desk reviews may by conducted by OHFLAC and/or the ASO in follow up to Incident Management Reports, complaint data, Plan of Corrections, etc.

Upon completion of each provider review, the ASO conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the ASO will make available to the provider a draft exit report and a Plan of Correction to be completed by the I/DD Waiver provider. If potential disallowances are identified, the I/DD Waiver provider will have 30 days from receipt of the draft exit report to send comments back to the ASO. After the 30 day comment period has ended, BMS will review the draft exit report and any comments submitted by the I/DD Waiver provider and issue a final report to the I/DD Waiver 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 I/DD Waiver Services. A cover letter to the I/DD Waiver provider's Executive Director will outline the following options to effectuate repayment:

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(1) Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or
(2) 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
(3) A recovery schedule of up to a 12 month period, through monthly payments or the placement of a lien against future payments.

If the I/DD Waiver provider disagrees with the final report, the I/DD Waiver provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in *Common Chapter 800, General Administration* of the West Virginia Medicaid Provider Manual. The I/DD Waiver provider must still complete the written repayment arrangement within 30 days of receipt of the 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 ASO review, then the I/DD Waiver provider will receive a final letter and a final report from BMS.

Reviews of participant-directed services are included in Section 513.9.2.1 for AwC and Section 513.9.2.2 for *Personal Options.*

513.2.4.3 Plan of Correction

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

1. How the deficient practice for the members 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.

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513.2.4.4 Self-Reviews

The ASO prepares and disseminates electronically an I/DD Waiver Self-Review Tool which 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. I/DD Waiver providers must use the approved format for submitting self reviews so that 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 I/DD Waiver provider as a West Virginia Medicaid provider.

I/DD providers are required to conduct self reviews and submit to the ASO via electronic format on a quarterly basis. The reporting period is as follows:

- January 1 to March 31 self-reviews submitted by April 15
- April 1 to June 30 self-reviews submitted by July 15
- July 1 to September 30 self-reviews submitted by October 15
- October 1 to December 31 self-reviews submitted by January 15

513.2.4.5 Training and Technical Assistance

The ASO develops and conducts training for I/DD Waiver 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.

513.2.4.6 Quality Improvement Advisory (QIA) Council

The QIA Council is the focal point of stakeholder input for the I/DD Waiver 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 ASO staff in program planning, development and evaluation consistent with its stated purpose. In this role, the QIA Council uses the I/DD Waiver Performance Indicators as a guide to:

- 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: former and/or current members (or their legal representatives) of the I/DD Waiver Program, service providers, advocates and other allies of people with intellectual and/or developmental disabilities.

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513.2.5 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 of this chapter. Reimbursement for services is made pursuant to *Chapter 600,* however, the following limitations also apply to the requirements for payment of services that are appropriate and necessary for I/DD Waiver Program Services described in this chapter.

- I/DD Waiver services are made available with the following limitations:
  - All members must live in West Virginia;
  - All I/DD Waiver regulations and policies must be followed in the provision of the services. This includes the requirement that all I/DD Waiver 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 member's IPP; and
  - Individual Member budgets and limitations described in this manual must be followed.
- I/DD Waiver services may be provided within 30 miles of the West Virginia border to members residing in a county bordering another state.
- In addition to the non-covered services listed in *Chapter 100, General Information*, of the West Virginia Medicaid Provider Manual, BMS will not pay for the following services:
  - The I/DD Waiver 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;
  - 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 I/DD Waiver program; and
  - I/DD Waiver 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, School-based services, Crisis services, Supported Employment services, LPN Services in excess of two hours per day or Respite Care services.
- Reimbursement for I/DD Waiver 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 six months by IDT), signed by all required IDT members and include all provided services.
  - 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.

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513.3 APPLICANT ELIGIBILITY AND ENROLLMENT PROCESS

In order for an applicant to be found eligible for the I/DD Waiver Program, they must:

- Meet medical eligibility
- Meet financial eligibility
- Be a resident of West Virginia
- Have chosen Home and Community-Based Services over services in an institutional setting (ICF/MR facility)

Enrollment in the I/DD Waiver Program is dependent upon the availability of a funded I/DD Waiver slot.

The applicant must have a written determination that they meet medical eligibility criteria. Initial medical eligibility is determined by the 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 I/DD Waiver slot is available, then the applicant must establish financial eligibility before being enrolled in the I/DD Waiver program. If a slot is not available, the applicant is placed on a wait list. When a slot becomes available, then the applicant in informed and must establish financial eligibility before being enrolled on the I/DD Waiver program.

513.3.1 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.

513.3.1.1 Initial Eligibility Determination Process

An applicant may obtain an application form (WV-BMS-I/DD-1) from local Behavioral Health Centers, I/DD Waiver providers, local/county DHHR Offices, Aging and Disability Resource Centers (ADRC), the ASO or the BMS website.

Completed applications must be submitted to the ASO at:

IRG d/b/a APS Healthcare
100 Capitol Street
Suite 600
Charleston, WV 25301

Or the completed application may be faxed via the secure Efax:

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1-866-521-6882
Or emailed to secure email to:
wviddwaiver@apshealthcare.com

Upon receipt of the WV-BMS-I/DD-1, the ASO time dates and stamps the application.

The ASO contacts the applicant within three (3) business days upon receipt of the WV-BMS-I/DD-1 and provides a list of psychologists in the IPN trained by the MECA who are available within the applicant's geographical area. The applicant chooses a psychologist in the IPN and works with the ASO 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 IPE and submitting it to the ASO. The ASO will verify the IPE is complete, signed and dated and will forward to the MECA. The IPE includes clinical verification that mental retardation with concurrent substantial deficits in three or more of the six major life areas (as defined in Section 513.3.2.2) was manifested prior to age 22 **or** a related condition which constitutes a severe and chronic disability with concurrent substantial deficits in three or more of the six major life areas was manifested prior to age 22. The evaluation includes assessments which support the diagnostic considerations offered and relevant measures of adaptive behavior.

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

The IP completes the IPE and submits it to the ASO within 60 days of the initial application.

The MECA makes a written final medical eligibility determination within 30 days of receipt of the completed IPE report and application from the ASO and a written decision is mailed to the applicant and/or their legal representative.

If an applicant is determined to be medically eligible, a funded I/DD Waiver 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 wait list 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 a Medicaid Fair Hearing form and a copy of the IPE is mailed by certified mail by the ASO 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 sixty (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

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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 wait list until a funded slot allocation 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 a Medicaid Fair Hearing form and a copy of the second IPE by certified mail by the ASO. 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, the ASO and 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 wait list 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,

The applicant who is determined not to be medically eligible may re-apply to the I/DD Waiver program at any time.

The applicant's right to a medical eligibility determination within 90 days may be forfeited if the applicant 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:

- IEP 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.

513.3.2 Initial Medical Eligibility

To be medically eligible, the applicant must require the level of care and services provided in an ICF/MR 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/MR provides services in an institutional setting for persons with intellectual disability or a related condition. An ICF/MR provides monitoring, supervision, training, and supports.

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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/MR.

The MECA determines the qualification for an ICF/MR level of care (medical eligibility) based on the IPE that verifies that the applicant has mental retardation 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 I/DD Waiver 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 I/DD Waiver Program Services, an applicant must meet the medical eligibility criteria in each of the following categories:

a. Diagnosis;
b. Functionality; and
c. Need for active treatment

513.3.2.1 Diagnosis

The applicant must have a diagnosis of mental retardation 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 I/DD Waiver 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 mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires services similar to those required for persons with mental retardation.

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

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- Likely to continue indefinitely; and,
- Must have the presence of at least three substantial deficits out of the six identified major life areas listed in Section 513.3.2.2.

513.3.2.2 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 (home living, social skills, employment, health and safety, community and leisure activities).

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 MR normative populations when mental retardation 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.

513.3.2.3 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.

513.3.3. Initial Financial Eligibility

Upon notification that an I/DD Waiver slot is available, the applicant or legal representative must make an application for financial eligibility at a local/county DHHR office.

An applicant for I/DD Waiver services who is not currently a member in a full-coverage Medicaid group and receives a medical card completes the application form, DFA-1, with an Economic Services Worker (ESW) who processes the application, makes a financial eligibility decision and

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notifies the applicant through written form (Economic Services Notification Letter – ESNL-A). **The member's Notice of Decision letter for medical eligibility for the I/DD Waiver Program must be presented to the ESW before financial eligibility can be determined.**

An applicant for I/DD Waiver services, who is a member 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 I/DD Waiver services. The ESW also provides written verification (ESNL-A) of financial application to the member 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.

513.3.3.1 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 financial 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 I/DD Waiver Program.

Assets

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

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513.3.4 Slot Allocation Referral and Selection Process

Provided a funded I/DD Waiver slot is available, the allocation process is based on:

- The chronological order by date of the ASO'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 a I/DD Waiver 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/MR, his/her chosen service option (Traditional or Traditional and Participant-Directed) as well as the chosen Service Coordination provider will be included and must be returned to the ASO within 30 days of receipt of the informational packet.

If the enrollee chooses to self direct some of their services through a Participant-Directed Option then they must choose their FMS Option (Agency with Choice or *Personal Options*). Upon receipt of the complete and signed Freedom of Choice form, the ASO will refer the member to his/her chosen Service Coordination provider and if indicated, AwC or *Personal Options* agency. The SC provider may reject the referral only if:

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 member'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 I/DD Waiver provider, proof of financial eligibility (ESNL-A) obtained from the WV DHHR during the financial eligibility determination must be presented to the I/DD Waiver provider.

513.3.5 Eligibility Effective Date

The initial effective date of a Medical Card for an applicant who has not previously acquired one is the **latest** of the following two dates (provided the member 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.

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513.4 MEMBER ANNUAL RE-DETERMINATION OF ELIGIBILITY PROCESS

In order for a member to be re-determined eligible, the member must:

- Meet medical eligibility;
- Meet financial eligibility;
- Be a resident of West Virginia; and
- Have chosen Home and Community-Based Services over services in an institutional setting (ICF/MR).

The member must also 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 (home living, social skills, employment, health and safety, community and leisure activities).

513.4.1 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 member'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 ASO and the results provided to the MECA. The MECA will determine medical eligibility annually based on this assessment of functioning as defined in Section 513.3.

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 MR normative populations when mental retardation 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 ASO will conduct the functional assessment up to 90 days prior to each member's anchor date. At the time of the annual functional assessment by the ASO, each member or legal

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representative must complete the Freedom of Choice Form (WV-BMS-I/DD-2) indicating their choice of level of care settings, service coordination agency and service delivery options. If determined medically eligible, the member and Service Coordination provider will also receive the individual budget allocation that was calculated by the ASO based upon the member's assessed needs.

If a member is determined not to be medically eligibility a written Notice of Decision, a Request for Hearing form and the results of the functional assessment are sent by certified mail by the ASO to the member or their legal representative. The member's service coordinator is also notified by the ASO. The denial of medical eligibility may be appealed through the Medicaid Fair hearing process if the Request for Hearing form is submitted by the member 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 member or their legal representative to request a second medical evaluation.

The second medical evaluation is completed within sixty (60) days by a member of the IPN at the expense of BMS.

If the member's medical eligibility is terminated and the member 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 member or their legal representative's receipt of the Notice of Decision.

If the member is determined to be medically eligible as a result of a Medicaid Fair Hearing, then services will continue if the member 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 member 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.

At any time prior to the Medicaid Fair hearing, the member or legal representative may request a pre-hearing conference. At the pre-hearing conference, the member and/or their legal representative, the ASO and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination.

More information on appealing medical eligibility can be found in Section 513.5.4 Member Appeals.

513.4.2 Annual Re-determination of Financial Eligibility

All I/DD Waiver members, except for Supplemental Security Income (SSI) recipients, must have financial eligibility re-determined annually by their local or county DHHR. Members who are found financially eligible will receive documentation from the DHHR (ESNL-A) which the member needs to present to their service coordination provider. The member must provide their

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Notice of Decision letter re-establishing their medical eligibility to the DHHR before financial eligibility can be established. Members must meet the following financial eligibility criteria:

Income

The member's monthly income may not exceed 300% of the current maximum monthly SSI payment for a single individual. 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 determination.

Assets

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

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

513.5 RIGHTS AND RESPONSIBILITIES OF MEMBERS/LEGAL REPRESENTATIVES

513.5.1 Member/Legal Representative Rights

The member retains all rights afforded to them under the law and the list below is intended to be limited to their rights as a member participating in the I/DD Waiver Program.

- Members 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 options by the ASO through the completion of a Freedom of Choice form (WV-BMS-I/DD-2) upon enrollment in the program and at least annually thereafter.
- Members and/or their legal representatives have a choice of I/DD Waiver providers.
- Members and/or their legal representatives have the right to address dissatisfaction with services through the I/DD Waiver provider's grievance procedure.
- Members directing their services through AwC or *Personal Options* will also have the right to address dissatisfaction regarding Financial Management Services. Each AwC provider and *Personal Options* must have a procedure for responding to and tracking member complaints.
- Members or their legal representatives have the right to access the Medicaid Fair Hearing process consistent with state and federal law.
- Members have the right to be free from abuse, neglect and financial exploitation.

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- Members and/or their legal representatives have the right to be notified and attend any and all of their IDT meetings, including critical juncture meetings.
- Members 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.
- Members and/or their legal representatives have the right to obtain advocacy if they choose to do so.
- Members and/or their legal representatives have the right to file a complaint with the ASO regarding the results of their functional assessment.
- Members 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.
- Members and/or their legal representative have the right to make decisions regarding their services.
- Members have the right to receive reasonable accommodations afforded to them under the ADA.

Each member is informed of these rights by their I/DD Waiver provider service coordination agency upon enrollment and at least annually thereafter.

513.5.2 Member/Legal Representative's Responsibilities

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

- To be present during IDT meetings. It is strongly recommended that the member, if medically and behaviorally able, be present and actively involved in their person-centered plan and IDT meetings. In extremely extenuating circumstances, the legal representative or other team members may participate by teleconferencing if they do not bill for the time spent in the IDT. The member **must** be present if they do not have a legal representative;
- To participate in the annual assessments for determination of medical eligibility and individualized budget;
- To participate in re-determination of financial eligibility at their local DHHR as required;
- To comply with all I/DD Waiver 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 member's living arrangements change, the member's needs change, the member is hospitalized or if the member needs to have a critical juncture meeting.

Failure to comply with these responsibilities may jeopardize the member's continuation of I/DD Waiver services.

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513.5.3 Member Grievances/Complaints

Members have a right to obtain oral and written information on the agency's rights and grievance policies. If a member or their legal representative is dissatisfied with the quantity of services or the provider of service, it is recommended that they follow the I/DD Waiver provider agency's grievance process. If the issue is not resolved at this level, the member or legal representative may file a formal complaint with the ASO. If the issue cannot be satisfactorily resolved through the ASO's intervention, the member or legal representative may choose another provider of service or request a Medicaid Fair Hearing consistent with state and federal law.

If a member or their legal representative is dissatisfied with the content of the annual functional assessment, they must notify the ASO within 60 days of assessment date. The Assessment Data Modification Request (WV-BMS-I/DD-13) form must be fully completed and must cite the items in question. The ASO 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 make every effort to purchase services within the budget allocated by the ASO. If the IDT cannot purchase all needed services within the budget, the Service Coordinator must contact the ASO to request additional services. If negotiation is unsuccessful, the Service Coordinator may request a Second Level Negotiation with the ASO for the additional services. The member and/or their legal representative may by-pass the First and Second Level Negotiations with the ASO and request a Medicaid Fair Hearing on the denial of the additional amount of services.

513.5.4 Member Appeals

If a member 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 ASO to the member or their legal representative. A notice is also sent to the member'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 member or their legal representative may also request a second medical evaluation.

The second medical evaluation must be completed within sixty (60) days by a member of the IPN. If the member 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 member 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 member or legal representative's receipt of the Notice of Decision, reimbursement for all I/DD Waiver services will cease.

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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 I/DD Waiver services will cease on the 13th day after receipt of the written Notice of Decision letter if the member 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 member is again denied medical eligibility based on the second medical evaluation,, the member 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 ASO. The member's service coordinator will also receive a notice. The member 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 member or their legal representative any time prior to the Medicaid Fair Hearing and the ASO will schedule. At the pre-hearing conference, the member and/or their legal representative, the ASO 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 member is eligible financially for Medicaid services without the I/DD Waiver 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 member 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.

513.6 MEMBER DISCHARGE

A member may be discharged from the I/DD Waiver Program for a reason outlined below. The Service Coordinator must complete and submit to the ASO a copy of the Member Transfer/Discharge Form (WV-BMS-I/DD-10) within seven (7) days to the ASO .

- A member's income or assets exceed the limits specified in Sections 513.3.3.1 and 513.4.2 of this chapter. The county DHHR office must be contacted, in addition to the ASO, 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 ASO of termination of the medical card. The Service Coordinator is responsible for monitoring the member's assets and is also the responsible party for reporting when the member's income or assets exceed the limits specified in Section 513.3.3.1 and

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514.4.2. The Service Coordinator may request information from the member or the member's payee or member'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 member's medical eligibility demonstrates that they are no longer medically eligible for the I/DD Waiver Program. The ASO notifies the member or their legal representative and the member's service coordinator of termination of services and of their right to appeal as outlined in Section 513.5.4 of this chapter
- A member or their legal representative voluntarily terminates Waiver services by signing the Transfer/Discharge form (WV-BMS-I/DD-10). The Service Coordinator must convene the IDT in the development of the IPP to transition the member to the new services when applicable.
- A member becomes deceased. The Service Coordinator must complete and submit the Notification of Member Death (WV-BMS-I/DD-11) and notify OHFLAC within 24 hours and submit the completed form to the ASO within seven days.
- A member or their legal representative fails to comply with all I/DD Waiver policies including monthly home visits by Service Coordinator, participation in required assessments, IDT meetings and IPP development, then the member may be discharged from the I/DD Waiver Program following consultation and approval from the ASO.
- A member does not access or utilize at least one direct care I/DD Waiver Service for a period of 180 consecutive days. If the member or their legal representative signed a Transfer/Discharge Form (WV-BMS-I/DD-10), then it is effective on the date of signature and this rule does not apply.

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

I/DD Waiver providers are prohibited from discharging, discriminating or retaliating in any way against a member 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 I/DD Waiver provider.

I/DD Waiver service coordination providers may not discharge a member if the member chooses to self direct part of their services through either of the Participant-Directed service options.

513.7 MEMBER TRANSFER

The member 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 member 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-

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to" providers. The Service Coordinator must complete and submit the Member Transfer/Discharge Form (WV-BMS-I/DD-10) within seven days to the ASO. 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 I/DD Waiver provider may not terminate services unless a viable IPP is in place that effectively transfers needed services from one I/DD Waiver provider to another provider and is agreed upon by the member and/or their legal representative and the receiving provider. Providers are prohibited from discriminating in any way against a member or legal representative wishing to transfer services to another provider agency.

513.8 INDIVIDUAL PROGRAM PLAN (IPP)

Central to the services that a member receives through the I/DD Waiver program is the member's IPP. Developing the IPP is the process by which the member is assisted by their Interdisciplinary Team which consists of their legal representative (when applicable), their advocate (when applicable) other natural supports the member chooses to invite as well as attendees required by the I/DD Waiver 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 member's needs, wishes, desires, and goals but based upon assessed needs. All IPP meetings should be scheduled at a time and location that takes into consideration the schedule and availability of the member and the other members of the team.

If the member is their own legal representative, then the member must attend the IPP. If the member has a legal representative, the legal representative must attend the IPP in person or by teleconferencing in extenuating circumstances and the member must also attend if medically and behaviorally able. If the member does not attend due to medical or behavioral issues, the service coordinator must ensure that the member understands the services outlined in their IPP to the best of their ability and is given an opportunity to sign the IPP within 10 days.

Individual Program Planning includes the Initial IPP which must be developed within seven 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.

The IPP should minimally include:

- All components in the WV-BMS-I/DD-05
    - Cover/Demographics
    - Meeting Minutes
    - Circle of Support/Goals and Dreams
    - Summary of Assessment and Evaluation Results
    - Medications

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- Individual Service Plan
  - I/DD Waiver Services
  - Non-I/DD Waiver Services and Natural Supports
- Individual Habilitation Plan and Task Analysis
- Tentative Weekly Schedule
- Signature Sheet (and rationale for disagreement if necessary)
- Behavior Support Plan or Protocol, if applicable, with signatures of developer and member/legal representative (must indicate consent by member/legal representative)
  - Dates that plan was approved, initiated and will be reviewed. If the plan includes restrictive measures, then approval by the I/DD Waiver Provider's Human Rights Committee must be attached. HRC must monitor plans with adverse procedures at least annually.
- Crisis Plan
- Individual Spending Plan if member is self-directing any of the Participant-Directed Services available

A Crisis Plan must be completed for each I/DD Waiver member. This shall be considered an attachment and part of the member's IPP. A Crisis Plan must be personalized and discuss any foreseeable issues which might put the member'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 I/DD Waiver services
- Any other member-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 members 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 member 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 members within 14 days of the date of the IDT team meeting by the Service Coordinator.

In extenuating circumstances (i.e. legal representative living out of state or inclement weather), IDT members may participate by teleconferencing, however they may not bill for the time spent

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in the IDT if participating by teleconference 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 member has been admitted to a crisis respite site, 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-I/DD-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 member 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, but shall not exceed 180 days. The IPP must be updated at critical juncture meetings to include IDT recommendations. 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. IDT meetings should be held in a location that is convenient to the member.

At a minimum, the IDT consists of:

- The member;
- Their legal representative as applicable;
- The member's Service Coordinator;
- Representatives of all I/DD Waiver providers that provide services to the individual; and
- A Medley Advocate if the member is a Medley Class Member.

If the member is their own legal guardian and is unable to attend due to behavioral or medical issues then the IPP must be rescheduled.

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

- Natural supports the member chooses to invite;

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- Professionals, such as a Therapeutic Consultant (TC), Behavior Support Professional (BSP), Registered or Licensed Practical Nurse (LPN), Physical Therapist, Occupational Therapist, Speech Therapist, Registered Dietician, etc.;
- Direct service workers, such as Day Habilitation Program providers, Person-Centered Support Workers, Respite workers, Supported Employment providers, and LPN's responsible for habilitation programs when the member receives 8 hours or more nursing in one day;
- 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 member 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 member 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 member, if medically and behaviorally able, utilizing a person-centered approach to planning.

513.8.2 Frequency of IDT Meetings and IPP Development

513.8.2.1 Seven Day IDT Meeting

This meeting is mandatory when a member receives an I/DD Waiver slot. This is the initial meeting that occurs within the first seven days of admission/intake by a new provider agency and must include I/DD Waiver services as well as other support services a member 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-I/DD-4) by the member'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.

513.8.2.2 Thirty Day IDT Meeting

The Initial IPP must be finalized within 30 days. The resulting IPP (WV-BMS-I/DD-5) completed by the member's service coordinator identifies the comprehensive array of services necessary to fully support the I/DD Waiver program member. This document must be reviewed annually and at least every 180 days.

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 regulations.

513.8.2.3 Transfer/Discharge IDT Meeting

This meeting is held when a program member transfers from one I/DD Waiver provider to another, chooses a different service delivery option or when the member no longer meets medical or financial eligibility. The transfer-from agency is responsible for coordinating the meeting and documenting the transfer. The member 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 days. The transfer-from agency must also send a Member Transfer/Discharge Form (WV-BMS-I/DD-10) to the ASO within seven 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 member 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 member needs to successfully access the new setting and services. A thirty day IDT must occur to finalize these services. The Service Coordinator must transfer the member in the CareConnection® by the effective date of the transfer.

A member may choose to direct their own services at any time through either of the Participant-Directed Service Options (AwC or *Personal Options)* by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within two (2) days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the chosen Participant-Directed Service agency and a participant-direct budget will be developed while all Traditional Services will remain with the I/DD Waiver provider(s).

A member may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within two (2) days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional Service agency and a Traditional service budget will be developed.

See Section 513.6 for valid reasons for discharge of a member from I/DD Waiver Services

513.8.2.4 Critical Juncture IDT Meeting

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

See Section 513.6 for appropriate reasons for discharge of a member from I/DD Waiver Services.

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513.8.2.5 Annual, Quarterly and Six-Month IDT Meetings

The IDT must meet up to 30 days prior to the member'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, but 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 I/DD Waiver:

1. Traditional Service Option
2. Participant-Directed Service Option (as provided by an Agency with Choice Model or the *Personal Options* Financial Management Service)

The Traditional Service Option is one of the delivery systems offered through the I/DD Waiver. A member has the option to choose all of their services through the Traditional Service Option or a combination of traditional services and the four participant-directed services. The four services available through the Participant-Directed Option are Person-centered Supports, Respite, Transportation and Goods & Services. All other requested services must be purchased through the Traditional Service Option.

The services available through the Traditional Service Option are fully described in Section 513.9.1.

The Participant-Directed Service Option is the other service delivery system offered through the I/DD Waiver. This system provides each member with 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 members have the opportunity to exercise choice and control are:

- Person-Centered Support Services
- Respite
- Transportation
- Participant-directed Goods and Services

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The Participant-Directed Service Option is available to every eligible I/DD Waiver member except for members living in OHFLAC licensed residential settings.

There are two Financial Management Service (FMS) models available to members and/or their legal/non-legal representatives to support their use of participant-directed services. These are the Agency with Choice (AwC) FMS model and the *Personal Options* FMS model. Under the AwC model, the I/DD Waiver provider serves as the fiscal agent and the member and/or their legal/non-legal representative along with the AwC provider serve as co-employers. Under the *Personal Options* model, *Personal Options,* serves as the fiscal agent and the member and/or their legal/non-legal representative serve as the employer of record.

Under the AwC FMS model, the member and/or their legal/non-legal representative and the I/DD Waiver provider are co-employers of the Qualified Support Workers for the member. The AwC FMS and the member and/or their legal/non-legal representative are responsible for managing the receipt and distribution of individuals' participant-directed budget funds. The AwC has the responsibility for processing and paying Qualified Support Workers' payroll and vendors' invoices for approved participant-directed goods and services. Together the AwC provider and the member and/or their legal/non-legal representative decide who provides orientation and training to the member's Qualified Support Workers. It may be the AwC provider, the member and/or their legal/non-legal representative or a combination of both.

Under the *Personal Options* FMS model, the member or their legal/non-legal representative is the employer of record of the Qualified Support Workers they hire directly. *Personal Options* acts as the employer agent to the employer of record who is either the member or their legal/non-legal representative. *Personal Options* is responsible for managing the receipt and distribution of individuals' participant-directed budget funds, verifying qualifications of workers, processing and paying Qualified Support Workers' payroll and vendors' invoices for approved participant-directed goods and services, providing orientation on enrolling with and using the *Personal Options* FMS and employer skills training to members and representatives, as appropriate.

A member may choose to direct their own services at any time through either of the Participant-Directed Service Options (AwC or *Personal Options)* by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within two (2) days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the chosen Participant-Directed Service agency and a participant-direct budget will be developed while all Traditional Services will remain with the I/DD Waiver provider(s).

A member may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within two (2) days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional Service agency and a Traditional service budget will be developed.

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These two options for Financial Management for participant-directed services, Agency with Choice and *Personal Options* are more fully described and defined in Section 513.9.2.

513.9.1 Traditional Service Options

The Traditional Service Option is available to every member enrolled in the I/DD Waiver. These services are available through I/DD Waiver providers after being determined as necessary and appropriate for the I/DD Waiver member. The I/DD Waiver provider has employer authority as well as fiscal responsibility for the services listed on the member's IPP. These services are provided in natural settings where the member resides and participates in community activities.

513.9.1.1 Behavior Support Professional: Traditional Option

Procedure Code: T2025

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. Services must be within the member's individualized budget.

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

Definition of Service:

This service is provided to members with identified maladaptive behaviors and documented social behavior skill deficits documented through one of the following conditions:

- Member must currently exhibit maladaptive behaviors so severe that the adaptive functioning and ability to receive adaptive training is limited or impossible unless maladaptive behaviors are reduced or eliminated.
- Member may have a history of behaviors beyond one year that have resulted in severe life threatening situations such as fire setting or arson or sexual assault or offending behaviors that result in bodily harm to others or self.
- Member must have identified behaviors on the IPP that require tracking of behavioral data for the functional assessment.
- Member must have a functional assessment that outlines one or more specific target behaviors that are currently or will be addressed in a behavioral protocol or a positive behavior support plan.

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The BSP is responsible to identify targeted maladaptive behaviors; develop hypotheses and Positive Behavior Support plans; develop habilitation plans and provide training in the person-specific aspects and method of a plan of intervention to the direct care staff (i.e. family, person-centered support workers, facility-based day habilitation workers, supportive employment providers, crisis workers and respite workers). The BSP also provides evaluation/monitoring of the effectiveness of the Positive Behavior Support plan through analysis of programming results.

I/DD Waiver provider agencies who submit their curriculum for approval to the West Virginia Positive Behavior Support (WV-PBS) Network may allow their agency staff who was formerly credentialed as Therapeutic Consultant Behavior Analysts or Therapeutic Consultant Behavior Specialists before October 1, 2011 to bill the BSP code as long as they meet all other requirements listed below. The WV-PBS Network approves all curriculums that meet the Association of Positive Behavior Support (PBS) standards of practice within six months of submission and the West Virginia I/DD Waiver provider completes training of agency staff within six months of approval of the curriculum. All curriculums submitted must include a minimum of 20 hours of training in APBS standards of practice and 10 hours of mentoring. This mentoring training is not member-specific and is not billable.

All newly hired agency staff must be either completely trained in a curriculum which has been approved by the WV-PBS Network or meet other requirements below before being allowed to bill the BSP code.

The Behavior Support Professional may perform the activities listed below.

- Take responsibility for all aspects of Positive Behavior Support services.
- Complete behavioral assessment or evaluation consisting of activities such as functional assessment of targeted behavior or analysis of behavioral data.
- Facilitate the development of Positive Behavior Support plans addressing behavioral protocols and behavioral guidelines.
- Train direct care staff to implement Positive Behavior Support plans.
- Develop behavioral protocols and behavioral guidelines for direct care staff or families.
- Develop methodology for intervention with the individual.
- Assess, evaluate and monitor the effectiveness of Positive Behavior Support plans.
- Develop adaptive habilitation plans based upon the member's assessed adaptive and maladaptive needs.
- Collaborate with Therapeutic Consultant(s) (when applicable) to ensure that positive behavior support strategies are consistently applied within all training strategies.
- Train direct care staff, model training strategies and observe staff to ensure that proper implementation of training strategies are imbedded across all aspects of habilitation. This may include training on members' health and safety needs as well as speech, physical and occupational therapy treatment activities.
- Facilitate person-centered planning as a component of the Positive Behavior Support Plan.

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- Present proposed member's restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information.
- May attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO if requested by the member or their legal representative.

Documentation:

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

- Member'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 member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 960 units/240 hours per member's annual IPP year in combination with Therapeutic Consultant Services.
- Member is limited to one BSP.
- If the member receives all direct care services from a single I/DD Waiver provider, the member is limited to one BSP or TC.
- If the member receives direct care services from more than one I/DD Waiver provider, the member/legal representative is responsible for choosing which provider will provide BSP services.
- Agency staff providing BSP services may not be an individual who lives in the member's own residence or family residence.
- If the assigned BSP is unavailable due to an emergency or illness another BSP or TC may provide services in their absence.
- Direct care services provided by the BSP must be billed utilizing the appropriate direct care service code.
- BSP services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/MR or another WV waiver program for planning purposes.

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- 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 member's file for quality assurance purposes.
    - Staff meetings for groups or individuals.
    - Monitoring of group home (fire drills, hot water heater temperature checks, etc.).
    - 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 member 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.

Agency Staff Qualifications:

In addition to meeting all the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3, agency staff providing BSP services must meet at least one of the standards listed below.

- Be a Board Certified Assistant Behavior Analyst (BCaBA) Certificate- Bachelor's degree, one year professional experience working with individuals with I/DD and completion of the West Virginia Positive Behavior Support (WV-PBS) Network's three hour overview of Positive Behavior Support; or
- Be a Board Certified Behavior Analyst (BCBA) Certificate-Master's degree, one year professional experience working with individuals with I/DD and completion of the WV-PBS Network's three hour overview of Positive Behavior Support; or
- Have a Bachelor of Arts (BA) or Bachelor of Science (BS) degree or a Masters of Arts (MA) or Masters of Science (MS) in a human services field and two years professional experience in the I/DD field and documented evidence of enrollment in the APBS standards of practice coursework/training as evidenced by: Enrollment in an approved BCBA or BCaBA university training course or enrollment in a specific curriculum training program that is pre-approved as meeting the APBS standards of practice by the WV-PBS Network or by an approved state agency. Agency staff must also be credentialed as a Therapeutic Consultant Behavior Analyst or a Therapeutic Consultant Behavior Specialist before October 1, 2011.

By January 1, 2013, the BSP must have one of the minimum acceptable credentials listed below.

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- Be a Board Certified Assistant Behavior Analyst (BCaBA) Certificate-Bachelor's degree, one year professional experience working with individuals with I/DD and completion of the three hour overview of Positive Behavior Support; or
- Be a Board Certified Behavior Analyst (BCBA) Certificate-Master's degree, one year professional experience working with individuals with I/DD and completion of the three hour overview of Positive Behavior Support; or
- Have a Bachelor of Arts (BA) or Bachelor of Science (BS) degree or a Masters of Arts (MA) or Masters of Science (MS) in a human services field and two years professional experience in the I/DD field and documented evidence of completion of APBS standards of practice coursework/training as evidenced by documentation of successful completion of an approved BCBA or BCaBA university training course or completion of agency specific curriculum based on the APBS standards of practice that have been approved by the WV-PBS Network or by an approved state agency.

513.9.1.1.2 Behavior Support Professional: Individual Program Planning: Traditional Option

Procedure Code: T2025-HT

Service Units: Unit = Event

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 member's individualized budget.

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

Definition of Service:

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

Individual Program Planning is the process by which the member 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.

Documentation:

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 regulations.

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 4 Events per member'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.
- This code is limited to the one BSP assigned to the member.
- Agency staff providing BSP services may not be an individual who lives in the member's own residence or family residence.

Agency Staff Qualifications:

In addition to meeting all the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3, agency staff must meet the qualifications defined in Section 513.8.1.1.

513.9.1.2 Crisis Services: Traditional Option

Procedure Code: T2034

Service Units: Unit = I hour

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on specific assessed needs and services must be within the member's individualized budget.

Under emergent circumstances which place the member'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 member's family residence, a Specialized Family Care Home, a licensed group home, any ISS and public community locations.

Definition of Service:

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 regulations.

The goal of this service is to respond to a crisis immediately, assess and stabilize the situation as quickly as possible. Crisis services are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavioral support planning, interventions, strategies and direct care. Except in emergent situations, this service requires prior authorization. This service is a 2:1 ratio (agency staff to member 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 behavioral support.

Documentation:

A detailed progress note is required. If the Direct Support Service Log (WV-BMS-I/DD-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.

- Member's Name
- Service code
- Date
- Start time
- Stop time
- Summary of the crisis service interventions
- Total time spent
- Signature of agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 336 units/336 hours per member's annual IPP year.
- May be provided concurrently with Service Coordination, Therapeutic Consultant, BSP Transportation and up to two hours of LPN nursing services per day.
- Person-Centered Supports, Facility-Based Day Habilitation, LPN when provided more than 2 hours a day, Respite and Supported Employment services may not be provided concurrently with this service.
- This service is not intended for use as emergency response for ongoing behavioral challenges.
- The agency staff to member ratio is 2:1.
- Agency staff providing Crisis services may not be an individual who lives in the member's own or family residence.

Agency Staff Qualifications:

All the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

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513.9.1.3 Dietary Therapy: Traditional Option

Procedure Code: 97802-AE

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 member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

Dietary Services are provided directly to the member 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 members; and
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the ASO if requested by the member or legal representative

Direct care services provided by the dietitian must be billed utilizing the appropriate direct care procedure code.

Documentation:

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

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 regulations.

- Member'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 member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 416 units/104 hours available per member's annual IPP year in combination with Physical Therapy and Occupational Therapy.
- The agency staff to member ratio is 1:1.
- Agency Staff providing Dietary Therapy services may not be an individual who lives in the member's home.

Agency Staff Qualifications:

All the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency Staff must be a licensed Dietitian in the State of WV.

If the Dietitian is contracted by the I/DD Waiver 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.

513.9.1.4 Electronic Monitoring/Surveillance System and On-Site Response: Traditional Option

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

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 regulations.

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 member's individualized budget.

Site of Service: This service may be provided in the adult member's family residence, a licensed group home and in any ISS.

Definition of Service:

Electronic Monitoring/Surveillance System and On-Site Response services include the provision of oversight and monitoring within the residential setting through off-site electronic surveillance. Also included is the provision of designated I/DD Waiver agency stand-by intervention staff prepared for prompt engagement with the member(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 member 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 member's home.
- This service may be installed in residential settings in which residing adult members, 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 I/DD Waiver 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 I/DD Waiver 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 members, any situation that appears to threaten the health and welfare of the member).
- The electronic monitoring system or company must receive notification of smoke/heat activation at each member's home.
- The electronic monitoring system or company must have two-way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of the members 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 member'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 members at the remote living site.
- The monitoring base staff will assess any urgent situation at a member's living site and call 911 emergency personal first if that is deemed necessary, then call the stand-by staff.

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- 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 member wishing to access this service must first be assessed and approved by the I/DD Waiver provider's Human Rights Committee (HRC) to ensure that the member's health and welfare would not be harmed by accessing this service. The approval of the HRC must be documented and attached to the member's IPP.
- After the approval of the HRC is obtained, the member 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 member's IPP.
    - The member, their legal representative and all IDT members are made aware of both the benefits and the risks of the operating parameters and limitations. Benefits may 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 members served by one stand-by intervention staff for on-site response is determined by the IDT and based upon the assessed needs of the members being served in specifically identified locations.
- The I/DD Waiver provider has stand-by intervention staff who meet the following standards:
    - Responds by being at the member'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 member need.
    - Assists the member 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 I/DD Waiver provider.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The electronic monitoring/surveillance to member ratios for this service are 1:1, 1:2, 1:3 and 1:4 and authorizations will be based on the number of I/DD Waiver members residing within the residence.
- 5,840 units (Average 16 hours per day) per member's annual IPP year.

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- Only electronic monitoring/surveillance systems approved by BMS will be used.
- The member 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 a member.

Provider Qualifications:

All stand-by intervention staff must meet all of the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3.

513.9.1.5 Environmental Accessibility Adaptations: Traditional Option

513.9.1.5.1 Environmental Accessibility Adaptations: Home: Traditional Option

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 assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home or any unlicensed ISS.

Definition of Service:

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

All EAA requests must be submitted by the Service Coordination provider to the ASO 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.

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 regulations.

Documentation:

I/DD Waiver provider must maintain all of the following documentation in the member's file.

- The original Request for Environmental Accessibility Adaptations form (WV-BMS-I/DD-08).
- Any assessments detailing the need for the EAA.
- The member'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 I/DD Waiver provider that the approved EAA was completed as approved.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- EAA-Home is not intended to replace the member's, member'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 and 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 must be portable.
- $1000 available per member's annual IPP year in combination with Environmental Accessibility Adaptations - Vehicle and/or Participant-Directed Goods and Services.

513.9.1.5.2 Environmental Accessibility Adaptations: Vehicle: Traditional Option

Procedure Code: T2039

Service Units: Unit = $1.00

Payment Limits: The amount of service is limited by the member's individualized budget.

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 member's individualized budget.

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 regulations.

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

Definition of Service:

Environmental Accessibility Adaptations-Vehicle (EAA-Vehicle) are physical adaptations to the vehicle including paying for accessibility adaptations if the member has the capacity to drive the vehicle EAA-Vehicle is documented on the member's IPP. The purpose of this service is to maximize the member's accessibility to the vehicle only.

All EAA requests must be submitted by the Service Coordination provider to the ASO 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.

Documentation:

I/DD Waiver provider must maintain all of the following documentation in the member's file.

- The original Request for Environmental Accessibility Adaptations form (WV-BMS-I/DD-08).
- Any assessments detailing the need for the EAA.
- The member'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 I/DD Waiver provider that the approved EAA was completed as approved.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- $1000 available per member's annual IPP year in combination with Environmentally Accessibility Adaptations - Home and/or Participant-Directed Goods and Services.
- 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 for regularly scheduled upkeep, maintenance and repairs of a vehicle except upkeep and maintenance of the modifications.

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 regulations.

513.9.1.6 Facility-Based Day Habilitation: Traditional Option

Procedure Code: T2021-U5 1:1-2 ratio
T2021-U6 1:3-4 ratio
T2021-U7 1:5-6 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 member's individualized budget.

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

Definition of Service:

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 member outside the residential home. The services must be based on assessment, be person-centered/goal oriented, and be meaningful/productive activities that are guided by the member's strengths, needs, wishes, desires, and goals.

Facility-Based Day Habilitation activities in the plan must be developed exclusively to address the habilitation and support needs of the member. Activities must consist of programs of instruction/training, supervision and assistance, specialist services and evaluations provided by or under the direct supervision of a Therapeutic Consultant or BSP (if applicable).

Facility-Based Day Habilitation activities must be based at the licensed site, but the member 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 three 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;

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 regulations.

- 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;
- Assistance to acquire appropriate attitudes and work habits, such as socially appropriate behaviors on the work site;
- Assistance to adjust to the production and performance standards of the workplace;
- Compliance training in workplace rules or procedures;
- Compliance with attendance to work activity training;
- Assistance with workplace problem solving; and
- Instruction in the appropriate use of work-related facilities (e.g., rest rooms, cafeteria/lunch rooms, and break areas.).

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

Documentation:

Documentation must be completed on a Direct Support Service Log (WV-BMS-I/DD-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.

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

Limitations/Caps:

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 regulations.

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The maximum annual units of Facility-Based Day Habilitation cannot exceed 6.240 units/1560 hours (Average 6 hours/day) per member's IPP year. When the member accesses other direct care services, these units are counted toward the daily cap of all direct care services listed in the Person-Centered Supports sections in the Traditional Option., excluding Respite.
- This service may not be billed concurrently with any other direct care services.
- Up to 48 units/12hours of Facility Day Habilitation services every three months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or Registered Nurses (RN) may bill for providing training to facility-based day habilitation staff.
- Agency staff to member 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 member's home.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.7 Occupational Therapy: Traditional Option

Procedure Code: 97530-GO

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized. Prior authorizations are based on assessed need and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

Occupational Therapy is provided directly to the member 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; and
- Consultation or demonstration of techniques with other service providers and family members.

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.

The occupational therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the ASO if requested by the member or their legal representative.

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

Documentation:

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

- Member'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 member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 416 units/104 hours per member's annual IPP year in combination with Physical Therapy and Dietary Therapy.
- The agency staff to member ratio for this service is 1:1.
- Agency staff providing Occupational Therapy services may not be an individual who lives in the member's home.

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 regulations.

- Agency staff providing Occupational Therapy services may not bill for administrative activities.

Agency Staff Qualifications:

All the requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency Staff must be a Licensed Occupational Therapist in the State of WV.

If the Occupational Therapist is contracted by the I/DD Waiver 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.

513.9.1.8 Person-Centered Support: Traditional Option

Two types of Person-Centered Supports (PCS) are available under the Traditional Option. PCS: Agency is available only to agency staff **not living** in the home with the member. PCS: Family is available only to family members or Specialized Family Care Providers **living** in the home with the member. Spouses of members are excluded from providing services. Under both services, the agency staff of the I/DD Waiver provider must meet all the qualifications in Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3.

513.9.1.8.1 Person-Centered Support: Agency: Traditional Option

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

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 member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS and public community locations. This service may not be provided in an agency staff person's home.

Definition of Service:

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 regulations.

Person-Centered Support (PCS) services consist of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

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

Agency staff 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).

PCS services may include member specific training. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the ASO is permitted if requested by the member or their legal representative.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD 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 agency staff should complete the accompanying Direct Care Progress Note to detail the issue. If training was provided the Person-Centered Support worker must also complete the task analysis.

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

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member ratio
- Start time
- Stop time

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 regulations.

- 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 agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS: Agency services cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor child or a Specialized Family Care Provider who provides care for a minor child. The IDT must make every effort to meet the member's assessed needs through natural supports.
- PCS: Agency may not substitute for federally mandated educational services.
- Agency staff providing PCS: Agency services may not be any individual who lives in the member's home.
- Up to 48 units/12hours of PCS: Agency services every 3 months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs and RNs may bill for providing training to PCS staff.
- The agency staff to member ratio codes for this service are 1:1, 1:2, 1:3 and 1:4.
- 1:1 and 1:2 are the only codes available in the member's family residence and in Specialized Family Care Homes.
- This service may not be billed concurrently with any other direct care service.
- 11,680 units/2920 hours (based upon average of eight hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available under the Traditional Option excluding Respite.
- 17,520 units/4380 hours (based upon average of 12 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct care services available under the Traditional Option excluding Respite.
- 35,040 units/8760 hours annually (based upon an average of 24 hours per day) per member's annual IPP year for members in ISS and licensed settings. This is in combination with all direct care services available under the Traditional Option.

PCS: Agency is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.

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 regulations.

PCS: Agency is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.8.2 Person-Centered Support: Family: Traditional Option

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 and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home and public community locations.

Definition of Service:

Person-Centered Support (PCS): Family consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community. PCS: Family 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

PCS: Family services must be assessment based and outlined on the member's IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs.

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 regulations.

PCS: Family services may include member specific training, attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the ASO.

Agency Staff providing PCS: Family must be a family member living in the member's home or a certified Specialized Family Care Provider providing this service in a certified Specialized Family Care Home. PCS: Family may not be provided to a member by the member's spouse.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD 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 agency staff should complete the accompanying Direct Care Progress Note to detail the issue. If training was provided the Person-Centered Support worker must also complete the task analysis.
The Direct Care Service Log must include all of the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member 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 agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS: Family cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor child or a Specialized Family Care Provider who provides care for a minor child.
- This service may not be provided by the member's spouse.
- PCS: Family may not substitute for federally mandated educational services.
- The amount of PCS: Family provided must be identified on the member's IPP.

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 regulations.

- Up to 48 units/12hours of Person-Centered Support services every three months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs and RNs may bill for providing training to PCS: Family agency staff.
- Agency staff to member ratio codes for PCS: Family are 1:1 and 1:2.
- This service may not be billed concurrently with any other direct care service.
- 11,680 units/2920 hours (based upon average of eight hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members eligible to receive public education services. This is in combination with all direct care services available under the Traditional Option excluding Respite.
- 17,520 units/4380 hours (based upon average of 12 hours per day) per member's annual IPP year for natural family/Specialized Family Care home settings for members not eligible to receive public education services. This is in combination with all direct services available under the Traditional Option excluding Respite.

PCS: Family is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.

PCS: Family is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.9 Physical Therapy: Traditional Option

Procedure Code: 97530-GP

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 member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

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 regulations.

Physical Therapy is provided directly to the member 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; and
- Consultation or demonstration of techniques with other service providers and family members.

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

The physical therapist may attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by the ASO if requested by the member or their legal representative.

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

Documentation:

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

- Member'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 member's individualized budget.

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 regulations.

- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 416 units/104 hours per member's annual IPP year in combination with Occupational Therapy and Dietary Therapy.
- The agency staff to member ratio for this service is 1:1.
- Agency staff providing Physical Therapy services may not be an individual who lives in the member's home.
- Agency staff providing Physical Therapy services may not bill for administrative activities.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency Staff must be a licensed Physical Therapist in the State of WV.

If the Physical Therapist is contracted by the I/DD Waiver 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.

513.9.1.10 Respite: Traditional Option

513.9.1.10.1 Respite: Agency: Traditional Option

Procedure Code: T1005-U1 1:1 ratio
T1005-U5 1:2 ratio
T1005-U6 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 and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed day program facility and public community locations. When this service is provided in a home setting other than the member's, the home setting must be a certified Specialized Family Care Home.

Definition of Service:

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 regulations.

Respite: Agency services 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 care-giver(s) to help prevent the breakdown of the primary care-giver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Services consist of temporary care services for an individual who cannot provide for all of their own needs.

Respite Agency services may be used to:

- Allow the primary care-giver to have planned time from the caretaker role;
- Provide assistance to the primary care-giver in crisis and emergency situations; and
- Ensure the physical and/or emotional well-being of the primary care-giver by temporarily relieving them of the responsibility of providing care.

Agency staff providing Respite: Agency services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by ASO if requested by the member or their legal representative.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD-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 agency staff should complete the accompanying Direct Care Progress Note to detail the issue. The Direct Care Service Log must include all of the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member 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 agency staff

Limitations/Caps:

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

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 regulations.

- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Respite: Agency services are not available to members living in ISS or licensed group home settings.
- Respite: Agency services are not to replace natural supports available to the member.
- Respite: Agency services may not be provided by an individual living in the member's own or family residence in which the member resides or within the Specialized Family Care Home where the member resides.
- Respite: Agency is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- Up to 48 units/12hours of Respite services every three months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to staff providing Respite: Agency Services.
- Respite: Agency Services may not be provided in an ICF/MR facility,
- 6,912 units/1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) per member's annual IPP year.
- This service may not be billed concurrently with any other direct care service.
- Agency staff to member ratios for this service are 1:1, 1:2, and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.10.2 Respite: Crisis Site: Traditional Option

Procedure Code: T1005-U7 1:1 ratio
T1005-U8 1:2 ratio
T1005-U9 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 specific assessed needs and services must be within the member's individualized budget.

Under emergent circumstances which place the members or other's health and safety at risk, this service may be immediately implemented without prior authorization up to a maximum of 72 hours.

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

Definition of Service:

Respite: Crisis Site Services 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 member's IPP may be provided by respite direct care staff.

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 ASO.

Respite: Crisis Site services usually occur after a critical juncture in treatment and must be approved by the IDT. If Respite: Crisis Site services are utilized due to a member's emergent need there must be a plan to transition the member back into the community developed at the time of admission by the service coordinator and the length of stay in the Crisis Respite site may not exceed 30 days per admission,

Service Coordinators must review the Crisis Respite Directory on the BHHF website and call the contact person listed in the directory or follow after-hours procedures available at on the Bureau for Behavioral Health and Health facilities website: www.wvdhhr.org/bhhf.

The referral packet to the Respite: Crisis Site must include the IPP that identifies the services to be provided and assessments as appropriate.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD-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 agency staff should complete the accompanying Direct Care Progress Note to detail the issue. The Direct Care Service Log must include all of the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member 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 agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 6,912 units/1,728 hours per year (averages out to 144 hours/month or 4.73 hours/day) per member's annual IPP year in combination with Agency Respite: Traditional Option and cannot exceed 24 hours per day.
- PCS cannot be billed in a Crisis Respite Site.
- Agency staff to member ratios for this service are 1:1, 1:2, and 1:3.
- This service may not be billed concurrently with any other direct care service.
- Respite: Crisis Site must be prior authorized by the ASO. Under emergent circumstances which place the member's or others' health and safety at risk, Respite: Crisis Site services may be immediately implemented without prior authorization up to a maximum of 72 hours.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.11 Service Coordination: Traditional Option

Procedure Code: T1016-HI

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 member'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 member.

Definition of Service:

Service Coordination services establish, along with the member, 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

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ensures that the maximum potential and productivity of a member is utilized in making meaningful choices with regard to their life and their inclusion in the community.

Once the member/legal representative has chosen a Service Coordination provider from the available I/DD Waiver providers, the agency assigns a Service Coordinator to the member. The member/legal representative may request the assignment of a specific Service Coordinator (SC) and when possible the agency honors the request. The member/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 member and/or legal representative with re-determination of financial eligibility as required at the DHHR office in the county where the member 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 member is found to be ineligible for I/DD Waiver Services during annual eligibility or financial redetermination.
- Provide oral and written information about the I/DD Waiver provider agency's rights and grievance procedures for members served by the agency.
- Assist with procurement of all services that are appropriate and necessary for each member within and beyond the scope of the I/DD Waiver Program.
- Inform families or custodians of children less than three years of age about the availability of Birth to Three Services.
- Act as an advocate for the member. The I/DD Waiver 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 member in the community while recognizing the member's unique cultural and personal value system.
- Interface with the ASO on behalf of the member 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 member, education and coordination of the most appropriate assessment setting that best meets the member's needs.
- 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 members 30 days in advance of meeting.
- Support the member as necessary to convene and conduct IDT meetings.

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- 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 the IPP to the IDT members and Participant-Directed service Option providers (if applicable) within 14 days of the IDT meeting.
- Monitor to ensure that the member's health and safety needs are addressed.
- Comply with reporting requirements of the WV IMS for members on their caseload.
- Personally meet monthly with the member and their paid or natural supports who are present with the member the time of the visit at the member's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented and that the member 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-I/DD-03).
- Personally meet at least every other month with the member and their support staff at the member's facility-based day program (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-I/DD-03).
- Provide planning and coordination before, during and after crises, including notifying the ASO if a member is admitted to a crisis site or state institution.
- Process Freedom of Choice forms (WV-BMS-I/DD-2) in the CareConnection® within two business days any time a member requests a change of service delivery options.
- Coordinate Transfer/Discharge meetings to ensure the linkage to a new service provider or service delivery option and access to services when transferring services from one provider agency to another or to another type of service delivery option. 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 options during annual IPP meetings and upon request by the member or legal representative.
- Inform the member of their rights at least annually.
- Attend and participate in the annual functional assessment for eligibility conducted by ASO.
- Present member's proposed restrictive measures to the I/DD Waiver 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.

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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.

- Member'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 member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 872 units/218 hours per member's annual IPP year.
- Up to 4 units of Service Coordination per month per member served may be billed to review services provided in order to verify the member receives services as indicated on the IPP.
- Service Coordinators may not provide services for more than 20 people, inclusive of non-I/DD Waiver members served by the agency.
- A member 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 member'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 services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/MR or another WV waiver program.
- Service Coordination cannot be billed for activities integral to the administration of foster care programs.

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- 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 member 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 member, interviewing, etc.
- Service Coordination cannot be billed for evaluation a member'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 member.
- 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 member to a WV Medicaid reimbursable service
- Service Coordination cannot be billed for activities not related to the member.
- Service Coordination cannot be billed for training Agency Staff and Qualified Support Workers.
- Service Coordination cannot be billed for developing goals for a member.
- 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.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to one of the following requirements listed below.

- Four year degree in a human service field and one or more years experience in the I/DD field.
- Four year degree in a human service field and less than one year of experience in the I/DD 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 six 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 I/DD 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

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of treatment plans for six months. This must be verified by supervisory documentation once per month).

- No degree or two year degree and is a Licensed Social Worker grandfathered in by the West Virginia Board of Social Worker Examiners due to experience in the I/DD field. (Restrictions - none)
- Registered Nurses with a 2 year RN degree employed prior to October 1, 2011.

513.9.1.12 Skilled Nursing: Traditional Option

513.9.1.12.1 Skilled Nursing: Licensed Practical Nurse: Traditional Option:

Procedure Code: T1003-U4 1:1 ratio
T1003-U3 1:2 ratio
T1003-U2 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 and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

Nursing services listed in the service plan are 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. Nursing services that must be provided by a LPN include but are not limited to: (Note: If these services are provided by an RN then the LPN code must be billed for reimbursement)

- Routine monitoring (data collection) of specific medical symptoms such as seizures, bowel habits, blood pressure, diet and exercise;
- 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 I/DD Waiver 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 I/DD Waiver provider policy;

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- Facilitate procurement of and monitoring of medical equipment;
- Keep emergency contact information updated and accurate;
- Bill for travel time between ISS, licensed group home and licensed day program settings for the purpose of passing medications.

If a member requires more than two hours per day of LPN service, the Request for Nursing Service (WV-BMS-I/DD-09) must be submitted to the ASO for prior authorization.

If the member receives two or more hours of skilled nursing services per day, then the LPN is responsible for providing direct care supports and training.

In ISS or licensed group homes, the total number of service units may exceed 24 hours per day when the LPN also passes medication.

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

Documentation:

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

- Member's Name
- Service code including modifier to indicate staff to member ratio
- Date of service
- Start time
- Stop time
- Total time spent
- Detailed summary of the service provided
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The maximum annual units of LPN services cannot exceed 11,680 units/2920 hours (Average 8 hours/day) per member's annual IPP year. When the member accesses other direct care services, these units are counted toward the cap listed in the Person-Centered Supports sections in the Traditional Option, excluding Respite
- This service may not be billed concurrently with any other direct care services.
- Agency staff to member ratio codes are 1:1, 1:2 and 1:3.
- Agency staff providing Skilled Nursing LPN services may not be an individual who lives in the member's home.

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- LPN 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 I/DD Waiver provider but not the I/DD Waiver manual.
    - Waiting at a physician's office.
    - Conducting group training on general medical topics.
    - Orientation training that is not member-specific.
    - Reviewing incident reports.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency staff must be a Licensed Practical Nurse in the State of WV or a licensed Registered Nurse in the State of WV.

513.9.1.12.2 Skilled Nursing: Licensed Registered Nurse: Traditional Option

Procedure Code: T1002-HI

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 member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

RN Skilled Nursing 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.

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

The RN may travel between ISS, licensed group home and licensed facility day program settings in order to pass medications.

The RN may attend and participate in the IPP and the annual assessment of functioning for eligibility conducted by ASO based upon the member or their legal representative's request.

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

Documentation:

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

- Member's Name
- Service code including modifier to indicate staff to member ratio
- Date of service
- Start time
- Stop time
- Total time spent
- Detailed summary of the service provided
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 480 units/120 hours per member's annual IPP year.
- The agency staff to member 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 member's home.
- RN services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/MR or another WV waiver program for planning purposes.
- RN services may not be billed for completing administrative activities including these listed below.

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- Attempting phone calls when the line is busy or leaving a message.
- Nursing assessments required by the I/DD Waiver provider but not the I/DD Waiver manual.
- Waiting at a physician's office.
- Reading LPN notes.
- Conducting group training on general medical topics.
- Orientation training that is not member-specific.
- Reviewing incident reports.
- Assessing LPN competency and providing support.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency staff must be a licensed Registered Nurse in the State of WV.

513.9.1.12.2.1 Skilled Nursing: Licensed Registered Nurse: Individual Program Planning: Traditional Option

Procedure Code: T2024-TD

Service Units: Unit = Event

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 member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations. The meeting cannot begin at one location and then be continued at another.

Definition of Service:

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

Individual Program Planning is the process by which the member 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

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goals, and preparation of interventions or strategies necessary to implement a person-centered plan.

Documentation:

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 4 Events per member'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.
- Agency staff providing Skilled Nursing RN IPP services may not be an individual who lives in the member's home.
- Only one RN may bill for this service during an IDT meeting.

Agency Staff Qualifications:

All the general requirements in Sections 513.1.12.2, 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency employee must be a licensed Registered Nurse in the State of West Virginia. .

513.9.1.13 Speech Therapy: Traditional Option

Procedure Code: 92507-GN

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 and services must be within the member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

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Speech Therapy is provided directly to the member 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; and
- Consultation or demonstration of techniques with other service providers and family members.

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

The speech therapist may attend and participate in IDT meetings and the annual assessment of functioning eligibility conducted by the ASO if requested by the member or their legal representative.

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

Documentation:

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

- Member'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 member's individualized budget.

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- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 96 units/96 events per member's annual IPP year for members below age 24.
- 48 units/48 events per member's annual IPP year for members age 24 and over.
- The agency staff to member ratio for this service is 1:1.
- Agency staff providing Speech Therapy services may not be an individual who lives in the member's home.
- Agency staff may not bill Speech Therapy services for completing administrative activities.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency Staff must be a licensed Speech Therapist in the State of WV.

If the Speech Therapist is contracted by the I/DD Waiver 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.

513.9.1.14 Supported Employment: Traditional Option

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 and services must be within the member's individualized budget.

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

Definition of Service:

Supported Employment Services 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 member's level of need.

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Supported Employment services include, but are not limited to:

- Vocational counseling (Example: Discussion of the member's on-the-job work activities);
- Job development and placement for a specific waiver member with the member present;
- 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;
- 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 Therapeutic Consultant. 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 ASO if requested by the member or their legal representative.

Documentation is maintained in the file of each member 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.

Documentation:

Documentation must include all of the following items.

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

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- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Agency staff providing Supported Employment services may not be an individual who lives in the member's home.
- The maximum annual units of supported employment cannot exceed 8,320 units/2080 hours (Average 8 hours/day) per member's annual IPP year. When the member accesses other direct care services, these units are counted toward the cap listed in the Person-Centered Supports section in the Traditional Option, excluding Respite
- This service may not be billed concurrently with any other direct care services.
- Group services for this service have an agency staff to member ratio of 1:2-4.
- Up to 48 units/12hours of Supported Employment services every three months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Supported Employment staff.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.1.15 Therapeutic Consultant: Traditional Option

Procedure Code: T2021

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 member's individualized budget.

Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, a licensed group home, any ISS, a licensed day program facility, crisis sites and public community locations.

Definition of Service:

Therapeutic Consultant develops training plans and provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e.,

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person-centered support workers, facility day habilitation providers and supportive employment providers). Also, the Therapeutic consultant provides training for respite workers (if applicable for "respite-relevant" training objectives or health or safety training objectives only). This service is provided to members with the assessed need for adaptive skills training. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction. This monitoring is performed and documented at minimum on a monthly basis. The Therapeutic Consultant observes the individual prior to developing a training plan. The Therapeutic Consultant follows up once the plan has been implemented to observe progress and revise the plan, as needed.

The Therapeutic Consultant may perform the following functions:

- Develops task analysis and person specific strategy or methodology for implementation of intervention or instruction plans for an individual;
- Evaluates environment(s) for implementation of the plan which creates the optimal environment for learning;
- Assists members in selecting the most suitable environment for their learning needs;
- Trains primary direct workers (i.e., person- centered support workers, facility-based day habilitation workers, supported employment and respite workers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans or guidelines);
- Assesses, evaluates and monitors the effectiveness of intervention or instruction plans (habilitation plans or behavioral guidelines) for habilitation training;
- Collects and evaluates data and completes a functional assessment around targeted behaviors to generate a recommendation for a Positive Behavior Support plan;
- Provides direct care services when needed and bills the appropriate direct care service code;
- Attends and participates in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO when requested by the member or their legal representative; and
- Presents proposed member's restrictive measures to the I/DD Waiver provider's Human Rights Committee if no other professional is presenting the same information.

Documentation:

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

- Member's Name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent

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- 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 member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 960 units/240 hours per member's annual IPP year in combination with BSP.
- Job Placement activities are limited to 20 units/five hours per quarter.
- Agency staff providing Therapeutic Consultant services may not be an individual who lives in the member's home.
- Direct care services provided by the TC must be billed utilizing the appropriate direct care service code.
- TC services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/MR or another WV waiver program for planning purposes.
- TC 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 member's file for quality assurance purposes.
    - Staff meetings for groups or individuals.
    - Monitoring of group home (fire drills, hot water heater temperature checks, etc.).
    - 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 member.
    - 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.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to one of the following requirements:

- Four year degree in a human service field and one or more years of professional experience in the I/DD field; or

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- Four year degree in a human service field and less than one year of professional experience in the I/DD field. (Restrictions - must be under the supervision of a Therapeutic Consultant or BSP Supervisor. Clinical supervision involves review of clinical activities, review of case notes and review of habilitation programming for six months. This must be verified by supervisory documentation once per month; or
- Four year degree in a non-human service field and one year professional experience in the I/DD field. (Restrictions - must be under the supervision of a Therapeutic Consultant or BSP Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of habilitation programming for six months. This must be verified by supervisory documentation once per month).

513.9.1.15.1 Therapeutic Consultant: Individual Program Planning: Traditional Option

Procedure Code: T2024-HI

Service Units: Unit = Event

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 member's individualized budget.

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

Definition of Service:

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

Individual Program Planning is the process by which the member and their IDT develop a plan based on a person-centered philosophy. The Therapeutic Consultant 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.

Documentation:

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

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Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 4 Events per member's annual IPP year.
- Therapeutic Consultant may attend all planning meetings, either face-to-face or by teleconference, but in order to bill the IPP code, the TC 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.
- Agency staff providing Therapeutic Consultant services may not be an individual who lives in the member's home.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to all of the requirements in Section 513.8.2.15.

513.9.1.16 Transportation: Traditional Option

513.9.1.16.1 Transportation: Miles: Traditional Option

Procedure Code: A0160-U1

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 and services must be within the member's individualized budget.

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

Definition of Service:

Transportation: Miles services are provided to the I/DD Waiver member for trips to and from the member's home, licensed I/DD Facility-based Day Habilitation Program 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.

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

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Documentation:

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

- Member's Name
- Service code
- Date of service
- "From" location
- "To" location
- Purpose of trip
- Total number of miles per trip

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 9,600 miles per member's annual IPP year (based on average of 800 miles per month).
- Member must be present in vehicle if mileage is billed.
- Must be related to a specific activity or service based on an assessed need and identified in the IPP.
- May utilized up to 30 miles beyond the West Virginia border by members living in a WV county bordering another state.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency staff 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.

513.9.1.16.2 Transportation: Trips: Traditional Option

Procedure Code: A0120-HI

Service Units: Unit = 1 Event

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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 member's individualized budget.

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

Definition of Service:

Transportation services are provided to the I/DD Waiver member in the I/DD Waiver provider's mini-van or mini-bus for trips to and from the member's home, licensed Facility-based Day Habilitation Program 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 seven passengers but less than 16 passengers.

Documentation:

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

- Member's Name
- Service code
- Date of service
- "From" location
- "To" location
- Purpose of trip
- Total number of miles per trip

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 4 one way trips per day or 874 trips annually.
- Member must be present in Agency-owned mini-van or mini-bus if trips are billed.

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- A trip must be related to a specific activity or service based on an assessed need and identified in the IPP.
- A trip may be billed concurrently with Person-Centered Support Services, Respite, Supported Employment and Facility-Based Day Habilitation.
- May utilized up to 30 miles beyond the West Virginia border by members living in a WV county bordering another state.

Agency Staff Qualifications:

All the general requirements in Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency employee must have a valid driver's license.

513.9.2 Participant-Directed Services

This option provides each eligible member with the opportunity to exercise choice and control over the participant-directed services they receive. The participant-directed services which members may self-direct are:

- Person-Centered Support Services
- Respite
- Transportation
- Participant-directed Goods and Services

Two Financial Management Service (FMS) models are available to members to support their use of participant-directed services. These are the Agency with Choice (AwC) FMS Model and the *Personal Options* FMS Model.

Under the AwC FMS model, the member's chosen I/DD Waiver provider is the Common Law Employer of the Agency Staff employed to provide services to the member. The AwC I/DD Waiver provider is responsible for all payroll functions, including determining wages and benefits to the Agency Staff. The member is a Managing Employer who shares in the responsibility of hiring, training, scheduling, supervising and dismissing the member's Agency Staff. The member may appoint a representative to assist with these functions. The relationship between the AwC I/DD Waiver provider and the member or their representative (when applicable) is that of a Co-Employer.

Under the AwC FMS model, no Agency Staff's hourly wage may exceed the Medicaid rate minus all mandatory deductions.

Under the AwC FMS Model, a member's appointed representative may also be employed by the member and paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed. These are:

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- The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
- The representative may not be paid for more than 40 hours per week for working for the member.

If a member's representative is not paid as an employee providing I/DD Waiver services to the member, then these safeguards do not apply.

Under the *Personal Options* FMS Model, the member is the Common Law Employer of the Qualified Support Workers hired by the member. The *Personal Options* FMS acts as the fiscal/employer agent to the member and is responsible for managing the receipt and distribution of the member's participant-directed budget funds, processing and paying Qualified Support Workers' payroll and transportation reimbursement as well as payment of vendors' invoices for approved participant-directed goods and services. The *Personal Options* FMS also provides information and assistance to members, their representatives and employees as appropriate. The members and their representatives, if applicable, control the work being performed on the member's behalf by hiring, training, scheduling, supervising and dismissing the member's direct care workers. A member may appoint a representative to assist with these functions, but the member remains the Common Law Employer.

Under the *Personal Options* FMS Model, a member's appointed representative may also be employed by the member and paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed. These are:

- The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
- The representative may not be paid for more than 40 hours per week for working for the member.

If a member's representative is not paid as an employee providing I/DD Waiver services to the member, then these safeguards do not apply.

The Traditional Service Option, which includes the full array of services, is still available to members who choose AwC or *Personal Options*, however the four services mentioned above may be participant-directed. The member who chooses to direct part or all of these services is required to purchase Service Coordination through the Traditional Service Option. Other services chosen by the member that are not part of the four participant-directed services also need to be purchased through the Traditional Service Option before any or all of the four participant-directed services may be purchased.

The Participant-Directed Service Option is available to every eligible I/DD Waiver member with the following exception: Members living in OHFLAC licensed residential settings are not eligible for Participant-Directed Services.

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A member may choose to direct their own services at any time through either of the Participant-Directed Service Options (AwC or *Personal Options)* by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within two (2) days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that can be self-directed will be referred to the chosen Participant-Directed Service agency and a participant-direct budget will be developed while all Traditional Services will remain with the I/DD Waiver provider(s).

A member may choose to stop directing their own services at any time by completing a Freedom of Choice Form (WV-BMS-I/DD-2). The Service Coordinator will enter the information into the CareConnection® within two (2) days of receipt and schedule a Transfer/Discharge IDT meeting. At this meeting, services that were self-directed will be referred to the chosen Traditional Service agency and a Traditional service budget will be developed.

The Agency with Choice participant-directed service option is described more fully in section 513.9.2.1. The *Personal Options* participant-directed service option is described more fully in Section 513.9.2.2.

513.9.2.1 Participant-Directed Services Option: Agency with Choice Model

One of the Financial Management Service (FMS) models available to individuals using participant-directed services is the AwC FMS model. Under this FMS model, I/DD Waiver providers may provide FMS to members and their representatives who select the AwC participant-directed service option, once the I/DD Waiver provider is certified as an AwC FMS provider by BMS. Under the AwC FMS model, the AwC FMS provider and the member enter into a Co-Employer arrangement. The AwC FMS provider is the primary or Common Law Employer while the member is the secondary or Managing Employer of the member's Qualified Support Worker(s). The member may appoint a representative to assist with these functions, but the member remains the Managing Employer.

Under the AwC FMS Model, a member's appointed representative may also be employed by the member and paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed. These are:

- The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
- The representative may not be paid for more than 40 hours per week for working for the member.

If a member's representative is not paid as an employee providing I/DD Waiver services to the member, then these safeguards do not apply.

As the Managing Employer, the member and the representative (when applicable):

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- Recruit/select and refer their preferred workers for hire to the AwC FMS provider for assignment back to them and
- Select the level of participation in which they are willing and able to engage in employer-related tasks.

As the Common Law Employer, the AwC FMS provider is responsible for:

- Meeting Medicaid program requirements;
- Hiring Agency Staff referred by the Managing Employer for assignment back to the Managing Employer and performing the human resource tasks;
- Verifying that Agency Staff meet criteria in Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 as well as each service definition;
- Training Agency Staff in their reporting requirements as stated in Section 513.2.3.
- Verifying citizenship and legal alien status of Agency Staff;
- Processing payroll and managing the related Federal, State, and local tax filings and payments;
- Processing and paying invoices for participant-directed goods and services that are authorized and approved in a member's participant-directed budget;
- Providing employer support as needed and requested by the Managing Employer;
- Providing workers' compensation insurance for Agency Staff; and
- Assisting the Managing Employer, as needed and requested in providing emergency back-up Agency Staff and managing those emergency supports.
- Providing orientation to the Managing Employer on using participant-directed services and AwC FMS; and
- Providing skills training for the Managing Employer to assist them in effectively performing as the Managing Employer of the Agency Staff.

The AwC FMS provider may not impose excessive barriers that discourage Managing Employers from recruiting and referring their preferred staff and/or performing as a Managing Employer. Each AwC FMS provider must be able to respond to inquiries for further information from a Managing Employer as follow-up to the ASO's educational component of the annual functional assessment or interest generated from any other source.

The AwC FMS provider makes available Information and Assistance (I&A) services to Managing Employers to support their use of participant-directed services and to perform effectively as the Managing Employer of the Agency Staff. I&A provided by the AwC FMS include:

(1) Managing Employer orientation sessions once the member and representative (when applicable) chooses to use participant-directed service and chooses an available AwC FMS provider; and,
(2) Skills training to assist Managing Employers to effectively use participant-directed services and FMS and perform the required tasks at the level they choose to participate as the Managing Employer of the Agency Staff.

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The Managing Employer orientation provides information on:

(1) The availability for the member and their representative to choose the level of participation they engage in as the Managing Employer of the Agency Staff;
(2) Completion of the Co-Employer agreement between the member and their representative and the AwC FMS;
(3) 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., Managing Employer, AwC FMS, ASO, SC, BMS);
(4) How to use the AwC FMS services;
(5) How to effectively perform as a Managing Employer of the Agency Staff;
(6) How to ensure that the Managing Employer is meeting Medicaid requirements and AwC FMS agreements, and,
(7) How a member would stop using participant-directed services and begin receiving traditional waiver services, if they so desire.

Support and/or skills training also would be available for performing the tasks required of a Managing Employer of Agency Staff (i.e., the Managing Employer may be having difficulty supervising an Agency Staff and skills training could be provided to help them improve their performance completing this task).

The AwC FMS provider's performance is monitored in a number of ways.

First, BMS reviews the AwC FMS provider candidate's readiness to perform the required FMS and I&A tasks by having all prospective entities complete an AwC FMS provider Self Assessment and evaluating the information submitted by the AwC FMS provider. The evaluation of an AwC FMS provider candidate's self assessment results in the following actions:

- An approval for the agency to immediately provide AwC FMS.
- A request for more information should the information provided in the AwC FMS provider Self Assessment fall short of the requirements for AwC FMS provider certification. The AwC FMS provider is required to re-submit a full, second self assessment addressing all areas of correction identified by BMS.

Second, the ASO conducts onsite AwC FMS Provider Performance Reviews on a defined cycle using a Review Protocol that includes all AwC FMS provider requirements as well as the agency's requirements as a I/DD Waiver provider.

With regard to the provision of AwC FMS, the ASO is responsible for:

- Distributing the Managing Employer satisfaction survey, developed by BMS, to AwC FMS providers and receiving and analyzing the survey results and reporting them to BMS annually.
- Conducting on site AwC FMS Provider Performance Reviews on a defined cycle using a Review Protocol based on the AwC FMS provider requirements.

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- In conjunction with BMS, ensuring corrective action occurs for significant and recurring failure to perform the AwC FMS provider requirements (i.e., gross over and under utilization (utilization determined by the utilization criteria in the agreements) of services, fraud, and ongoing and unresolved health and safety issues).

If the ASO finds that an AwC FMS provider is not meeting AwC FMS provider requirements as a result of conducting the AwC FMS Provider Performance Review, the ASO may recommend the following actions to BMS for approval and execution.

- Require a Plan of Correction (POC) be completed while continuing to provide AwC FMS.
- Require a POC be completed, as well as, freezing new enrollees to the AwC FMS provider until notified by the BMS otherwise.
- Require a POC be completed, as well as, applying monetary disallowances of noted AwC FMS administrative reimbursements due.
- Recommend decertification of the AwC FMS provider to BMS with a request to initiate transfer support for members and legal/non-legal representatives using the AwC FMS provider.

513.9.2.1.1 Participant-Directed Option Agency with Choice Model Services

All Agency Staff who are hired to provide services under the Agency with Choice Model must meet the standards in Sections 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3.

Under the AwC FMS model, no Agency Staff's hourly wage may exceed the Medicaid rate minus all mandatory deductions.

513.9.2.1.1.1 Financial Management Services: Participant-Directed Option: Agency with Choice Model

Procedure Code: T2040

Service Units: Unit = Event

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget. The annual budget for participant-directed services is to be determined following the purchase of Traditional Services.

Definition of Service:

Members choosing to direct their services under the Agency with Choice Model function as a Managing Employer and must obtain Financial Management Services through an I/DD Waiver provider who is a certified Agency with Choice provider that provides the following services:

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1) Assists a Managing Employer to exercise budget authority by:
    - Acting as a neutral bank, receiving and disbursing public funds, tracking and reporting on the member's budget funds (received, disbursed and any balances); and,
    - Processing and paying invoices for goods and services in the member's approved service plan.
2) Assists a Managing Employer to exercise Managing Employer authority by:
    - Assisting the Managing Employer in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the BCIS Form I-9 for each support service worker the member employs);
    - Collecting and processing support worker's timesheets;
    - Operating 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); and,
    - Distributing payroll checks on the member's behalf.
3) Assists with additional functions, including:
    - Providing orientation/skills training to a Managing Employer about their responsibilities when they function as the co-employer of the Agency Staff; and
    - Providing ongoing information and assistance to Managing Employers.

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Limited to one event per month/12 events per year.

Provider Qualifications:

- Each Agency with Choice FMS provider is verified initially and annually by BMS.

513.9.2.1.1.2 Goods and Services: Participant-Directed Option: Agency with Choice Model

Procedure Code: T2028-HI

Service Units: Unit = $1.00

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

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

Definition of Service:

Goods and Services 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 membership in the community and/or increase member's safety in the home environment;
- The member does not have the funds to purchase the item or service or the item or service is not available through another source; and
- Goods and Services are purchased from the member's participant-directed budget.

Documentation:

- Goods and Services are 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 member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- To access Participant-directed Goods and Services the member must also access at least one other type of participant-directed service during the budget year—i.e. PCS, Respite and/or transportation.
- 1000 units ($1,000) per member's IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home and Participant-Directed Goods and Services – *Personal Options* Option.
- The following represents a non-inclusive list of 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 individual member;
    - Room and board;
    - Personal items and services not related to the qualifying disability;

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- Gifts for workers/family/friends, payments to someone to serve as a representative,
- Clothing, food and beverages;
- Electronic entertainment equipment;
- Utility payments;
- Swimming pools and spas;
- Costs associated with travel;
- Household furnishings such as comforters, linens, drapes and furniture
- Vehicle expenses including routine maintenance and repairs, insurance 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;
- Day care; and
- Discretionary cash.

Provider Qualifications:

All goods and services must be purchased from an established business or otherwise qualified entity or individual and prior approved by the ASO. The AwC is responsible for maintaining on file receipts and other approved documentation.

513.9.2.1.1.3 Person-Centered Support: Participant-Directed Option: Agency with Choice Model

Procedure Code: S5125-U7 1:1 ratio
S5125-U8 1:2 ratio
S5125-U9 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget. The annual budget for participant-directed services is determined following the purchase of Traditional Services.

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Site of Service: This service may be provided in the member's family residence, a Specialized Family Care Home, an unlicensed ISS and public community locations. This service may not be provided in the Agency Staff's home unless the Agency Staff's home is also the member's home.

Definition of Service:

Person-Centered Support (PCS) consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

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

PCS services must be assessment-based, outlined on the member's IPP and may not exceed the annual individualized participant-directed budget allocation.

Agency staff passing 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).

Agency Staff who provide Person-Centered Support may not be the member's spouse.

Agency staff providing PCS services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the ASO.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD07) 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 Agency Staff should complete the accompanying Direct Care Progress Note to detail the issue. If

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training was provided the Person-Centered Support worker must also complete the task analysis documentation.

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

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate Agency Staff to member 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 Agency Staff

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget. The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.
- This service may not be billed concurrently with any other direct care service.
- PCS cannot replace the routine care, and supervision which is expected to be provided by the parent of a minor member or by a Specialized Family Care Provider providing care to a minor child. The IDT makes every effort to meet the member's assessed needs through natural supports.
- The member's appointed representative may also be employed by the member paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed as stated below:
    - The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
    - The representative may not be paid for more than 40 hours per week for working for the member.
- PCS may not substitute for federally mandated educational services.
- PCS must be based upon assessed needs, address identified health and safety issues and be outlined in the member's IPP.

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- PCS is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary change in environment.
- PCS is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- Up to 48 units/12hours of Person-Centered Support services every three months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Person-Centered Support staff.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.2.1.1.4 Respite: Participant-Directed Option: Agency with Choice Model

Procedure Code: T1005-UA 1:1 ratio
T1005-UB 1:2 ratio
T1005-UC 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member'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 provided in the member's home, a Specialized Family Care Home and public community locations. When this service is provided in a home setting other than the member's, the home setting must be a certified Specialized Family Care Home.

Definition of Service:

Respite Services are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver. Respite is designed to focus on the needs of the primary care-giver for temporary relief and to help prevent the breakdown of the primary care-giver due to the physical burden and emotional stress of providing continuous support and care to the member. Respite Care services consist of temporary care services for an individual who cannot provide for all of

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their own needs. Persons providing respite services may participate in person-centered planning.

Respite Care may be used to:

- Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members
- Provide assistance to the primary care-giver or member in crisis and emergency situations
- Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.
- Up to 48 units/12hours of Respite services every three months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Respite staff.
- May attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.

Documentation:

Documentation must be completed on the Direct Care Service Log (WV-BMS-I/DD07) 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 Agency Staff should complete the accompanying Direct Care Progress Note to detail the issue.
The Direct Care Service Log must include the following items.

- Member's Name
- Service Coordination Provider Name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate Agency Staff to member 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 Agency Staff

Limitations/Caps:

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 regulations.

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- The Agency Staff to member ratio for this service is 1:1, 1:2 and 1:3.
- Only 1:1 or 1:2 ratios are allowed to be utilized in a member's family residence or in a Specialized Family Care Home.
- This service may not be billed concurrently with any other direct care service.
- Respite services are not available to members living in ISS or licensed group home settings.
- Respite services may not be provided by a member's spouse or any other individual living in the member's home.
- Respite is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met.

513.9.2.1.5 Transportation: Miles – Participant-Directed Option: Agency with Choice Model

Procedure Code: A0160-U1

Service Units: Unit = 1 mile

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member'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 member's IPP and based on assessed need.

Definition of Service:

- Transportation: Miles services are provided to the I/DD Waiver member for trips to and from the member's home, licensed I/DD Facility-based Day Habilitation Program or Supported Employment activities, or to the site of a planned community-based activity or service which is addressed on the IPP and based on assessed need.

- This service may be billed concurrently with Person-Centered Support Services: Agency with Choice or, Respite: Agency with Choice.

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Documentation:

Agency staff must complete the transportation log section of the Direct Support Documentation Form (WV-BMS-I/DD07) to include all of the following items.

- Member's Name
- Service code
- Date of service
- "From" location
- "To" location
- Purpose of trip
- Total number of miles per trip

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

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Member must be present in vehicle if mileage is billed.
- Must be related to a specific activity or service based on an assessed need and identified in the IPP.
- May be within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of West Virginia.
- The member's legal guardian may function as the representative and also be paid for providing transportation services to the member if certain safeguards are observed. These are:
    - The legal guardian is a single parent residing in the home with the member.
    - The legal guardian may not be paid for more than 40 hours per week for working for the member.

Agency Staff Qualifications:

All the general requirements in Section 513.2.2.1, 513.2.2.1.1, 513.2.2.1.2 and 513.2.2.1.3 must be met in addition to the following requirement:

- Agency Staff 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.

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513.9.2.2 Participant-Directed Services: *Personal Options* Financial Management Service Option

Another Financial Management Service (FMS) model available to members to support their use of participant-directed services is *Personal Options*. Under *Personal Options*, the member is the Common Law Employer of the Qualified Support Workers they hire directly. The member may appoint a representative to assist with these functions, but the member remains the Common Law Employer.

No Qualified Support Worker's hourly wage may exceed the Medicaid rate minus all mandatory deductions. All Qualified Support Worker's hired by the member must meet the requirements in Sections 513.9.2.1, 513.9.2.1.1 and 513.9.2.1.2.

Under the *Personal Options* FMS Model, a member's appointed representative may also be employed by the member and paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed. These are:

- The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
- The representative may not be paid for more than 40 hours per week for working for the member.

If a member's representative is not paid as an employee providing I/DD Waiver services to the member, then these safeguards do not apply.

The *Personal Options* Fiscal/Employer Agent is responsible for managing the receipt and distribution of individuals' participant-directed budget funds, processing and paying Qualified Support Workers' payroll and reimbursements for transportation as well as vendors' invoices for approved participant-directed goods and services. The Personal Options Fiscal/Employer Agent is also required to provide information and assistance to members and their representatives as appropriate.

Under *Personal Options* FMS option, the member is the Common Law Employer of the Qualified Support Workers they hire directly.

The Common Law Employer is responsible to:

- Elect the participant-directed option.
- Work with their Resource Consultant (RC) to become oriented and enrolled in the Participant-Directed Option, enroll Qualified Support Workers, 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 Worker(s).
- Provide required and member-specific training to Qualified Support Worker(s).

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- Determine Qualified Support Workers' work schedule and how and when the Qualified Support Worker should perform the required tasks.
- Supervise Qualified Support Workers' daily activities.
- Evaluate their qualified support worker's performance.
- Review, sign and submit qualified support workers' time sheets to the *Personal Options* Fiscal/Employer Agent.
- Maintain documentation in a secure location and ensure employee confidentiality.
- Discharge their Qualified Support Worker, when necessary.
- Notify their SC of any changes in service need.

Personal Options fiscal/employer agent is responsible for:

1) Assisting Common Law Employers exercising budget authority;
2) Acting as a neutral bank, receiving and disbursing public funds, tracking and reporting on the member's budget funds (received, disbursed and any balances);
3) Monitoring members' spending of budget funds in accordance with members' approved spending plans;
4) Submitting claims the state's claim processing agent on behalf of the member/employer;
5) Processing and paying invoices for transportation and goods and services in the member's approved participant-directed spending plan
6) Assisting members exercising employer authority;
7) Assisting the member 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 member employs);
8) Assisting in submitting criminal background checks of prospective Qualified Support Workers;
9) Collecting and processing support worker's timesheets;
10) Operating 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) Distributing payroll checks on the member's behalf;
12) Executing Simplified Medicaid provider agreements on behalf of the Medicaid agency;
13) Providing orientation/skills training to members about their responsibilities when they function as the employer of record of their direct support workers; and
14) Providing ongoing information and assistance to Common Law Employers.
15) Monitoring and reporting data pertaining to quality and utilization of the *Personal Options* FMS as required to BMS.

The *Personal Options* Fiscal/Employer Agent is not the Common Law Employer of the member's Qualified Support Worker(s). Rather, the *Personal Options* Fiscal/Employer Agent assists the member/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* fiscal/employer agent operates under §3504

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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.

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 *Personal Options* include:

- Common Law Employer orientation sessions once the member chooses to use participant-directed services and enrolls with *Personal Options*, and,
- Skills training to assist Common Law Employers to effectively use participant-directed services and FMS and perform the required tasks of an employer of record of Qualified Support Workers. Common Law Employer orientation provides information on:
  (1) 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,*, ASO, SC, BMS),
  (2) How to use *Personal Options*,
  (3) How to effectively perform as a Common Law Employer of their Qualified Support Workers,
  (4) How to ensure that the Common Law Employer is meeting Medicaid and *Personal Options* requirements, and
  (5) How a member would stop using participant-directed services and begin to receive traditional waiver services, if they so desire. Skills training curricula reinforce Medicaid, *Personal Options*, federal and state labor, tax and citizenship and legal alien status requirements and provide a review of best practices for performing the tasks required of a Common Law Employer of a Qualified Support Worker (i.e., the Common Law Employer may be having difficulty reviewing, signing and submitting Qualified Support Workers' time sheets and skills training could be provided to help them improve their performance completing this task).

Personal Options provides I&A supports to members and their representatives (when applicable) who wish to function as Common Law Employers. The educational presentations provide interested members with information on the role and responsibilities of *Personal Options* and each of the other interested parties (i.e., member, representative, Qualified Support Worker, vendors of participant-directed goods and services and BMS) and what it is required of the member to be a Common Law Employer to his or her Qualified Support Worker(s). These presentations provide the venue through which a member may enroll in the participant-directed option. *Personal Options* makes available I&A supports to members and their representatives (when applicable), to implement and support their use of participant-directed services and performing as an employer of record.

If *Personal Options* is selected by the member, *Personal Options*, rather than the Service Coordinator provides Information & Assistance (I&A) service that includes:

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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* fiscal/employer agent's role in regards to payment for services, goods, etc.
6. Assisting Common Law Employers with determining participant-directed budget expenditures (hiring, or purchasing participant-directed goods and services).
7. Providing Common Law Employers with a list of approved purchases or criteria for selection of participant-directed goods and services.
8. Assisting with the development of an individualized spending plan based upon the member's annual participant-directed budget.
9. Making available to the member/representative a process for voicing complaints/grievances pertaining to the *Personal Options* fiscal/employer agent's performance.
10. Providing additional oversight to the Common Law Employer as requested or needed.
11. Monitoring and reporting information about the member's utilization of the participant-directed budget to the member, representative, SC and BMS.
12. Explaining all costs/fees associated with the member directing their own services.

With regard to the provision of *Personal Options* FMS, the ASO is responsible for:

- Distributing the *Personal Options* FMS satisfaction survey, developed by BMS, to Personal Options members or their representatives (when applicable) and receiving and analyzing the survey results and reporting them to BMS annually.
- Conducting *Personal Options* FMS Performance Reviews on a defined cycle using a Review Protocol based on the Personal Options FMS requirements

513.9.2.2.1 Qualifications for Qualified Support Workers

All Qualified Support Workers must meet the qualifications listed below.

- 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;

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- Documented training on First Aid by a certified trainer from the American Heart Association (AHA) or the American Red Cross (ARC) to include always having current First Aid certification upon hire and as indicated per expiration date on the AHA or ARC card;
- Documented training in Cardiopulmonary resuscitation (CPR) by a certified trainer from the American Heart Association (AHA) or the American Red Cross (ARC) to include always having current CPR certification upon hire and as indicated per expiration date on the AHA or ARC card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the QSW);
- Documented training on Member-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, CIB/NCIC background checks.

513.9.2.2.1.2 Criminal Investigation Background (CIB) Check Requirements for Qualified Support Workers

All Qualified Support Workers having direct contact with members must, at a minimum, have a state level CIB check initiated upon hire which includes fingerprints. This check must be conducted initially and again every three years. If the current or prospective employee has lived out of state within the last five years, the Qualified Support Worker must have an additional federal background check utilizing fingerprints through the National Crime Information Database (NCID) also initiated upon hire and every three years of employment. An individual cannot be employed by a member/Employer who is directing their own services if ever convicted of:

- Abduction;
- Any violent felony crime including but not limited to rape, sexual assault, homicide, or felonious battery;
- Child/adult abuse or neglect;
- Crimes which involve the exploitation of a child or an incapacitated adult;
- Any type of felony battery;
- Felony arson;
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm;
- Felony drug related offenses within the last 10 years;
- Felony DUI within the last 10 years;
- Hate crimes;
- Kidnapping;
- Murder/ homicide;
- Neglect or abuse by a caregiver;

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- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct;
- Purchase or sale of a child;
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure;
- Healthcare fraud; and
- Felony forgery.

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be made available to the member before continuing the employment of the Qualified Support Worker.

513.9.2.2.1.3 Office of the Inspector General (OIG) Medicaid Exclusion List Requirements for Qualified Support Workers

The Office of the Inspector General (OIG) Medicaid Exclusion List must be checked by the *Personal Options* F/EA agent for every Qualified Support Worker who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Exclusion List cannot provide Medicaid services. The list can be checked at http://exclusions.oig.hhs.gov/.

513.9.2.3 Services Available under the *Personal Options* Participant-Directed Option

513.9.2.3.1 Goods and Services: *Personal Options* Participant-Directed Option:

Procedure Code: T2021-SCI

Service Units: Unit = $1.00

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

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

Definition of Service:

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:

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- An item or service that would decrease the need for other Medicaid services and/or promote full membership in the community and/or increase member's safety in the home environment.
- The member 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.
- The need for PDGS supported by an assessed need documented in the IPP.
- PDGS must be pre-approved by the *Personal Options* F/EA 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.

Documentation:

Receipts or other documentation of Goods and Services must be provided to the *Personal Options* F/EA by the member/representative.

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- 1000 units ($1,000) per member's IPP year in combination with Traditional Environmental Accessibility Adaptations- Vehicle and Home and Participant-Directed Goods and Services – Agency with Choice.
- To access Participant-directed Goods and Services the member must also access at least one other type of participant-directed service during the budget year—i.e. PCS, Respite and/or transportation.
- 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 individual member;
    - Room and board;
    - Personal items and services not related to the qualifying disability;
    - Gifts for workers/family/friends, payments to someone to serve as a representative,
    - Clothing, food and beverages;
    - Electronic entertainment equipment;
    - Utility payments;
    - Swimming pools 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 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;
- Day care; and
- Discretionary cash.

Provider Qualifications:

All Goods and Services must be purchased from an established business or other qualified entity or individual and prior approved by the *Personal Options* F/EA. The *Personal Options* F/EA is responsible for maintaining on file receipts and other approved documentation.

513.9.2.3.2 Person-Centered Support: *Personal Options* Participant-Directed Option:

Procedure Code: S5125-UA

Service Units: Unit = 15 minutes

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member'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 provided in the member's family residence, a Specialized Family Care Home, an unlicensed ISS and public community locations. This service may not be provided in the Qualified Support Worker's home unless the worker's home is also the member's home.

Definition of Service:

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 regulations.

Person-Centered Support (PCS) consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in the community in which the member resides, works, receives their education, accesses health care, and engages in social and recreational activities. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence, personal choice and allow for maximum inclusion into their community.

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
- Capacity for Independent Living

PCS services must be assessment based and outlined on the member's spending plan. PCS activities may be completed in the member's residence or in public community settings. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs. Qualified Support Workers (QSW) Staff providing PCS services may participate in person-centered planning, IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.

Documentation:

The Qualified Support Worker must document the hours provided per day to the member. The documentation must be specific to the service and must include:

- Member's Name
- 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 QSW and the member and representative (when applicable)

If a Therapeutic Consultant or a Behavior Support Professional is involved in training plans carried out by the QSW, documentation is completed through those training plans per the member's IPP. This documentation must be maintained by the member/employer and provided to the TC or BSP as needed for oversight of training programs.

Limitations/Caps:

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- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- PCS services are available to members living in the following types of residential settings: the member's family residence, Specialized Family Care Homes and unlicensed ISS.
- This service may not be billed concurrently with any other direct care service.
- PCS cannot replace the routine care, and supervision which is expected to be provided by a parent of a minor member or a Specialized Family Care Provider caring for a minor child. The IDT makes every effort to meet the member's assessed needs through natural supports.
- The member's appointed representative may also be employed by the member paid for providing I/DD Waiver services under certain circumstances and if certain safeguards are observed as stated below:
    - The representative/employee is a single parent residing in the home with the member and no other person is available to act as the representative or employee.
    - The representative may not be paid for more than 40 hours per week for working for the member.
- PCS may not substitute for federally mandated educational services.
- PCS is not available while the member is hospitalized in a Medicaid certified hospital except when the behavioral needs of the member arise due to the temporary to change in environment.
- PCS is not available in nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.
- PCS may not be provided by the member's spouse.
- Up to 48 units/12hours of Person-Centered Support services every three months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may bill for providing training to Person-Centered Support staff.

Qualified Support Worker Qualifications:

All of the requirements in section 513.9.2.2.1, 513.9.2.2.2 and 513.9.2.2.3 must be met.

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513.9.2.3.3 Respite: Participant-Directed Option: *Personal Options* Model

Procedure Code: T1005-UD

Service Units: Unit = 15 minutes

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member'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 provided in the member's home, a Specialized Family Care Home and public community locations. When this service is provided in a home setting other than the member's, the home setting must be a certified Specialized Family Care Home.

Definition of Service:

Respite Services are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver. Respite is designed to focus on the needs of the care-giver for temporary relief and to help prevent the breakdown of the care-giver due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Care services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing respite services may participate in person-centered planning.

Respite may be used to:

- Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members
- Provide assistance to the primary care-giver or member in crisis and emergency situations
- Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.
- This service may not be billed concurrently with any other direct care service.
- Up to 48 units/12hours of Respite services every three months per member may be billed, if necessary, for the purpose of training in member-specific instruction (i.e. behavioral intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only TCs, BSPs or RNs may provide training to Respite staff.
- Allow the QSW to attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by ASO.

Documentation:

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The Qualified Support Worker must document the hours provided per day to the member. The documentation must be specific to the service and must include:

- Member's Name
- 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 QSW and the member and representative (when applicable)

If a Therapeutic Consultant or a Behavior Support Professional is involved in training plans carried out by the Respite worker, documentation is completed through those training plans per the member's IPP. This documentation must be maintained by the member/employer and provided to the TC or BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- This service may not be billed concurrently with any other direct care service.
- Respite services are not available to members living in ISS or group home settings.
- Respite services may not be provided by the member's spouse or any other individual living in the member's home, or by someone living within the Specialized Family Care Home where the member resides.
- The QSW to member ratio for this service is 1:1.
- Respite is not available in medical hospitals, nursing homes, psychiatric hospitals or rehabilitative facilities located either within or outside of a medical hospital.

Qualified Support Worker Qualifications:

All of the requirements in section 513.9.2.2.1, 513.9.2.2.2 and 513.9.2.2.3 must be met.

513.9.2.3.4 Transportation: Miles: *Personal Options* Participant-Directed Option:

Procedure Code: A1060-U3

Service Units: Unit = 1 mile

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

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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 member's IPP and based on assessed need.

Definition of Service:

- Transportation: Miles services are provided to the I/DD Waiver member for trips to and from the member's home, licensed I/DD Facility-based Day Habilitation Program 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: *Personal Options* option or Respite: *Personal Options* option.

Documentation:

The member'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:

- Member's Name
- Date of Service
- "From" location
- "To" location
- Purpose of trip

Total number of miles for the trip

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- The annual budget allocation may be adjusted (increased or decreased) only if changes have occurred regarding the member's assessed needs.
- Member must be present in vehicle if mileage is billed.
- Must be related to an assessed need in the IPP.
- May be within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of Wes Virginia.
- The amount of transportation provided to a member directing their services must be identified on their spending plan and may not exceed the annual participant-directed budget allocation.
- The member's legal guardian may function as the representative and also be paid for providing transportation services to the member if certain safeguards are observed. These are:
    - The legal guardian is a single parent residing in the home with the member.

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- The legal guardian may not be paid for more than 40 hours per week for working for the member.

Qualified Support Worker Qualifications:

All of the requirements in section 513.9.2.2.1, 513.9.2.2.2 and 513.9.2.2.3 must be met in addition to the following requirement:

- The Qualified Support Worker 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.

513.10 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

GENERAL REQUIREMENTS

- I/DD Waiver Program provider agencies must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Information*; *Chapter 300, Provider Participation; and Chapter 800, General Administration* of the Provider Manual. This can be found at the BMS Web Site (www.dhhr.wv.gov/bms).
- I/DD Waiver Program provider agencies must comply with all other documentation requirements of this chapter.
- All required documentation must be maintained by the I/DD Waiver provider for at least five years in the member'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 five 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.
- 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

I/DD Waiver Program provider agencies must maintain a specific record for all services received for each I/DD Waiver Program member including, but not limited to:

- Each I/DD Waiver provider who provides Service Coordination services is required to maintain all required I/DD Waiver documentation on behalf of the State of West Virginia and for state and federal monitors.

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- All I/DD Waiver 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 the CareConnection®, it must be used 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 web site (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 I/DD Waiver 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 in Section 513.9, including all subsections of 513.9, Description of Covered Services.
- 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.

513.11 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 I/DD Waiver program must be authorized with the ASO. Services requiring prior authorization (refer to Section 513.10) must be submitted to the ASO 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 I/DD Waiver providers are forwarded to the ASO.

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513.12 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. I/DD Waiver Program providers must bill all third party liabilities such as a member'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 member, 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* of the I/DD Waiver policy manual or outside of the scope of federal regulations.

513.13 PAYMENTS AND PAYMENT LIMITATIONS

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

When a member is an inpatient in a West Virginia medical hospital and the member's behavioral needs require additional support staff, then the member 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.

No I/DD Waiver services may be charged while an individual is receiving services as an inpatient in an ICF/MR facility, a state institution, nursing facility, rehabilitation facility, psychiatric facility, or as a member of another other waiver program. Thirty days prior to discharge from one these programs, Service Coordination, Therapeutic Consultant, Behavior Support Professional and Registered Nurse may be billed to plan the member's discharge.

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.

513.14 HOW TO OBTAIN INFORMATION

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For information concerning procedure codes and diagnosis codes, refer to *Chapter 100, General Information.*

SERVICE	PERSON OR COMPANY	PHONE NUMBER	FAX NUMBER
I/DD Program Manager	Bureau for Medical Services	304-356-4904	304-558-4398
Claims Processing	Molina Medicaid Solutions	304-888-483-0793 (for Providers) 304-348-3380 (for Members)	304-348-3380
Medical Eligibility Contracted Agent (MECA)	Psychological Consultation & Assessment	304-776-7230	304-776-7247
Administrative Services Organization (ASO)	Innovative Research Group (IRG) d/b/a APS Healthcare, Inc.	1-866-385-8920	304-866-521-6882
Personal Options Fiscal Employer Agent (F/EA)	Public Partnerships, LLC (PPL)	1-877-908-1757	304-296-1932

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