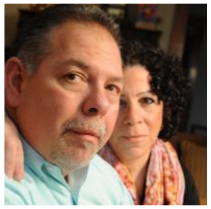
Bureau for Medical Services

Traumatic Brain Injury Waiver (TBIW) Program

Chapter 512

September 2015



WEST VIRGINIA
Department of
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BUREAU FOR
MEDICAL SERVICES

Agenda

Introductions

- Bureau for Medical Services (BMS) staff
- APS Healthcare staff
- Participants

Overview of the BMS Provider Manual Chapter 512 TBIW

- Policy Metadata
- Background
- Provider Participation Requirements
- Program Eligibility
- Policy
- Glossary

Questions and Answers

The Traumatic Brain Injury Waiver Provider Manual

An Overview of Changes

TBIW Manual-Global Changes

- Manual design and flow have been changed
- More information has been added to the manual to provide guidance to providers
- Language changes:
  - Utilization Management Contractor (UMC) instead of Administrative Service Organization (ASO)
  - Person rather than Member
  - Personal Attendant Professional
- Focus on Person-Centered
- Manual includes language referencing the UMC Web Portal
  - Not in effect yet but will be implemented
- Child Protective Services has been added as a reporting agency since children are now being served
- Description of Service Options has been expanded

TBIW Manual-Changes to the Program

- Age of eligibility has been changed to three years and older
- Diagnosis has been revised to include anoxic brain injury due to near drowning
- Financial eligibility must be determined prior to the initial medical eligibility assessment
- Eligibility criteria has been expanded allowing a combination of deficit areas on the Pre-Admission Screen (PAS) from 13 to 17 areas
- New Procedure Codes:
  - Personal Options Model for Personal Attendant Services (S5125 UC)
  - Non-Medical Transportation Services (A0160 U2)

Policy Metadata

- The Policy Metadata is found on page five of Chapter 512. It includes information regarding:
  - Creation of Chapter 512
  - Author
  - Initial approval date
  - Initial effective date
  - Latest revisions and approval dates
  - Next policy review date

Background and Program Description

- Administered pursuant to Title XIX of the Social Security Act and Chapter Nine of the West Virginia Code
- Sets forth the Bureau for Medical Services requirements for the TBIW program provided to people eligible for West Virginia Medicaid
- Long-term alternative which provides services that enable individuals to live at home rather than receiving nursing facility care
- Provides home and community-based services to West Virginia residents who are medically and financially eligible to participate in the program

Background and Program Description (Cont.)

- Applicants must be at least three years old and have a documented traumatic brain injury, defined as

Non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or an injury caused by anoxia due to near drowning

- Services include
  - Case Management
  - Personal Attendant Services
  - Non-Medical Transportation
- People may choose service delivery model
  - Traditional (Agency) Model
  - Participant-Directed Model (known as Personal Options)

Background and Program Description (Cont.)

- Take Me Home, West Virginia (TMH) Overview
  - Federally funded demonstration grant program that provides services and supports for people wishing to transition from long-term care to the community
- Bureau for Medical Services Contractual Relationships:
  - The Utilization Management Contractor (UMC) implements the administrative functions related to the operations of the Waiver and other functions
  - The Fiscal Employer Agent (F/EA) provides support to people who chose the Personal Options Model

PROVIDER PARTICIPATION REQUIREMENTS

Provider Agency Certification

The provider certification section of the manual has been expanded. New requirements for TBIW providers include:

- Written policies and procedures for the use of personally and agency owned electronic devices, which include, but are not limited to the following:
  - Prohibits using personally identifiable information in texts and subject lines of emails
  - Prohibits the use of personally identifiable information in the body of emails unless the email is sent securely through a Health Insurance Portability and Accountability Act (HIPAA) compliant connection
  - Forbids personally identifiable information be posted on social media sites
  - Prohibits the use of public Wi-Fi connections
  - Informs agency employees that during the course of an investigation, information related to the case on their personal cell phone may be discoverable
  - Requires all electronic devices be encrypted

Provider Agency Certification (Cont.)

- All providers are required to have and implement policies and procedures for people with limited English proficiency and/or accessible format needs that are culturally and linguistically appropriate to ensure meaningful access to services
- All providers are required to have computer(s) for staff with HIPAA secure email accounts, UMC web portal software, internet access and current (within last five years) software for spreadsheets

Provider Agency Certification

- Written policies and procedures to avoid conflict of interest (if agency is providing both Case Management and Personal Attendant Services) must include at a minimum:
  - Education of Case Managers on general conflict of interest/professional ethics with verification
  - Annual signed conflict of interest statements for all Case Managers and the agency director
  - Process for investigating reports on conflict of interest complaints
  - Process for reporting to BMS
  - Process for reporting complaints to professional licensing boards for ethics violations

Criminal Background Checks

West Virginia Clearance for Access: Registry & Employment Screening (WV CARES):

- West Virginia is one of 25 states awarded grant funds from the Centers for Medicare and Medicaid Services (CMS) to create a comprehensive background check program for employees who have direct access to patients
- The program's purpose is to protect people from neglect, abuse and financial exploitation
- All long-term care facilities and providers licensed by the West Virginia Department of Health and Human Resources are required to conduct employee background checks

Criminal Background Checks (Cont.)

512.2.1.1 Pre-screening

512.2.1.2 Fingerprinting

512.2.1.3 Employment fitness determination

512.2.1.4 Provisional employees

512.2.1.5 Variance

512.2.1.6 Appeals

512.2.1.7 Responsibility of the hiring entity

512.2.1.8 Record retention

512.2.1.9 Change in employment

Office Criteria

- Any authentication method for electronic and stamped signatures must meet the following basic requirements:
  - Unique to the person using it
  - Capable of verification
  - Under the sole control of the person using it
  - Linked to the data in such a manner that if the data is changed, the signature is invalidated

Quality Improvement System (QIS)

The Quality Improvement System is designed to:

- Collect data necessary to provide evidence that the Centers for Medicare and Medicaid Services (CMS) Quality Assurances are being met
- Ensure the active involvement of interested parties in the quality improvement process
- Ensure remediation and/or systemic quality improvement within the program

CMS Quality Assurances:

- Data is collected and analyzed for all Quality Assurances and sub-assurances based on West Virginia's Quality Performance Indicators, as approved by CMS
- The primary sources of discovery include TBIW provider reviews; incident management system reports; complaints/grievances; abuse and neglect reports; administrative reports; the West Virginia Participant Experience Survey-Brain Injury (PES-BI); oversight of delegated administrative functions; and the Quality Improvement Advisory Council

Quality Improvement System (QIS) (Cont.)

Role and Purpose of the TBIW Quality Improvement Advisory Council:

- Focal point of stakeholder input for the TBIW program
- Plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies
- Advises and assists BMS and the UMC staff in program planning, development and evaluation consistent with its stated purpose

Self Audits

- The TBIW providers must use the approved format for submitting self-audits to Office of Program Integrity (OPI)
- Failure to submit self-audits may jeopardize the future status of the TBIW provider as a West Virginia Medicaid provider
- TBIW providers are required to conduct self-audits, complete an affidavit attesting to the accuracy of the self-audit and submit to the Office of Program Integrity along with the original Excel spreadsheet and repayment forms
- The self-audit form can be found on the TBIW website at: http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/TBIW/Pages/Policy-and-Forms.aspx
- For more information on sanctions available to BMS, see *Chapter 800, Program Integrity*

Staff Qualifications/Training Requirements

- Training for all staff that comes into contact with a person receiving TBIW services must be culturally and linguistically appropriate
  - All training materials must be approved by the UMC

Case Manager Initial and Annual Training

Case Manager Initial and Annual Training Requirements:

- Conflict Free Case Management training
- Must maintain professional licensure training requirements
- Person-Centered Planning and Service Plan Development
- Training on Personal Options service delivery model
- Recognizing and reporting abuse, neglect and exploitation
- HIPAA training

Personal Attendant Initial Training

Requirements:

A. Cardiopulmonary Resuscitation (CPR) training

B. First Aid training

C. Infectious Disease Control training-must use the current training material provided by Infectious Disease Control

D. Direct Care Skills-four hours of training focused on assisting individuals with Traumatic Brain Injuries with activities of daily living:

- Must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area or an approved internet training provider
- At least one hour of the training must be person specific on the job training and must be documented
- When applicable, one hour training specific to children/adolescents with TBI

E. Abuse/Neglect/Exploitation Identification training

F. Personal Attendant Professional Ethics

G. Health and Welfare

H. People First Language

Non-Medical Transportation Services Qualifications

- TBIW Personal Attendant Professionals providing transportation services must have:
  - A valid driver's license
  - Proof of current vehicle insurance and registration

- They must also:
  - Abide by local, state, and federal laws regarding vehicle licensing, registration and inspections
  - Provide proof of this upon hire and annually

Incident Management

Reporting Requirements, Incident Management Documentation and Investigation Procedures:

- If a death occurs in addition to reporting to the UMC (or WV IMS when available), the Case Manager must complete the mortality notification form within the next business day of learning of the death of a person on the TBIW and send the form to the UMC

Documentation and Record Retention Requirements

Specific Requirements (NEW):

TBIW program provider agencies must maintain a specific record for all services received for each person receiving TBIW services, including, but not limited to:

- Required on-site documentation may be maintained in an electronic format as long as the documentation is accessible to individuals who may need to access it
- Electronic health record and electronic signature requirements described in *Chapter 100, General Administration and Information of the BMS Provider Manual*

PROGRAM ELIGIBILITY AND ENROLLMENT

Program Eligibility and Enrollment

Applicants for the TBIW program must meet all of the following criteria to be eligible:

- Be three years of age or older
- Be a permanent resident of West Virginia
- Have a traumatic brain injury defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or an injury caused by anoxia due to near drowning
- Be approved as medically eligible for nursing facility level of care
- Score at a Level VII or below on the Rancho Los Amigos Levels of Cognitive Functioning Scale
- Ages three to 17 years of age must score at a Level II or higher on the Rancho Los Amigos Pediatric Level of Consciousness Scale
- Be an in-patient in a licensed nursing facility; an in-patient in a hospital or a licensed rehabilitation facility to treat TBI; or living in a community setting at the time of application
- Meet the Medicaid Waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient
- Choose to participate in the TBIW program as an alternative to nursing facility care

Financial Eligibility-Pre-Medical Eligibility

The financial eligibility process starts once an applicant applies to the TBIW program by submitting the initial Medical Necessity Evaluation Request (MNER) form to the UMC

The UMC will process the completed MNER and send the following documents to the applicant/applicant's representative (if applicable):

- Notice of Receipt of MNER
- DHS-2 form (yellow)
- Instructions for determining financial eligibility
- Service Delivery Model Selection form
- Freedom of Choice-Provider Selection forms (Case Management and Personal Attendant Agencies)
- Instructions for returning completed selection forms to the UMC

Financial Eligibility-Pre-Medical Eligibility (Cont.)

- The UMC will send a notice of receipt of initial MNER to referring entity
- The applicant/applicant's representative (if applicable) must submit the yellow DHS-2 form to their local county Department of Health and Human Resources (DHHR) office to determine financial eligibility
  - The yellow DHS-2 form will include an expiration date. It will not be accepted at the county DHHR office after the expiration date

Financial Eligibility-Pre-Medical Eligibility (Cont.)

- Upon receipt of the completed Freedom of Choice Case Management Selection form, the selected Case Management Agency will be informed by the UMC
  - Within five business days of receipt of this notification, the Case Manager must make an initial contact by telephone or face-to-face with the applicant/applicant's representative (if applicable) to offer assistance in determining financial eligibility
  - Either the applicant/applicant's representative or Case Manager must submit a yellow DHS-2 form along with a letter from the UMC to the county DHHR office to determine financial eligibility based on TBIW criteria

Financial Eligibility-Pre-Medical Eligibility (Cont.)

- If the applicant is determined financially ineligible by the county DHHR office, a medical eligibility assessment will not be scheduled by the UMC and the MNER will be closed
- The UMC will notify the applicant/applicant's representative (if applicable) that the MNER has been closed due to financial ineligibility
- In the event that there is a wait list for the TBIW program, section 512.8 addresses how a Managed Enrollment List will be handled

Medical Criteria-Additional PAS Deficits

- #26 k – Vision
  - Level 3 or higher (Impaired/Not Correctable)
- #26 l – Hearing
  - Level 3 or higher (Impaired/Not Correctable)
- #26 m – Communication
  - Level 3 or higher (Understandable with aids)
- #27 a, b, c – Individual has skilled needs in one or more of these areas
  - Physical Therapy, Speech Therapy, and Occupational Therapy have been added
- #28 – Individual is not capable of administering his/her own medications or needs prompting/supervision
- #34 f, k, m, p – Clinical and Psychological Data - Behaviors

Medical Criteria-Rancho

Rancho Los Amigos Levels of Cognitive Functioning Scale

- A score of Level I through Level VII must be obtained

Rancho Los Amigos Level Pediatric of Consciousness Scale

- A score of Level II through Level V must be obtained

Medical Re-Evaluation

- A Medical Necessity Evaluation Request must be submitted to the UMC after being signed and dated by the person and/or the legal representative (if applicable) and referent
  - The forms must be provided to the UMC and a copy of the original form with the signatures must be maintained by the referent in the person's file
  - The Case Manager must check the re-evaluation line at the top of the form
  - A referent's signature is required annually and must include the ICD diagnosis code(s)

Medical Re-Evaluation (Cont.)

- The request can be submitted up to 90 calendar days prior to the anchor date, and no later than 45 calendar days prior to the anchor date
  - A person's medical eligibility is at risk if the MNER is submitted less than 45 calendar days prior to the anchor date
  - MNERs received after the anchor date do not constitute a reason for an appeal

Enrollment

Once an applicant has been determined both financially and medically eligible, the Case Manager must request Program Enrollment from the UMC by completing an Enrollment Request Form

- Financial eligibility is not completed until the DHS-2 form (white) is submitted to and returned from the county DHHR office to the Case Management Agency(CMA)
- The CMA submits the DHS-2(white) and the enrollment request form to the UMC
- The UMC will complete the enrollment and provide a Confirmation Notice to the Case Management Agency and the Personal Attendant Service Provider Agency or the F/EA, if the person chose Personal Options

Enrollment (Cont.)

- Once an applicant has been determined both financially and medically eligible, the Case Manager must request program enrollment from the UMC by completing the Enrollment Request form
- No Medicaid reimbursed TBIW services may be provided until the Case Management agency is in receipt of the person's Enrollment Confirmation Notice
- For monthly reporting purposes, agencies are to report people on the TBIW as active the month they receive their Confirmation Notice for that person
- The F/EA must maintain a file which contains the Enrollment Confirmation Notice for people choosing Personal Options. The confirmation notice initiates the initial phone contact to the person within three business days

Person-Centered Service Plan Development

- The Case Manager must send the person's Service Plan, Assessment and Request for Service Authorization form to the UMC within five calendar days of the Service Plan meeting
- The UMC reviews the request for service authorization and when approved will provide the Prior Authorization Notice and approved final budget to the Case Management Agency, Personal Attendant Agency or the F/EA
- It is the Case Management Agency's responsibility to send a copy of the Service Plan and the approved final budget to the person and/or their legal representative within seven business days from receipt of approval from the UMC
- Services are not intended to replace supports/services that a child would receive from the school system during a school day or educational hours provided during home schooling

Service Plan Addendum and Interim Service Plan Development

Service Plan Addendum:

- A Service Plan Addendum is completed to document a change in the person's needs
  - These changes would include such things as an additional service needed after release from a hospital, a person wants to change days of week or times they receive services, or an informal support is going to provide the service for the person as opposed to the Personal Attendant
  - A Service Plan Addendum does not take the place of a required six-month or annual Service Plan meeting

Interim Service Plan Development:

- Only available to people who have chosen to use the Traditional Service Model

Budget Development

- A person's budget is developed once their Person-Centered Service Plan is completed
  - A person on the program would have access to an annual maximum budget of $35,000
  - Not everyone will receive the maximum budget amount
  - Individual budget is based on the frequency of program covered services as outlined in the Person-Centered Service Plan
- UMC will prorate a person's budget when necessary to align with the person's anchor date
- People choosing Personal Options, the participant-directed model, will develop a Spending Plan based on the budget developed from the Person-Centered Service Plan
  - The Spending Plan helps people determine how their budget will be used

POLICY

Covered Services

The following services are available to people on the TBIW if they are deemed necessary and appropriate during the development of and are listed on their Service Plan:

- Case Management Services
- Personal Attendant Services
- Non-Medical Transportation Services

Case Management Services

Documentation Requirements:

- All contacts with, or on behalf of a person, must be ***legibly documented*** within the person's record and include:
  - Date and time of contact (includes start and stop time)
  - Description of the contact
  - Signature of the Case Manager
- At a minimum, Case Manager must make contact with the person and/or their legal representative once per month and document the contact on the Case Management Monthly Contact form
- Case Management Agencies may not bill for transportation services
- Resource Consultants working for the F/EA are not Case Managers

Personal Attendant Responsibilities

- Primary function is to provide hands-on personal care assistance outlined in the Service Plan
- As time permits, may also provide other incidental services such as changing linens, meal preparation and light housekeeping (sweeping, mopping, dishes, and dusting)
- At no time may the time spent on incidental services exceed the amount of time spent on hands-on personal care assistance
- May also assist the person to complete essential errands and community activities

Personal Attendant Responsibilities (Cont.)

- All services provided must appear on the Service Plan and must be fully documented on required forms and comply with the Bureau for Medical Services (BMS) documentation standards
- Must inform the Case Manager of any changes in the person's health, safety or welfare
- Must complete all required TBIW training per BMS policy
- Personal Attendant services can be provided on the day of admission and the day of discharge from a nursing home, hospital or other in-patient medical facility

Personal Attendant Responsibilities (Cont.)

- The manual now includes an expanded description of the services that a Personal Attendant can provide. These descriptions include activities of daily living, independent activities of daily living, essential errands and community activities
- All personal care assistance needs as outlined on the Service Plan must take place before essential errands or community activities can occur
- Personal Attendants must complete the Personal Attendant Worksheet daily, documenting the time of services (including start and stop times) and the condition of the person

Personal Attendant Responsibilities (Cont.)

- Personal Attendant services are not intended to replace supports/services that a child would receive from the school system during a school day/year
- Functions/tasks that **cannot be performed** include, but are not limited to, the following:
  - Care or change of sterile dressings
  - Colostomy irrigation
  - Gastric lavage or gavage
  - Care of tracheostomy tube
  - Suctioning
  - Vaginal irrigation
  - Give injections, including insulin

Personal Attendant Responsibilities (Cont.)

- Administer any medications, prescribed or over-the-counter
- Perform catheterizations, apply external (condom type) catheter
- Tube feedings of any kind
- Make judgments or give advice on medical or nursing questions
- Application of heat
- Nail trimming if the person is diabetic

- If at any time a Personal Attendant is witnessed to be, or suspected of, performing any prohibited tasks, the provider agency, or the Case Manager must be notified immediately

Non-Medical Transportation Services

- There is an expanded description of transportation services in the new manual. Some points to remember:
  - Non-medical transportation must occur in the person's local home community unless otherwise stated in the Service Plan and must be the closest location to the person's home
  - Non-Emergency Medical Transportation (NEMT) is available through the State Plan for transportation to and from medical appointments and must be utilized

Non-Medical Transportation Services (Cont.)

- The Case Manager must document on the Service Plan the availability of the person's family, friends, or other community agencies to provide non-medical transportation first
- Non-medical transportation services may be provided within 30 miles of the West Virginia border to people residing in a county bordering another state
- Non-medical transportation services has a service limit of 300 units per calendar month

Non-Medical Transportation Services (Cont.)

Documentation Requirements:

- All transportation with, or on behalf of, the person receiving TBIW services must be included in the Service Plan and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity)
- The Service Plan must document the purpose of the travel and the destination
- The Personal Attendant must document on the Personal Attendant Worksheet accurate miles traveled, exact location of the beginning and ending destination and reason for the travel

Transportation Services-NEMT

- Non-Emergency Medical Transportation (NEMT) is available to people who have Medicaid and need assistance in order to keep scheduled medical appointments and treatments
- In order to be eligible for NEMT you must:
  - Be a Medicaid member
  - Have an appointment for a Medicaid approved medical treatment from a Medicaid provider
- For more information, to request gas mileage reimbursement, or schedule a trip please call the Medicaid NEMT broker, MTM at 1-844-549-8353, Monday-Friday 7 a.m. to 6 p.m. at least five business days before your appointment

Transportation Services-NEMT (Cont.)

- Information required when scheduling NEMT:
  - Person's name
  - Medicaid ID number
  - Home address
  - Phone number
  - Where the member is to be picked up
  - Name, address and phone number of health care provider
  - Date and time of your appointment
  - General reason for the appointment
  - Any special needs such as a wheelchair accessible vehicle, assistance during the trip or someone to ride with you

Billing Procedures

The new manual includes a new section on billing procedures. Some points to be mindful of:

- Claims must not be processed for less than a full unit of service
- After arriving at the number of billable units, billing must take place on the last date in the service range
- Billing cannot be rounded more than once within a calendar month
- The billing period cannot overlap calendar months
- Medicaid is the payer of last resort
- Claims will not be honored for services (inclusive of service code definitions) provided outside of the scope of Chapter 512 or outside of the scope of federal regulations

Payments and Payment Limitations

- TBIW providers must comply with the payment and billing procedures and requirements described in Chapter 600, Reimbursement Methodologies of the Provider Manual
- No TBIW services may be charged while an individual is an in-patient in a nursing home, hospital, rehabilitation facility or other in-patient medical facility, except for Personal Attendant services. Personal Attendant services may be provided on the day of admission and day of discharge
- 30 days prior to discharge from one of these programs, Case Management services may be billed to plan the person's discharge to ensure services are in place

Provision of TBIW and Home Health Agency Services

- People who have been determined eligible for and are enrolled in the TBIW program may receive services from a home health agency that do not duplicate TBIW services
- Home health agency services provided to the person on the TBIW must be coordinated by the TBIW Case Management Agency, and in general may only include skilled nursing care or therapy services for post-hospitalization stays or acute episodes of chronic conditions
- The need for home health services must be documented in the person's Service Plan
- Documentation of the referral from the person's attending physician must be maintained in the person's records of both the TBIW provider agency and the home health agency

Voluntary Agency Closure

- A provider agency may terminate their participation In the TBIW program
- If at all possible, a joint visit with the person will be made by both the agency ceasing participation and the new one selected in order to explain the transfer process
  - If a joint visit is not possible, both providers must document how contact was made with the person to explain the transfer process
- Services must continue to be provided until all transfers are completed by the UMC
- The agency must submit their final continuing certification for any part of the year they provided services prior to closing

Involuntary Agency Closure

- The Bureau for Medical Services (BMS) may administratively terminate a provider agency's participation in the TBIW program
- The agency must submit their final continuing certification for any part of the year they provided services prior to closing
- All program records must be made available to BMS upon closing

Rights and Responsibilities

- The following are changes in the Rights and Responsibilities of Chapter 512:
  - Notify the Case Manager and Resource Consultant (if applicable) of any changes in their legal representation and/or guardianship and provide copies of the appropriate documentation
  - Not ask Personal Attendant Professionals to provide services that are excluded by policy or not on their Service Plan. (Refer to Section 512.16 Personal Attendant Services)
  - Family, friends, neighbors and community agencies that can provide transportation must be utilized before TBIW transportation services
  - People using Personal Options must notify their Resource Consultant within 24 hours when they terminate an employee

Transfers to Another Agency or Personal Options

- A person on the TBIW program may request to transfer to another provider or to Personal Options at any time
- The effective date of transfers will be the first date of the next month if the transfer is received by the 17th of the month

Discontinuation of Services

- The following require a Request for Discontinuation of Services form be submitted and approved by the UMC:
  - No services have been provided for 180 continuous days-example, an extended placement in long-term care or rehabilitation facility
  - Unsafe environment-an unsafe environment is one in which the personal attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy
  - The person is persistently non-compliant with the Service Plan
  - Person no longer desires services
  - Person no longer requires services

Discontinuation of Services (Cont.)

- When the UMC receives an unsafe closure request, they will review and make a recommendation to the Bureau for Medical Services based upon the evidence submitted
- Documentation to support the unsafe environment should come from multiple sources if possible, i.e., the Personal Attendant agency and the Case Management agency

Recommendations include:

- Suspend services for up to 90 days to allow the person receiving TBIW services time to remedy the situation. The Case Manager will reassess at 30, 60 and 90 days and make a recommendation to the UMC at any time during the 90-days suspension to reinstate services
- Immediate closure

Discontinuation of Services (Cont.)

Unsafe Environment Closure

Due to the nature of unsafe environment closure, the person is not eligible for the option to continue existing services during the fair hearing process.

GLOSSARY

Glossary

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

PROGRAM FORMS

New Forms

- Mortality Notification Form
- Personal Attendant Training Documentation Form

Revised Forms

- Enrollment Request Form
- Enrollment Confirmation Notice
- Monthly Case Management (CM) Contact Form
- Monthly CM Agency Reporting Form
- Monthly Personal Assistant (PA) Agency Reporting Form
- Incident Reporting Form
- Person-Centered Service Plan
- Person-Centered Assessment
- Personal Attendant Worksheet

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

QUESTIONS & ANSWERS

Contact

For information contact:

Bureau for Medical Services

350 Capitol Street, Room 251

Charleston, WV 25301

Phone: 304-558-1700

Email: Teresa.M.McDonough@wv.gov

APS Healthcare

Phone: 866-385-8920

Fax: 866-607-9930

Email: wvtbiwaiver@apshealthcare.com