APS Healthcare

I/DD Waiver POLICY CLARIFICATIONS

Contents

Annual Functional Assessments 2
Behavior Support Professional 3
Certification/Recertification (Eligibility/Re-eligibility) 5
Direct Care Services 6
I/DD Waiver CareConnection® 9
Individual Program Plan 11
Intellectual/Developmental Disabilities (I/DD) Waiver Forms 16
Interdisciplinary (IDT) Meetings 19
Personal Options 21
Person-Centered Supports 23
Provider Reviews 24
Qualified Provider/Training 26
Respite Care 31
Service Coordination (SC) 32
Skilled Nursing Services 33
Therapeutic Consultant (TC) 35
Transportation 39
Utilization Management 42
WV IMS 46

Annual Functional Assessments

Q47: For those members with Anchor Dates of 10/1/2011 and later whose APS Assessments were conducted ***prior*** to 10/1/2011, will the Service Coordinator be required to review the Freedom of Choice form with these members retroactively?

A47: APS' review and completion of the Freedom of Choice form cannot occur until those assessments that occur 10/1/2011 and after. If a member wishes to alter their choice of I/DD Waiver services to an ICF/MR, wishes to transfer Service Coordination or wishes to select a different service delivery model, the SC should complete the I/DD-02 Freedom of Choice form. Otherwise, APS will complete the form with these members during their next functional assessment.

Q59: Is a member's legal representative required to attend the Annual Functional Assessment? If the legal representative does not attend, when would they complete a I/DD-02 Freedom of Choice Form?

A59: The legal representative is not required to attend the APS Annual Functional Assessment but they are required to sign the I/DD-02 Freedom of Choice form. When the legal representative is not available to complete the form at the Annual Functional Assessment, the SC must ensure its completion. Once completed, by the SC, information regarding Service Delivery Model selection should be entered by the agency into CareConnection® and the I/DD-02 should be attached using the Attach Documents feature. The agency must also maintain a copy of the signed I/DD-02 in the member file.

Q127: Will the SC agency receive the original I/DD-02 Freedom of Choice Form following its completion at the Annual Functional Assessment?

A127: When the I/DD-02 is completed during the member's Annual Functional Assessment, APS will provide the agency with the original, provided the SSF who completes the form is able to make a copy for APS' records. If the assessment takes place at a venue that does not provide access to a copy machine, the SSF will retain the original in order to make a copy. The original will be provided to the agency at the next opportunity.

Q49: For those members who have fixed IPP dates 10/1/2011 or shortly after, APS will have already conducted the annual functional assessment, and will not have completed the I/DD-02 Freedom of Choice Form. Will the SC agency be required to complete this form for these members?

A49: APS will not complete I/DD-02s until those assessments conducted 10/1/2011 and after. If a member indicates they would like to make a change as is indicated on the form, the Service Coordination agency would be responsible to review, complete and

follow-up with choices selected on the form. Otherwise, APS will review the I/DD-02 with these members at their next annual functional assessment.

Behavior Support Professional

Q86: If a TC is currently enrolled in an approved training for Behavior Support Professional and has completed the first session, can they bill the Behavior Support Professional code as they continue to work to complete their training, as long as the service was agreed upon by the team and is listed on the client's IPP?

A86: For the first six months following implementation of the new I/DD Waiver Policy Manual, it was acceptable for individuals who previously provided Behavior Specialist or Behavior Analyst services to MR/DD members to bill the Behavior Support Professional code provided they were enrolled in, and had completed, at least the first session of an approved curriculum. This six-month period was from October 1, 2011 to March 31, 2012.

Q91: If a member wishes to manage their own staff via the Personal Options Service Delivery Model and does not wish to have Behavior Support services or a Positive Behavior Support plan, what criteria will be in place upon review by OHFLAC or APS Healthcare?

A91: Regardless of the Service Delivery Model a member chooses, they may choose for their needs to be met via informal supports. This would mean a member with a behavioral need may not have to have a formal Positive Behavior Support Plan. The need could be addressed on the member's IPP and then it would be very important for the member/representative/family to give updates on progress of their intervention methods (whether formal or informal) during home visits, IPP meetings, etc. The Service Coordinator is also responsible to obtain updates during home visits and make recommendations for various alternatives, as determined necessary.

Q101: Can a newly hired Therapeutic Consultant who has 2 years professional experience, a BA/BS degree, and is ENROLLED in an approved Positive Behavior Support training bill/provide the Behavior Support Professional code?

A101: All newly hired agency staff must be either completely trained in a curriculum which has been approved by the WV-PBS Network or meet BCBA or BCaBA requirements before being allowed to bill the BSP code.

Q123: If a member currently has a Behavior Support Plan and wishes to discontinue it, is this acceptable?

A123: The IDT must discuss to ensure the member's needs are met (and he or she is not in jeopardy) if the needs for behavioral intervention are met through natural or informal supports. These decisions and recommendations should be documented on the member's IPP. The SC should also monitor implementation of an informal plan during home visits to continually ensure the member's needs are met.

Q143: Can an agency bill both TC and BSP codes for the same member?

A143: Yes, an agency can bill both TC and BSP codes for the same member. Depending on a member's habilitation and behavior support needs, agencies may wish to request a combination of the two services to meet the member's needs. In combination, the number of units purchased could not exceed the service limit of 960 units annually.

Q145: How does an agency determine whether to request Therapeutic Consultant Services or Behavior Support Professional Services for a member?

A145: Agencies can use many sources of information to determine whether it is appropriate to request Therapeutic Consultant (TC) services or Behavior Support Professional (BSP) services for a member. Results of APS Assessments, particularly the ICAP Problem Behavior and Maladaptive Behavior Index Scores sections, may also be used. Consider in the Problem Behavior Section, the maladaptive activities and their level of seriousness. If behaviors in the following categories: "Hurtful to Self"; "Hurtful to Others"; and/or "Destructive to Property" are "moderately serious", "very serious", or "extremely serious" this could indicate to the team that the member may need significant intervention. When considering the Maladaptive Behavior Index Scores, indications of "moderately serious", "serious", or "very serious" scores could signify the need for higher levels of intervention. There are other factors unique to the member that may also be considered. When requesting Behavior Support Professional services, be certain to include any documentation that may be support the request, such as a Behavior Support Plan or monthly documentation.

Q146: Can an agency use another agency's approved PBS Curriculum to train staff to provide the Behavior Support Professional Code?

A146: If an agency wishes to use another agency's approved curriculum, it is expected that they would still go through the Application Process. In the application, the agency who is using another agency's curriculum must indicate they are using a pre-approved curriculum and specify which agency developed the curriculum. They would also be required to submit their mentoring plan and list of trainers with credentials for approval. In addition, in order to qualify to train others, an individual must meet at least one of the following three criteria:

1. Be the developer of an approved training as indicated on the submitted application;

2. Be able to provide documentation that certifies completion of an approved training course (though not necessarily the course for which they are the trainer);

OR

3. Be a Board Certified Behavior Analyst or Assistant and have documentation certifying completion of the Overview of Positive Behavior Support as stated in the I/DD Waiver Manual.

Q151: Do licensed psychologists meet the qualifications to be an approved BSP Curriculum trainer?

A151: WV's approved BSP Curriculums require that certain factors be included that are not necessarily addressed in the course of training for a Licensed Psychologist. As such, though a person may be a Licensed Psychologist, he/she would still be required to receive the same training as all others who will provide the training.

Q154: Now that agencies can use both TC and BSP for a member, does the staff providing these services need to be the same person or can a TC be used for habilitation activities and a BSP to address behavior support issues?

A154: An agency may choose to utilize one or more staff to provide for a member's adaptive and maladaptive habilitation programming, or it can be the same agency staff.

Q159: If an I/DD Waiver member receives services from more than one agency and this member has a Behavior Support Plan, which agency's Human Rights Committee is responsible for approving the plan?

A159: A Behavior Support Plan must be presented to a Human Rights Committee for approval if it recommends the use of restrictive measures. Plans should be presented to the HRC of the agency that was responsible for developing the plan; if members use more than one agency for their services, approval from the HRC for the Positive Behavior Support Plan should be communicated to all involved agencies.

Q158: Can individuals who are receiving Birth to Three Services also receive I/DD Waiver Services?

A158: While individuals can participate in both the Birth-to-Three program and I/DD Waiver program, they may not have duplicative services. For example, Birth-to-Three offers physical therapy; if an I/DD Waiver member chooses to receive PT through Birth-to-Three, they may not receive that service through the I/DD Waiver program.

Certification/Recertification (Eligibility/Re-eligibility)

Q132: How does a WV resident who is in out-of-state placement apply for I/DD Waiver?

A132: Per the Waiver Policy Manual, individuals who apply for the program must be residents of WV. If a WV resident is in out-of-state placement and wishes to apply for the WV I/DD Waiver program, an I/DD-01 application should be submitted by the individual or his/her legal representative to APS Healthcare. APS will verify the member's residency status. If an applicant is determined to be a non-resident of WV, he/she (or his/her legal representative if applicable) will be contacted by APS Healthcare and advised that the applicant cannot be considered until residency is established.

The application process is the same for those children who are in out-of-state placement, **however,** if an IP is used who is not a member of the IPN, the individual and/or legal representative (if applicable) will be responsible for ensuring payment for the IPE. If a psychologist who is not a member of the IPN is used, adherence to application timelines is still expected.

Q135: How does the MECA make eligibility determinations?

A135: The MECA receives the ICAP and the ABAS-II from APS, reviews the materials, and based upon the ABAS-II scores, makes an eligibility determination. The ABS was a frequently used instrument prior to the change on October 1, 2011. The Code of Federal Regulations requires that individuals meet the entry-level criteria on an annual basis and that their eligibility must be established annually.

Q140: Are ICAP results considered for eligibility/recertification purposes? Though a previous FAQ indicated that it was not a consideration in program termination, a termination letter for a member cited the ICAP as a source of consideration for discharge.

A140: On a termination letter, all documents reviewed for eligibility or recertifications are listed. For example, if an IEP or discharge summary is submitted, and the member is terminated, these documents will be listed on the termination letter as having been reviewed. Terminations are based on the ABAS-II, but other information may be utilized to support an eligibility determination.

Direct Care Services

Q1: On the crosswalk of codes the current day hab codes are listed beside Facility-based Day Habilitation, however in our agency all the day habilitation is community-based. How will APS know which codes to convert to PCS and which to convert to Facility-based Day Habilitation?

A1: Beginning 10/1/2011 DH services for those members who are currently accessing community-based Day Habilitation and Prevocational Training codes will crosswalk to the Facility-based Day Habilitation codes. This will be the case until either a Critical Juncture or at the member's next Annual IPP. Providers should proceed as follows:

- Continue to bill the Day Habilitation or Prevocational Training code(s) for the member (codes from the MR/DD Manual reflecting what is on the member's IPP) until either the Annual or Critical Juncture.
- For services provided 10/1/2011 and after – Submit the new rate for this code to Molina for payment (ex. Code for DH 1:1 is T2021U4. Bill T2021U4 with a rate of $4.98 per unit.
- At the time of the Annual IPP or Critical Juncture: If the member is accessing Day Habilitation primarily in the community, this would equate to Person-Centered Support (S5125U1-S5125U9 and/or S5125UA).
- At the time of the Annual IPP or Critical Juncture: If the member is accessing Day habilitation or Prevocational Training in a facility, this would equate to Facility-Based Day Habilitation (T021U5, T2021U6, T2021U7).

Q2: For individuals who access out-of-home respite in the home of a Specialized Care Provider please offer suggestions as to how agencies can continue to provide this service without the potential for large amounts of over-time. A week in respite (even if supplemented with other services) would be well over a 40-hour week.

A2: Three possible options are:

1) If the agency limits the employee to 40 hours/week, anything over would be considered a natural support,
2) Arrange for multiple providers who are available to meet the member's needs without any one provider exceeding 40 hours per week,
3) Access respite through Participant-Directed services (Personal Options), where the provider would be exempt from overtime.

Q6: If an agency has converted NO contracted providers to employees will the CRH (old code) still crosswalk to the new rate?

A6: Yes. Bill the CRH code and the rate is $2.74/15 min for services provided 10/1/2011 and after.

Q7: If an agency has not converted contract providers by Oct 1 can they still be paid for respite under the old codes?

A7: Respite Care under the Traditional Service Delivery Model (staff are employees of the agency) has no differentiation of contracted vs. employee. Even if you have a contract with them, they are still considered staff (whether contracted or formally employed). The rate for Respite 1:1 is $5.01/15 min regardless of whether you contract with that person or employ them.

Q73: If a member does not currently have a paid job placement, but does participate in work related discussions would T2019/T2019-HQ (SEI/SEG) be the appropriate billing code for these activities?

A73: Supported Employment may include Vocational counseling (Example: Discussion of the member's on-the-job work activities) and Job development and placement for a specific waiver member with the member present. "Work-related discussions" would fall under job development and placement when the member is present.

Q90: Are there specific criteria for a member to be approved for 8 hrs a day of PCS-Family?

A90: Criteria for authorization of a particular number of units will not be established. Authorizations for all services are based on the individual member's need, as presented to APS Healthcare at the time of purchase request.

Q107: Will providers still be able to provide Facility-based Day Habilitation for individuals who are over 18 but still in school, during summer and holiday breaks?

A107: Facility-based day habilitation services will be limited to those members who are age 18 and over only.

Q112: In a workshop setting, if one staff is working with two members, one of whom is accessing "new" waiver services and one of whom is still using "old" waiver services, would it be correct for the staff to bill Facility-based Day Habilitation 1:1-2 for the member using "new" services Prevocational Group for the member using "old" services?

A112: The answer depends on which specific services the member is receiving while at the Facility-based Day Habilitation setting. For the member receiving "new" services, it would be appropriate to bill the Facility Day Habilitation 1:1-2 code. The other member should receive the service identified on his/her IPP (may have been Prevocational Training-Group or Day Habilitation 1:2).

Q122: Can annual service limits for direct support services be increased to accommodate an extra day for Leap Year (2012)?

A122: No. Since there is no daily or monthly limit for services, it is not necessary to add a one-day exception for 2012. For those in an ISS or Group Home Setting, there are already enough units to accommodate training and Leap Year. Q162: Can two family members who live in the same residence as a member both provide PCS: Family services, as long as they are not billing at the same time?

A162: Yes, two persons who qualify as staff to provide PCS: Family can both provide the service as long as there is no duplication (times don't overlap).

Q164: What is the minimum age for an I/DD Waiver member to access an Individualized Support Setting (ISS)?

Q164: In order to access an ISS, members must be 18 or older.

Q172: Supported Employment is described as services that "enable individuals to engage in paid, competitive employment." Would volunteer work be considered as "training in skills essential to obtain and retain employment" as described under the included services? While appropriate jobs are scarce in our area, we may be better able to provide our consumers volunteering opportunities; can such opportunities fall under Supported Employment in terms of billing as they serve to develop and strengthen job skills?

A172: Yes, Supported Employment can be billed for developing job skills, including volunteer opportunities, as long as the IPP indicates that the team has agreed that this is the service to best meet the member's need.

I/DD Waiver CareConnection®

Q25: Will an upgraded I/DD Waiver CareConnection® include the current selection of privilege levels? For example, can we still assign an individual to read-only, read/write, or read/write/submit administrative privileges?

A25: Yes. There are no anticipated changes to Service Coordinator and SC Agency administrator roles. SC read, SC read/write, and SC read/write/submit will still be options when setting up Service Coordinators as users in the system.

Q40: Since Service Coordinators (SC's) are required to attend APS assessments, is it appropriate to list the Service Coordinator as a respondent on the demographics page of the CareConnection®?

A40: If the SC is attending as a respondent, then include them as a respondent on the demographics page of CareConnection®. If they are attending but not serving as a respondent (for example they are new to the member's case), they should not be listed as a respondent.

Q49: In recent Provider Trainings, it has been indicated that APS Registration Coordinators will review services for appropriateness (within budget, within service limits, etc.). Does this mean if the SC makes an error with a purchase in these areas, it will be caught on that end?

A49: APS will continue to review all service requests submitted for authorization. The Registration Coordinators will check to ensure services requested are within budgets, within service limits, appropriate to the member and consistent with identified health and safety needs. It is highly recommended, though, that agencies provide training on the manual and oversight to their own employees to ensure understanding of the new rules prior to submission. If APS notices mistakes, the SC will be contacted to remedy.

Q93: In the past, when an annual purchase was entered and subsequently approved by a Registration Coordinator, the end dates of the previous year's authorizations were automatically rolled back by the system. Is this still the case with the new system, or do users need to manually roll back end dates each time an annual purchase is submitted?

A93: When a user requests, receives approval for, and services are accepted by the new provider, an authorization is generated. If this occurs during a submission for which IDT Type is "Annual" the CareConnection® will automatically roll back the end dates for all services purchased for the previous budget year.

Q96: When services are requested in excess of the member's budget, APS Registration Coordinators are requesting the IDT to review and reduce services to stay within budget. When the IDT determines that, in order to meet member need, services requested cannot be reduced, what is the next step?

A96: The Negotiations/Appeals Process is available to teams when they do not agree with authorization decisions made by APS Healthcare on a member's behalf. When APS is unable to authorize services as requested, this will be indicated by the purchase request being "Closed" in CareConnection®. APS Registration Coordinators will also recommend an alternate value of "approvable" units for the service. Teams can decide whether they would like to resubmit the request with the recommended approvable units or proceed to the next step. If the team would like to proceed, the SC will complete a Second Level Negotiation Request form and forward to Tiffany Angel at tangel@apshealthcare.com. If resolution is not reached at the Second Level Negotiation, the member has the option to proceed to Medicaid Fair Hearing.

Q98: The sample IPP lists "Health & Safety Issues Identified" in the evaluation section. Since the DD2A (Annual Physical) and DD3 (Psychological Evaluation) are no longer required, health/safety info will likely come from alternate sources, including IDT members. If so, why is the health/safety tab still present on the Care Connection?

A98: Although the former DD2A (Annual Medical Evaluation) and former DD3 (Psychological Evaluation) are no longer required components in determining eligibility for the I/DD Waiver program, they are still assessments that program members may need. Even if a medical evaluation is not required, members should (and likely would) have annual physical examinations that would detail individual medical/health issues; some will also have psychiatrist/psychologist interventions to meet needs. This

information should be communicated and kept updated in the "Medical" tab of the CareConnection®.

Individual Program Plan

Q3: For those members who have a fixed IPP date of 10/1/2011, what process should be followed regarding the previous manual's provision allowing teams to hold IPPs 30 days after the Anchor Date. What process should be followed when purchasing services in CareConnection®? If the meeting is held prior to 10/1/2011 is the team supposed to access "new" or "old" services?

A3: For those members who have fixed Anchor Dates of 10/1/2011 through 10/15/2011, providers may have the additional 30-day "after the fixed IPP" grace period to conduct your IDT meeting. Anyone with a fixed date of 10/16/2011 and after must comply with the I/DD manual policy stating that IPPs must occur within 30 days prior to the fixed date. When purchasing services for these members:

- If the IDT is conducted prior to 10/1/2011, you have the option to request authorization for either "old" MR/DD manual services and comply with MR/DD policy –or- request authorization for "new" I/DD manual services and comply with I/DD policy manual.
    - NOTE: 10/1/2011 and after, you MAY NOT receive authorization for "old" MR/DD services in the CareConnection® unless exception is granted by APS.
    - NOTE: Prior to 10/1/2011, you MAY NOT purchase "new" I/DD services in the CareConnection®
- If the IDT is conducted 10/1/2011 or after, you must request authorization for "new" I/DD manual services

Q10: Is the Individualized Habilitation Plan/Task Analysis required at quarterly IPP reviews if nothing has changed?

A10: Yes. The IHP and Task Analysis are a part of the I/DD-05 (IPP) and should be included with all Annual and quarterly meetings of the IDT. The only exception would be for 7-day meetings or addendums to a plan already in place.

Q11: For natural families, does the IDT decide if health and safety training is needed and what those health and safety needs are? Or will that still be required for all traditional service providers?

A11: It is required that every program member have identified health and safety needs met, and that training occur of staff supporting those needs. If the member chooses Personal Options, the member/representative is responsible to train the staff on health and safety needs. If staff is a provider under the Traditional model, the provider agency

is responsible. If under the Traditional model, the member/legal representative choose not to access the services of a Therapeutic Consultant, the member/legal representative is responsible for training staff on the member's specific [formal or informal] habilitation and health and safety needs. This training must be documented on an I/DD-06. It is strongly encouraged that these responsibilities be very clearly documented on the member's IPP. If staff is employed through Agency with Choice, the member/representative and the provider agency share responsibility of training staff.

Q20: If a member who chooses the Traditional with Personal Options Service Delivery Model has a Critical Juncture to transition prior to October 1, 2011, must the psychologist be present?

A20: For this type of Critical Juncture meeting, the psychologist would not be required, but may attend, if the member already has IPP Development-Psychologist units available. In this scenario, the member would access "new" I/DD Waiver policy manual services and rules.

Q21: For IPPs held on or after 10-1-11, the RN's attendance will continue to be optional. Some members/legal representatives have noted they no longer wish to have the RN attend meetings. Since the RN is still on the IPP to attend, do they need to attend an IPP for the IDT to note it is no longer a service need, or can they just not attend and the SC note why in the IPP?

A21: If this type of change occurs, the RN would not need to attend a meeting, but it would be considered a change in the member's need, and would necessitate accessing all new services/rules in the I/DD Waiver manual.

Q28: If a member elects to continue to receive "old" services throughout the remainder of their service year, are rules in the "old" policy manual or the "new" manual with respect to service limits?

A28: If a member decides to continue to receive "old" services, the services on the IPP should be provided as originally decided by the IDT and as authorized.

Q32: Is there still a 10-day window prior to the 3-month, 6-month and 9-month anniversary of the anchor date for holding quarterly reviews or 6-month meetings? Also, if there are changes to goals at these meetings, must training occur prior to the anchor date anniversary?

A32: The 10-day window in which to conduct quarterly IPPs prior to the "anniversary of the anchor date" has been expanded to 30 days. Example: If the member's Anchor Date date is 05/01/2012, the IDT must convene within 30-days prior to 05/01/2012 to conduct the Annual. The 3-month IPP is due 08/01/2012-IDT therefore the team must convene within 30-days prior to 08/01/2012.

Changes reflected in these meetings must have training occur prior to service provision.

Q39: If a member requires a critical juncture, when do the new services go into effect? For example, if a member's service year ends 11/30 and a Critical Juncture is held on 10/15, necessitating a transition from "old" services to "new" services. What is the effective date of those "new" services? Does it roll back to 10/01? Does it roll forward to 11/01?

A39: New services cannot start until at least the date the IDT meets and agrees to those services. The IDT may make the effective date any time the date of the meeting or after.

Q42: Please clarify what is meant in the manual by "The member's IPP must specify the number of miles per service. For example, "up to 100 miles per month shall be used for transporting the member to and from his job location." Does this mean the service associated with the transportation should be included on the IPP, or that the specific location should be included on the IPP?

A42: The number of miles per service should be indicated on the member's IPP. For example, 400 miles for Facility Day Habilitation –or- 800 miles for Person-Centered Supports-Family, etc.

Q46: The IHP and Task Analysis are required to be attached to every I/DD-05. What if no programs are completed/documented and the member has no TC?

A46: If this occurs, the IHP and TA would be not applicable. It is recommended, though that the IPP clearly identify how the member's needs are being met, especially when there is no active training and no TC.

Q52: The manual indicates that the RN, TC, etc. should attend all meetings if they are on the team. Is there any flexibility in this? For instance, if a member has minor medical issues and chooses to purchase minimal units of RN for minimal activities, and just wanted the RN to attend the annual meeting is that an option?

A52: The member will have the option to determine when and whether an RN or TC should attend meetings. The result should be clearly documented on the IPP.

Q62: For members who have a current Anchor Date that is other than the 1st of a month, will the Anchor Date be at the first of the following month, the previous month, or stay the same?

A62: Anchor Dates (and ultimately medical eligibility dates) will equal the fixed IPP date, regardless of whether it falls on the first of the month.

Q63: Are Medical Powers of Attorney/Healthcare Surrogates required to be at a member's IDT meetings?

A63: Medical Powers of Attorney are a means for a person to indicate "advanced directives" in the event it is determined that he or she is not medically able to make decisions on his or her own behalf. MPOAs are a venue to plan for the future. Unless the member is not medically able to make decisions, the MPOA would not be a required team member. Healthcare Surrogates are identified by medical providers in the event the member is unable to make decisions. If a program member has an identified Healthcare Surrogate, they would be required to attend all IDT meetings.

Q97: The sample IPP lists a "Person Centered Assessment" in the evaluation section. What assessment does this refer to and who is responsible to complete it?

A97: A Person-Centered Assessment is an assessment of the member's hopes/goals/dreams, strengths, gifts, supports etc. These things are captured as part of the I/DD-05 IPP document. Additionally, there are resources available such as MAPS and PATHS to assess and determine needs from a person-centered perspective. The SC may complete this/these assessments.

Q99: The sample IPP lists "Psychological/Psychiatric" in the evaluation section. Since the DD3 (Psychological Evaluation in MR/DD Policy Manual effective 11/1/07 to 9/30/11) is no longer required, what specifically are you looking for?

A99: Many program members still require psychological or psychiatric intervention even though it is not required for eligibility purposes (former DD3). The assessment summary and recommendation should be member-specific. If a member has a psychologist/psychiatrist, they would have updated information to include on the IPP. Otherwise, a member may not have an up-to-date psychological evaluation to report in the assessment summary and recommendations section of the IPP.

Q100: The sample IPP lists "Diagnosis" in the evaluation section. Where and how is this information obtained?

A100: Diagnosis should reflect the most recent 5-axis diagnoses for the member. If a provider suspects that a diagnosis has changed, the member should be referred to the medical or psychological/psychiatric professional for additional assessment.

Q104: If a member decides to access participant directed services via the Traditional with Personal Options Service Delivery Model and does not purchase any nursing services would the agency continue to need to maintain a list of medications and continue to request HRC approval for psychotropic medications?

A104: The I/DD-05 IPP includes a section specifically for medications. It is required that this section be completed/updated as IDTs occur. If medications are used as a restriction, then yes, they would require Human Rights Committee approval.

Q118: What documents are expected to be attached when an IPP is amended as a result of a Critical Juncture?

A118: A Critical Juncture IPP may include simple changes to a complete change of all of the member's services and providers. All components of the I/DD-05 IPP document should be used to document Critical Junctures. At minimum, addendums to IPPs should include documentation of verbal agreement/approval by the members of the Interdisciplinary Team prior to implementing. Signatures of all team members should be acquired at the earliest juncture, such as at the home visit. For additional information regarding when to hold a Critical Juncture and how to document its associated addendum to the IPP, see Addendum Clarification and IPP Addendum Example dated 12/16/2011.

Q121: For purchase requests that have not been approved within the 14-day timeline that the SC must disseminate the IPP to the IDT, what is the process for the SC to follow regarding sending out the budget to the IDT?

A121: If resolution is not reached within the 14-day timeline, the SC should send the IPP as was discussed by the team and services submitted for approval through APS Healthcare. The SC will work with the IDT throughout the negotiation process to ensure their continued approval for any service changes/requests. Once services are ultimately approved, the SC should send to the IDT a note/memo notifying the team that services have been approved (or closed/denied as applicable) and a copy of the budget sheet from the I/DD Waiver CareConnection® which outlines all services approved (or other status, as applicable). Notify the team members that this finalized list of services should be attached to the original IPP that they already received.

Q129: When documenting IPPs for those members who are switching in the middle of their service year from "old" services to "new" services, how should duration be indicated?

A129: The duration of service (start date through end date) should reflect the date the new I/DD service is effective through the end of the member's service year.

Q165: Is it sufficient to list a member's medications, dosage, purpose etc on form IDD-05 in the section provided, or must they also be listed in the ISP section?

Q165: To list them in the medication section of form IDD-05 is sufficient.

Q176: The signature page has a column titled "Date this IPP was sent out." If this is filled out properly, will this satisfy a reviewer that "documentation exists that the SC disseminated copies of the IPP to the IDT members within 14 calendar days from the date that the IDT meeting was held"?

A176: In addition to this column being completed on the signature page of the I/DD-05, a progress note indicating when, how, and to whom the completed IPP document was sent should be completed.

Intellectual/Developmental Disabilities (I/DD) Waiver Forms

Q18: With the implementation of the I/DD Waiver policy manual, should providers utilize new or old forms – specifically, members who are still accessing services under the MR/DD policy manual?

A18: The new I/DD Waiver forms should be used for all services and for all program members beginning 10/01/2011.

Q22: If a member is receiving support services, as opposed to habilitation/training at a Facility-based Day Habilitation site, will I/DD-07 documentation be sufficient to meet OHFLAC documentation requirements?

A22: Per OHFLAC, documentation required by Waiver will be sufficient for OHFLAC's needs, provided that the activities/supports/treatments are included in the Individualized Program Plan.

Q27: Currently, some employees/staff fax or e-mail their documentation to the agency for billing/payment and send in original documentation at a later date. Are faxed/electronic signatures acceptable? Are original documents required to be on file?

A27: Faxed/electronic signatures are acceptable.

Q36: On the I/DD-07, Direct Support Service Log, will it be acceptable to use a crosswalk of old and new service types for the service name and code section?

A36: Beginning 10/01/2011, the I/DD-07 may be used for all direct support documentation. Whether or not you are billing "old" codes for one member or "new" codes for another member, the I/DD-07 should reflect the services on the IPP, the services for which there is an authorization, and the services that will be billed to Molina (all of which must match).

Q45: Are DD17 (MR/DD QMRP/Therapeutic Consultant Credentialing forms) still required?

A45: No, credentialing forms will not be required. APS will review Qualified Provider files for the presence of required credentialing and training documentation in relation to the service provided by the employee.

Q51: Are agencies required to maintain an I/DD-06 form in the file for trainings that have cards with expiration dates such as CPR/FA?

A51: The I/DD-06 is only required for member-specific trainings. If an agency chooses to document additional trainings on the I/DD-06, they may do so, but it is not required.

Q59: Is a member's legal representative required to attend the Annual Functional Assessment? If the legal representative does not attend, at what time would they complete an I/DD-02 Freedom of Choice Form?

A59: The legal representative is not required to attend the APS Annual Functional Assessment. They are, however, required to sign the I/DD-02 Freedom of Choice form. When the legal representative is not available to complete the form at the Annual Functional Assessment, the SC must ensure its completion. Once completed, by the SC, information regarding Service Delivery Model selection should be entered by the agency into CareConnection®. Service Coordinators may also wish to upload the document into CareConnection® using the Attach Documents feature.

Q53: Is it acceptable for agencies to insert IHPs that are developed using a computer program into the IPP, or is it required that the Service Coordinator enter the information into the document?

A53: It is acceptable and most appropriate for the TC/BSP to develop the IHP/Task Analysis. The TC/BSP would then forward information to the SC for inclusion/attachment to the IPP.

Q58: Should the required detailed progress notes for LPN services be documented on the I/DD-07, or should they be documented elsewhere?

A58: If the provider agency chooses, the I/DD-07 Direct Support Progress Note may be modified for use to document LPN services (detailed progress summary). Additionally, the provider agency may choose to utilize a form of their choosing. The exception to the requirement of the "detailed progress note" is the form that was disseminated some time ago in which LPNs can document medication administration via a "check off" form. This form will be revised and included as the "I/DD-14" in the menu of available forms.

Q105: Please clarify on the I/DD-03 SC HV_DV Combined how Service Start Time and Service Stop time, then Service Time Duration and Travel Time Duration should be documented.

A105: Service Time Duration = Time spent conducting the home visit; Travel Time Duration = Time spent traveling to and from the home visit; Total Time = Service Time Duration + Travel Time Duration; Service Start Time = Time the SC started the home visit (got to the home and began the visit); Service Stop Time = Time the SC ended the home visit (left the home).

Q117: BMS has indicated the standardized I/DD Waiver forms be utilized by all providers. Is it possible that forms can be modified for specific agency purposes if all the required fields are present?

A117: The integrity of the form and all required information must be maintained; however, the forms may be modified to meet specific member or provider needs. For example, the I/DD-05 (IPP) document has a format for meeting minutes. Many providers would prefer to have a more comprehensive summary of meeting minutes, which would be acceptable. The IHP/Task Analysis portion of the I/DD-05 may be modified to meet the specific member's goals/objectives and provider scoring methodologies. The I/DD-07 Travel Log may be modified to include an additional column reflecting an agency-specific (billing department) requirement.

Q126: Should the I/DD-02 Freedom of Choice form be forwarded to APS Healthcare regardless of service delivery model chosen?

A126: No. The I/DD-02 form will be completed by the APS Healthcare Service Support Facilitator at the time of the Annual Functional Assessment, unless the member's legal representative is not present at the assessment. Under those circumstances, the SC should complete the form with the legal representative at the next earliest juncture. Following completion, the SC should upload the completed form to the WV I/DD CareConnection® using the Attach Documents feature, indicate the Service Delivery Model selected by the legal representative in CareConnection® and maintain the original in the member file.

Q128: Should SC agencies still complete the DD7/7A (Informed Consent Documents MR/DD Policy Manual effective 11/1/07 to 9/30/11) in addition to the I/DD-02 Freedom of Choice?

A128: No. The DD7/7A are no longer forms applicable to the I/DD Waiver program; the I/DD-02 form replaces the DD7/7A.

Q131: Is it acceptable for a member identification number, assigned by the provider agency, to be indicated on service notes instead of the member's name?

A131: APS and OHFLAC would both need access to the "code" identifier list for review (Example: Code 123 is equivalent to John Doe). Reviewers must be able to know who

each document references. This is especially critical when reviewing incident reports and Human Rights Committee activities, since these items may not be placed in a member's file.

Q167: If a new member does not designate a service provider on the IDD-02 Freedom of Choice form at the time of their initial APS Assessment, how much time do they have to make this decision?

A167: New members must access services within 90 days of their slot allocation date, therefore must decide on a service coordination provider with enough time for services to be provided within that 90-day time period. When new members are notified of their slot allocation and start date, they are provided with an I/DD Waiver Provider Reference Guide from which they can make their choice of service provider.

Interdisciplinary (IDT) Meetings

Q34: Does the removal of the 30 day window after the fixed date affect only new budgets or does it apply to all existing budgets?

A34: The 30-day window is not reflective of "budgets." It's reflective of the time span available for IDTs to convene prior to the fixed IPP date. Any Annual IPPs held when the fixed date is 10/16/2011 (FAQ #3 references an extension for those fixed IPP dates through 10/15/2011) or after must be held within 30 days prior to the fixed date. This also applies to quarterly meetings-IPP must be held within 30 days prior to due date.

Q114: Can RNs bill the IPP Planning Code when attending IDT meetings via MDTV?

A114: Yes. In order to bill the IPP Planning Code when attending via MDTV, the RN must attend the entire meeting.

Q125: As TC, BSP, and RN are only allowed a maximum of 4 IPP Planning Events per year, how would those professionals bill if there are more than the authorized number of IDT meetings held during the member's service year (for example, if Critical Juncture or Transfer Meetings are held)?

A125: Each TC, BSP and RN can provide up to 4 events per service year per authorization and member need. Any identified needs above 4 units must be billed under the professional code.

Q174: Regarding guardianship, if a Waiver member has a parenting plan that indicates both parents have guardianship, do both parents need to attend the IDT meetings? If a member has two guardians and they disagree with one another about the member being on the Waiver program, how should this be handled?

A174: For Waiver purposes only, if a member has one or more legal representative(s) at least one must be present at IDT meetings. Legal documents, however, may be specific to a member and should be considered on a case-by-case basis. For example, if a member's parents are divorced and their custody/guardianship agreement indicates they are court-ordered to share in decisions regarding medical care then both parents would need to be present. In the event that parents/guardians have differing opinions on whether or not the member should be on the Waiver program, this should also be handled on a case-by-case basis, depending on the legal documents pertaining to the individual.

Miscellaneous

Q5: Can those staff who previously contracted under Community ResHab/Respite/Adult Companion be classified as exempt from overtime and minimum wage under the new I/DD Waiver manual?

A5: APS cannot give advice on taxes, overtime, or the Fair Labor Standards Act. The Act exempts some employees from its overtime pay and minimum wage provisions, and it also exempts certain employees from the overtime pay provisions only. Because the exemptions are narrowly defined, employers should check the exact terms and conditions for each by contacting their local Wage and Hour Division office *http://www.dol.gov/whd/america2.htm*. West Virginia's office is: Charleston Area Office US Dept. of Labor Wage & Hour Division 500 Quarrier Street Suite 120 Charleston, WV 25301-2130.

Q124: If a member is still receiving "old" services, are they still bound by "old" service limits? Do "old" service limits, such as the 70 units per month Service Coordination limit, still apply?

A124: If the member is receiving services under the MR/DD manual, they are subject to rules and limitations of the MR/DD manual. In this example, the member should not exceed 70 units per month of Service Coordination.

Q157: Can Waiver services be provided to members who are incarcerated?

A157: No Medicaid services can be billed for individuals who are in jail/prison.

Q168: Can a staff person who is not a nurse and not AMAP certified administer an Epi-pen if needed?

A168: Yes, in emergency situations, non-nursing staff who are not AMAP certified may administer an Epi-pen if they have been trained by a nurse and have written permission from the member's legal representative to do so.

Q171: If two I/DD Waiver members are related and live in the same home, is it possible for them to combine an EAA Vehicle authorization to purchase one item? For example, is it possible for two members to combine their EAA dollars to purchase one van lift for the family vehicle?

A171: All EAA requests will continue to require prior authorization, and decisions for such will continue to be based on individual members' needs. In the example above, however, if two related members live in the same home and both have mobility issues that require a van lift for the family vehicle, this is permissible.

Personal Options

Q23: For members who choose the Traditional and Personal Options Service Delivery Model, what documents will the Service Coordination agency be expected to maintain?

A23: All documentation retention requirements at the Service Coordination agency are the same regardless of the Service Delivery Model utilized by the member. The only exception to this is that time and attendance documentation for services provided through the Traditional and Personal Options Service Delivery Model will be maintained by the Fiscal/Employer Agency, Public Partnerships Limited, LLC. APS will access these documents, including direct-care, transportation, and Participant-Directed Goods and Services documentation, through PPL for reviews. Completed task analysis and behavioral data tracking documentation (if applicable) should be maintained by the agency providing TC/BSP.

Q69: Why is it that the reimbursement rate for Person-centered Supports under Personal Options is $10.96/hour but staff can only be paid up to $9.88 per hour?

A69: The $1.08 difference allows the program member, as the employer, to ensure that certain federally-required benefits are paid. These include Social Security and Medicare and Federal Unemployment Insurance. These costs add up to $1.08 per hour of service billed.

Q70: Please explain the discrepancy in rates for Respite Care Services under the Traditional Service Delivery Model ($20.04 per hour) and the Traditional and Personal Options Service Delivery Model ($10.96 per hour).

A70: Staff hired to provide Respite Care under the Traditional Service Delivery Model are considered employees of the provider agency. The rate under this model

($20.04/hour) includes not only the federally-required benefits, (Social Security, Medicare and Unemployment Insurance) but also worker's compensation insurance. Providers must also pay 5.5% for Medicaid Provider Tax. Finally, this rate affords an allowance for the agency to provide supplemental benefits. These may include health insurance, 401K, and/or paid leave such as sick time/vacation time.

Q82: Can a program member choose to participant-direct PCS-Family and still continue to receive some PCS-Agency?

A82: Yes. A program member can receive PCS-Family through a participant-directed service delivery model and PCS-Agency through the traditional service delivery model.

Q91: If a member wishes to manage their own staff via the Personal Options Service Delivery Model and does not wish to have Behavior Support services or a Positive Behavior Support plan, what criteria will be in place upon review by OHFLAC or APS Healthcare?

A91: Regardless of the Service Delivery Model a member chooses, they may choose for their needs to be met via informal supports. This would mean a member with a behavioral need may not have to have a formal Positive Behavior Support Plan. The need could be addressed on the member's IPP and then it would be very important for the member/representative/family to give updates on progress of their intervention methods (whether formal or informal) during home visits, IPP meetings, etc. The Service Coordinator is also responsible to obtain updates during home visits and make recommendations for various alternatives, as determined necessary.

Q104: If a member decides to access participant directed services via the Traditional Services with Personal Options Service Delivery Model and does not purchase any nursing services would the agency continue to need to maintain a list of medications and continue to request HRC approval for psychotropic medications?

A104: The I/DD-05 IPP includes a section specifically for medications. It is required that this section be completed/updated as IDTs occur. If medications are used as a restriction, then yes, they would require Human Rights Committee approval.

Q113: As new members receive Waiver slots and begin to receive services with a provider agency, is there a trial period during which time they are required to choose the Traditional Service Delivery Model before choosing to participant-direct their services?

A113: No. The member may choose to access any of the Service Delivery Models at any time. Prior to receiving a slot, APS will forward a Freedom of Choice form to the member/legal representative. On this form, they will indicate their choice of ICF/MR vs. Waiver, choice of Service Coordination provider, and choice of Service Delivery Model.

Q147: If a member chooses participant-directed services using the Personal Options model, do their employees require a WV DHHR background check (Protective Services Record Check)?

A147: Yes, effective 7/1/12, members who choose to access participant-directed services using the Personal Options Service Delivery model must require their employees to also pass the WV DHHR background check (Protective Services Record Check). This check must be initiated upon hire.

Person-Centered Supports

Q8: Is it correct that Person-Centered Support staff must be employed by an agency rather than serve as a contracted provider?

A8: The manual does not dictate whether providers employ or contract for any service. This is between the agency and the WV Department of Labor and your attorneys. You can bill for person-centered support. If the provider is a family member who lives with the program member, providers should bill S5125U5 Person Centered Support-Family at $2.74/15 min. If the staff does not live with the member, it would be appropriate to bill S5125U1 at $5.01/15 min.

Q85: Can Person-Centered Supports (or other services) be provided during regular school hours?

A85: BMS will not dictate when services can be provided; however it would never be acceptable to bill Person-Centered Support (or any I/DD Waiver services) during the hours the member is receiving home-schooling. It is always necessary to ensure that no I/DD Waiver services are substituted for federally mandated educational services. Lack of school compliance with an IEP or another identified educational need will not justify the use of I/DD services to meet the need.

Q89: If individuals have a current authorization for Community Residential Habilitation but wish to change to PCS-Family because they anticipate being able to provide 8 hrs a day, will this put all the other previously approved services in jeopardy of not being approved based on their current assessment-based budget amount?

A89: Services are authorized based on assessed need and the individualized budget for the specific program member. APS cannot know or pre-determine whether or not services would "be in jeopardy" or even whether a member will be authorized for a service limit of 8 hours per day.

Q90: Are there specific criteria for a member to be approved for 8 hrs a day of PCS-Family?

A90: Criteria for authorization of a particular number of units will not be established. Authorizations for all services are based on the individual member's need, as presented to APS Healthcare at the time of purchase request.

Q119: If a member's parents have shared custody in two separate homes, what codes would be appropriate for the parents' service provision?

A119: Both homes would be considered the member's home in a shared custody arrangement. Both parents would only be eligible to provide Person-Centered Supports. Respite is not an option because Respite providers cannot live with the member.

Q133: Can an individual who resides in an ISS setting through the week receive PCS-Family services from a SFCP on the weekends?

A133: Someone who lives in an ISS can not receive PCS-Agency or PCS-Family on the weekends in a Specialized Family Care Home. PCS-Agency cannot be provided in a staff member's home unless it is also the member's home; PCS-Family cannot be provided unless the member lives in the home. Only Respite can be provided out of the member's home in someone else's home, but ISS residents are not eligible for respite.

Q153: Can a parent provider who bills Person-Centered Supports: Family for a Waiver member also bill to provide Personal Care services to that same member?

A153: I/DD Waiver policy has no restrictions related to whether or not PCS-Family staff can also provide Personal Care serves. Whether or not staff is hired is at the discretion of the Personal Care agency. According to the Medicaid Personal Care Manual, If the parent is determined eligible for employment with the Personal Care agency, the member is over the age of 21, and qualifies for Personal Care, then parent providers can do both. Personal Care services and I/DD Waiver services can be provided on the same day but may not be provided at the same time.

Provider Reviews

Q137: What documents does APS expect to see in the member's home?

A137: See OHFLAC's Behavioral Health Regulations for additional OHFLAC requirements. Per the current I/DD Waiver Provider Review tool, APS expects to find the following in the member's home:

- Personal demographic/emergency contact. If community activities are planned, a copy will be taken in a sealed envelope for emergency use only

- Current complete IPP including current psychological, social and physical evaluations [summaries] , current behavior support plan, activity schedule, Crisis Plan, IHP and IEP if there is one
- [ISS/GH] Current doctor's orders for every medication administered at that site, even if the client self administers
- Current daily direct support documentation, task analysis and/or staff notes
- [ISS/GH] Current MARs
- Copies of other pertinent medical or evaluative information relevant to treatment

Q161: In today's electronic age, is there any flexibility in the way records can be maintained on-site (such as in an ISS, member's family home, and/or facility-based day habilitation sites)?

A161: It is acceptable for documentation that is required to be on-site, such as current IPPs and staff documentation, to be maintained in an electronic format, as long as the documentation is accessible to individuals who may need to access it.

Q169: If an agency has its own process in place to review monthly training requirements and can produce its own reports/information in regards to staff having current training qualifications, is it necessary for the agency to utilize the self-review tool distributed by APS Healthcare?

A169: Agencies may keep their own records, however, to ensure that all necessary information for the self-reviews is received and for consistency in processing, it will be required that the self-review tool provided by APS Healthcare be submitted with all the required information by the due-date. The self-review tool was created to be very user friendly for providers.

Q175: How will potential paybacks be handled for self-reviews?

A175: When an agency identifies, via the required self-review, that self-disclosure is necessary, they will report this to the Office of Quality and Program Integrity by:

- Identifying the repayment option of choice on the West Virginia Medicaid Standard Repayment Provision for All Overpayment Notifications (attached);
- Completing the Remit Voucher (attached) if repayment is being made via check;
- Completing the West Virginia Medicaid Self-Report Form (attached), identifying the Recipient Name, Medicaid ID#, Date of Service, Procedure Code, Amount Billed, Amount Paid, Paid Date, Refund Amount, and Reason for Error;
- Submit all of the above documents to:
  Paula Duff

Office of Quality and Program Integrity
West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol St.
Room 251
Charleston, WV 25301

- For inquiries please call 1.866.243.9010.

PLEASE NOTE THAT, UPON IDENTIFICATION OF THE NEED TO SELF-DISCLOSE, AGENCIES SHOULD REPORT TO OQPI. PROVIDERS SHOULD NOT WAIT UNTIL THE END OF THEIR SELF-REVIEW PERIOD TO DO SO.

Qualified Provider/Training

Q11: For natural families, does the IDT decide if health and safety training is needed and what those health and safety needs are? Or will that still be required for all traditional service providers?

A11: It is required that every program member have identified health and safety needs met, and that training occur of staff supporting those needs. If the member chooses Personal Options, the member/representative is responsible to train the staff on health and safety needs. If staff is a provider under the Traditional model, the provider agency is responsible. If under the Traditional model, the member/legal representative choose not to access the services of a Therapeutic Consultant, the member/legal representative is responsible for training staff on the member's specific [formal or informal] habilitation and health and safety needs. This training must be documented on an I/DD-06. It is strongly encouraged that these responsibilities be very clearly documented on the member's IPP. If staff is employed through Agency with Choice, the member/representative and the provider agency share responsibility of training staff.

Q12: Beginning 10/1/2011 all staff will be required to have applicable state and/or federal background checks (fingerprints) upon hire and every 3 years thereafter. Our agency has been doing fingerprints since OHFLAC started requiring them in 2009, in addition to the on-line checks. For those employees whose hire date pre-dates the 2009 directive, what is the time expectation for agencies to take fingerprints and process them? We will have a lot of employees to process, as will other agencies.

A12: BMS issued a memorandum 08/24/2011 stating that providers have until 10/01/2012 to initiate CIB fingerprint checks for existing employees hired prior to the OHFLAC clarification in 2009. This extension does not apply to new hires.

Q13: Can Office of Inspector General (OIG) check results be maintained in a separate file or must they be maintained in employees' Personnel files?

A13: It would be acceptable to maintain monthly OIG checks in a separate file. Keep in mind, though, that for agency self-reviews and APS provider reviews, reviewers must be able to verify this requirement per staff person and per dates.

Q16: How often must the Protective Services Record Check be completed?

A16: The Protective Services Record Check is only required upon hire.

Q19: How does an agency/provider acquire proof of an acceptable Federal Criminal History Check since only the individual can request it?

A19: Individuals can request fingerprint checks from the FBI but they can not have them sent to an agency or other entity. They would have to receive them and take them to their prospective employer. Please refer additional questions to the FBI web site http://www.fbi.gov/about-us/cjis/backgroundchecks#documentContent.

Q24: The I/DD Waiver manual requires training on the Heimlich maneuver, however, the American Red Cross does not refer to this as the Heimlich maneuver. Will the training, as indicated by the American Red Cross suffice to meet the requirement?
A24: Yes. Training, on (formerly known as Heimlich) abdominal thrust techniques as labeled by the American Red Cross will meet requirements.

Q27: Currently, some employees/staff fax or e-mail their documentation to the agency for billing/payment and send in original documentation at a later date. Are faxed/electronic signatures acceptable? Are original documents required to be on file?

A27: Faxed/electronic signatures are acceptable.

Q30: If billing "old" MR/DD codes through the remainder of a member's IPP service year, do direct support staff require training described in the "old" manual, "new" manual, or both?

A30: Any new direct support staff providing direct support services 10/1/2011 and after should be trained on the items as indicated in the "new" I/DD Waiver manual regardless of whether you are billing a "new" or "old" code. Example: Someone was hired 9/30/2011, but did not begin billing a direct support code (Agency Residential Habilitation) until 10/5/2011. This would crosswalk to Person-Centered Supports and the staff should receive the training required under the [new] I/DD Waiver manual.

Q31: Must all member specific training occur prior to the IPP anchor date, or is there a 30- day grace period?

A31: There is no grace period for member-specific training. All member-specific training must occur prior to service provision. Additionally, this would not occur at only the Annual IPP; it should occur throughout the service year, as new medical, habilitation or other issues arise.

Q41: What is meant by "Training on Emergency Procedures, such as Crisis Intervention and restraints" as is indicated in the I/DD Waiver Manual training requirements?

A41: Any staff working with a particular member should be trained on their specific needs. If a member has restraints as a reactive measure in a positive behavior support plan, then that staff person should have training in restraints. If a member does not exhibit need for such intervention, then the staff should be trained generally on de-escalation (for example) or other applicable techniques. Separate from this, all staff should have general training in crisis intervention and emergency procedures. This would include training on the member's specific Crisis Plan.

Q56: If a staff person lives out of state, is it still necessary to have the WV CIB?

A56: Yes, because they have worked or will be working in WV, this provider would be required to have both the WV CIB and the Federal CIB check.

Q81: If an employer conducts the Protective Services Record check on a staff and finds substantiated abuse/neglect on the record, is the expectation that the provider review the report and make a determination about whether that staff can provide service –or- is the expectation that the employee can not be employed?

A81: Background check policies are in place to ensure first and foremost, member health and safety. BMS has the responsibility to protect members from maltreatment. If an agency employs a staff who bills for services while he or she has substantiated incidents of child or adult maltreatment, services provided by that staff would be disallowed. Also, current policy does not provide for provisional employment if and while background and registry checks are being challenged.

Q83: How long will CIB results be valid when a staff is responsible to bring their own results back to the agency (ref. Federal CIB)? What if a staff works at one agency for only a week and then goes to work at another agency. Are they required to obtain a new CIB?

A83: If the staff obtains federal CIB at one agency, works there for a short time, and then goes to work for another agency, the staff will be required to obtain a new CIB at the new agency.

Q84: If a new employee is sent for fingerprints and agencies have 3 months to receive results while the person works, how do agencies know they really went for prints?

A84: The provider agencies have autonomy in determining a way to ensure staff follow-up in obtaining CIBs. One option might be to have a standardized form staff take with them to the site where they could have someone at the state police office verify the date the staff was fingerprinted. Another option is to require a receipt for payment.

Q88: In the past, if an agency could not produce a copy of a staff person's CPR/FA certification card, a class roster signed by the instructor was considered sufficient proof that the staff person was certified. Would a roster printed from an online course be considered sufficient as well?

A88: The printed roster, with identifying information of the instructor would suffice because the logon would be considered an electronic signature.

Q106: Can BMS accept the American Safety and Health Institute's (ASHI) First Aid/CPR training?

A106: Yes. ASHI's resuscitation programs for basic and advanced life support conform to national standards and are based on the same scientific guidelines and treatment recommendations used by the American Heart Association (AHA) and American Red Cross (ARC) for course development. ASHI's basic first aid, CPR/AED, and advanced resuscitation training programs (ACLS/PALS) require successful completion of a written exam and competent performance of hands-on skills evaluated by an authorized Instructor. In addition, American CPR is also an approved vendor.

Q109: If an applicant has been in the US from another country and has a valid work visa, must agencies complete some form of international Criminal Investigation Background (CIB) check?

A109: The I/DD Manual does not include a requirement for international background checks. If the applicant has lived or worked outside of WV in the last 5 years, the agency must complete WV state and federal checks.

Q110: OHFLAC requires the Court-Appointed Guardians to have the Motion for Authorization to Receive Compensation for Services Rendered to the Incapacitated Person Order in order to avoid any conflict of interest in receiving compensation from I/DD Waiver. What is APS Healthcare's stance on this if the Court-Appointed Guardian has not had this completed?

A110: This is not just an OHFLAC requirement, but is WV State law, passed March 11, 2011, and in effect from the date of passage. See WV H.B. 2885. Currently (11/03/2011), this issue alone will not be cause for disallowance during an APS

retrospective review. Per OHFLAC "It has been more than 30 days since the law requiring parents to have their guardian/behavioral health employee status reviewed/approved by the courts. Should OHFLAC during a survey discover that the I/DD Waiver provider does not have a copy of the form submitted to the court in the member's file and the court's approval, this could result in a deficiency, depending on the scope (number of problem files) found."

Q142: If a Protective Services Record Check that originally came back with substantiation was later found to be in error, is a written statement from WV DHHR indicating the error sufficient for the personnel file?

A142: Yes, that is enough documentation to have on file and continue to resubmit a form to make sure it gets cleared up. Be sure to make copies of the letter from DHHR.

Q146: Can an agency use another agency's approved PBS Curriculum to train staff to provide the Behavior Support Professional Code?

A146: If an agency wishes to use another agency's approved curriculum, it is expected that they would still go through the Application Process. In the application, the agency who is using another agency's curriculum must indicate they are using a pre-approved curriculum and specify which agency developed the curriculum. They would also be required to submit their mentoring plan and list of trainers with credentials for approval. In addition, in order to qualify to train others, an individual must meet at least one of the following three criteria:

1. Be the developer of an approved training as indicated on the submitted application;
2. Be able to provide documentation that certifies completion of an approved training course (though not necessarily the course for which they are the trainer);

OR

3. Be a Board Certified Behavior Analyst or Assistant and have documentation certifying completion of the Overview of Positive Behavior Support as stated in the I/DD Waiver Manual.

Q147: If a member chooses participant-directed services using the Personal Options model, do their employees require a WV DHHR background check (Protective Services Record Check)?

A147: Yes, effective 7/1/12, members who choose to access participant-directed services using the Personal Options Service Delivery model must require their employees to also pass the WV DHHR background check (Protective Services Record Check). This check must be initiated upon hire.

Q150: Under payment selections on the West Virginia Scan Services—Information Form, there are the following sections available for background checks: NCPA/VCA background check (WV state and FBI check) $34.10, State and Federal background $48.10, and State and Federal with DHHR facility number (Central Abuse) $38.10. If the scenario is that a staff lives in Maryland but works in WV, which one should be used? Does another state background check need to be completed in Maryland also?

A150: All staff must have a State CIB via the Central Abuse Registry, and if they've lived out of state within the past five years, must also have an FBI check. As such, this would indicate that if a staff person lives in Maryland (or any other state other than WV), not only would that person need a state CIB but would also require an FBI check.

Q155: Is American CPR an acceptable training for First Aid/CPR?

A155: Yes, in addition to American Red Cross, American Heart Association, and American Safety and Health Institute (ASHI), American CPR is an acceptable trainer. For up-to-date information on which courses are acceptable, go to: http://www.dhhr.wv.gov/bms/hcbs/IDD/Pages/Training.aspx

Respite Care

Q65: Is it permissible for Respite Care to be provided while the primary caregiver of a WV I/DD member works outside the home?

A65: Yes, this restriction, as was indicated in the MR/DD manual is removed in the I/DD Manual.

Q87: Once a member's 30-day authorization for Crisis Respite Care has been exhausted, is the Crisis Respite site allowed to bill Person-Centered Supports?

A87: A Crisis Respite site may bill only Crisis Respite for a maximum of 30 days per stay. Immediately upon admittance to a Crisis Respite site, the IDT should begin planning for discharge to occur within 30 days. No I/DD Waiver billing may occur after the 30 day period of Crisis Respite has been exhausted.

Q134: The I/DD Manual indicates that 48 units of training per quarter are permitted for Respite Care. The manual does not, however, mention training under the crisis respite code. Was that an oversight in the manual, or can training not be billed to the crisis respite code?

A134: Training can be billed for services under Crisis Respite. This was an oversight in the I/DD Manual. The overall limit for Respite Care (Agency Respite, Personal Options Respite and Crisis Respite) cannot be exceeded.

Q156: When requesting respite care, what factors should teams take into consideration?

A156: Approval for respite care services is based on each individual and their primary caregiver's circumstance. Since the purpose of respite care is to give the primary caregiver a much deserved break, teams should consider: additional responsibilities of the caregiver, whether or not the caregiver works/volunteers/attends school outside the home, whether the member is in school or participates in day habilitation, individual factors that would contribute to the primary caregiver's difficulty in providing care, the member's behavioral and healthcare needs, and/or any other factors unique to the member and his/her primary caregiver.

Service Coordination (SC)

Q38: What if the member/representative refuses to allocate enough funds in the budget toward the purchase of Service Coordination?

A38: Service Coordinators may wish to share with members/Legal Representatives the tasks, time, and units required to fulfill I/DD Waiver and licensure requirements. Services provided and billed should be transparent to the member so that they can make good decisions. While CMS dictated that BMS could not implement a minimum number of units required per month for Service Coordination (or any services), APS/BMS will be happy to educate families about Service Coordinator requirements. Ultimately, members have the option to "shop around" if another agency is willing and able to provide required services while utilizing fewer units.

Q40: Since Service Coordinators (SC's) are required to attend APS assessments, is it appropriate to list the Service Coordinator as a respondent on the demographics page of the CareConnection®?

A40: If the SC is attending as a respondent, then include them as a respondent on the demographics page of CareConnection®. If they are attending but not serving as a respondent (for example they are new to the member's case), they should not be listed as a respondent.

Q43: If a program member is accessing "old" MR/DD services throughout the remainder of their service year, is the Service Coordinator required to conduct a bi-monthly day habilitation visit (as is indicated as a requirement in the pre-10/1/2011 manual)?

A43: Beginning 10/1/2011, community-based DH and Supported Employment visits would not be required, even if the member is still accessing services under the MR/DD manual.

Q149: How do I go about getting Personal Care Services for members on my caseload?

A149: If eligible, I/DD Waiver members may use Personal Care Services to supplement their existing Waiver services. To apply for Personal Care Services for an I/DD Waiver member, Service Coordinators should contact an approved Personal Care Agency. To do so, the member and his/her legal representative (if applicable) should choose a provider in their area from the list of approved Personal Care Agencies , which can be found at this link: http://www.wvseniorservices.gov/HelpatHome/MedicaidPersonalCare/PersonalCareAgencies/tabid/112/Default.aspx The chosen agency will arrange for a Registered Nurse to conduct a Personal Care Needs Assessment. Once this initial assessment is completed, the Registered Nurse with the chosen agency will determine whether to recommend further evaluation by a physician. If the RN recommends further evaluation, a physician will complete a Personal Care Medical Eligibility Assessment (PCMEA) form. When completed, the Registered Nurse with the member's chosen Personal Care Agency will review the PCMEA to determine if the applicant meets the medical needs criteria for Personal Care Services. For more information on the Personal Care Program, including eligibility criteria, go to: http://www.dhhr.wv.gov/bms/Documents/bms_manuals_Chapter_517_Pers_Care.pdf to access BMS' Personal Care Manual.

Q163: If a member has two residences, such as in a joint-custody situation, should the Service Coordinator conduct two home visits, one at each home?

A163: If a member's specific needs warrant more than one home visit due to health and safety concerns, and is feasible for the agency to conduct the visits (e.g. both homes are in the agency's catchment area) then the SC can conduct both visits. SCs should ensure any identified issues are reported to the appropriate authorities, such as Adult or Child Protective Services. Additionally, SCs should be sure not to get involved in custody disputes.

Skilled Nursing Services

Q33: The I/DD Manual states as a limitation "Nursing assessments required by the I/DD Waiver provider but not the I/DD Waiver manual." Since the nursing assessment is no longer a requirement, is it billable?

A33: A nursing assessment, as required by the member's needs, is allowable and billable. It would not be acceptable to implement multiple nursing assessments, such as the Waiver nursing assessment and the HART. Also, some provider agencies require a specific nursing assessment as a part of their Quality Improvement/Assurance process. It is not acceptable to bill for services that are not needed, warranted, or wanted by the

program member or their representative for the purposes of satisfying an agency requirement.

Q37: With LPN being considered in the allowable number of direct care units, how will Facility-based Day Habilitation programs be affected, as AMAPs are not allowed to pass medications?

A37: LPN services will be considered direct support when the provider is billing more than 2 hours/day. When the LPN is providing LPN services greater than 2 hours/day, it is expected that the LPN also provide habilitation training (which will count toward the hours of direct support). If an LPN is at a facility day program and only administering medications or providing services less than 2 hours/day, then it can be provided in addition to the direct support (i.e. the Facility Day Habilitation provider does not have to stop billing while the LPN is administering medication).

Q60: RN is not listed as a service that can be billed concurrently with crisis services. Is this intentional?

A60: The I/DD manual indicates the following as a limitation for Crisis Service: "May be provided concurrently with Service Coordination, Therapeutic Consultant, BSP Transportation and up to two hours of LPN nursing services per day." The RN not being listed is an oversight. BMS will correct and add RN as a service that can be billed concurrently with Crisis service.

Q102: If there are 3 members who live in the home, and the LPN is providing services for each one individually would the LPN bill 1:1, or 1:3?

A102: In a 3-person home which requires a nurse 24 hours/day, there are basically two options: Bill LPN 1:3, with no other staff 24 hours/day –or- bill LPN 1:1 plus an additional staff person billing direct supports 1:2. With this option, each member in the home could be considered for authorization for up to 8 hours of LPN1:1 per day. If the nurse is individually working with a particular member (such as medication administration) he/she would bill LPN 1:1.

Q103: When the LPN is traveling to a member's home to pass meds where there are 3 members requiring this service, which LPN ratio is billed?

A103: The LPN should bill 1:1 for one member during travel time. This time should be disseminated equally among all members receiving med admin (i.e. bill for member A day 1, bill for member B day 2, etc.) so that the travel is fairly distributed across member purchase requests and will not disproportionately use one member's individualized budget over another's.

Q104: If a member decides to access participant directed services via the Traditional with Personal Options Service Delivery Model and does not purchase any nursing services would the agency continue to need to maintain a list of medications and continue to request HRC approval for psychotropic medications?

A104: The I/DD-05 IPP includes a section specifically for medications. It is required that this section be completed/updated as IDTs occur. If medications are used as a restriction, then yes, they would require Human Rights Committee approval.

Q114: Can RNs bill the IPP Planning Code when attending IDT meetings via MDTV?

A114: Yes. In order to bill the IPP Planning Code when attending via MDTV, the RN must attend the entire meeting.

Q141: Is it permissible to contract LPN and/or RN services?

A141: It is, however agencies are responsible to ensure that contract providers abide by the same background, credentialing, training, and other requirements specified in the manual for anyone providing WV I/DD Waiver services. Employee files must contain all documentation supporting those credentials.

Q160: Do Registered Nurses need to complete monthly summaries?

A160: Whether or not monthly summaries are necessary for a member will be a team decision, made based on the typical duties an LPN or RN does for/with the member and how frequently those duties occur. Frequency of summaries will depend on what is necessitated by the member's medical needs.

Q177: While annual Nursing Assessments are no longer required by Waiver, are they permitted and billable if an ISS resident's treatment team feels such an assessment is clinically warranted?

A177: Nursing assessments should not be conducted as a matter of routine, but rather, if, due to a member's medical needs, the team determines that nursing services are necessary. If the team does identify that the member's medical needs warrant Nursing Assessments, the frequency of those assessments should be conducted based on the individual member's need.

Therapeutic Consultant (TC)

Q4: Will CED's training be shared with providers so that providers can use it to train their own staff?

A4: No. The approval provided by the WVAPBS Network for WVU CED's curriculum is an approval that the applicant has individuals capable of providing the training and also capable of providing the required 10 hours of mentoring following training. The application for approval requires an agency to list the individuals that will be doing the training and their credentials. Thus, CED's training is not a "train the trainers" event.

Q17: Should scoring of Task Analysis be completed by the TC only?

A17: Scoring (actually calculating of the numbers) does not have to be done by the TC. Some agencies have their midnight staff calculate the numbers while the member is sleeping, and then the TC bills for analyzing the data. This practice would be considered acceptable as long as the staffs' data calculation does not compromise safety, health, and oversight of the program member and is verified for accuracy

Q35: Is it possible that training outside those indicated in the I/DD manual can be used to satisfy requirements to provide the Behavior Support Professional code?

A35: No. In order to bill the BSP code, a staff must either access a training approved through the WVAPBS Network or be a BCBA or BcaBA (or be enrolled in coursework to become a BCBA/BcaBA).

Q15: At one point, it was discussed that Therapeutic Consultants/Behavior Support Professionals might be able to bill their time spent travelling to and from Medicaid functions. Can these professionals bill their travel time with the 10/1/2011 manual?

A15: No. TCs and BSPs may not bill time spent travelling.

Q39: Can a TC or BSP bill for entering incidents into the Incident Management System (IMS) under the "new" waiver?

A39: No. The I/DD manual did add a provision for SCs to enter incidents into the Incident Management System, but not Therapeutic Consultants or Behavior Support Professionals.

Q48: If a member participates in Facility-based Day Habilitation and attends 6 hours per day, are they required to have 6 hours of active training each day?

A48: No. Part of the definition for Facility-based Day Habilitation includes "supervision and assistance." Some "down-time" would be acceptable.

Q53: Is it acceptable for agencies to insert IHPs that are developed using a computer program into the IPP, or is it required that the Service Coordinator enter the information into the document?

A53: It is acceptable and most appropriate for the TC/BSP to develop the IHP/Task Analysis. The TC/BSP would then forward information to the SC for inclusion/attachment to the IPP.

Q54: For members admitted to an I/DD Crisis Unit, can the unit bill the Behavior Support Professional code, since one will most likely already be identified for the member from the referring agency? Crisis Unit BSPs must complete functional assessments and most often times assist the consumer's IDT by making recommendations for changes to the behavior plan.

A54: The code billed would depend on the member's assessed need and appropriate services as identified by the IDT and approved by the ASO. A TC (as well as a BSP) can complete functional assessments and assist the IDT by making recommendations for changes to the behavior plan.

Q71: Can TC/BSPs bill for training Direct Care Staff on how to use and implement the I/DD-7 Direct Support Service Log that is in the new Waiver Manual?

A71: If an agency is conducting a mass training on the new forms it would not be a billable activity. If a TC/BSP is meeting individually with staff to ensure they receive proper training on providing information/communication relevant to a specific member's case, it would be appropriate and billable.

Q72: If a member has 2 TCs on their IDT will the TCs split the 4 events allotted for IPP and the 960 units allotted per members annual IPP? Or will each TC have 4 units for IPP and 960 units per members annual IPP?

A72: The annual limit for Therapeutic Consultant is 960 units regardless of the number of TCs on the case. The annual limit for Therapeutic Consultant IPP Planning is 4 units regardless of the number of TCs on the case. If the number of units for IPP Planning are exhausted prior to the end of the service year, the TC may bill units of regular TC (T2021HN) for time spent attending IDT meetings.

Q76: Can a Therapeutic Consultant (instead of a Behavior Support Professional) perform the functions around development, monitoring, etc. of a Positive Behavior Support Plan?

A76: Yes. The TC should perform positive behavior support functions unless the program member meets the requirements as described in the I/DD Waiver Manual. These requirements include:

- 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 –or-

- 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.

Please note that all Positive Behavior Support Plans must meet the standards found within the Association of Positive Behavior Support. These standards can be found at http://www.apbs.org/about_APBS.htm#standards_of_practice . Training on these standards can be fulfilled through successful completion of a curriculum approved by the APBS Network.

Q86: If a TC is currently enrolled in an approved training for Behavior Support Professional and has completed the first session, can they bill the Behavior Support Professional code as they continue to work to complete their training, as long as the service was agreed upon by the team and is listed on the client's IPP?

A86: For the first six months following implementation of the new I/DD Waiver Policy Manual, it was acceptable for individuals who previously provided Behavior Specialist or Behavior Analyst services to MR/DD members to bill the Behavior Support Professional code provided they were enrolled in, and had completed, at least the first session of an approved curriculum. This six-month period was from October 1, 2011 to March 31, 2012.

101: Can a newly hired Therapeutic Consultant who has 2 years professional experience, a BA/BS degree, and is ENROLLED in an approved Positive Behavior Support training bill/provide the Behavior Support Professional code?

A101: All newly hired agency staff must be either completely trained in a curriculum which has been approved by the WV-PBS Network or meet BCBA or BCaBA requirements before being allowed to bill the BSP code.

Q143: Can an agency bill both TC and BSP codes for the same member?

A143: Yes, an agency can bill both TC and BSP codes for the same member.

Q144: Can an agency use more than one TC provider for a member? For example, if a member attends a facility-based day habilitation program operated by an agency, can that same agency have a TC for that member at the day program and a different TC for the member's residential services?

A144: **Yes**, an agency can use more than one TC employed by the same agency. For example, if a member receives Person-Centered Supports: Family and also attends a Facility-based day program, an agency-employed TC may develop training activities for PCS: Family providers, while another TC, also employed by that same agency, may develop training activities to be implemented at the Facility-based day program.

Q145: How does an agency determine whether to request Therapeutic Consultant Services or Behavior Support Professional Services for a member?

A145: Agencies can use many sources of information to determine whether it is appropriate to request Therapeutic Consultant (TC) services or Behavior Support Professional (BSP) services for a member. Results of APS Assessments, particularly the ICAP Problem Behavior and Maladaptive Behavior Index Scores sections, may also be used. Consider in the Problem Behavior Section, the maladaptive activities and their level of seriousness. If behaviors in the following categories: "Hurtful to Self"; "Hurtful to Others"; and/or "Destructive to Property" are "moderately serious", "very serious", or "extremely serious" in this could indicate to the team that the member may need significant intervention. When considering the Maladaptive Behavior Index Scores, indications of "moderately serious", "serious", or "very serious" scores could signify the need for higher levels of intervention. There are other factors unique to the member that may also be considered. When requesting Behavior Support Professional services, be certain to include any documentation that may be support the request, such as a Behavior Support Plan or monthly documentation.

Q154: Now that agencies can use both TC and BSP for a member, does the staff providing these services need to be the same person or can a TC be used for habilitation activities and a BSP to address behavior support issues?

A154: An agency may choose to utilize one or more staff to provide for a member's adaptive and maladaptive habilitation programming, or it can be the same agency staff.

Transportation

Q66: If the goals and dreams of the individual indicate a desire to attend church services, is it permissible to bill PCS: Family or PCS: Agency and transportation-miles to and from church, as well as the time in church? In order to bill miles, does the staffing level in the vehicle need to conform to 1:1 in order to make the billing valid? Is any part of the above billable?

A66: Billable Transportation and activities must be for the primary purpose of meeting the member's assessed needs (not the needs of the staff or the family). If the primary purpose of the staff transporting and attending church service with the member is to meet the needs of that member, it would be a covered and appropriate use of the transportation and PCS codes. If the family goes to church every Sunday and the member attends as does the rest of the family, it would not be covered.

Q67: Can goals and dreams activities occur out of state as a billable activity, provided these activities are properly documented in the IPP under a paid service? Is the "30 mile" limit still in effect? Is the activity billable as PCS?

A67: In general, Medicaid cannot pay for services out of state. However, if a member lives in a border county, services may be provided within 30 miles of the state border to meet an assessed need.

Q68: If paid under I/DD Waiver, are the total miles to a doctor's appointment billable if the doctor is out of state and doctor's visits have been listed under the Transportation of the ISP?

A68: If the member is accessing a physician/medical service that is not available in West Virginia –and-that physician/medical services provider is billing WV Medicaid, transportation to that appointment is billable provided the service is indicated on the member's IPP. The IDT should also look at Non-emergency Medical Transportation (NEMT) as a viable means to be reimbursed for these types of medical services.

Q74: Would a 5-passenger agency car be billed as Transportation-miles if it is being used to transport member(s)? Is Transportation-miles only billed when staff vehicles are being used to transport member(s)?

A74: Any vehicle originally equipped to transport less than 7 passengers would qualify to provide the Transportation-Mile service. Transportation-Mile may be billed in both staff-owned and agency-owned vehicles.

Q92: In our Sheltered Workshop, we often use delivery or specialty delivery trucks to fulfill member needs of supported employment training. Is it possible to bill the Transportation-Trip code for these routes, or must our agency use Transportation-Mile since the truck is not configured to seat 7?

A92: Transportation other than as provided by an agency-owned minibus or minivan with original configuration to seat 7 should be provided/billed as Transportation-Mile. Delivery of goods should not be considered as Transportation-mile or trip; the expectation would be that the delivery of a good should include the costs associated with transportation. Billable transportation would include only those occurrences where the member is being transferred specifically to or from a supported employment, facility day habilitation or person-centered supports location.

Q95: What service should be utilized while transporting a member to/from a Facility-Based Day Habilitation?

A95: If the member requires support during transit to/from Facility-based Day Habilitation (due to either medical or behavioral issues), Person-centered Support should be provided.

Q103: When the LPN is traveling to a member's home to pass meds where there are 3 members requiring this service, which LPN ratio is billed?

A103: The LPN should bill 1:1 for one member during travel time. This time should be disseminated equally among all members receiving med admin (i.e. bill for member A day 1, bill for member B day 2, etc.) so that the travel is fairly distributed across member purchase requests and will not disproportionately use one member's individualized budget over another's.

Q111: Transportation: Trips: Traditional Option-what is the definition of a one-way trip? Also, if there are two members being transported in an agency van, would trips be billed for each member or just one?

A111: Transportation-Trip may be billed/provided for each member on the agency's mini-van or mini-bus. The intent of the Transportation-Trip code has not changed from the previous MR/DD manual. Examples of one way trips include but are not limited to the following (A0120-HI):

- Community Based Programming: Member starts from his/her home, goes to the post office, travels to a store, and travels to a restaurant and returns home is one (1) trip.
- Facility Based Programming: Member starts from his/her home, goes to the facility based day program and stays for six (6) hours. This is one (1) trip. Member leaves the day program facility at the end of the day and returns home. This is one (1) trip.

Q116: Please offer suggestions to limit restrictions on what our members need and want to do related to the 9,600 available units for transportation-mile per year?

A116: Some Options include the availability to:

- Access Non-emergency Medical Transportation (NEMT) for medical appointments through the local DHHR and utilize Waiver mileage for employment, community, habilitation and other approved activities and/or,
- Access transportation services through Personal Options in which the member may use funds from other approved services to exceed service limitations.

Q170: When RNs travel from one ISS to another, what code do they bill?

A170: An RN should bill the LPN code, as passing medications (therefore traveling to pass medications) is within the scope of LPN duties.

Utilization Management

Q26: The new manual lists codes for PCS Family 1:1 and PCS Family 1:2. If two program members reside in the home, is the PCS Family provider expected to automatically bill at 1:2?

A26: If one provider is training and/or supporting two persons at the same time, this must be billed at the 1:2 ratio. If there is an additional provider for the other program member, each may use a 1:1 ratio if their teams identify this is appropriate when considering ICAP scores and additional assessments.

Q29: If a member chooses to continue with "old" services, can "old" services such as Psychological Services or IPP Development--Psychologist be provided?

A29: You may continue to have the psychologist bill IPP Development-Psychologist, if the member wishes to keep them at the meeting through the remainder of the service year. If you run out of units for this, though, you may not purchase additional ones. Providers may not bill evaluation codes (psychological evaluations, medical evaluations, social histories) for services provided 10/1/2011 and after, as they will no longer be required. These are the only services that a member/agency cannot "ride out" through the remainder of their service year. If a member needs to access one of these evaluation services, they will need to access it through Medicaid State Plan.

Q57: If a parent has only one member in the home and one or two additional children who are not on waiver, do they still bill 1:1?

A57: The parent would bill 1:1 in this scenario.

Q44: If two program members receive Agency Residential Habilitation 1:2 under "old" services, and one member wishes to transition from "old" services to "new" while the other wants to stay with "old" services is it possible to bill 1:2 PCS and 1:2 ARH at the same time?

A44: Because the two services would crosswalk, it would be acceptable to bill 1:2 PCS and 1:2 ARH.

Q55: If two members who live in the same home choose to continue with "old" services until the end of their current service year, and the provider is authorized to bill the CRH code for both members, is there still the requirement that a second party be responsible for one member while the other is receiving CRH or could the provider continue to bill for one person then switch to the other, with no other responsible party present?

A55: Program members may continue to access services on their current IPPs until either a Critical Juncture or the next Annual IPP. As Community Residential Habilitation in the MR/DD manual does not have a 1:2 code option, the provider could bill only 1:1 for each member. Times for this service for each member should not overlap. Ideally, as member A transitions to I/DD, member B would transition also. If this is not the case, When Member A transitions to I/DD services, the provider should bill 1:2 for member A (when the other member is present and no other caregivers are available) and 1:1 for member B until either a Critical Juncture or member B's annual IPP.

Q61: The manual indicates that each member may have 12 hours of training billed by direct staff each quarter for training. If a member resides in an ISS and has 6 staff on their team all billing PCS services those staff could have not more than a 2 hour training each for their annual health and safety and goal training without exceeding the quarterly amount. This leaves no additional billable time for training new staff or if a staff person were to need re-training in that quarter. Most of the time, other quarters require less training time. Most other limitations are an annual limit. Is it possible to use more than 12 hours in a quarter of PCS services for training if it does not exceed 48 hours in a year?

A61: The current manual indicates the following: "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." Based on the feedback in this FAQ BMS will include this as a revision to the manual, and will remove the quarterly limitation on training.

Q75: If a member chooses to not make the transition from "old" to "new" services immediately, is it appropriate for a team to purchase "old" services prior to Oct 1, 2012 "just in case"?

A75: This would not be acceptable. No services should be purchased "just in case." Services and authorizations are based on assessed need, agreement by the IDT, and documentation on the member's IPP.

Q77: If someone has both a family provider and an agency employee, and the PCS services have group auths, how will the auths for family provider PCS be distinguished from agency PCS if there are group auths for each? Won't they both be S5125?

A77: Related to "group authorizations" which will apply to Person-Centered Support-Agency (S5125U1, U2, U3, U4) and Facility-based Day Habilitation (T2021 U5, U6, U7), APS will send (to the provider and to Molina) the "root" code. For PCS-Agency 1:1, 1:2, 1:3 and 1:4, APS will send "S5125" with the total number of units. However, for PCS-Family, APS will send S5125U5, U6 as applicable (not included in group authorizations). Both the provider and Molina should be able to differentiate "family" from "agency" by

what is sent. Facility Day Habilitation group auths will have T2021 (only the root) for the code, but TC, will be indicated as T2021HN (new code).

Q78: Since all authorizations are now annual, how will agencies know how many units of a service a member has remaining in their service year, particularly when more than one agency provides services?

A78: Agencies providing services are responsible to have utilization management systems in place that provide them with the ability to track units of service utilized/billed. It is the expectation that each agency be able to report at the IDT meetings (if not earlier) units used. This is not only necessary for transfer/authorization purposes, but is also necessary for IDTs to make good decisions about purchasing services.

Q79: The manual indicates that, for a member who lives in an Individualized Support Setting that is staffed 24-hours per day, the maximum number of Person-Centered Support services they are eligible for is 35,040 per year. This is exactly 365 days x 96 possible units per day. The manual says that 48 units per quarter can be used for training. It would not be possible to bill training in addition to direct care services given the limit of 35,040.

A79: When authorizing services, APS will implement internal thresholds up to which services can be approved if applicable and appropriate. Consistent with the current threshold, APS can authorize up to 35,712 units of direct support services to allow for additional times needed for staff training.

Q80: When a member transfers to "new" services, will APS roll back the end-dates on "old" codes to ensure that an old service is not accidentally billed, or is that something each agency will need to track on their own?

A80: The Service Coordinator (or SC agency) will be required to roll back end dates and units in the event the member transfers to "new" services. APS will not authorize replacement services until the replaced services are modified.

Q94: Can APS/BMS make exception to the rule being implemented in which a user cannot request a modification increasing the number of "old" MR/DD service units if submitted after 10/1/2011? What if an agency forgets to purchase a particular service? What if an agency made a mistake on the service or number of units requested?

A94: There is no remedy if an agency forgot to purchase a particular service. If the agency made a key-punching error then this will be looked at on a case by case basis. BMS is willing to review instances that occurred during the month of September 2011 which made it difficult to purchase the correct amounts at the close of the month, but is

not willing to go back any further. Submit requests on the attached I/DD Authorization Modification Request Form to APS wviddwaiver@apshealthcare.com for consideration.

- Requests due to poor utilization management will not be considered.
- Requests for modification of services that have an end date prior to September 1, 2011 will not be considered.
- Requests that are not a result of an IDT meeting and documentation on an IPP will not be considered.
- Requests for current/active authorizations (for old MR/DD services) will not be considered – if the member has a change in need throughout the service year, they must purchase new I/DD Waiver services.

Q115: When billing services in the Molina website, are location codes required? It was previously mentioned that a location code is not required for the new TC codes under the new waiver manual. Is this true of ALL codes under the new waiver manual? If not, where can we obtain the location codes that correlate to the new waiver manual codes?

A115: Molina has indicated that a place of service is required on all 1500 claims. Regarding the MRDD waiver configuration, T2021U7UH is restricted to POS 12 and T2021U7UF is restriction to POS 53.

Q148: Can Service Coordinators bill for completing Utilization Management activities?

Q148: While it is correct that Service Coordinators may not bill for completing UM activities such as processing billing, it would be appropriate for Service Coordinators to review Utilization Reports periodically for members on their caseload. These reviews can assist the SC and the team in identifying the frequency that authorized services are being provided throughout the member's service year. If it is discovered during these reviews that authorized services are not being provided as documented in the member's Annual IPP, issues can be addressed in a timely manner. This could be a billable activity, if the time indicated for providing this service is supported by the documentation in the case note.

Q166: If a member has an authorization for "old" services that will expire 10/1/12 or later, can these services be billed through Molina?

A166: Molina **will not** pay on "old" services with a Service Date after 9/30/12, even if there is an authorization in place. For example, if a member whose anchor date is 10/5/12 still has "old" services with authorization dates from 10/5/11-11/3/12, "new" services for 10/1/12-10/4/12 must be requested. Teams must hold a meeting to identify appropriate "new" services for that time period and these services must be requested via CareConnection®. This discussion could take place at the member's Annual IDT meeting.

Q173: What are the formula and rationale used to determine the proration of units when modification requests are being made?

A173: Prorated units for Direct Care Services (ie—Person-Centered Supports, Facility-Based Day Habilitation, LPN, and/or Supported Employment but **excluding Respite Care**) are required when authorizations are being requested for services for a partial year. The number of prorated units is determined by identifying the number of days left in the member's service year from the date the team identifies the new number of units/service is needed (this CANNOT be a date in the past). The maximum number of units allowed for the service for a full year is divided by 365 to get the maximum number of average daily units. This number is then multiplied by the number of days left in the member's service year to determine the maximum number of units that can be authorized for that member for the remainder of his/her service year. Proration of this type would apply when members' needs for the number of units and/or type of Direct Care Services change (moving from a Natural Family setting to an ISS, for example) or who are new to the program.

Clinical Services (ie—Service Coordination, Therapeutic Consultant, and/or Behavior Support Professional) **and Respite Care** will not be subject to proration. Requests for clinical service units made for a partial year must be clinically necessary; APS staff will request documentation to support the number of units of a clinical service if review is needed prior to making an authorization determination.

At no time should units be purchased as a means of "Reconciliation." Please refer to the attached memo from BMS dated 4/16/12 regarding modifications that indicates:

- Modifications will not be considered based on a provider's inability to accurately maintain records of service usage versus units prior authorized.
- Modifications will be considered based on member preference, needs, goals, circumstance and documented evidenced by a Critical Juncture.
- In order to be considered, supporting documentation must be dated prior to the service (change/modification) being implemented.
- Supporting documentation must include signatures of all IDT members; dates of signatures must be consistent with the date the team member agreed upon the change in service need.

Please note that this is NOT an all-inclusive list; for additional information regarding modification requests, please see the memo.

WV IMS

Q139: If a Service Only Provider enters an incident into the IMS, is it necessary for the Service Coordinator to do so as well?

A139: If both the Service-Only Provider and the Service Coordination Provider entered the incident into the system, it would artificially inflate numbers. Best practices would indicate that the personnel for the agency where the incident occurred would be responsible for entering the incident into the IMS. If the incident occurs with a Service-Only Provider, the Service Coordinator should be notified of the incident by the Service-Only Provider.