



**CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR
MR/DD WAIVER SERVICES
CHANGE LOG**

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| 513.1 | Definitions | 06-04-2007 | 1-1-08 |
| 513.2.5 | Criminal Investigation Background Check | 06-04-2007 | 1-1-08 |
| 513.3 | Member Eligibility and Enrollment Process | 06/04/2007 | 1-1-08 |
| 513.6 | Right to Appeal | 06-04-2007 | 1-1-08 |
| 513.7.1 | Index of Covered Services | 06-04-2007 | 1-1-08 |
| 513.7.2 | Individual Program Plan | 06-04-2007 | 1-1-08 |
| 513.7.2.1 | Interdisciplinary Team (IDT) Composition | 06-04-2007 | 1-1-08 |
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| 513.7.6.1 | Community Residential Habilitation | 06-04-2007 | 1-1-08 |
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| 513.7.7 | Adult Companion Services | 06-04-2007 | 1-1-08 |
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| 513.10 | Service Requiring Prior Authorization | 06-04-2007 | 1-1-08 |
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| 513.14 | Attachment 1: MR/DD Waiver Documents | 06-04-2007 | 1-1-08 |
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| 513.7.5 | Respite Services | 11-01-2006 | 12-01-2006 |
| 513.7.6.2 | Agency Residential Habilitation Service | 11-01-2006 | 12-01-2006 |
| 513.7.7 | Adult Companion Services | 11-01-2006 | 12-01-2006 |
| 513.3.1 | Application and Medical Eligibility | 09-25-2006 | 11-01-2006 |
| 513.7.1 | Index of Covered Services | 09-25-2006 | 11-01-2006 |
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| 513.13.07.12 | Extended Professional Services | 09-25-2006 | 11-01-2006 |
| 513.7.13; 513.7.13.1; 513.7.13.2 | Skilled Nursing Services by RN, Nursing Services by LPN | 09-25-2006 | 11-01-2006 |
| 513.12.1 | Payment and Limitations | 09-25-2006 | 11-01-2006 |
| Chapter 513 | All Sections | 06-27-2006 | 07-01-2006* 10-01-2006 |
| 513.1 | Definitions | 06-27-2006 | 10-01-2006 |
| 513.2 | Provider Participation | 06-27-2006 | 07-01-2006 * 10-01-2006 |
| 513.2.1 | General | 06-27-2006 | 10-01-2006 |
| 513.2.2 | Specific Requirements | 06-27-2006 | 10-01-2006 |
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| 513.3.2 | Financial | 06-27-2006 | 10-01-2006 |
| 513.3.3 | Service Allocation | 06-27-2006 | 10-01-2006 |
| 513.4 | Re-Determination | 06-27-2006 | 10-01-2006 |
| 513.5 | Rights of Members | 06-27-2006 | 10-01-2006 |
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| 513.8 | Reporting Alleged Abuse and Neglect | 06-27-2006 | 10-01-2006 |
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| 513.10.1 | Individual Program (IPP Components) | 06-27-2006 | 10-01-2006 |
| 513.10.2 | Individual Program Plan Implementation | 06-27-2006 | 10-01-2006 |
| 513.10.3 | Review of the Individual Program Plan | 06-27-2006 | 10-01-2006 |
| 513.11 | Services Provided by Relatives or Friends | 06-27-2006 | 10-01-2006 |
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| 513.13 | Covered Services | 06-27-2006 | 10-01-2006 |
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| 513.13.15 | Intermittent Nursing | 06-27-2006 | 10-01-2006 |
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| 513.14 | How to Obtain Information | 06-27-2006 | 10-01-2006 |
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| 513.2.2 | Specific Requirements | 10-24-2004 | 12-01-2004 |
| 513.2.3 | Reporting Requirements | 10-24-2004 | 12-01-2004 |
| 513.2.4 | Documentation and Record Retention Requirements | 10-24-2004 | 12-01-2004 |
| 513.2.5 | Service Limitations | 10-24-2004 | 12-01-2004 |
| 513.3 | Member Eligibility | 10-24-2004 | 12-01-2004 |



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| 513.3 | Medical Eligibility, Criteria | 10-24-2004 | 12-01-2004 |
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| 513.3.3 | Service Allocation (Slot) | 10-24-2004 | 12-01-2004 |
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| 513.7 | Right to Appeal | 10-24-2004 | 12-01-2004 |
| 513.9.2 | Prior Authorization Process | 10-24-2004 | 12-01-2004 |
| 513.10 | Interdisciplinary Team (IDT) | 10-24-2004 | 12-01-2004 |
| 513.10.1 | Individual Program Plan (IPP) Components | 10-24-2004 | 12-01-2004 |
| 513.10.2 | Individual Program Plan, Implementation | 10-24-2004 | 12-01-2004 |
| 513.10.3 | Review of the Individual Program Plan, Program Monitoring and Change | 10-24-2004 | 12-01-2004 |
| 513.11 | Services Provided by Relatives or Friends | 10-24-2004 | 12-01-2004 |
| 513.12 | Billing Procedures | 10-24-2004 | 12-01-2004 |
| 513.12.1 | Payment and Limitations | 10-24-2004 | 12-01-2004 |
| 513.13.1 | Service Coordination | 10-24-2004 | 12-01-2004 |
| 513.13.2 | Residential Habilitation | 10-24-2004 | 12-01-2004 |
| 513.13.3 | Adult Companion Services | 10-24-2004 | 12-01-2004 |
| 513.13.4 | Extended Physician Services (Annual Medical Evaluation) | 10-24-2004 | 12-01-2004 |
| 513.13.8 | Qualified Mental Retardation Professional (QMRP) | 10-24-2004 | 12-01-2004 |
| 513.13.9 | Day Habilitation Program | 10-24-2004 | 12-01-2004 |
| 513.13.10 | Prevocational Training | 10-24-2004 | 12-01-2004 |
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**June 04, 2007
Section 513.1**

Introduction: Section 513.1, Paragraph 6
Old Policy: N/A



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New Policy: Critical Juncture is any time that there is a significant juncture in the member's life that requires a meeting of the Interdisciplinary Team. The occurrence may require that a service needs to be decreased, increased or changed. A critical juncture constitutes a change in the member's needs such as behavioral, mental health or physical health, service/service units, support, setting, or a crisis.

Introduction: Section 513.1, Paragraph 8, sentence 7

Old Policy: The content of the IPP is guided by the member's needs, wishes, desires, and goals.

New Policy: The content of the IPP is guided by the member's needs, wishes, desires, and goals as stated or assessed by the member or the member's IPP team.

Introduction: Section 513.1, add new Paragraph 12, Local Community

Old Policy: N/A

New Policy: **Local Community** is the home neighborhood or location where other community members carry out their local daily routine and activities.

Introduction: Section 513.1, Paragraph 15

Old Policy: **Psychologist under Supervision for Licensure** is an individual who:

- Is an unlicensed psychologist with a documented, completed degree in psychology at the level of a Ph.D., Psy.D. Ed.D., M.A., or M.S.

- Has met the requirements of, and is formally enrolled in, the WV Board of Examiners of Psychologists Supervision Program

New Policy: **Psychologist under Supervision for Licensure** is an individual who is an unlicensed psychologist with a documented, completed degree in psychology at the level of a Ph.D., Psy.D. Ed.D., M.A., or M.S. or has met the requirements of, and is formally enrolled in, the WV Board of Examiners of Psychologists Supervision Program.

Introduction: Section 513.1, add new paragraph 17, Qualified Mental Retardation Professional

Old Policy: N/A

New Policy: **Qualified Mental Retardation Professional** is a professional with, at minimum, a bachelor's degree in a human service field and at least one year of experience working directly with persons with mental retardation and/or related conditions; and is a doctor of medicine or osteopathy, a registered nurse or an individual who holds at least a bachelor's degree in a human service field.

Section 513.2

Introduction: Section 513.2, Provider Participation, second paragraph, first sentence



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Old Policy: Services based on assessed needs and will provide service registration information to the claims payer.

New Policy: The ASO will provide authorization for services that are based on the member's assessed needs and will provide service registration information to the claims payer.

Introduction: Section 513.2, first table box

Old Policy: Office of Behavioral & Alternative Health Care

New Policy: Office of Home and Community Based Services

Introduction: Section 513.2.1, General

Old Policy: Office of Facility Health, Licensure, and Certification (OHFLAC)

New Policy: Office of Health Facilities Licensure and Certification (OHFLAC)

Introduction: Section 513.2.4, Reporting Alleged Abuse and Neglect

Old Policy: Anyone providing services to an MR/DD Waiver member who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 64 Series 11), WV State Code WV State Code§ 9-6-1, § 9-6-9, and § 49-6A-2 to report the incident to:

DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office. A Child Protective Services (CPS) or an Adult Protective Services (APS) Worker may be assigned to investigate the suspected or alleged abuse.

- OHFLAC may also be contacted at (304) 558-0050 to assist with referring the report to the proper authorities.

New Policy: Anyone providing services to an MR/DD Waiver member who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 64 Series 11), WV State Code WV State Code§ 9-6-1, § 9-6-9, and § 49-6A-2 to report the incident to the local DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office. A Child Protective Services (CPS) or an Adult Protective Services (APS) Worker may be assigned to investigate the suspected or alleged abuse.

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

Introduction: Section 513.2.5, Provider Training

Old Policy: Individuals providing Service Coordination, Residential Habilitation, Day Habilitation, Pre-vocational, Supported Employment, Adult Companion II, Respite II, Nursing,



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Skills Specialist, and Behavioral Specialist/Analyst must be trained in the following (provide verification and dates of the initial training and those training which require recertification):

New Policy: Individuals providing Service Coordination, Residential Habilitation, Day Habilitation, Pre-vocational, Supported Employment, Adult Companion II, Respite II, Nursing, Skills Specialist, and Behavioral Specialist/Analyst services must be trained in the following:

Introduction: Section 513.2.5, last paragraph

Old Policy: Provider agencies must maintain a record of the training verification.

New Policy: Provider agencies must maintain a record of the training verification or recertification.

Introduction: Criminal Investigation Background Check (CIB)

Old Policy: N/A

New Policy: Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. At a minimum, a state level criminal investigation background check must be conducted. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

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



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Section 513.3

Introduction: Section 513.3, Member Eligibility and Enrollment Process, first bullet under Member Eligibility

Old Policy: The member must have a determination of Medical Eligibility. Medical eligibility is determined by submitting an application packet to BMS for member consideration.

New Policy: The member must have a determination of Medical Eligibility. Medical eligibility is determined by submitting an application packet to State MR/DD Waiver Office for member consideration.

Introduction: Section 513.3.1, Application and Medical Eligibility, Initial Application Packet, third sentence

Old Policy: The Service Coordinator is then responsible for submitting the full application packet to the State MR/DD Waiver office within the mandatory time lines.

New Policy: The Service Coordinator is then responsible for submitting the full application packet to the State MR/DD Waiver office within the mandatory time frames.

Introduction: Section 513.3.1, Application and Medical Eligibility, Initial Application Packet, fifth paragraph.

Old Policy: For this program, individuals must meet the diagnostic criteria for medical eligibility not only by the relevant test scores, but also the narrative descriptions contained in the documentation.

New Policy: For the MR/DD Waiver program, individuals must meet the diagnostic criteria for medical eligibility not only by the relevant test scores, but also the narrative descriptions contained in the documentation.

Introduction: Section 513.3.1, Application and Medical Eligibility, Initial Application Packet, last three bullets.

Old Policy: The State MR/DD Waiver office will make a final medical eligibility determination within 45 days of receipt of the packet.

- An eligible applicant will be enrolled into the Waiver program once the allocation (slot) is available.

- The applicant's right to a final eligibility determination within 90 days may be abrogated when: A Service Coordination agency cannot complete a full application packet because the applicant or an examining physician delays or fails to take required action.

New Policy: The State MR/DD Waiver office will make a final medical eligibility determination within 45 days of receipt of the packet. An eligible applicant will be enrolled into the Waiver program once the allocation (slot) is available. The applicant's right to a final eligibility determination within 90 days may be abrogated when a Service Coordination agency cannot



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complete a full application packet because the applicant or an examining physician delays or fails to take required action.

Introduction: Section 513.3.1, Application and Medical Eligibility, Medical Eligibility, Medical Eligibility Criteria, paragraph five

Old Policy: The evaluations must demonstrate that an applicant has a diagnosis of mental retardation and/or a related developmental condition, which constitutes a severe and chronic disability. For this program, individuals must meet the diagnostic criteria for medical eligibility not only by the relevant test scores, but also the narrative descriptions contained in the documentation.

New Policy: The evaluations must demonstrate that an applicant has a diagnosis of mental retardation and/or a related developmental condition, which constitutes a severe and chronic disability. For this program, individuals must meet the diagnostic criteria for medical eligibility not only by the relevant test scores, but also the narrative descriptions contained in the documentation. To be eligible, the member:

Introduction: Section 513.3.1, Application and Medical Eligibility, Medical Eligibility, Medical Eligibility Criteria, paragraph after bullet Tuberos Sclerosis.

Old Policy: Additionally, mental retardation and/or related conditions with associated concurrent adaptive deficits:

- Were manifested prior to the age of 22, and
- Are likely to continue indefinitely.

- Must have the presence of a least three (3) substantial deficits as that term is defined in Title 42, Chapter IV, Part 435.1009 of the Code of Federal Regulations (CFR). Substantial deficits associated with a diagnosis other than mental retardation or a related diagnosis do not meet eligibility criteria. Additionally, any individual needing only personal care services does not meet the eligibility criteria. Individuals diagnosed with mental illness whose evaluations submitted for medical eligibility determination with no indication of a previous co-occurring history of mental retardation or developmental disability prior to age 22 must provide clinical verification through the appropriate eligibility documentation that their mental illness is not the primary cause of the substantial deficits and the mental retardation or developmental disability occurred prior to the age of twenty-two (22).

New Policy: Additionally, the member who has a diagnosis of mental retardation and/or related conditions and associated concurrent adaptive deficits must have the following:

- Manifested prior to the age of 22, and
- Likely to continue indefinitely.
- Must have the presence of a least three (3) substantial deficits out of five of the major life areas (term is defined in Title 42, Chapter IV, Part 435.1009 of the Code of Federal



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Regulations or CFR. Refer to Section 513.3.1, Functionality section for a list of the major life areas.

Introduction: Section 513.3.1, Application and Medical Eligibility, Medical Eligibility, Medical Eligibility Criteria: Level Of Care Section

Old Policy: The applicant or legal representative must be informed of the right to choose between ICF/MR services and home and community-based services under the MR/DD Waiver Program and informed of his/her right to a fair hearing (Informed Consent, DD-7).

New Policy: The applicant or legal representative will be informed of the right to choose between ICF/MR services and home and community-based services under the MR/DD Waiver Program and informed of his/her right to a fair hearing at the time of application (Informed Consent, DD-7).

Introduction: Section 513.3.1, Application and Medical Eligibility, Medical Eligibility, Medical Eligibility Criteria, Conditions Ineligible

Old Policy: N/A

New Policy: **Conditions Ineligible**

- Substantial deficits associated with a diagnosis other than mental retardation or a related diagnosis do not meet eligibility criteria.
- Additionally, any individual needing only personal care services does not meet the eligibility criteria.
- Individuals diagnosed with mental illness whose evaluations submitted for medical eligibility determination indicate no previous history of co-occurring mental retardation or developmental disability prior to age 22. The member's clinical evaluators must provide clinical verification through the appropriate eligibility documentation that their mental illness is not the primary cause of the substantial deficits and the mental retardation or developmental disability occurred prior to the age of twenty-two (22).

Introduction: Section 513.3.2, Financial Eligibility, first paragraph

Old Policy: The applicant or legal representative must make an application. However, it is the responsibility of the Service Coordinator to assist the member and ensure that the application is made. Written notification of medical eligibility for the MR/DD Waiver Program must be presented to the local/county DHHR to ensure accurate Medicaid coding for the appropriate Waiver program.

New Policy: The applicant or legal representative must make an application for financial eligibility. However, it is the responsibility of the Service Coordinator to assist the member and ensure that the application is made. Written notification of medical eligibility for the MR/DD



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Waiver Program must be presented to the local/county DHHR where the member resides to ensure accurate Medicaid coding for the appropriate Waiver program.

Introduction: Section 513.3.2, Financial Eligibility, Financial Eligibility Criteria, first paragraph

Old Policy: An Economic Service Worker in the DHHR office in the county/local area where the individual resides determines financial eligibility. In order to be eligible to receive MR/DD Waiver Program Services an applicant must meet the following financial eligibility criteria:

New Policy: The applicant must meet the following financial eligibility criteria:

Introduction: Section 513.3.3, Enrollment in MR/DD Waiver Program Services, Service Allocation (Slot) Criteria

Old Policy: BMS determines the number of allocations based on the total number of allocations available for the current fiscal year. The number of individuals to be served and the average cost of services per individual are established using formulas developed by BMS and CMS.

New Policy: The total number of allocations available for the current fiscal year is determined by BMS. The number of individuals to be served and the average cost of services per individual are established using formulas approved by CMS.

Introduction: Section 513.3.3, Enrollment in MR/DD Waiver Program Services, Eligibility Effective Date, first paragraph after second bullet

Old Policy: Payment for medically necessary and medically appropriate MR/DD Waiver Program Services is available on behalf of eligible Medicaid members who have been determined in need of MR/DD Waiver Program Services, subject to the conditions and limitations that apply to these services. In order to be eligible to receive MR/DD Waiver Program Services, an applicant must:

New Policy: Payment for medically necessary and medically appropriate MR/DD Waiver Program Services is available on behalf of eligible Medicaid members who have been determined in need of MR/DD Waiver Program Services, subject to the conditions and limitations that apply to these services. In order to be eligible to receive MR/DD Waiver Program Services, an applicant will:

Introduction: Section 513.3.4, Re-Determination of Medical Eligibility, Frequency Requirement for Psychological Evaluation, second paragraph after bullet titled Children

Old Policy: Once the annual re-certification packet is received by the state MR/DD Waiver office, the following transpires:

– The required evaluations (DD-2A, DD-3, etc) are reviewed by the State Waiver Office. If indicated, additional information may be requested provided the information is applicable and available as needed in order to determine recertification.



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- The State Waiver Office sends a memorandum to the member's local DHHR, Economic Service (ES) Worker, informing him/her of re-certification. The ES Worker is then authorized to review the member for financial eligibility for services.

--A copy of the memorandum is also sent to the member and the Service Coordination provider agency. This memorandum includes the member's effective date of recertification of medical eligibility.

Failure to submit the Annual Re-certification Application packet to the State MR/DD Waiver office within 30 days of the expiration date of the member's eligibility may result in any of the following:

- A request to hold the submission of claims for reimbursement
- Loss of reimbursement for services provided
- Loss of Medical Card through the West Virginia DHHR (Medicaid coverage)

New Policy: Once the annual re-certification packet is received by the state MR/DD Waiver office, the following transpires:

- The required evaluations (DD-2A, DD-3, etc) are reviewed by the State Waiver Office. If indicated, additional information may be requested provided the information is applicable and available as needed in order to determine recertification.
- Following annual eligibility determination, the State Waiver Office sends an eligibility re-certification notice to the member, the member's Service Coordination provider agency, and the member's local DHHR, Economic Service (ES) Worker, of the re-certification. The notification includes the member's effective date for medical eligibility.
- The local DHHR is then authorized to review the member's financial eligibility.

Failure of the service coordination provider to submit the Annual Re-certification Application packet to the State MR/DD Waiver office within 30 days of the expiration date of the member's eligibility may result in any of the following:

- Request to hold the submission of claims for reimbursement
- Loss of reimbursement for services provided
- Loss of Medicaid coverage for the member.

Section 513.6

Introduction: Section 513.6, Right to Appeal, Appeal of a Denial of a Service by the State MR/DD Waiver Program Office, whole section

Old Policy: If the appeal is not resolved by the State MR/DD Waiver Program Coordinator to the satisfaction of the appellant, the person may then appeal in writing to the Bureau for Medical Services, MR/DD Waiver Program, 350 Capitol Street Room 251, Charleston, WV 25301. BMS will arrange a hearing to resolve the matter.



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- **The Statement of Rights is available at the State MR/DD Waiver Office, behavioral health providers, and local DHHR offices.** The Statement of Rights is a detailed description of their right to apply for MR/DD Waiver services, receive a timely response and to be informed of their appeal rights. This document is included in the Application Information Packet.
- If MR/DD Waiver services are terminated or reduced by the State, the member will receive a Notice of Decision and a Request for Hearing form. The termination and/or reduction of services may be appealed through the fair hearing process.
- **90 Days to Request a Hearing:** The member has ninety (90) days to request a hearing after a Notice of Decision regarding eligibility has been received. Any member or authorized legal representative may request a hearing and must do so either by a written request or by using the “Request for Hearing” form. Refer to Request for Fair Hearing form.
- **13 Days to Request to Continue Services When Requesting a Hearing:** If services are terminated by the State and a hearing is requested, services will continue until a hearing decision is rendered. If an applicant/member wishes to appeal a decision they must submit the request for a hearing or pre-hearing conference within 13 days of receipt of the “Notice of Decision” to continue to receive services in the interim. Services are not continued while petitioning the appellate court.
- Upon notice of denial, the service coordinator must arrange for an emergency IDT meeting to develop a “back-up” plan for transition.
- Any applicant/member who requests a fair hearing shall be entitled to a final administrative action within ninety (90) days of the date of the request for hearing, unless the applicant waives his or her request for a final administrative action within ninety (90) days.
- If the applicant/member was denied MR/DD Waiver Program services, the applicant shall have the right to a second medical or psychological examination at the expense of the WV DHHR. Any additional documents pertinent to the condition affecting eligibility must be submitted 10 working days prior to the hearing.
- The applicant/member shall have the right to access their waiver application file and copies shall be provided free of charge by BHHF.
- If needed, DHHR will coordinate or assist the Board of Review in arranging transportation to the hearing.
- If the decision regarding eligibility (Level of Care) for the program is upheld by the hearing officer, on the date of the hearing decision, services under the MR/DD Waiver Program will cease. It is essential that upon notice of denial, that the service coordinator must arrange for the emergency IDT meeting to develop a “back-up” plan for transition. If the applicant/member is eligible financially for Medicaid services without the MR/DD Waiver program, other services may be available for the individual.
- If the decision regarding eligibility (Level of Care) for the program is reversed by the hearing officer, the person is eligible for enrolment into the program on the date of the written hearing provided an allocation (slot) is available.



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New Policy: **The Statement of Rights is available at the State MR/DD Waiver Office, behavioral health providers, and local DHHR offices.** The Statement of Rights is a detailed description of their right to apply for MR/DD Waiver services, receive a timely response and to be informed of their appeal rights. This document is included in the Application Information Packet.

If the appeal is not resolved by the State MR/DD Waiver Program Coordinator to the satisfaction of the appellant, the person may then appeal in writing to the Bureau for Behavioral Health and Health Facilities (BHFF), MR/DD Waiver Program, 350 Capitol Street Room 350, Charleston, WV 25301. BMS will arrange a hearing to resolve the matter.

If MR/DD Waiver services are terminated or reduced by the State, the member will receive a Notice of Decision and a Request for Hearing form. The termination and/or reduction of services may be appealed through the fair hearing process.

90 Days to Request a Hearing: The member has ninety (90) days to request a hearing after a Notice of Decision regarding eligibility has been received. Any member or authorized legal representative may request a hearing and must do so either by a written request or by using the "Request for Hearing" form (refer to Request for Fair Hearing form in Section 513.14. Attachment 1: MR/DD Waiver Documents).

When the member requests a hearing, the member has 13 Days to submit a request to BHFF to continue services. If services are terminated by the State and a hearing is requested, services will continue until a hearing decision is rendered. If an applicant/member wishes to appeal a decision they must submit the request for a hearing or pre-hearing conference within 13 days of receipt of the "Notice of Decision" to continue to receive services in the interim. When a member chooses to petition the appellate court following the final appeal decision on an MR/DD Waiver hearing, services are not continued while petitioning the appellate court. Upon notice of denial, the Service Coordinator must arrange for an emergency IDT meeting to develop a "back-up" plan for transition. If the decision regarding eligibility (Level of Care) for the program is upheld by the hearing officer, on the date of the hearing decision, services under the MR/DD Waiver Program will cease. It is essential that upon notice of denial, that the Service Coordinator must arrange for the emergency IDT meeting to develop a "back-up" plan for transition. If the applicant/member is eligible financially for Medicaid services without the MR/DD Waiver program, other services may be available for the individual.

Any applicant/member who requests a fair hearing shall be entitled to a final administrative action within ninety (90) days of the date of the request for hearing, unless the applicant waives his or her request for a final administrative action within ninety (90) days.

If the applicant/member was denied MR/DD Waiver Program services, the applicant shall have the right to a second medical or psychological examination at the expense of the WV DHHR. Any additional documents pertinent to the condition affecting eligibility must be submitted 10 working days prior to the hearing.

The applicant/member shall have the right to access their waiver application file and copies shall be provided free of charge by BHFF.



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If needed, BHHF will coordinate or assist in arranging transportation to the hearing.
If the decision regarding eligibility (Level of Care) for the program is reversed by the hearing officer, the person is eligible for enrollment into the program on the date of the written hearing provided an allocation (slot) is available.

Introduction: Section 513.6, Right to Appeal, Appeal of an Individual Program Plan (IPP), paragraph 4

Old Policy: If the appeal is not resolved satisfactorily by the State MR/DD Waiver Program Coordinator, the person may then appeal to BMS. The appeal should be forwarded to the Bureau for Medical Services, MR/DD Waiver Program, 305 Capitol Street Room 251, Charleston, WV 25301. Board of Review will arrange a hearing to resolve the matter.

New Policy: If the appeal is not resolved satisfactorily by the State MR/DD Waiver Program Coordinator, the person may then appeal to BHHF for a Medicaid fair hearing. The appeal should be forwarded to the Bureau for Behavioral Health and Health Facilities (BHHF), MR/DD Waiver Program, 305 Capitol Street Room 350, Charleston, WV 25301. Board of Review will arrange for a hearing to resolve the matter.

Introduction: Section 513.6, Right to Appeal, Negotiation of a Budget Allocation by the Administrative Service Organization, title and paragraph

Old Policy: **Negotiation of a Budget Allocation by the Administrative Service Organization**

The IDT must make every effort to purchase services within the budget allocated by the ASO. If the IDT cannot purchase all needed services within the budget, the Service Coordinator may contact the ASO with rationale for the need to negotiate a new budget. If negotiation is unsuccessful, the Service Coordinator may request a **Second Level Negotiation with the ASO.**

New Policy: **Appeal of a Budget Allocation by the Administrative Service Organization**

The IDT must make every effort to purchase services within the budget allocated by the ASO. If the IDT cannot purchase all needed services within the budget, the Service Coordinator may contact the ASO with rationale for the need to negotiate a new budget. If negotiation is unsuccessful, the Service Coordinator may request a **Second Level Negotiation with the ASO. Only the member or the member's guardian or healthcare surrogate may request a fair hearing.**

Section 513.7

Introduction: Section 513.7.2, Individual Program Plan Development (IPP), Definition, second paragraph, first sentence

Old Policy: This group that is inclusive of the member participates in the IPP meeting for the purpose of review of assessments or evaluations, discussion of recommendations or



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individualized needs, identification of resources or methods of support, outline of service options and training goals, and preparation of interventions or strategies necessary to implement a person centered plan.

New Policy: The team, that includes the member, participates in the IPP meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person centered plan.

Introduction: Section 513.7.2, Individual Program Plan Development (IPP), Frequency of Review of IPP

Old Policy: The IPP is to be developed on an annual basis. Minimally, the annual IPP must be reviewed at a six-month interval. IPP reviews should occur on a quarterly basis, however, for those IDT teams that do not review the annual IPP quarterly; a rationale must be given for not reviewing the IPP quarterly. The IPP must be reviewed at critical junctures (refer to definitions for critical juncture).

New Policy: The IPP is to be developed on an annual basis. Minimally, the annual IPP must be reviewed at a six-month interval. IPP reviews should occur on a quarterly basis. For those IDT teams that do not review the annual IPP quarterly, rationale must be given for not reviewing. The IPP must be reviewed at critical junctures (refer to definitions for critical juncture).

The psychologist and the registered nurse are required to attend the annual and six-month review of the IPP. MR/DD Waiver does not require the psychologist and nurse to attend the quarterly review IPP meetings. For the quarterly meetings, both the psychologist and registered nurse may send recommendations to the Service Coordinator for review at the quarterly team meetings.

A physician, psychologist or a registered nurse may attend the meeting by interactive video (MDTV or webcam) and may bill for the IDT team meeting if attending for the entire event. The physician, psychologist, or the nurse may not bill for telephone conferencing. The service must not include facility (“set-up”) cost or connection cost for the MDTV or webcam.

Introduction: Section 513.7.2, Individual Program Plan Development (IPP), Review of the Individual Program Plan—Program Monitoring and Change, add sixth bullet

Old Policy: Situations that may warrant an earlier review include, but are not limited to:

- The member has successfully completed an objective(s) included in the IPP
- The member is regressing or losing skills already gained
- The member is failing to progress toward identified objectives after reasonable efforts have been made
- The member is being considered for training towards new objectives
- The member is having a minor or major occurrence in his/her life.



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New Policy: Situations that may warrant an earlier review include, but are not limited to:

- The member has successfully completed an objective(s) included in the IPP
- The member is regressing or losing skills already gained
- The member is failing to progress toward identified objectives after reasonable efforts have been made
- The member is being considered for training towards new objectives
- The member is having a minor or major occurrence in his/her life.
- The member experiences a critical juncture (See Section 513.1 for definition of critical juncture)

Introduction: Section 513.7.2.1, Interdisciplinary Team (IDT) Composition, sixth and seventh bullet

Old Policy: A physician or registered nurse is required if the member is receiving skilled nursing services on the Waiver Program or if the person has a medical need as determined by the nursing or physician recommendation and team verification

- A psychologist is required when the member has the need for specialized psychological evaluation and intervention due to co-existing mental health disorders or behavioral needs

New Policy: A physician or registered nurse is required if the member is receiving skilled nursing services, or medical services that require RN oversight. The IDT may choose to invite the nurse and/or physician for other reasons when the team indicates that the need exists. The nurse is not required to attend quarterly meetings but may submit recommendations to the Service Coordinator for review at the quarterly IDT meetings. The nurse may attend the IDT meeting by interactive video (MDTV or web cam). The service does not cover the facility (“set-up”) cost or connection cost (not telephone conferencing). The nurse must not bill for telephone conferencing.

- A psychologist is required when the member has the need for specialized psychological evaluation and intervention due to co-existing (DSM IV TR Axis I diagnosis of Schizophrenia and other psychotic disorders and mood disorders) mental health disorders or behavioral needs. The only exception is if the member resides with a natural or adoptive family who addresses the DSM IV TR Axis I mental health disorder and/or behavioral needs independent of the MR/DD Waiver program through a physician/psychiatrist; and the team agrees to the exception. The psychologist is not required to attend the quarterly IDT meetings but may submit recommendations to the Service Coordinator for review at the quarterly IDT meetings. The psychologist may attend the IDT meeting by interactive video (MDTV or web cam). The service does not cover the facility (“set-up”) cost or connection cost (not telephone conferencing). The nurse must not bill for telephone conferencing.



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Introduction: Section 513.7.2.1, Interdisciplinary Team (IDT) Composition, third bullet in next set of bullets

Old Policy: Direct service providers, such as Day Habilitation Program providers, Residential Habilitation providers and counselor

New Policy: Direct service providers, such as Day Habilitation Program providers, Residential Habilitation providers, Respite providers, Adult Companion providers, Pre-vocational providers, Supported Employment providers, and LPN's responsible for habilitation programs when the member receives eight (8) hours or more nursing in one day, and counselor

Introduction: Section 513.7.2.1, Interdisciplinary Team (IDT) Composition, IDT Meeting Attendance, first paragraph

Old Policy: Attendance at the IDT meeting is extremely important. The IDT meeting attendance is a responsibility of each of the team members. Strong efforts must be made in scheduling an IDT to secure the attendance of all members of the Interdisciplinary Team. The IDT should only be rescheduled for extenuating circumstances. A total of two (2) requests to re-schedule the IDT may occur when extenuating circumstances exist. IDTs **must** be rescheduled **to occur** within 30 days of the expiration date. The following conditions exist:

New Policy:

Any individual who is part of the team is very important, therefore, attendance at the IDT meeting is extremely important. The IDT meeting attendance is a responsibility of each of the team members. Strong efforts must be made in scheduling an IDT to secure the attendance of all members of the Interdisciplinary Team. The IDT should only be rescheduled for extenuating circumstances. A total of two (2) requests to re-schedule the IDT may occur when extenuating circumstances exist. The IDT **must** be rescheduled **to occur** within 30 days of the expiration date. For rescheduling of the IDT, the following conditions exist:

Introduction: Section 513.7.2.1, Interdisciplinary Team (IDT) Composition, IDT Meeting Attendance, fourth bullet

Old Policy: In extenuating circumstances, family members or guardians may participate by teleconferencing or video conferencing if the family member or guardian does not bill for the time spent in the IDT. The member, the service coordinator, and the other designated members must be physically present during the IDT.

New Policy: In extremely extenuating circumstances, family members, guardians or other team members may participate by teleconferencing if the family member, guardian or other team member does not bill for the time spent in the IDT. The member, the Service Coordinator, and the other designated members must be physically present during the IDT.



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Introduction: Section 513.7.2.1, Interdisciplinary Team (IDT) Composition, IDT Meeting Attendance, add fifth bullet

Old Policy: N/A

New Policy: The only exception to the IDT attendance is the registered nurse or the psychologist. The registered nurse or the psychologist may participate by interactive video (MDTV or webcam) and may bill for the service when they are present at the IDT for the entire event. All other team members may not participate or bill for the IDT event by means of interactive video (MDTV or webcam).

Introduction: Section 513.7.2.1, Interdisciplinary Team (IDT) Composition, Critical Juncture Meetings

Old Policy: **Crisis IDT Meeting** – This type of IDT Meeting occurs when a member is experiencing a crisis (example: behavioral, medical, housing and service provision). In the event that all team members cannot be present (for a crisis IDT meeting only), a written report of the crisis IPP must be disseminated to all members within five (5) working days.

New Policy: Critical Juncture is any time that there is a significant juncture in the member's life that requires a meeting of the Interdisciplinary Team. The occurrence may require that a service needs to be decreased, increased or changed. A critical juncture constitutes a change in the member's needs such as behavioral, mental health or physical health, service/service units, support, setting, or a crisis.

Crisis IDT Meeting – This type of IDT Meeting occurs when a member is experiencing a crisis (example: behavioral, medical, housing and service provision). In the event that all team members cannot be present (for a crisis IDT meeting only), a written report of the crisis IPP must be disseminated to all members within five (5) working days. When the IDT has requested a prior authorization and the approval or denial is received by the Service Coordinator, the Service Coordinator may utilize the crisis IDT format to notify the IDT team members.

Introduction: Section 513.7.3, Service Coordination, Site of Service

Old Policy: Any location required in order to complete all necessary duties for the member.

New Policy: The provider may provide service coordination in any location in the home or community setting which allows the service coordinator to complete all necessary duties for the member.

Introduction: Section 513.7.3, Service Coordination, Application and Eligibility Process, third bullet

Old Policy: Submit the Annual Medical Evaluation (DD-2A) and psychological evaluation (DD3) {if applicable} for re-certification to the State office no later than thirty (30) days past the expiration date. Services may not be reimbursed if an individual's certification has expired past the thirty (30) day time frame.



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New Policy: Submit the Annual Medical Evaluation (DD-2A) and psychological evaluation (DD3) {if applicable} for re-certification to the State office no later than thirty (30) days past the expiration date. Services may not be reimbursed if an individual's certification has expired past the thirty (30) day time frame. It is the Service Coordinator's responsibility to ensure that the member's medical and financial eligibility is monitored and determined annually.

Introduction: Section 513.7.3, Service Coordination, Linkage/Referral and Rights, add new paragraph at end of section

Old Policy: N/A

New Policy: Interface with the ASO on behalf of the member in regards to the assessment process, purchase of services, or budget process. Activities may include linkage, submission of information, coordination of choice of appropriate assessment respondents on behalf of the member, education and coordination of the most appropriate assessment setting that best meets the member's needs. The Service Coordinator may also conduct communication with other service providers on the IDT to allow for continuity of services/payment for services, and timely budgeting of services. These activities promote an assessment and budget that reflects the needs of the member.

Introduction: Section 513.7.4, Transportation, Service Restrictions, add 3 bullets at end of section

Old Policy: N/A

New Policy: A0120-HI and A0160 -HI cannot be billed concurrently.

- A0120-HI may not be utilized when a provider is transported in a private vehicle (car) or agency vehicle (car). Only a van or "mini-bus" may be utilized with A0120-HI.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

Introduction: Section 513.7.5, Respite Care, Respite Services, second and third paragraphs after set of bullets

Old Policy: Up to forty eight (48) units of Level 2 (Agency) Respite Care services per member per three (3) months may be charged, if necessary, for the purpose of training the Respite Care service provider in person-specific instruction (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Training received by the Respite Care provider must be provided by a Therapeutic Consultant, either the Skills Specialist or Behavior Specialist/Analyst.



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Up to four (4) units of respite may be charged by the Level 2 (Agency) Respite Care service provider to participate in the development of the annual IPP and 4 units may be charged to participate in the 6-month IPP review. Billing may occur only for program planning meetings required by the MR/DD Waiver Program as outlined above.

New Policy: Up to forty eight (48) units of Respite Care services per member per three (3) months may be charged, if necessary, for the purpose of training the Respite Care service provider in person-specific instruction (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Training received by the Respite Care provider must be provided by a Therapeutic Consultant, either the Skills Specialist or Behavior Specialist/Analyst.

In addition to the 48 units of training, the respite provider may utilize up to four (4) units of respite to participate in the development of the annual IPP and 4 units may be charged to participate in the 6-month IPP review. Billing may occur only for program planning meetings required by the MR/DD Waiver Program as outlined above.

Introduction: Section 513.7.5, Respite Care, Respite Services, Documentation

Old Policy: Documentation shall include name of MR/DD Waiver member, the content of the activity, the relationship of that activity to an objective on the IPP, the actual time spent, including start and stop times for the day of service, date of service, the staff to member ratio and the signature and credentials of the staff providing the service on the Respite Documentation Form (DD-12). Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.

New Policy: Documentation shall include the following:

- Name of MR/DD Waiver member
- Content of the activity.
- Relationship of that activity to an objective on the IPP
- Actual time spent, including start and stop times for the day of service
- Date of service
- Staff to member ratio
- Signature and credentials of the staff providing the service.

The provider is required to utilize the Respite Documentation Form (DD-12). The summary on the DD-12 should discuss specifics of the task or activity and should not be a general description such as “completing task analysis”. Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.



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Introduction: Section 513.7.5, Respite Care, Respite Services, Provider Qualifications, Respite Care Level I, second paragraph

Old Policy: **Respite Care Level I** Providers are individuals contracted by an agency who have been chosen by the member or the member's legal representative. Providers may include SFCP and/or biological or adoptive family members or relatives. The Respite Care Level 1 provider cannot reside with the member. Respite Care Level I is an optional service for Waiver providers.

New Policy: **Respite Care Level I** Providers are individuals contracted by an agency who have been chosen by the member or the member's legal representative. Providers may include Specialized Family Care Providers (SFCP) and/or biological or adoptive family members or relatives. The Respite Care Level 1 provider cannot reside with the member. Respite Care Level I is an optional service for Waiver providers.

Introduction: Section 513.7.5, Respite Care, Respite Services, Provider Qualifications, Respite Care Level I, last bullet

Old Policy: Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

New Policy: Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.5, Respite Care, Respite Services, Provider Qualifications, Respite Care Level II, first paragraph

Old Policy: **Respite Care Level II** Providers must be employees of the behavioral health provider and must meet the following requirements:

New Policy: **Respite Care Level II** Providers must be employees of the behavioral health provider. The Respite Care Level II provider must not reside with the member. Respite Care Level II providers must meet the following requirements:

Introduction: Section 513.7.5, Respite Care, Respite Services, Provider Qualifications, Respite Care Level II, last bullet

Old Policy: Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.



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New Policy: Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.6, Residential Habilitation (residential based services includes both agency residential habilitation and community residential habilitation), Definition, third paragraph

Old Policy: All Residential services are provided under the supervision of a Therapeutic Consultant. A Therapeutic Consultant will either be a Skills Specialist or a Behavioral Specialist/Analyst. The Skills Specialist or the Behavioral Specialist/Analyst will work in conjunction and/or collaboration with the designated Residential Habilitation provider(s) to ensure the implementation of Residential Habilitation Services. (See Section 513.7.11 of this chapter).

New Policy: All Agency Residential services are provided under the supervision of a Therapeutic Consultant. Community Residential Habilitation services are provided under clinical oversight of the Therapeutic Consultant. A Therapeutic Consultant will either be a Skills Specialist or a Behavioral Specialist/Analyst. The Skills Specialist or the Behavioral Specialist/Analyst will work in conjunction and/or collaboration with the designated Residential Habilitation provider(s) to ensure the implementation of Residential Habilitation Services. (See Section 513.7.11 of this chapter).

Introduction: Section 513.7.6.1, Community Residential Habilitation, Service Limits

Old Policy: 16 units (4 hours) per day (Limit of 4 hours per day combined with T2017-U4, T2017-U3, T2017-U2, T2017-U1)

New Policy: 496 units per month (Limit of 496 units per month combined with T2017-U4, T2017-U3, T2017-U2, T2017-U1 and up to 744 units per month with prior authorization)

Introduction: Section 513.7.6.1, Community Residential Habilitation, Payment Limits

Old Policy: Only those services that have been identified as necessary in the Extraordinary Care Assessment are allowable for reimbursement. Any units in excess of four (4) hours per day up to six (6) hours must be approved by the local waiver contact person prior to November 1, 2006 and by the ASO November 1, 2006 and beyond. The local Waiver contact person cannot authorize units in excess of four (4) hours after November 1, 2006.

New Policy: Only those services that have been identified as necessary in the Extraordinary Care Assessment are allowable for reimbursement. Any units in excess of 496 per month up to 744 units per month must be approved by the local waiver contact person prior to November 1, 2006 and by the ASO November 1, 2006 and beyond. The local Waiver contact person cannot authorize units in excess of four (4) hours after November 1, 2006.



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Introduction: Section 513.7.6.1, Community Residential Habilitation, Prior Authorization, add sentence to end of section.

Old Policy: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

New Policy: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Residential services above 496 units per month that includes Community Residential Habilitation or a combination of Community Residential Habilitation and Agency Residential Habilitation, needs prior authorization.

Introduction: Section 513.7.6.1, Community Residential Habilitation, Provider Qualifications, add bullet

Old Policy: N/A

New Policy: Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.6.1, Community Residential Habilitation, Documentation

Old Policy: Community Residential Habilitation providers must complete the Community Residential Habilitation Documentation from (DD 12).

New Policy: Community Residential Habilitation providers must complete the Community Residential Habilitation Documentation from (DD 12). The summary should discuss specifics of the task or activity and should not be a general description such as "completing task analysis". Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.

Introduction: Section 513.7.6.1, Community Residential Habilitation, Service Restrictions, add 2 bullets

Old Policy: N/A



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New Policy: Community Residential Habilitation providers may not bill for overnight supervision and monitoring.

-The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

Introduction: Section 513.7.6.2, Agency Residential Habilitation, Service Limits

Old Policy: 96 daily, 2616 monthly, combined service limits (Combined service limits include S5135, S5135 UN, S5135 UP Adult Companion Services Level 1-contracted and S5135-U4, S5135-U3, S5135-U2Adult Companion Services Level 2 - agency and Community Residential Habilitation T2017- UA) Staff / Member Ratio 1:1, 1:2, 1:3, and 1:4 Residential

New Policy: 2616 monthly, combined service limits (Combined service limits include S5135, S5135 UN, S5135 UP Adult Companion Services Level 1-contracted and S5135-U4, S5135-U3, S5135-U2Adult Companion Services Level 2 - agency and Community Residential Habilitation T2017- UA) (Note: 513.7.6.1. caps Community Residential Habilitation {T2017-UA} in combination with Agency Residential habilitation {T2017 U4, T2017 U3, T2017 U2, and T2017} U1 to 496 units per month without prior approval/authorization and 744 units per month with prior authorization). Staff / Member Ratio 1:1, 1:2, 1:3, and 1:4 Residential

Introduction: Section 513.7.6.2, Agency Residential Habilitation, Provider Qualifications, third bullet

Old Policy: Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member;

New Policy: Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member; See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.6.2, Agency Residential Habilitation, Service Restrictions, first sentence, third bullet

Old Policy: A maximum of 8 hours per day (32 units) of monitoring and supervision may be provided to a member.

New Policy: A maximum of 8 hours per day (32 units) of monitoring and supervision may be provided to a member for overnight supervision. Overnight supervision must be provided by alert and “awake” staff.



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Introduction: Section 513.7.7, Adult Companion Services, Conditions of Contracting, fourth bullet, add sentence
Old Policy: N/A
New Policy: See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.8, Day Habilitation Program, Definition, first paragraph
Old Policy: The purpose of Day Habilitation is to offer a structured program that is designed to promote the acquisition of skills or maintenance of skills outside the residential home. Day Habilitation activities must occur during naturally occurring routines of the day for the member.
New Policy: Day Habilitation is a structured program that is designed to promote the acquisition of skills or maintenance of skills for the member outside the residential home. Day Habilitation activities must occur during naturally occurring routines of the day for the member.

Introduction: Section 513.7.8, Day Habilitation Program, Provider Qualifications, add bullet
Old Policy: N/A
New Policy: See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.9, Prevocational Training, Provider Qualifications, third bullet, add sentence
Old Policy: N/A
New Policy: See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.9, Prevocational Training, Site of Service, add paragraph
Old Policy: N/A
New Policy: Services may be delivered by the pre-vocational provider in a community setting.

Introduction: Section 513.7.10, Supported Employment, Payment Limits
Old Policy: MR/DD Waiver Supported Employment services may not be substituted for those services available through DRS through a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation of referral, to DRS must be maintained by the provider agency in the individual's record of service.



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New Policy: MR/DD Waiver Supported Employment services may not be substituted for those services available through Division of Rehabilitation Services (DRS) through a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation of referral, to DRS must be maintained by the provider agency in the individual's record of service.

Introduction: Section 513.7.10, Supported Employment, Provider Qualifications, fourth bullet, add sentence

Old Policy: N/A

New Policy: See Section 513.2.6 Criminal Investigation Background Check for further requirement.

Introduction: Section 513.7.11, Therapeutic Consultative Services (Therapeutic Consultative Services includes skills specialist, behavioral specialist and behavioral analyst), Role of Therapeutic Consultant, third paragraph

Old Policy: A Skills Development Specialist will act as the Therapeutic Consultant if there are no significant maladaptive issues present. The residential setting may have one consultant for the member and the day setting may have one (1) consultant for the member. The day setting includes day habilitation, prevocational, and supported employment Services.

New Policy: A Skills Development Specialist will act as the Therapeutic Consultant if there are no significant maladaptive issues present. The residential setting may have one consultant for the member and the day setting may have one (1) consultant for the member. The day setting includes Day Habilitation, Prevocational, and Supported Employment Services. A third Therapeutic Consultant may be added only if there is a second or third provider for a day setting activity.

Introduction: Section 513.7.11, Therapeutic Consultative Services (Therapeutic Consultative Services includes skills specialist, behavioral specialist and behavioral analyst), Role of Therapeutic Consultant, Role of Therapeutic Consultant, fifth and sixth paragraphs

Old Policy: In the event that there is more than one (1) Therapeutic Consultant, the Residential Therapeutic Consultant will act as the primary Therapeutic Consultant. A secondary Therapeutic Consultant may be necessary if the individual is also receiving services in a day setting such as day habilitation, prevocational, or supported employment services. The Residential Therapeutic Consultant will be the primary Consultant responsible for coordinating the collaboration of the total habilitation plans and behavioral support plans, protocols, or guidelines. All habilitation plans (residential, day, prevocational/supported employment) must be developed in collaboration. The point of collaboration is the IDT. All Therapeutic Consultant's



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involved with the member’s habilitation plans must sign each part of the plan (residential, day, prevocational/supported employment) indicating the plans are consistent with adaptive training methodologies, strategies, areas of skill improvement and maladaptive issues or interventions. The ASO will provide ICAP adaptive and maladaptive finding to the IDT. The IDT may use these finding to assist in prioritizing the member’s habilitation and training needs. Plans must be correlated with the results found in both the adaptive and maladaptive findings of the ICAP assessment.

Therapeutic Consultants are responsible for the writing and collection of the habilitation plans, and training of the individuals who will be implementing the direct training with the member.

New Policy:

In the event that there is more than one (1) Therapeutic Consultant, the Residential Therapeutic Consultant will act as the primary Therapeutic Consultant. Additional Therapeutic Consultants (up to two) may be necessary if the individual is also receiving services from different providers in a day setting such as day habilitation, prevocational, or supported employment services.

The Residential Therapeutic Consultant will be the primary Consultant responsible for coordinating the collaboration of the total habilitation plans and behavioral support plans, protocols, or guidelines. All habilitation plans (residential, day, prevocational/supported employment) must be developed in collaboration. The point of collaboration is the IDT.

All Therapeutic Consultant’s involved with the member’s habilitation plans must sign each part of the plan (residential, day, prevocational/supported employment) indicating the plans are consistent with adaptive training methodologies, strategies, areas of skill improvement and maladaptive issues or interventions. The ASO will provide ICAP adaptive and maladaptive finding to the IDT. The IDT may use these finding to assist in prioritizing the member’s habilitation and training needs. Plans must be correlated with the results found in both the adaptive and maladaptive findings of the ICAP assessment. Therapeutic Consultants are responsible for the writing and collection of the habilitation plans, and training of the individuals who will be implementing the direct training with the member.

A Therapeutic Consultant must be a qualified mental retardation specialist. Providers must use the DD-17 for credentialing purposes. Any credential that the providers verify on this form must be filed with the provider agency.

Introduction: Section 513.7.11, Therapeutic Consultative Services (Therapeutic Consultative Services includes skills specialist, behavioral specialist and behavioral analyst), Role of Therapeutic Consultant, add section, Specialty Consultant for Hearing or Visual Impairment Needs

Old Policy: N/A

New Policy: **SPECIALTY CONSULTANT FOR HEARING OR VISUAL IMPAIRMENT NEEDS**



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A provider who is certified or specially trained to provide mobility or adaptive training for an individual who is visually impaired or adaptive training for a member who is hearing impaired may be added to a member's team for consultation purposes only. Verification of the provider's qualifications as a Specialty Consultant for hearing or visual impairment must be maintained in the provider agency's files (example: certification or specialized training). This provider is a skills specialist and may bill for only skills specialist services. This provider may consult with the team for a total of **20 units per IPP year**. The Specialty Consultant may consult with the other Therapeutic Consultants on the team, assess the member, or make recommendations to the team regarding adaptations for training activities. Recommendations must be maintained in the member record in writing.

Introduction: Section 513.7.11.1, Skills Specialist, Definition, Skills Specialist Core Job Functions, second bullet

Old Policy: Evaluate environment(s) for implementation of the plan which creates the optimal environment for learning.

New Policy: Evaluate environment(s) for implementation of the plan which creates the optimal environment for learning. (TC should select the most suitable environment for the consumer's learning needs. For example, if the consumer has an aversion to noisy environments, the TC would be aware of this and would steer the consumer/team from training in such environments as possible)

Introduction: Section 513.7.11.1, Skills Specialist, Definition, Skills Specialist Core Job Functions, add bullet

Old Policy: N/A

New Policy: Collect and evaluate data around targeted behaviors when this activity leads to a functional assessment and a behavior support plan (Skills Specialist may collect data to determine the need for a behavior specialist or a behavior analyst) Once the need for a behavior specialist/analyst is determined, the skills specialist would no longer provide the service.

Introduction: Section 513.7.11.1, Skills Specialist, Definition, Skills Specialist Core Job Functions, Provider Qualifications, fifth and sixth bullets

Old Policy: Demonstrated competencies as determined by the provider that the individual can perform the core job functions of a skills development specialist.

- Providers must have a Criminal Investigation Background Check. CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.



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New Policy: Demonstrated competencies as determined by the provider that the individual can perform the core job functions of a skills specialist. Providers without one year post graduate professional experience may provide skills specialist services under the direct supervision of a QMRP professional with a Masters degree in social work, psychology or counseling or a licensed psychologist.

- Providers must have a Criminal Investigation Background Check. CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.11.1, Skills Specialist, Definition, Skills Specialist Core Job Functions, Provider Qualifications, Site of Service

Old Policy: The Skills Specialist's office, the individual's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Skills Specialist's service.

New Policy: This service may be provided in the Skills Specialist's office, the individual's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Skills Specialist's service.

Introduction: Section 513.7.11.1, Skills Specialist, Definition, Skills Specialist Core Job Functions, Service Restrictions, second bullet

Old Policy: Behavior Specialist may not provide aquatic therapy, art therapy, dance therapy, music therapy, pet therapy, aroma therapy, and equestrian therapy. Additionally, Skill building instruction or activities around these types of therapies may not be provided.

New Policy: Skills Specialist may not provide aquatic therapy, art therapy, dance therapy, music therapy, pet therapy, aroma therapy, and equestrian therapy. Additionally, skill building instruction or activities around these types of therapies may not be provided.

Introduction: Section 513.7.11.2, Behavior Specialist, Prior Authorization

Old Policy: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1, and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will



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register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

Eligibility for Behavior Analyst services require a rating of moderate, severe or critical on the annual ICAP rating of “maladaptive” behaviors or a comparable functional assessment.

Exception: When a member is in crisis, a functional analysis may be utilized to assess the member’s maladaptive behaviors. The ASO must have verification.

During the transition to the ASO, a functional analysis must be utilized to assess the need for Behavioral Support Services. Following the establishment of the member’s individual budget, the annual ICAP assessment as completed by the ASO will be required for all routine use of the Behavioral Support Services (with the exception of members in crisis).

New Policy: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1, and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

See Eligibility Criteria for the Service and prior authorization.

Introduction: Section 513.7.11.2, Behavior Specialist, add new section, Eligibility Criteria for the Service

Old Policy: N/A

New Policy: The following is a list of criteria that must be exhibited in order to receive this behavioral service. Once a targeted behavior is established, this service may be utilized for the purpose of behavioral tracking when the behavioral data leads to a positive behavior support plan or behavior protocol. One or more of the conditions must be met:

- Member must currently exhibit maladaptive behaviors or have a recent history of maladaptive behaviors that have occurred no more than one year from the date of implementation of the service (verification by historical evaluation, assessment behavior support plan, behavior plan or IPP only).
- Member may have a history of behaviors beyond the one year that have resulted in severe life threatening situations such as fire setting or arson or sexual assault or offending or behaviors that result in severe bodily harm to others. Eligibility for this criteria must be prior authorized by the ASO.
- Member must have identified behaviors on the IPP that require tracking of behavioral data for the functional assessment
- Member must have a functional assessment that outlines one or more specific targeted behaviors that are currently or will be addressed in a behavioral protocol or a positive



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behavior support plan **OR** member must have an ICAP rating of moderate, severe or critical on the maladaptive range

- Member may have an active behavior protocol in place if behaviors are infrequent or if the behaviors are not occurring at the time of implementation of the service **OR** member may have a behavior support plan in place.

Introduction: Section 513.7.11.2, Behavior Specialist, Provider Qualifications, sixth bullet, add sentence

Old Policy: N/A

New Policy: See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.11.2, Behavior Specialist, Site of Services

Old Policy: The Behavioral Specialist's office, the individual's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Behavioral Specialist's services.

New Policy: This service may be performed at the Behavioral Specialist's office, the individual's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Behavioral Specialist's services.

Introduction: Section 513.7.11.3, Behavior Analyst, Payment Limits

Old Policy: Providers without credentials for their area of specialty may not provide the service. The Residential setting consultant and the day setting consultant may collaborate no more than 8 units per calendar year for the purpose of plan development.

New Policy: Providers without credentials for their area of specialty may not provide the service. The Residential setting consultant and the day setting consultant may collaborate up to 8 units per calendar year for the purpose of plan development.

Introduction: Section 513.7.11.3, Behavior Analyst, Prior Authorization

Old Policy: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1, and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take

into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.



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Eligibility for Behavior Analyst services require a rating of moderate, severe or critical on the annual ICAP rating of “maladaptive” behaviors or a comparable functional assessment.

Exception: When a member is in crisis, a functional analysis may be utilized to assess the member’s maladaptive behaviors. The ASO must have verification.

During the transition to the ASO, a functional analysis must be utilized to assess the need for Behavioral Support Services. Following the establishment of the member’s individual budget, the annual ICAP assessment as completed by the ASO will be required for all routine use of the Behavioral Support Services (with the exception of members in crisis).

New Policy: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1, and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

See Eligibility Criteria for the Service and prior authorization.

Introduction: Section 513.7.11.3, Behavior Analyst, add section, Eligibility Criteria for the Service

Old Policy: N/A

New Policy: The following is a list of criteria that must be exhibited in order to receive this behavioral service. Once a targeted behavior is established, this service may be utilized for the purpose of behavioral tracking when the behavioral data leads to a positive behavior support plan or behavior protocol. One or more of the conditions must be met:

- Member must currently exhibit maladaptive behaviors or have a recent history of maladaptive behaviors that have occurred no more than one year from the date of implementation of the service (verification by historical evaluation, assessment behavior support plan, behavior plan or IPP only).
- Member may have a history of behaviors beyond the one year that have resulted in severe life threatening situations such as fire setting or arson or sexual assault or offending or behaviors that result in severe bodily harm to others. Eligibility criteria must be prior authorized by the ASO.
- Member must have Identified behaviors on the IPP that require tracking of behavioral data for the functional assessment
- Member must have a functional assessment that outlines one or more specific targeted behaviors that are currently or will be addressed in a behavioral protocol or a positive behavior support plan **OR** member must have an ICAP rating of moderate, severe or critical on the maladaptive range



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- Member may have an active behavior protocol in place if behaviors are infrequent or if the behaviors are not occurring at the time of implementation of the service **OR** member may have a behavior support plan in place

Introduction: Section 513.7.11.3, Behavior Analyst, Provider Qualifications, sixth bullet, add sentence

Old Policy: N/A

New Policy: See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.11.3, Behavior Analyst, Documentation

Old Policy: A detailed progress note or evaluation report for each service is required. The documentation should include the service code description of the service, date, time spent, including start and stop times and signature and credentials of the Skills Specialist. All data obtained for a functional analysis must be maintained in the member's record. Service units are to be rounded on a monthly basis, not daily or weekly.

New Policy: A detailed progress note or evaluation report for each service is required. The documentation should include the service code description of the service, date, time spent, including start and stop times and signature and credentials of the Behavior Analyst. All data obtained for a functional analysis must be maintained in the member's record. Service units are to be rounded on a monthly basis, not daily or weekly.

Introduction: Section 513.7.13.1, Nursing Services by RN, Provider Qualifications, add sentence to second bullet

Old Policy: N/A

New Policy: See Section 513.2.6 Criminal Investigation Check for further requirements.

Introduction: Section 513.7.13.2, Nursing Services by LPN, Provider Qualifications, add sentence to second bullet

Old Policy: N/A

New Policy: See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.14, Crisis Services, Provider Qualifications, add sentence to fifth bullet



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Old Policy: N/A

New Policy: See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Introduction: Section 513.7.15, Environmental Accessibility Adaptations, Definition, second bullet

Old Policy: The Service Coordinator will complete and submit a DD-19 form to the **Service Coordination Agency Contact Person** to authorize the request for an Environmental Accessibility Adaptation covered by this benefit.

New Policy: The Service Coordinator will complete and submit a DD-19 form to the ASO to authorize the request for an Environmental Accessibility Adaptation covered by this benefit.

Introduction: Section 513.7.15, Environmental Accessibility Adaptations, add section Restriction

Old Policy: N/A

New Policy: The service coordination provider agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for the cost of services must be issued to the vendor of the EAA service. The provider agency must maintain verification of payment to the vendor and a receipt verifying the service was provided.

Introduction: Section 513.7.16.2, Psychological Evaluations (Triennial and Annual), add section

Old Policy: N/A

New Policy: Each member must receive a psychological evaluation to determine medical eligibility. Both the DD-2 (physician's medical evaluation) and the DD-3 (psychological evaluation) are utilized in the determination of the need for ICF-MR level of care.

Specific testing instruments or assessments utilized by the psychologist are based upon the member's need. Procedure codes utilized by the psychologist are based upon the type of assessment or testing conducted by the psychologist and based upon the unique clinical needs of the member. The procedure code utilized by the psychologist is not dependent upon whether the evaluation is an annual or a triennial evaluation, but must be determined based upon the activity performed during the evaluation. Members may not have a need to utilize all service codes under Psychological Evaluations. The



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following codes may be utilized during the annual or the triennial psychological evaluations, provided the activity matches the code (Refer to 90801, 96101, 96111, 96110 for specific definitions and restrictions):

- 90801 Psychiatric Diagnostic Interview (intake)
- 96101 Psycho-diagnostic testing, with report
- 96110 Developmental Testing, limited
- 96111, developmental testing, extended

GENERAL DEFINITION OF NEURO-COGNITIVE TESTING:

Cognitive functioning
Cognitive processes
Visual motor responses
Abstract abilities
Adaptive and Maladaptive behavioral functioning

Results in an Outcome:

Administration of test- generates material that is formulated into a report that includes data, analysis of the data or results of the testing, and recommendations.

- A comprehensive psychological evaluation must be completed every 3 years for all members utilizing the DD-3 format.
- The comprehensive evaluation may be updated by a psychologist, the following 2 years by interviewing the individual, checking the individual's current status, completing adaptive behavior scales and updating all recommendations for children below 18 years of age. An annual psychological evaluation is not required for adults 18 years of age and older. The DD-3 format must be utilized.

Psychological Evaluation, Triennial Services must include:

- Intellectual testing
- Measures of adaptive behavior
- Interview with the individual
- Other age appropriate and/or disability-specific evaluation methods.

This service also includes a review of current status, recommendations for instructional services to increase skills and other therapeutic interventions, diagnostic impression(s), statement supported by evaluation results indicating if the individual requires an ICF/MR level of care based on his/her need for habilitative services and recommendation supported by evaluation results that home and community-based services are appropriate.

A comprehensive psychological evaluation must be completed every 3 years for all members. The comprehensive evaluation may be updated by a psychologist, the following 2 years by



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interviewing the individual, checking the individual's current status, completing adaptive behavior scales and updating all recommendations for children below 18 years of age. An annual psychological update is not required for adults 18 years of age and older.

Psychological Evaluations, Triennial services must be provided by a psychologist with at least a Master's degree in psychology from an accredited program and licensed to practice in WV or eligible to be licensed to practice in WV and under the supervision of a WV licensed psychologist.

The Psychological Evaluation, Annual Update service must include:

- Specific scores of a standardized adaptive behavior measure
- Observation of the person
- Prognosis statement regarding how the person will function with continued ICF/MR level of care
- DSM-IV format with an ICD-9 diagnosis
- Recommendations for adaptive training and behavioral supports.

This service must include training recommendations and a clear recommendation as to an appropriate placement. If the recommendation is for an alternative level of care, specific information to support the new placement must be included.

The Adaptive Behavior Scales previously mentioned must be completed on the Adaptive Behavior Scales for adults (ABS-RC: 2) and Adaptive Behavior Scales for children ages 3 to 18 years (ABS-S: 2). Children age three and below may utilize the Vineland Adaptive Behavior Scale or other age-appropriate standardized measurements of adaptive functioning.

Psychological Evaluation, Annual Update services must be provided by a psychologist with at least a Master's degree in psychology from an accredited program and licensed to practice in WV or eligible to be licensed to practice in WV and under the supervision of a WV licensed psychologist.

Introduction: Section 513.7.16.2.1, Psychiatric (Psychological) Diagnostic Interview Examination

Old Policy: [refer to Section 513.7.16.2 Psychiatric (Psychological) Diagnostic Interview Examination]

PROCEDURE CODE: 90801-HI

SERVICE UNITS: Session/Event

SERVICE LIMITS: Completed on individual new to the provider of the service

PAYMENT LIMITS: No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform or submit a claim.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective



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November 1, 2006, the service must be based upon the assessed need of the member, identified by the IDT and included on the individualized Waiver budget. The ASO will register the service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Psychiatric diagnostic interview examination by a licensed psychologist includes a history, mental status, and a disposition, and may include communication with family or other sources. This code is to be utilized with a member new to the provider of the service. The psychological evaluation must include the evaluator’s recommendation regarding ICF-MR level of care.

New Policy:

- PROCEDURE CODE:** 90801-HI
Psychiatric Diagnostic Interview Examination.
- SERVICE UNITS:** Session/Event
- SERVICE LIMITS:** Completed on individual new to the provider of the service with registration.
- PAYMENT LIMITS:** No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform the testing.
- PRIOR AUTHORIZATION:** Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective November 1, 2006, the service must be based upon the assessed need of the member, identified by the IDT and included on the individualized Waiver budget. The ASO will register the service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed one event.

DEFINITION

Psychiatric diagnostic interview examination is an all-inclusive evaluation of a member’s functional level(s), mental status, history and a disposition performed by a psychiatrist or psychologist. It may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.

NOTE: THIS CODE MAY ONLY BE USED WHEN THE MEMBER IS NEW TO THE PROVIDER.

SITE OF SERVICE

Psychologist’s office, individual’s home or other applicable community locations

DOCUMENTATION

Documentation must contain the completed evaluation (DD-3) signed by the psychiatrist or psychologist. The documentation must include place of evaluation and date of service. The license number of the psychiatrist or psychologist must also be present.

TRIENNIAL OR ANNUAL EVALUATIONS



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This code may be utilized either for the triennial or annual evaluation and is dependent upon the member's needs. This service may not be provided unless the member is new to the provider agency.

Introduction: Section 513.7.16.2.2, Psychological Testing with Interpretation and Report
Old Policy: (refer to Section 513.7.16.3, Psychological Testing with Interpretation and Report)

PROCEDURE CODE: 96101-HI

SERVICE UNITS: 1 hour (maximum of 4 hours)

SERVICE LIMITS: One evaluation every three years for all members (adult and child).
(Cannot be utilized within three year period with 96111)

PAYMENT LIMITS: No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform or submit a claim.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

New Policy:

PROCEDURE CODE: 96101-HI

SERVICE UNITS: 1 hour (maximum of 4 hours)

SERVICE LIMITS: One evaluation every three years for all members (adult and child).
(Cannot be utilized within three year period with 96111)

PAYMENT LIMITS: No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform this service.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed one evaluation every three years.

DEFINITION

96101 psychological testing is a service that is provided per hour of the psychologist's or physician's time face-to face time with patient, includes the time interpreting test results and preparing the report. Psychological testing includes:

Psycho-diagnostic Assessment of the following, with interpretation and report:



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- Emotionality
- Intellectual Abilities
- Personality
- Psychopathology

Examples include the MMPI, Rorschach, and the WAIS. The psychologist includes the results of the ABS assessment in his evaluation. Psychologist administers the WAIS, Wechsler Scales for the purpose of assessment of an ICF-MR level of care, adaptive training recommendations, and interpretation of testing results and report.

SITE OF SERVICE

Psychologist's office, individual's home or other applicable community locations

DOCUMENTATION

Documentation must contain the completed evaluation, signed by the qualified licensed psychologist. The psychologist license number, place of the evaluation, date of service and time spent must also be included in the documentation.

TRIENNIAL OR ANNUAL EVALUATIONS

This code may be utilized either for the triennial or annual evaluation and is dependent upon the member's needs and the testing conducted by the psychologist.

RESTRICTION

This service may not be utilized within a three year period with 96101.

If a Service Coordinator administers the ABS prior to the psychological evaluation and the Service Coordinator provides the results of the evaluation to the psychologist, the Psychologist may not bill for administering the ABS. The psychologist may include historical evaluations or assessments in the report but may not bill for an assessment he/she did not conduct. When a trained/qualified Service Coordinator administers the ABS, the Service Coordinator may bill service coordination because the ABS is an assessment. If the psychologist billed for the ABS, this would result in duplication of service/payment for the ABS activity.

The psychologist may bill 96101 for the assessments that he/she administered during the evaluation. The psychologist may bill for the interpretation of the "raw data" from the ABS and include it in his/her report.

Psychologist includes the results of the ABS assessment in his evaluation. Psychologist administers the WAIS, Wechsler Scales for assessment of an ICF-MR level of care, adaptive training recommendations, interpretation of testing results and report.



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Introduction: Section 513.7.16.2.3, Psychological Testing—Developmental Testing Extended with Interpretation and Report

Old Policy: (refer to Section 513.7.16.4 Psychological Testing—Developmental Testing Extended with Interpretation and Report (Triennial Psychological Evaluation))

PROCEDURE CODE: 96111-HI

SERVICE UNITS: event

SERVICE LIMITS: One evaluation every three years for all members (adult and child).
(Cannot be utilized within three year period with 96101)

PAYMENT LIMITS: No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform or submit a claim a triennial psychological evaluation.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Psychological Evaluation, Triennial Services must include:

- Intellectual testing
- Measures of adaptive behavior
- Interview with the individual
- Other age appropriate and/or disability-specific evaluation methods.

This service also includes a review of current status, recommendations for instructional services to increase skills and other therapeutic interventions, diagnostic impression(s), statement supported by evaluation results indicating if the individual requires an ICF/MR level of care based on his/her need for habilitative services and recommendation supported by evaluation results that home and community based services are appropriate.

A comprehensive psychological evaluation must be completed every 3 years for all members. The comprehensive evaluation may be updated by a psychologist, the following 2 years by interviewing the individual, checking the individual's current status, completing adaptive behavior scales and updating all recommendations for children below 18 years of age. An annual psychological update is not required for adults 18 years of age and older.

Psychological Evaluations, Triennial services must be provided by a psychologist with at least a Master's degree in psychology from an accredited program and licensed to practice in WV or eligible to be licensed to practice in WV and under the supervision of a WV licensed psychologist.

SITE OF SERVICE

Psychologist's office, individual's home or other applicable community locations



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DOCUMENTATION

Completion of the Psychological Evaluation (DD-3).

DEFINITION

The Psychological Evaluation, Annual Update service must include:

- Specific scores of a standardized adaptive behavior measure
- Observation of the person
- Prognosis statement regarding how the person will function with continued ICF/MR level of care
- DSM-IV format with an ICD-9 diagnosis
- Recommendations for adaptive training and behavioral supports.

This service must include training recommendations and a clear recommendation as to an appropriate placement. If the recommendation is for an alternative level of care, specific information to support the new placement must be included.

The Adaptive Behavior Scales previously mentioned must be completed on the Adaptive Behavior Scales for adults (ABS-RC:2) and Adaptive Behavior Scales for children ages 3 to 18 years (ABS-S:2). Children age three and below may utilize the Vineland Adaptive Behavior Scale or other age appropriate standardized measurements of adaptive functioning.

Psychological Evaluation, Annual Update services must be provided by a psychologist with at least a Master’s degree in psychology from an accredited program and licensed to practice in WV or eligible to be licensed to practice in WV and under the supervision of a WV licensed psychologist.

SITE OF SERVICE

Psychologist’s office, individual’s home or other applicable community locations

DOCUMENTATION

Written report signed and dated exclusively by the psychologist. License number must also be present.

New Policy:

PROCEDURE CODE: 96111-HI

SERVICE UNITS: Event

SERVICE LIMITS: One evaluation every three years for all members (adult and child). (Cannot be utilized within three year period with 96101)

PAYMENT LIMITS: No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform a psychological evaluation.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with



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the claims agent will not be reimbursed. Prior approval needed to exceed one evaluation every three years.

DEFINITION

Extended developmental testing includes the administration of standardized developmental instruments utilized for the assessment of behavioral functioning, with interpretation, and report in the following areas:

- Motor skills
- Language skills
- Social skills
- Adaptive skills
- Cognitive functioning

Examples of standardized developmental instruments include the ABS, Vineland, SIB, and others. This does not include standardized measures intellectual functioning such as the WAIS and others. This service is intended for adaptive and maladaptive behavioral assessment only. If this code is billed, the **psychologist must administer the assessment**. If the Service Coordinator administers the ABS, the psychologist may not bill this code.

SITE OF SERVICE

Psychologist's office, individual's home or other applicable community locations

DOCUMENTATION

Documentation must contain the completed interpretation and report, signed by the licensed psychologist. The psychologist license number, place of the evaluation, date of service and time spent must also be included in the documentation.

TRIENNIAL OR ANNUAL EVALUATIONS

This code may be utilized either for the triennial or annual evaluation and is dependent upon the member's needs and the testing conducted by the psychologist.

Introduction: Section 513.7.16.2.4, Psychological Testing Developmental Testing—Limited with Interpretation and Report

Old Policy: [refer to Section 513.7.16.5, Psychological Testing Developmental Testing—Limited with Interpretation and Report (Annual Psychological Evaluation)]

PROCEDURE CODE: 96110-HI

SERVICE UNITS: event

SERVICE LIMITS: One evaluation annually for children under age 18. Adults are not required to have an annual psychological update unless the condition warrants an evaluation for treatment purposes. Annual psychological evaluations are not required for level of care determination for adults over 18 years of age. Children under the age of 18 are required to submit an annual psychological update for level of care determination.



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PAYMENT LIMITS: No provider with credentials other than those specified for a psychologist or a psychologist under supervision may perform or submit a claim for this service.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006, the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Developmental Testing by a psychologist including limited developmental testing with Interpretation and report. Developmental testing includes, but is not limited to; Developmental Screening Test 11, early Language Milestone Screen and other developmental screening instruments. Documentation requires scoring and interpretation of testing and a written report including findings and recommendations.

Psychological Evaluation, Annual Update service must include:

- Specific scores of a standardized adaptive behavioral measure;
- Observation of the person;
- Prognosis statement regarding how the person will function with continued ICF/MR level of care;
- DSM-IV TR format with diagnostic codes and descriptors on all five axes;
- Recommendations for adaptive training and behavior supports for instructional services to increase skills and other therapeutic interventions;
- Recommendations supported by evaluation results indicating if the individual requires an ICF/MR level of care based on his/her need for habilitative services;
- Recommendation supported by evaluation results, that home and community-based services are appropriate.

A comprehensive psychological evaluation must be completed every 3 years for all members. The comprehensive evaluation may be updated by a psychologist, the following 2 years by interviewing the individual, checking the individual's current status, completing adaptive behavior scales and updating all recommendations for children below 18 years of age. An annual psychological evaluation is not required for adults 18 years of age and older.

Psychological Evaluations must be provided by a psychologist with at least a Master's Degree in psychology from an accredited program and licensed to practice in WV or eligible to be licensed to practice in WV and under the supervision of a WV licensed psychologist.

SITE OF SERVICE

Psychologist's office, individual's home, or other applicable community locations

DOCUMENTATION

Completion of the Psychological Evaluation (DD-3)

New Policy:



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PROCEDURE CODE: 96110-HI

SERVICE UNITS: Event

SERVICE LIMITS: One evaluation annually for children under age 18. Adults are not required to have an annual psychological update unless the condition warrants an evaluation for treatment purposes. Annual psychological evaluations are not required for level of care determination for adults over 18 years of age. Children under the age of 18 are required to submit an annual psychological update for level of care determination

PAYMENT LIMITS: No provider with credentials other than those specified for a psychologist or a psychologist under supervision may perform this service.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006, the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed service limits.

DEFINITION

Developmental testing; limited with interpretation and report is intended for diagnostic screening only. Once a member has a confirmed diagnosis, it is no longer necessary to screen. The psychologist may determine that it is clinically necessary to administer extended developmental testing rather than administer limited testing. The provider may not bill 96110 prior to 96111 nor may the provider bill both codes concurrently. Limited developmental testing is not a screening tool for extended developmental testing. Members may never need this assessment.

Examples: Screening Test II, Early Language Milestone Screening, GARS, with interpretation and report. .If this code is billed, the **psychologist must administer the assessment.**

SITE OF SERVICE

Psychologist's office, individual's home, or other applicable community locations

DOCUMENTATION

Documentation must contain the completed interpretation and report, signed by the licensed psychologist. The psychologist license number, place of the evaluation, date of service and time spent must also be included in the documentation.

TRIENNIAL OR ANNUAL EVALUATIONS

This code may be utilized either for the triennial or annual evaluation and is dependent upon the member's needs and the testing conducted by the psychologist.

Introduction: Section 513.7.17, Social History, Site of Service



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Old Policy: Social worker's office, individual's home or other applicable community location.

New Policy: This service may be performed in the Social worker's office, individual's home or other applicable community location.

Introduction: Section 513.9, Dual Processes for Transition to Individual Waiver Budget, add bullet

Old Policy: N/A

New Policy: The ASO will monitor health and safety as it relates to requests for service authorizations (Example: Member lives in an ISS setting and cannot administer his/her own medication. The budget does not request nursing nor does the Service Coordinator identify if the home is provided with AMAP certified staff to assist the member with his/her medications).

Section 513.10

Introduction: Section 513.10.1, Services Requiring Prior Authorization, third and fourth bullet

Old Policy: Waiver Nursing services that can be performed by a LPN (T1003 HI U4/U3/U2) **in excess of two (2) hours per day**

- Community Residential Habilitation in excess of four (4) hours per day with a maximum of six (6) hours per day

New Policy: Waiver Nursing services that can be performed by a LPN (T1003 HI U4/U3/U2) **in excess of 248 units per month**

- Community Residential Habilitation in excess of 496 units per month with a maximum of 744 units per month

Introduction: Section 513.10.1, Services Requiring Prior Authorization, sixth bullet

Old Policy: Respite in a general medical hospital

New Policy: Respite in a general medical hospital (may not be provided in a psychiatric hospital or an acute care hospital with a distinct part psychiatric unit)

Section 513.11.2

Introduction: Section 513.11.2, Mountain Health Choices, add new section

Old Policy: N/A

New Policy: Members on the MR/DD Waiver program cannot be a member of the Mountain Health Choices program at this time.



**CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR
MR/DD WAIVER SERVICES
CHANGE LOG**

**November 01, 2006
Section 513.7.1**

Introduction: Index to Covered Services

Old Policy: Procedure Codes referenced were:

| | |
|-------------|--------------------------------------|
| T1005-UA-U4 | Respite Care Level I, 1:1 ratio |
| T1005-UA-U3 | Respite Care Level I, 1:2 ratio |
| T1005-UA-U2 | Respite Care Level I, 1:3 ratio |
| T1005-UB-U4 | Respite Care Level II, 1:1 ratio |
| T1005-UB-U3 | Respite Care Level II, 1:2 ratios |
| T1005-UB-U2 | Respite Care Level II, 1:3 ratios |
| S5135-UA-U4 | Adult Companion Level I, 1:1 ratio |
| S5135-UA-U3 | Adult Companion Level I, 1:2 ratios |
| S5135-UA-U2 | Adult Companion Level I, 1:3 ratios |
| S5135-UB-U4 | Adult Companion Level II, 1:1 ratio |
| S5135-UB-U3 | Adult Companion Level II, 1:2 ratios |
| S5135-UB-U2 | Adult Companion Level II, 1:3 ratios |

New Policy: Procedures Codes are:

| | |
|----------|---|
| T1005 | Respite Care Level I, 1:1 ratio effective 12 -01-2006 |
| T1005-UN | Respite Care Level I, 1:2 ratios effective 11-01-2006 |
| T1005-UP | Respite Care Level I, 1:3 ratios effective 11-01-2006 |
| T1005-U4 | Respite Care Level II, 1:1 ratio effective 12-01-2006 |
| T1005-U3 | Respite Care Level II, 1:2 ratios effective 11-01-2006 |
| T1005-U2 | Respite Care Level II, 1:3 ratios effective 11-01-2006 |
| S5135 | Adult Companion Level I, 1:1 ratio effective 12-01-2006 |
| S5135-UN | Adult Companion Level I, 1:2 ratios effective 11-01-2006 |
| S5135-UP | Adult Companion Level I, 1:3 ratios effective 11-01-2006 |
| S5135-U4 | Adult Companion Level II, 1:1 ratio effective 12-01-2006 |
| S5135-U3 | Adult Companion Level II, 1:2 ratios effective 11-01-2006 |
| S5135-U2 | Adult Companion Level II, 1:3 ratios effective 11-01-2006 |

Change: New Procedure Codes Added.

Directions: Replace Section 513.7.1



**CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR
MR/DD WAIVER SERVICES
CHANGE LOG**

Section 513.7.5

Introduction: Respite Services

Old Policy: Procedure Codes referenced were:
 T1005-UA-U4 Respite Care Level I, 1:1 ratio
 T1005-UA-U3 Respite Care Level I, 1:2 ratios
 T1005-UA-U2 Respite Care Level I, 1:3 ratios
 T1005-UB-U4 Respite Care Level II, 1:1 ratio
 T1005-UB-U3 Respite Care Level II, 1:2 ratios
 T1005-UB-U2 Respite Care Level II, 1:3 ratios

New Policy: Procedure codes are:
 T1005 Respite Care Level I, 1:1 ratio effective 12-01-2006
 T1005-UN Respite Care Level I, 1:2 ratios effective 11-01-2006
 T1005-UP Respite Care Level I, 1:3 ratios effective 11-01-2006
 T1005-U4 Respite Care Level II, 1:1 ratio effective 12-01-2006
 T1005-U3 Respite Care Level II, 1:2 ratios effective 11-01-2006
 T1005-U2 Respite Care Level II, 1:3 ratios effective 11-01-2006

Change: Procedure Codes Changed.

Directions: Replace Section 513.7.5

Section 513.7.6.2

Introduction: Agency Residential Habilitation Services – Service Limits

Old Policy: Procedure Codes referenced were:
 S5135-UA-U4 Adult Companion Level I, 1:1 ratio
 S5135-UA-U3 Adult Companion Level I, 1:2 ratios
 S5135-UA-U2 Adult Companion Level I, 1:3 ratios
 S5135-UB-U4 Adult Companion Level II, 1:1 ratio
 S5135-UB-U3 Adult Companion Level II, 1:2 ratios
 S5135-UB-U2 Adult Companion Level II, 1:3 ratios

New Policy: Procedure Codes are:
 S5135 Adult Companion Level I, 1:1 ratio effective 12-01-2006
 S5135 UN Adult Companion Level I, 1:2 ratio effective 11-01-2006
 S5135 UP Adult Companion Level I, 1:3 ratios effective 11-01-2006
 S5135- U4 Adult Companion Level II, 1:1 ratio effective 12-01-2006



**CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR
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CHANGE LOG

S5135- U3 Adult Companion Level II, 1:2 ratios effective 11-01-2006
S5135- U2 Adult Companion Level II, 1:3 ratios effective 11-01-2006

Change: Procedure Codes Changed

Directions: Replace Section 513.7.6.2

Section 513.7.7

Introduction: Adult Companion Services

Old Policy: Procedure Codes referenced were:

S5135-UA-U4 Adult Companion Level I, 1:1 ratio
S5135-UA-U3 Adult Companion Level I, 1:2 ratios
S5135-UA-U2 Adult Companion Level I, 1:3 ratios
S5135-UB-U4 Adult Companion Level II, 1:1 ratio
S5135-UB-U3 Adult Companion Level II, 1:2 ratios
S5135-UB-U2 Adult Companion Level II, 1:3 ratios

New Policy: Procedure Codes are:

S5135 Adult Companion Level I, 1:1 ratio effective 12-01-2006
S5135 UN Adult Companion Level I, 1:2 ratio effective 11-01-2006
S5135 UP Adult Companion Level I, 1:3 ratio effective 11-01-2006
S5135- U4 Adult Companion Level II, 1:1 ratio effective 12-01-2006
S5135- U3 Adult Companion Level II, 1:2 ratio effective 11-01-2006
S5135- U2 Adult Companion Level II, 1:3 ratio effective 11-01-2006

Change: Procedure Codes Changed – Clarification of Site of Service

Directions: Replace Section 513.7.7

September 25, 2006

Chapter 513, ALL Sections

Introduction: Chapter 513, Covered Services, Limitations, and Exclusions for MR/DD Waiver Services



CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES CHANGE LOG

Old Policy: Introduction of the Administrative Organization's role in establishing the Individualized Waiver Budget will become effective 07-01-2006.* The Remainder of the Manual will become effective 10-01-2006.

New Policy: Introduction of the Administrative Organization's role in establishing the Individualized Waiver Budget became effective 07-01-2006.* The Remainder of the Manual will become effective 11-01-2006.

Change: The Introduction of the Administrative Organization's role in establishing the Individualized Waiver Budget began 07-01-2006. The Remainder of the Manual will become effective 11-01-2006 instead of 10-01-2006.

Directions: Replace Chapter 513, Sections 513.1, 513.2, 513.2.1, 513.2.2, 513.2.3, 513.2.4, 513.2.5, 513.3, 513.3.1, 513.3.2, 513.3.3, 513.3.4, 513.4, 513.5, 513.6, 513.7, 513.7.1, 513.7.2, 513.7.2.1, 513.7.3, 513.7.4, 513.7.5, 513.7.6, 513.7.6.1, 513.7.6.2, 513.7.7, 513.7.8, 513.7.9, 513.7.10, 513.7.11, 513.7.11.1, 513.7.11.2, 513.7.11.3, 513.7.12, 513.7.13, 513.7.13.1, 513.7.13.2, 513.7.14, 513.7.15, 513.7.16, 513.7.16.1, 513.7.16.2, 513.7.16.3, 513.7.16.4, 513.7.16.5, 513.7.17, 513.8, 513.9, 513.10, 513.10.1, 513.10.2, 513.11, 513.11.1, 513.12, 513.12.1, 513.13, 513.14.

Section 513.3.1

Introduction: Section 513.3: Member Eligibility; Section 513.3.1: Application and Medical Eligibility; Section 513.3.2: Financial; Section 513.3.3: Enrollment in MR/DD Program; Section 513.3.4: Re-determination of Medical Eligibility

Old Policy: Section 513.3.1 Major Life areas stated with definitions.

New Policy: Removed definitions for Major life areas.

Change: Major Life areas stated: self-care, receptive or expressive language (communication), learning (functional academics), mobility, and self-direction, capacity for independent living (home living, social skills, employment, health and safety, community use, leisure). Added Code of Federal Regulation Reference.

Directions: Replace Section 513.3.1



CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES CHANGE LOG

Section 513.7.1

Introduction: Index of Covered Services

Old Policy: Typographical error GM utilized instead of GN for Speech Therapist modifier.

New Policy: GM changed to GN.

Change: Typographical error corrected.

Directions: Replace Section 513.7.1

Section 513.7.5

Introduction: Respite Care

Old Policy: Did not have specific educational requirements for Contracted Respite Providers.

New Policy: Contracted Respite Providers do not have educational requirements specified.

Change: Removed language regarding educational requirements for Contracted Respite Providers.

Directions: Replace Section 513.7.5

Section 513.7.12

Introduction: Extended Professional Services – Speech Therapist

Old Policy: Speech Therapy unit was 15 minutes. Combination of Registered Dietician, Physical Therapist, Occupational Therapist and Speech Therapist was 40 units per month.

New Policy: Speech Therapy is an event code with up to four events per month. Combination for Physical Therapist, Occupational Therapist and Registered Dietician is 30 units per month. Behavioral Consultation by Licensed Psychologist is 4 units per year.



CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES CHANGE LOG

Change: Speech Therapy is an event code with up to four events per month. Combination limits for Physical Therapist, Occupational Therapist and Registered Dietician is 30 units per month.

Directions: Replace Section 513.7.12.

Sections 513.7.13; 513.7.13.1; 513.7.13.2

Introduction: Skilled Nursing Services, Skilled Nursing Services – Nursing Services by R.N., Skilled Nursing Services – Nursing Services by LPN

Old Policy: Language was not precise as to LPN needs authorization after two hour per day, and Skilled Nursing by a RN does not require PA.

New Policy: (Section 513.7.13.1 Reworded for better clarity. (Skilled Nursing Services that can only be completed by a R.N. does not require prior authorization). (Section 513.7.13.2 Reworded for better clarity – Skilled Nursing Services that can be completed by LPN does require prior authorization after 8 units per day).

Change: Sections 513.7.13.1 and 513.7.13.2 reworded for better clarity.

Directions: Replace Sections 513.7.13, 513.7.13.1, 513.7.13.2

Section 513.12.1

Introduction: Payment and Limitations Payment

Old Policy: Stated: MR/DD Waiver Program providers must comply with the payment and billing procedures and requirements described in Chapter 600, Reimbursement of the Provider Manual.

New Policy: Refers to Chapter 600 to specifically RBRVS, CPT codes and the need to include a location code for CPT codes.

Change: Refers to specific aspects of Chapter 600.

Directions: Replace Section 513.12.1



CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES CHANGE LOG

Section 513

Introduction: Introduction

Old Policy: Introduction of the Administrative Organization in Establishing the Individualized Waiver Budget will become effective 07-01-2006.* The remainder of the Manual will become effective 10-01-2006.

New Policy: Introduction of the Administrative Organization in Establishing the Individualized Waiver Budget will become effective 07-01-2006.* The remainder of the Manual will become effective 10-01-2006.

Change: The Introduction of the Administrative Organization in Establishing the Individualized Waiver Budget began 07-01-2006. The remainder of the Manual will become effective 10-01-2006.

Directions: Replace Chapter 513 – Introduction of the Administrative Organization in Establishing the Individualized Waiver Budget will become effective 07-01-2006*. The remainder of the Manual will become effective 10-01-2006.

Section 513.1

Introduction: Definitions

Old Policy: Listed Definitions utilized in the MR/DD Waiver Program.

New Policy: Added Circle of Support, Administrative Service Organization, Developmental Disability; Mental Retardation, Critical Juncture, Legally Responsible Adult, Therapeutic Consultant, Changed Interdisciplinary Team, Individual Program Plan, Specialized Family Care Provider, MR/DD Waiver Program; Deleted Individual Service Plan, Individual Habilitation Plan.

Change: Added, Changed, and Deleted Definitions.

Directions: Replace Section 513.1

Section 513.2

Introduction: Provider Participation



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Old Policy: Addressed BHHF as the agency who administers the MR/DD Waiver Program, and Community Behavioral Health Provider Agencies as the providers of MR/DD Waiver Services.

New Policy: Includes the role of APS Healthcare, Inc. * APS Healthcare will begin their role July 1, 2006.

Change: Added language to include role of APS Healthcare, Inc. The ASO will begin their role in the Waiver program 07-01-2006.

Directions: Replace Section 513.2

Section 513.2.1

Introduction: General

Old Policy: Addressed General Requirements for Provider Participation in the MR/DD Waiver Program.

New Policy: Specificity for the CON, State Licensure Requirements, and BMS enrollment process.

Change: Added CON, State Licensure Requirements and added more specificity to BMS enrollment requirements.

Directions: Replace Section 513.2.1

Section 513.2.2

Introduction: Specific Requirements

Old Policy: Addressed Specific Requirements for Provider Participation in the MR/DD Waiver program.

New Policy: Addresses specific responsibilities of Agency Administration and the Agency Contact Person.

Change: Specificity added for Agency Administration and the Agency Contact Person.

Directions: Replace Section 513.2.2



CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES CHANGE LOG

Section 513.2.3

Introduction: Reporting Requirements

Old Policy: Addressed Reporting Requirements for Providers of MR/DD Waiver Services.

New Policy: Addresses specific time frames for Report Summaries to be submitted to BHHF, addresses case load size for the Service Coordinator, and addresses change of status.

Change: Added specific time frames, addressed case load size and added specificity to reporting changes in status. Added 48 hour time limit for notification by provider to BHHF of transfer of member to service coordination agency.

Directions: Replace Section 513.2.3

Section 513.2.4

Introduction: Documentation and Record Retention Requirements

Old Policy: Addressed Documentation and Record Retention Requirements. (Section 513.8)

New Policy: References the DD 26 – Record Retention Guidelines. (Section 513.2.4)

Change: Added language to reference the DD 26 – Record Retention Guidelines; previously Section 513.8.

Directions: Replace Section 513.8 in previous manual with Section 513.2.4

Section 513.2.5

Introduction: Service Limitations

Old Policy: Addressed Service Limitations. (Section 513.11)

New Policy: Includes Individual Waiver budget. (Section 513.2.5)

Change: Added language to include the Individual Waiver budget; Previous Manual



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Section 513.11.

Directions: Replace Section 513.11 in previous manual with Section 513.2.5

Section 513.2.5

Introduction: Service Exclusions

Old Policy: Addressed Service Exclusions. (Section 513.11)

New Policy: MR/DD Waiver services may not be provided concurrently unless otherwise indicated in the service definition. (Section 513.2.5)

Change: Added language – MR/DD Waiver services may not be provided concurrently unless otherwise indicated in the service definition; relocated to Section 513.11.1

Directions: Replace Section 513.11.1 in previous manual with Section 513.2.5

Section 513.3

Introduction: Member Eligibility

Old Policy: Addressed Member Eligibility.

New Policy: Member Eligibility and Enrollment Process are addressed as two distinct categories.

Change: Broke Member Eligibility into two distinct categories. Re-worded for better clarity.

Directions: Replace Section 513.3

Section 513.3.1

Introduction: Application

Old Policy: Addressed Application Process.

New Policy: More specificity about time frames; change in requirements for eligibility Documents needed. Definitions added to major life areas. Deleted the DD-5 requirement for new applicants.



CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES CHANGE LOG

Change: Specificity about time frames; each major life area defined; re-worded for better clarity. Deleted the DD-5 requirement for new application packets.

Directions: Replace Section 513.3.1

Section 513.3.2

Introduction: Financial

Old Policy: Addressed Financial Eligibility process for the MR/DD waiver program.

New Policy: Re-worded for better clarity.

Change: Re-worded for better clarity.

Directions: Replace Section 513.3.2

Section 513.3.3

Introduction: Enrollment in MR/DD Program

Old Policy: Heading – Service Allocation (Slot) Approval.

New Policy: Heading of Section – Enrollment in MR/DD Waiver Program Services.

Change: Changed Heading of Section to Enrollment in MR/DD Waiver Program Services; re-worded for better clarity.

Directions: Replace Section 513.3.3

Section 513.4

Introduction: Re-determination of Medical Eligibility

Old Policy: Heading – Re-determination. (Section 513.4)

New Policy: Heading of Section – Re-determination of Medical Eligibility; frequency of psychological assessments addressed. (Section 513.3.4)



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Change: Changed Heading of Section to Re-determination of Medical Eligibility; psychological for adults only required every three years; re-worded for better clarity; Section 513.4 in previous manual relocated to Section 513.3.4.

Directions: Replace Section 513.4 in previous manual with Section 513.3.4

Section 513.5

Introduction: Rights of Members

Old Policy: Heading – Rights of Members. (Section 513.5)

New Policy: Heading of Section – Rights of Members and New Applicants. (Section 513.4)

Change: Changed Heading of Section to Rights of Members and New Applicants; re-worded for better clarity; Section 513.5 in previous manual.

Directions: Replace Section 513.5 in previous manual with Section 513.4

Section 513.6

Introduction: Member Discharge

Old Policy: Addressed members being discharged from the MR/DD Waiver program. (Section 513.6)

New Policy: Addresses the need for the member and/or legal representative to sign DD16 – Exit/Transfer form. (Section 513.5)

Change: Requirement that member and/or legal representative needs to sign DD16 – Exit/Transfer form when being exited from the MR/DD Waiver program; relocated to Section 513.5.

Directions: Replace Section 513.6 with Section 513.5

Section 513.7

Introduction: Right to Appeal

Old Policy: Addressed member's right to appeal. (Section 513.7)



CHAPTER 513—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES CHANGE LOG

New Policy: Change in content if decision is upheld by the hearing officer; member and or legal representative needs to give permission to appeal; added negotiation of budget allocation by the ASO. (Section 513.6)

Change: Requirement that member and/or legal representative needs to sign DD16 – Exit/Transfer form when being exited from the MR/DD Waiver program; added negotiation of budget allocation by the ASO.
Relocated to Section 513.6.

Directions: Replace Section 513.7 with Section 513.6

Section 513.8

Introduction: Reporting Alleged Abuse and Neglect

Old Policy: Addressed Reporting of Alleged Abuse and Neglect (Section 513.8)

New Policy: More references added to address requirements for reporting alleged abuse and neglect. (Section 513.2.4)

Change: Added additional references to address requirements for reporting alleged abuse and neglect; re-worded for better clarity; relocated to Section 513.2.4.

Directions: Replace Section 513.8 with Section 513.2.4

Section 513.9

Introduction: Prior Authorization

Old Policy: Addressed Prior Authorization. (Section 513.9)

New Policy: Addresses Prior Authorization. (Section 513.10)

Change: Reworded for better clarity; relocated to Section 513.10.

Directions: Replace Section 513.9 with Section 513.10

Section 513.9.1

Introduction: Services Requiring Prior Authorization



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Old Policy: Addressed Services Requiring Prior Authorization (Section 513.9)

New Policy: Addresses Prior Authorization; Role of APS Healthcare, Identifies actual services needing prior authorization. *APS will begin their role July 1, 2006. (Section 513.10.1)

Change: Added language to include APS Healthcare; identifies actual services needing prior authorization, addresses that staffing in excess of 1:1 cannot be considered unless for crisis services; relocated to Section 513.10.1.

Directions: Replace Section 513.9 with Section 513.10.1

Section 513.9.2

Introduction: Prior Authorization Process

Old Policy: Addressed Prior Authorization Process. (Section 513.9.2)

New Policy: Addresses the ASO's role in the Prior Authorization Process. (Section 513.10.2)

Change: Added language to include the ASO; relocated to Section 513.10.2.

Directions: Replace Section 513.9.2 with Section 513.10.2

Section 513.10

Introduction: Interdisciplinary Team (IDT) Composition

Old Policy: Addressed the Composition of the IDT. (Section 513.10)

New Policy: Professional staff only needs to attend the IDT if there is a medical/clinical need; personal centered philosophy is addressed; team attendance is addressed. Added initial or transfer meeting header. (Section 513.7.2.1)

Change: Professional staff only needs to attend the IDT if there is a medical/clinical need; need for person centered philosophy addresses; restrictions on the amount of times an IDT may be rescheduled included; re-worded for better clarity; replaced "QMRP" with Therapeutic Consultant; reinforced that Medicaid cannot reimburse without a valid IPP; relocated to Section 513.7.2.1.



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Directions: Replace Section 513.10 with Section 513.7.2.1

Section 513.10.1

Introduction: Individual Program Plan (IPP) Components

Old Policy: Addressed the components of the Individual Program Plan. Staff utilized QMRP 1, 2, & 3 codes for their involvement in the IDT process for developing the IPP. (Section 513.10.1)

New Policy: Distinct codes for staff involvement in the IDT process for developing of the IPP; IPP format (DD5) revised to better reflect personal centered philosophy. (Section 513.7.2)

Change: Prior authorization language added to address the introduction of the individualized waiver budget; distinct codes added for staff for their involvement in the IDT process for developing of the IPP; IPP format, DD5 revised to better reflect personal centered philosophy; re-worded for better clarity; relocated to Section 513.7.2.

Directions: Replace Section 513.10.1 with Section 513.7.2

Section 513.10.2

Introduction: Individual Program Plan Implementation

Old Policy: Addressed the Implementation of the Individual Program Plan. (Section 513.10.2)

New Policy: Addresses required special, initial or transfer meetings, critical juncture meetings and discharge meetings in Section 513.7.2.1. Addresses that services cannot be reimbursed when the IPP has expired or is invalid. (Section 513.7.2.1)

Change: Deleted Section 513.10.2; merged into Section 513.7.2.1.

Directions: Delete Section 513.10.2

Section 513.10.3

Introduction: Review of the Individual Program Plan, Program Monitoring and Change



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Old Policy: Addressed situation warranting earlier review of the IPP (Section 513.10.3)

New Policy: Deleted; merged into Section 513.7.2.1 (Section 513.7.2.1)

Change: Deleted Section 513.10.3 and merged into Section 513.7.2.1

Directions: Deleted Section 513.10.3

Section 513.11

Introduction: Services Provided by Relatives or Friends

Old Policy: Description of services provider criteria (Section 513.11)

New Policy: Incorporated into specific service code under provider requirements for specific service code.

Change: Refer to provider requirement for specific service code

Directions: Delete Section 513.11

Section 513.12

Introduction: Billing Procedures

Old Policy: Addressed Billing Procedures in the MR/DD Waiver program.

New Policy: Addresses Billing Procedures in the MR/DD Waiver program.

Change: Re-worded for better clarity.

Directions: Replace Section 513.12

Section 513.12.1

Introduction: Payment and Limitations

Old Policy: Addressed Payment and Limitations in the MR/DD Waiver program.

New Policy: Addresses Payment and Limitations in the MR/DD Waiver program.



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Change: Re-worded for better clarity.

Directions: Replace Section 513.12.1

Section 513.13

Introduction: Description of Covered Services

Old Policy: Addressed Covered Services. (Section 513.13 to Section 513.13.15)

New Policy: Addresses Covered Services. Added Crisis Services (Section 513.7. to Section 513.7.14)

Change: Added an Index of Covered Services; relocated to Section 513.7 and Section 513.7.1. Added Crisis Services Section 513.7.14.

Directions: Replace Section 513.13 with Section 513.7 and Section 513.7.1. Refer to Section 513.7.14

Section 513.13.1

Introduction: Service Coordination

Old Policy: Addressed Service Coordination services. (Section 513.13.1)

New Policy: Introduces Individualized Waiver Budget; addresses specifics about Service Coordination services. (Section 513.7.3)

Change: Prior authorization language added to address the introduction of the individualized waiver budget; re-worded for better clarity, added specificity; added headings for categories of service activity; relocated to Section 513.7.3

Directions: Replace Section 513.13.1 with Section 513.7.3

Section 513.13.2

Introduction: Residential Habilitation



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Old Policy: Addressed Residential Habilitation services, both Community Residential and Agency Residential Habilitation services. (Section 513.13.2)

New Policy: Introduces Individualized Waiver Budget; more specificity added; has to relate to a goal/objective in the IPP; services must be developed exclusively to address the identified habilitation need of the member, activities should not be integrated to occur concurrently with the personal or work activities of a staff and/or family member; and must occur where the rest of the community typically conducts their local shopping, banking, etc.; Community Residential Habilitation has the introduction of the Extraordinary Care Assessment; refer to Section 513.7.6 (Residential Habilitation). Section 513.7.6.1 (Community Residential Habilitation), Section 513.7.6.2 (Agency Residential Habilitation). (Sections 513.7.6, 513.7.6.1, 513.7.6.2)

Change: Prior Authorization added to address the introduction of the individualized waiver budget ; prior authorization language added to address the introduction of the Individualized waiver budget; specificity added; re-worded for better clarity, addition of the Extraordinary Care Assessment; relocated to Sections 513.7.6. 513.7.6.1, 513.7.6.2.

Directions: Replace Section 513.13.2 with Sections 513.7.6. 513.7.6.1, 513.7.6.2.

Section 513.13.3

Introduction: Adult Companion

Old Policy: Addressed Adult Companion Services. (Section 513.13.3)

New Policy: Introduces Individualized Waiver Budget; Added ratios, Adult Companion Services specifically defined. (Section 513.7.7)

Change: Prior Authorization added to address the introduction of the individualized waiver budget; prior authorization language added to address the introduction of the individualized waiver budget; ratios added; specificity added; re-worded for better clarity, relocated to Section 513.7.7.

Directions: Replace Section 513.13.3 with Section 513.7.7

Section 513.13.4

Introduction: Extended Physician Services (Annual Medical Evaluation)



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Old Policy: Addressed Extended Physician Services (Section 513.13.4)

New Policy: Introduces Individualized Waiver Budget; addresses Extended Physician Services. (Section 513.7.16.1)

Change: Prior Authorization added to address the introduction of the individualized waiver budget; re-worded for better clarity; relocated to 513.7.16.1

Directions: Replace Section 513.13.4 with Section 513.7.16.1

Section 513.13.5

Introduction: Psychological Evaluation: Triennial Evaluation

Old Policy: Addressed Triennial Psychological Evaluation. (Section 513.13.5)

New Policy: Introduces Individualized Waiver Budget; addresses Triennial Psychological Evaluation – Utilize CPT code Psychological with interpretation and report 96801 HI(513.7.16.2) and/or 96101 HI (513.7.16.3) or 96111 HI(refer to 513.7.16.4).

Change: Prior Authorization added to address the introduction of the individualized waiver budget; re-worded for better clarity; changed from a QMRP service to a CPT code 96101 HI or 96111 HI; added Psychological with interpretation and report. Refer to Sections 513.7.16.2, 513.7.16.3, 513.7.16.4.

Directions: Replace Section 513.13.5 with Sections 513.7.16.2, 513.7.16.3, 513.7.16.4

Section 513.13.6

Introduction: Psychological Evaluation: Annual Update

Old Policy: Addressed Psychological Evaluation, Annual Update (Section 513.13.6)

New Policy: Introduces Individualized Waiver Budget; addresses Psychological Evaluation, Annual Update; changed from a QMRP service to a CPT code 96110 HI. (Section 513.7.16.5)



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Change: Prior Authorization added to address the introduction of the individualized waiver budget; changed from a QMRP service to a CPT code 96110 HI; re-worded for better clarity; relocated to Section 513.7.16.5.

Directions: Replace Section 513.13.6 with Section 513.7.16.5

Section 513.13.7

Introduction: Initial Social History

Old Policy: Addressed Initial Social History (Section 513.13.7)

New Policy: Introduces Individualized Waiver Budget; addresses Initial Social History and Social History Update. (Section 513.7.17)

Change: Prior Authorization added to address the introduction of the individualized waiver budget; Initial Social History, H0031 HI is completed at the time of enrollment. Social History Update H0031 HI TS is completed if deemed necessary by the IDT; re-worded for better clarity; relocated to Section 513.7.17.

Directions: Replace Section 513.13.7 with Section 513.7.17

Section 513.13.8

Introduction: QMRP Services

Old Policy: QMRP I, QMRP II, and QMRP III service codes (Section 513.13.18)

New Policy: Introduces new Therapeutic Consultative Services replacing QMRP I and QMRP II service codes. Move QMRP III to Extended Professional Services. Add new modifiers to codes. (Sections 513.7.11.1, 513.7.11.2, and 513.7.11.3)

Change: Role clarification of the Therapeutic Consultant (Section 513.7.11); Introduces the Skills Specialist (Section 513.7.11.2); Introduces the Behavior Analyst (Section 513.7.11.3); Introduces the Behavior Specialist-Psychologist (Section 513.7.11.3); Differentiated Residential and Day Therapeutic Consultants.

Directions: Replace Section 513.13.18 with Sections 513.7.11.1, 513.7.11.2, and 513.7.11.3



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Section 513.13.9

Introduction: Day Habilitation Program

Old Policy: Addressed Day Habilitation Services (Section 513.13.9)

New Policy: Individualized Waiver Budget Introduced; more specificity; has to related to a goal/objective in the IPP; services must be developed exclusively to address the identified habilitation need of the member, activities should not be integrated to occur concurrently with the personal or work activities of a staff and/or family member; and must occur where the rest of the community typically conducts their local shopping, banking, etc. (Section 513.7.8)

Change: Prior Authorization added to address the introduction of the individualized waiver budget; added language that is more specific; has to related to a goal/objective in the IPP; services must be developed exclusively to address the identified habilitation need of the member, activities should not be integrated to occur concurrently with the personal or work activities of a staff and/or family member; and must occur where the rest of the community typically conducts their local shopping, banking, etc.; re-worded for better clarity; relocated to Section 513.7.8.

Directions: Replace Section 513.13.9 with Section 513.7.8

Section 513.13.10

Introduction: Prevocational Training

Old Policy: Addressed Prevocational Training (Section 513.13.10)

New Policy: Individualized Waiver Budget Introduced; new providers will need to go through Certificate of Need Summary Process. (Section 513.7.9)

Change: Prior Authorization added to address the introduction of the individualized waiver budget; changes in language in regard to referral to DRS; New Prevocational providers will need to go through CON Summary Process; re-worded for better clarity; relocated to Section 513.7.9.

Directions: Replace Section 513.13.10 with Section 513.7.9



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Section 513.13.11

Introduction: Supported Employment

Old Policy: Addressed Supported Employment. (Section 513.13.11)

New Policy: Individualized Waiver Budget Introduced; new providers will need to go through Certificate of Need Summary Process. (Section 513.7.10).

Change: Prior Authorization added to address the introduction of the individualized waiver budget; changes in language in regard to referral to DRS; New Supported Employment providers will need to go through CON Summary Process; re-worded for better clarity; relocated to Section 513.7.10.

Directions: Replace Section 513.13.11 with Section 513.7.10

Section 513.13.12

Introduction: Transportation

Old Policy: Addressed Transportation; limit to 1300 miles per month for A0160 HI. (Section 513.13.12)

New Policy: Individualized Waiver Budget Introduced; all travel must be directly linked to the IPP goal/objective; travel needs to occur in the member's community; authorization will be needed for travel over 700 miles per month – limit of 1300 miles per month will be maintained. (Section 513.7.4)

Change: Prior Authorization added to address the introduction of the individualized waiver budget; language added that travel needs to occur in member's community, needs to be linked to the IPP; re-worded for better clarity; authorization process added for travel over 700 miles per month; re-worded for better clarity; relocated to Section 513.7.4.

Directions: Replace Section 513.13.12 with Section 513.7.4

Section 513.13.13

Introduction: Respite Care



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Old Policy: Addressed Respite Services. (Section 513.13.13)

New Policy: Individualized Waiver Budget Introduced; Ratio added; scope of service better defined. (Section 513.7.5)

Change: Prior Authorization added to address the introduction of the individualized waiver budget; added ratios 1:1, 1:2, and 1:3; language added to more clearly define this code; re-worded for better clarity; relocated to Section 513.7.5.

Directions: Replace Section 513.13.13 with Section 513.7.5

Section 513.13.14

Introduction: Involved Nursing

Old Policy: Addressed LPN Nursing Services (Section 513.13.14)

New Policy: Individualized Waiver Budget Introduced; combines Involved Nursing (previously 513.13.14) and Intermittent Nursing (previously 513.13.15) (Sections 513.7.13, 513.7.13.2).

Change: Prior Authorization added to address the introduction of the individualized waiver budget; merges Involved Nursing and Intermittent Nursing; re-worded for better clarity; relocated to Sections 513.7.13, 513.7.13.2.

Directions: Replace Section 513.13.14 with Sections 513.7.13, 513.7.13.2

Section 513.13.15

Introduction: Intermittent Nursing

Old Policy: Addressed LPN Nursing Services. (Section 513.13.15)

New Policy: Individualized Waiver Budget Introduced; combines Involved Nursing (previously Section 513.13.14) and Intermittent Nursing (previously Section 513.13.15) (Sections 513.7.13, 513.7.13.2).

Change: Prior Authorization added to address the introduction of the individualized waiver budget; merges Involved Nursing and Intermittent Nursing; re-worded for better clarity; relocated to Sections 513.7.13, 513.7.13.2.



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Directions: Replace Section 513.13.15 with Sections 513.7.13, 513.7.13.2

Section 513.13.16

Introduction: Environmental Accessibility Adaptations

Old Policy: Addressed Environmental Accessibility Adaptations. (Section 513.13.16)

New Policy: Prior Authorization added to address the introduction of the individualized waiver budget; addresses Environmental Accessibility Adaptations. (Section 513.7.15)

Change: Prior Authorization added to address the introduction of the individualized waiver budget; re-worded for better clarity; relocated to Section 513.7.15.

Directions: Replace Section 513.13.16 with Sections 513.7.15

Section 513.14

Introduction: How to Obtain Information

Old Policy: Addressed How to Obtain Information. (Section 513.13.16)

New Policy: Broke into two distinct sections, 513.13 and 513.14. Section 513.14 addresses the documents utilized by the MR/DD Waiver Program.

Change: Broke into two distinct sections; deleted DD-6, DD-8, DD-10, DD-11, and replaced with DD-12. Added release of information to DD-7 and DD-7A, Added Extra-ordinary Care Assessment, and DD-26 (Record Retention and Storage).

Directions: Replace Section 513.14.16 with Sections 513.13 and 513.14

January 31, 2005

Section 513.3.1

Introduction: Changed to include DD2A instead of DD1A, deleted Economical Self-sufficiency.

Directions: Replace the pages containing these sections.

Change: Replace current sections with the updated ones.



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

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible members. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all state and federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed in writing otherwise by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS requirements for payment of services provided to eligible WV Medicaid members under the Waiver Program for persons with Mental Retardation and/or Developmental Disabilities.

The policies and procedures set forth herein are the regulations governing the provision of services under the Waiver Program for Persons with Mental Retardation and Developmental Disabilities (MR/DD Waiver) of the Medicaid Program administered by the Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV.

513.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of the services in the MR/DD Waiver Program described in this chapter.

Active Treatment is a comprehensive training program which necessitates the availability of trained staff to aggressively and systematically address the acquisition of skills to improve, maintain or prevent the regression of basic activities of daily living as they relate to self-care, mobility, communication, learning, self-direction, and the capacity for independent living. Active treatment does not include services to maintain generally independent members who are able to function with little supervision or in the absence of a continuous active treatment program.

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

Administrative Service Organization: (ASO) The Administrative Service Organization is responsible for assessing Waiver members' needs, functionality and supports and determining an individualized budget. The ASO also provides education for members, their families and providers. The ASO interfaces with the claims management system to ensure that purchased services are properly reimbursed.

Circle of Support is defined as a group of people with either a professional or personal vested interest in the member who offer either evaluation, planning, advocacy, or support to the member on an ongoing basis.



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

Developmental Disability is defined as persons with related conditions who have a severe, chronic disability that meets all of the following conditions: It is attributable to Cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. It is manifested before the person reaches age 22; it is likely to continue indefinitely; it results in substantial functional limitations in three or more of the following areas of major life activity: (1) Self-care, (2) Understanding and use of language, (3) Learning, (4) Mobility, (5) Self-direction and (6) Capacity for independent living. (Refer to Code of Federal Regulations 42, 435.1010).

Individual Program Plan (IPP) is an outline of proposed activities that primarily focus on the establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by persons with developmental disabilities. It is designed to ensure accessibility, accountability, and continuity of support and services. This service also ensures that persons with developmental disabilities have opportunities to make meaningful choices with regard to their life, and inclusion in the community. The IPP must include both paid and unpaid, or natural supports in the individual's life. The IPP (DD-5 – version 07-01-2006) is the critical document that combines all information from the evaluations to guide the service delivery process. The development of the IPP is a joint effort between the member and other individuals such as the professionals and natural supports involved in the member's life. The content of the IPP is guided by the member's needs, wishes, desires, and goals as stated or assessed by the member or the member's IPP team. Services identified in the plan are based upon medical necessity.

Intensive Support Setting (ISS) is defined as a residential home setting with one to three (1-3) people living in the home.

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

Legally Responsible Adult is the parent of a minor child or a court appointed legal guardian for an adult or child.

Local Community is the home neighborhood or location where other community members carry out their local daily routine and activities.

Mental Retardation means significantly sub-average intellectual functioning which manifest itself in a person during his developmental period and which is characterized by his inadequacy in adaptive behavior. West Virginia Code §27-1-3.



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Office of Behavioral Health and Health Facilities (BHHF) is the office that oversees services for people who are at risk for substance abuse, mental illness, or developmental disabilities.

Psychologist under Supervision for Licensure is an individual who is an unlicensed psychologist with a documented, completed degree in psychology at the level of a Ph.D., Psy.D. Ed.D., M.A., or M.S. or has met the requirements of, and is formally enrolled in, the WV Board of Examiners of Psychologists Supervision Program.

Therapeutic Consultant is a professional who provides behavioral assessment, behavioral goal or support plan development, member specific training of direct care providers, data analysis or interpretation, and re-assessment of behavioral progress related to therapeutic behavioral interventions. These professionals provide services indirectly to the member to meet the behavioral, therapeutic, and person-specific needs. Therapeutic Consultant services may be provided by agency personnel or through contracted providers of this service. Therapeutic Consultant Services is a required component for the oversight of any training program or direct care services. Additional qualifications may be necessary dependent upon the specific service.

Qualified Mental Retardation Professional is a professional with, at minimum, a bachelor's degree in a human service field and at least one year of experience working directly with persons with mental retardation and/or related conditions; and is a doctor of medicine or osteopathy, a registered nurse or an individual who holds at least a bachelor's degree in a human service field.

Specialized Family Care Provider (SFCP) is an independently certified provider who operates a home which has received certification through the DHHR Family Based Care Program. Both the home and provider are certified by a Family Based Care Specialist.

Waiver Program for Members with Mental Retardation and Developmental Disabilities (MR/DD Waiver Program) is WV's home and community-based services program for individuals who have mental retardation and/or developmental disabilities. It is administered by the Bureau for Medical Services (BMS) in collaboration with BHHF pursuant to a Medicaid waiver option approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for the Title XIX MR/ DD Waiver Program. The MR/DD Waiver Program is a health care coverage program that reimburses for services to instruct, train, support, supervise, and assist individuals who have mental retardation and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible in their lives. The MR/DD Waiver Program provides services in natural settings (local neighborhood shopping entities, banks, libraries, etc), homes and local communities where the member resides instead of Intermediate Care Facility/Mental Retardation (ICF/MRs).

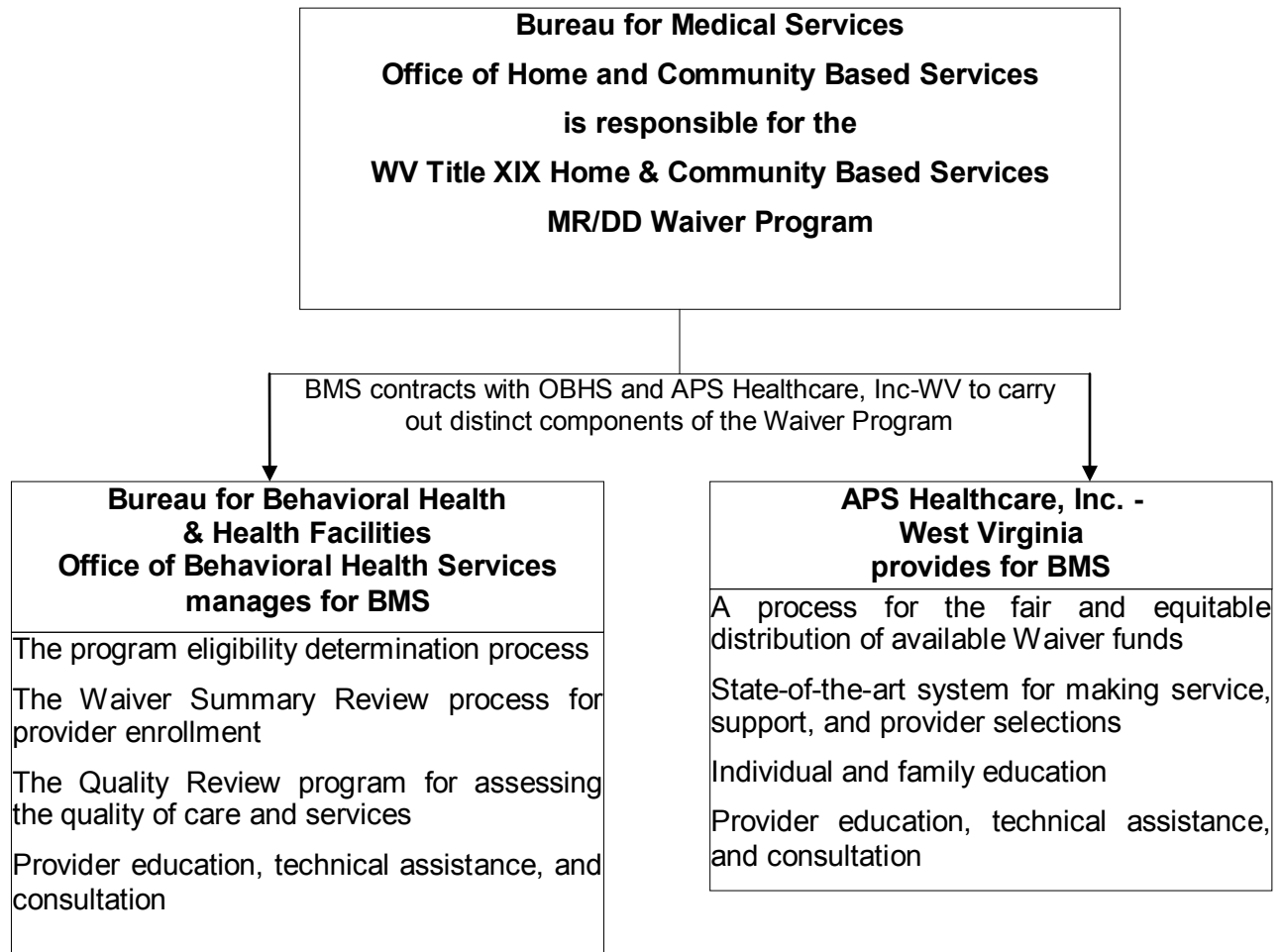
513.2 PROVIDER PARTICIPATION

BMS contracts with an Administrative Services Organization (ASO), APS Healthcare, Inc. – West Virginia, and the Bureau for Behavioral Health and Health Facilities (BHHF). They both act as an agent of BMS. BHHF administers the operation of the MR/DD Waiver Program. The Administrative Service Organization will conduct education for providers, members, advocacy groups, and DHHR. The ASO will provide a framework and a process for the purchase of waiver.



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The ASO will provide authorization for services that are based on the member’s assessed needs and will provide service registration information to the claims payer. BMS contracts with community behavioral health provider agencies for the provision of services for members.



513.2.1 GENERAL

In order to participate in the WV Medicaid Program and receive payment from BMS, MR/DD Waiver Program provider agencies must meet the following requirements:

- Receive Certificate of Need approval from the WV Health Care Authority and/or CON Summary Review Committee
- Meet and maintain all applicable licensing, accreditation, and certification requirements



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- Obtain a behavioral health license through the Office of Health Facilities Licensure and Certification (OHFLAC)
- Meet and maintain all BMS enrollment requirements including a valid provider agreement on file that is signed by the provider and BMS.

513.2.2 SPECIFIC REQUIREMENTS

In addition to the provider participation requirements as set forth in Chapter 300, Provider Participation Requirements, MR/DD Waiver Program provider agencies must:

- Meet and maintain the standards established by the Secretary of the U. S. Department of Health and Human Services (DHHS), and all applicable state and federal laws governing the provision of these services. Providers must receive Health Care Authority approval to provide behavioral health services via the Certificate of Need process (CON). Prevocational services and supported employment entities acknowledged by a Division of Rehabilitation Services vendor, and a MR/DD Waiver provider prior to July 1, 2006 will be granted a grandfather status.
- Ensure that the service was delivered and documentation meets regulatory standards before the claim is submitted for payment.
- Ensure that all required documentation is maintained at the agency on behalf of the State of WV and accessible for state and federal audits.
- Agency Administration is responsible for ensuring:
 - All staff have the mandatory MR/DD Waiver Program training prior to the delivery of services.
 - The agency hires and retains qualified professionals.
 - The agency has evidence of implementing a utilization review and quality improvement process which includes verification that services have been provided and the quality of those services meets the standards of the MR/DD Waiver Program and all other applicable licensing and certification bodies.
 - All agency documentation is current and meets state and federal standards.
- Assign an Agency Contact Person who is responsible for ensuring:
 - Home and Day Program visits are made in accordance with MR/DD Waiver policy (service coordination provider agencies only)
 - Annual level of care evaluations and submission to the state for level of care determination are completed for medical eligibility (service coordination provider agencies only)
- The staff are implementing the IPPs of all members in the MR/DD Waiver Program
- The provider agency must operate a credentialing process that ensures the qualifications of Therapeutic Consultant providers as referenced in Section 513.7.11



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513.2.3 REPORTING REQUIREMENTS

Provider agencies must maintain an incident database, monitor trends, and take action if necessary.

Quarterly Incident Report Summaries must be submitted to BHHF within the following time-frames:

- January 1 through March 31; Report due to the State by April 15
- April 1 through June 30; Report due to the State by July 15
- July 1 through September 30; Report due to the State by October 15
- October 1 through December 31; Report due to the State by January 15.

Service Coordination Agency must submit the Member Exit/Transfer Form (DD-16). The DD-16 must include the last date of service provided.

Mortality Notification (DD-20) is due to the State MR/DD Waiver Office within seven days from the date of death.

The Service Coordination Agency must notify the State MR/DD Waiver Office in writing, if they are exceeding the maximum case load cap. The Service Coordination Agency must address the following in writing within forty eight (48) hours:

- The number of members per each Service Coordinator whose case load exceeds twenty members (e.g., Service Coordinator Name, # of members).
- The agency plan, including time lines for hiring and training new Service Coordinators
- The agency must include a back-up plan to cover emergencies.

The Service Coordination Agency must notify the State MR/DD Waiver Office of any changes in status (change of address, telephone number, service coordination provider, habilitation provider, etc)

- The Service Coordinator is required to notify the state waiver office of the transfer of a member to another service coordination agency **within two (2) working days**.
- The transferring agency is responsible for the notification.
- Lack of notification of the transfer will affect the prior authorization for service or registration of services to the correct service provider(s) and subsequent payment of claims for services.

513.2.4 REPORTING ALLEGED ABUSE AND NEGLECT

Anyone providing services to an MR/DD Waiver member who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 64 Series 11), WV State Code WV State Code § 9-6-1, § 9-6-9, and § 49-6A-2 to report the incident to the local DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect



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may be made anonymously to the county DHHR office. A Child Protective Services (CPS) or an Adult Protective Services (APS) Worker may be assigned to investigate the suspected or alleged abuse.

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

513.2.5 PROVIDER TRAINING

Individuals providing Service Coordination, Residential Habilitation, Day Habilitation, Pre-vocational, Supported Employment, Adult Companion II, Respite II, Nursing, Skills Specialist, and Behavioral Specialist/Analyst services must be trained in the following:

- Overview of Developmental Disabilities
- People First Language
- Normalization
- Sensitivity to Individual/Family Needs/Concerns
- Participant Rights and Confidentiality
- Recognition of and Reporting of Neglect and Abuse
- Positive Behavior Support
- Non-violent Crisis Intervention (not required for community residential habilitation)
- Current MR/DD Waiver Manual and Home and Community Based Waiver Services
- Current Certification in CPR
- Current Certification in First Aid
- Documentation
- Participant Specific Training in Health/safety and Habilitation Objectives Needed to Provide Direct Care Services
- Person-Centered Planning

Individuals providing Adult Companion 1 and Respite 1 must provide evidence that they have training in:

- Current Certification in CPR
- Current Certification in First Aid
- Recognition and Reporting of Neglect and Abuse
- Documentation

Additionally, individuals providing Service Coordination must have training in:

- Community Resources
- Home Visits
- Day Habilitation Visits
- Facilitation of IDT Meetings
- Developing/documenting an IPP



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- Linkage, referral, and advocacy
- Crisis planning

Additionally, Skills Specialist and Behavioral Specialist/Analyst must have training in:

- Development of Task Analysis and/or Methodology
- Overview of Positive Behavioral Support
- Development of Behavioral Guidelines, Protocols, and Positive Behavioral Support Plans

Provider agencies must maintain a record of the training verification or recertification.

513.2.6 CRIMINAL INVESTIGATION BACKGROUND CHECK (CIB)

Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. At a minimum, a state level criminal investigation background check must be conducted. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

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



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513.3 MEMBER ELIGIBILITY AND ENROLLMENT PROCESS

MEMBER ELIGIBILITY

- The member must have a determination of Medical Eligibility. Medical eligibility is determined by submitting an application packet to State MR/DD Waiver Office for member consideration.
- The member must have a determination of Financial Eligibility. Once medical eligibility is established, members make application at the local Department of Health & Human Resource (DHHR) office for assessment of financial eligibility.

MEMBER ENROLLMENT

Once financial eligibility is determined, the member is eligible to be enrolled in the MR/DD Waiver Program. The member must be a resident of the State of West Virginia. Members must meet both the medical and financial eligibility. The member may be enrolled in the Waiver program upon the availability of an allocation (slot).

513.3.1 APPLICATION AND MEDICAL ELIGIBILITY

- A member may obtain an application information packet from local Behavioral Health Centers, local/county DHHR Offices or the State MR/DD Waiver Office.
- Once the applicant completes the DD-14, he/she will submit the DD-14 to the selected MR/DD Waiver provider agency or the State MR/DD Waiver Office.
- Upon receipt of the DD-14, the Waiver provider agency will sign and date the DD-14.
- The Waiver provider agency will forward a copy of the DD-14 to the State Waiver office. Applications should be addressed to the Bureau for Behavioral Health and Health Facilities (BHFF), Waiver Department, 350 Capitol Street, Room 350, Charleston, WV 25301

The Application Form (DD-14) may be submitted as:

- An Application which indicates the individual requires services in 0 – 90 days and requires full eligibility determination within 90 days or
- A “Statement of Interest” which indicates the individual requires services beginning in 91 days or greater.
- The Application must be fully completed and a Service Coordination Agency selected by the applicant and/or legal representative to ensure processing without delay.
- Once the State MR/DD Waiver Office receives the application, it will be processed and the applicant will be placed on the Planning Registry when the member chooses over 90 days on the application (statement of interest). The Planning Registry is maintained by the State MR/DD Waiver office.



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- The application process includes the preparation of the application packet and determination of medical eligibility and should occur within 90 days (45 days to complete the packet and 45 days to determine eligibility).
- The application process will begin upon the initial signature date indicating the receipt of the application (DD-14) by the Waiver provider agency. The provider must submit a completed packet to the State MR/DD Waiver office from this date of signature within a 45 day time frame.

Initial Application Packet

- A full initial application packet is the packet of required information and assessments which describe the applicant's needs. The Service Coordinator is responsible for arranging the assessments and compiling the required documentation for the full application packet. The Service Coordinator is then responsible for submitting the full application packet to the State MR/DD Waiver office within the mandatory time frames. If a member chooses to change agencies prior to the completion of the full application packet, the Service Coordinator is responsible for coordinating the packet with the new Service Coordinator and notifying the State Waiver office if the change in Service Coordinators constitutes a change in status of provider agencies.
- All MR/DD Waiver Program Services covered in this chapter are subject to a determination of medical necessity. Each initial application packet must have the following:
 - A Completed Annual Medical Evaluation (DD-2A).
 - A Completed Comprehensive Psychological Evaluation (DD-3) that includes clinical verification that the mental retardation and/or related condition with associated concurrent adaptive deficits were manifested prior to the age of 22, and are likely to continue indefinitely.

For the MR/DD Waiver program, individuals must meet the diagnostic criteria for medical eligibility not only by the relevant test scores, but also the narrative descriptions contained in the documentation.

The following evaluation may be submitted as applicable but is not a requirement for the application packet:

- A completed Social History (DD-4)
- Any other documentation or information as deemed necessary by DHHR for the determination of medical eligibility. For this program, individuals must meet the diagnostic criteria for medical eligibility not only by the relevant test scores, but also the narrative descriptions contained in the documentation. The following may be needed for specified age groups:
 - IEP, for school-age children
 - Birth to Three assessments for children age three and below.

The Initial Medical Evaluation (DD-2A), Psychological Evaluation (DD-3), and Informed Consent forms (DD-7 and DD-7A) are to be maintained on site at the local service coordination provider agency and made available for state or federal monitors to review.



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The State MR/DD Waiver office will make a final medical eligibility determination within 45 days of receipt of the packet. An eligible applicant will be enrolled into the Waiver program once the allocation (slot) is available. The applicant's right to a final eligibility determination within 90 days may be abrogated when a Service Coordination agency cannot complete a full application packet because the applicant or an examining physician delays or fails to take required action.

MEDICAL ELIGIBILITY

Medical Eligibility Criteria

The MR/DD State Waiver Office determines the medical eligibility for an applicant in the MR/DD Waiver Program. In order to be eligible to receive MR/DD Waiver Program Services, an applicant must meet the following medical eligibility criteria:

- Have a diagnosis of mental retardation and/or a related condition,
- Require the level of care and services provided in an ICF/MR (Intermediate Care Facility for the Mentally Retarded) as evidenced by required evaluations and corroborated by narrative descriptions of functioning and reported history. An ICF/MR provides services in an institutional setting for persons with mental retardation or related condition. An ICF/MR facility provides monitoring, supervision, training, and supports.

MR/DD State Waiver Office determines the level of care (medical eligibility) based on the Annual Medical Evaluation (DD-2A), the Psychological Evaluation (DD-3) and verification if not indicated in the DD-2A and DD-3, that documents that the mental retardation and/or related conditions with associated concurrent adaptive deficits were manifested prior to the age of 22, and are likely to continue indefinitely. Other documents, if applicable and available, that can be utilized include the Social History, IEP for school age children, Birth to Three assessments, and other related assessments.

The evaluations must demonstrate that an applicant has a diagnosis of mental retardation and/or a related developmental condition, which constitutes a severe and chronic disability. For this program individuals must meet the diagnostic criteria for medical eligibility not only by the relevant test scores, but also the narrative descriptions contained in the documentation. To be eligible, the member:

- Must have a diagnosis of mental retardation, with concurrent substantial deficits (substantial limitations associated with the presence of mental retardation), and/or
- Must have a related developmental condition which constitutes a severe and chronic disability with concurrent substantial deficits. Examples of related conditions which may, if severe and chronic in nature, make an individual eligible for the MR/DD Waiver Program include but are not limited to, the following:
 - Any condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires services similar to those required for persons with mental retardation.
 - Autism



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- Traumatic brain injury
- Cerebral Palsy
- Spina Bifida
- Tuberos Sclerosis

Additionally, the member who has a diagnosis of mental retardation and/or related conditions and associated concurrent adaptive deficits must have the following:

- Manifested prior to the age of 22, and
- Likely to continue indefinitely.
- Must have the presence of a least three (3) substantial deficits out of five of the major life areas (term is defined in Title 42, Chapter IV, Part 435.1010 of the Code of Federal Regulations or CFR. Refer to Section 513.3.1, Functionality section for a list of the major life areas.

Functionality

- Substantially limited functioning in three (3) or more of the following major life areas; (“substantially limited” is defined on standardized measures of adaptive behavior scores as three (3) standard deviations below the mean or less than one (1) percentile when derived from non MR normative populations or in the average range or equal to or below the seventy fifth (75) percentile when derived from MR normative populations. The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological, the IEP, Occupational Therapy evaluation, etc.). Applicable categories regarding general functioning include:
 - **Self-care**
 - **Receptive or expressive language** (communication)
 - **Learning** (functional academics)
 - **Mobility**
 - **Self-direction**
 - **Capacity for independent living** (home living, social skills, employment, health and safety, community and leisure activities).

For applicable major life functioning areas, refer to Code of Federal Regulation (CFR): 42 CFR 435.1010.

Active Treatment

- Requires and would benefit from continuous active treatment.

Medical Eligibility Criteria: Level of Care

- To qualify for ICF/MR level of care, evaluations of the applicant must demonstrate:



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

The applicant or legal representative will be informed of the right to choose between ICF/MR services and home and community-based services under the MR/DD Waiver Program and informed of his/her right to a fair hearing at the time of application (Informed Consent, DD-7).

Conditions Ineligible

- Substantial deficits associated with a diagnosis other than mental retardation or a related diagnosis do not meet eligibility criteria.
- Additionally, any individual needing only personal care services does not meet the eligibility criteria.
- Individuals diagnosed with mental illness whose evaluations submitted for medical eligibility determination indicate no previous history of co-occurring mental retardation or developmental disability prior to age 22. The member's clinical evaluators must provide clinical verification through the appropriate eligibility documentation that their mental illness is not the primary cause of the substantial deficits and the mental retardation or developmental disability occurred prior to the age of twenty-two (22).

513.3.2 FINANCIAL ELIGIBILITY

The applicant or legal representative must make an application for financial eligibility. However, it is the responsibility of the Service Coordinator to assist the member and ensure that the application is made. Written notification of medical eligibility for the MR/DD Waiver Program must be presented to the local/county DHHR where the member resides to ensure accurate Medicaid coding for the appropriate Waiver program.

An Economic Service (ES) Worker will take the application for financial eligibility (on a DHHR form labeled the ES-2 form) and the local/county DHHR office will determine financial eligibility for the MR/DD Waiver Program. If a person is Medicaid eligible and already has a medical card, the applicant, applicant's legal guardian, or the Service Coordinator must contact the local/county DHHR office once eligibility is established to ensure he/she is properly coded.

Individuals who are eligible for both Supplemental Security Income (SSI) and the MR/DD Waiver Program will not have to re-establish their financial eligibility every 6 months. Annual re-determination of financial eligibility for SSI benefits is used to re-establish financial eligibility for the MR/DD Waiver Program.

Financial Eligibility Criteria

The applicant must meet the following financial eligibility criteria:

- **Income**



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The individual's monthly income may not exceed 300% of the current maximum monthly Supplemental Security Income (SSI) payment. The maximum monthly SSI payment may be found by contacting the local county DHHR office or local Social Security Administration office.

- Only the individual's personal income is considered for determination.
- The parent's income is not considered for determining financial eligibility.
- An individual does not have to be SSI eligible to become eligible for the MR/DD Waiver Program.
- **Assets**
 - An individual's assets, excluding residence and furnishings, may not exceed \$2,000.
 - The parent's assets are not considered for determining financial eligibility.
 - Only the individual's assets are considered for determination.

513.3. 3 ENROLLMENT IN MR/DD WAIVER PROGRAM SERVICES

In order to be eligible to enroll in MR/DD Waiver Program Services, an applicant must meet both the medical and financial eligibility criteria. After medical and financial eligibility have been established, the member is ready for the enrollment process. This involves being approved for a Waiver allocation (slot).

Service Allocation (Slot) Criteria

The total number of allocations available for the current fiscal year is determined by BMS. The number of individuals to be served and the average cost of services per individual are established using formulas approved by CMS.

Service Allocation (Slot) Referral and Selection Process

Provided an allocation (slot) is available, the allocation process is based on:

- Chronological order by date of the state's receipt of the fully completed initial application packet
- The date of a fair hearing decision if medical eligibility is established as a result of a Medicaid fair hearing.

Eligibility Effective Date

The initial effective date of a Medical Card for an applicant who has not previously acquired one will be the latest of the following two dates (provided the member has a Waiver allocation):

- The date of medical eligibility (Psychological Evaluation, DD-3) which is established by the psychological evaluation or addendum (if the psychological is more than 90 days old) in an initial application packet



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- The date on which the applicant made the application for financial eligibility at the local/county DHHR office.

Payment for medically necessary and medically appropriate MR/DD Waiver Program Services is available on behalf of eligible Medicaid members who have been determined in need of MR/DD Waiver Program Services, subject to the conditions and limitations that apply to these services. In order to be eligible to receive MR/DD Waiver Program Services, an applicant will:

- Meet the medical eligibility criteria as required by this section
- Meet the financial eligibility criteria as required by this section
- Be approved for a MR/DD Waiver Service Allocation (*slot*), as required by this section

Members enrolled in the MR/DD Waiver Services Program are excluded from enrollment in a Medicaid managed care program.

513.3.4 RE-DETERMINATION OF MEDICAL ELIGIBILITY

Re-determination of medical eligibility must be completed annually for each member. Pursuant to federal law, an individual must qualify for recertification at least annually. Eligibility determination must be made on current eligibility criteria, not on past Waiver eligibility. The fact that a recipient had previously received waiver services shall have no bearing. The date of the member's medical re-eligibility is the date the annual medical evaluation (DD-2A) was signed.

Annual Re-certification Application Packet

At minimum, the Annual Medical Evaluation (DD-2A), and the most current Psychological Evaluation (DD-3) must be submitted (see frequency requirements for psychological evaluation of adult or child). DHHR may also request any and all additional documents for the purpose of medical eligibility determination.

Frequency Requirement for Psychological Evaluation

- **Adults:** For adults age 18 and older, a comprehensive psychological evaluation is required triennially (once per three year intervals).
- **Children:** For children under 18 years of age, a comprehensive psychological evaluation is required triennially while a psychological update is required annually.

The Service Coordinator is responsible for submitting the annual re-certification application packet to the state Waiver Office. The state must review and approve the level of care needed prior to an individual becoming re-certified.

Once the annual re-certification packet is received by the state MR/DD Waiver office, the following transpires:



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- The required evaluations (DD-2A, DD-3, etc) are reviewed by the State Waiver Office. If indicated, additional information may be requested provided the information is applicable and available as needed in order to determine recertification.
- Following annual eligibility determination, the State Waiver Office sends an eligibility re-certification notice to the member, the member's Service Coordination provider agency, and the member's local DHHR, Economic Service (ES) Worker, of the re-certification. The notification includes the member's effective date for medical eligibility.
- The local DHHR is then authorized to review the member's financial eligibility.

Failure of the service coordination provider to submit the Annual Re-certification Application packet to the State MR/DD Waiver office within 30 days of the expiration date of the member's eligibility may result in any of the following:

- Request to hold the submission of claims for reimbursement
- Loss of reimbursement for services provided
- Loss of Medicaid coverage for the member

Re-certification application packets should be addressed to the Bureau for Behavioral Health and Health Facilities, Waiver Department, 350 Capitol Street, Room 350, Charleston, WV 25301.

513.4 RIGHTS OF MEMBERS AND NEW APPLICANTS

- Applicants have a right to appeal a denial of medical eligibility.
- Members have a right to appeal an Individual Program Plan (IPP).
- Members have a right to appeal a denial of a covered service.
- Members have a right to appeal the termination of MR/DD Waiver services.
- Members have a right to obtain oral and written information on the agency's rights and grievance procedures for members served by the agency.
- All applicants/members must be given a choice between services either in an ICF/MR or by means of a home and community-based service under the MR/DD Waiver Program when Waiver services are determined to be a feasible alternative to institutional care (DD-7).
- The applicant/member and/or legal representative must also be informed of the right to choose between home and community-based service providers under the MR/DD Waiver Program and informed of his/her right to a fair hearing (Informed Consent DD-7A). Any change of provider will require a meeting of the Interdisciplinary Team.



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513.5 MEMBER DISCHARGE

A member will be discharged from the MR/DD Waiver Program under the following conditions:

- A member's income or assets exceed the limits specified in Section 513.3.2 of this chapter. The county DHHR office must be contacted, in addition to the state MR/DD Waiver Program Coordinator's office, any time an individual's income or assets exceed the limits. The county DHHR office will close the Medicaid file upon notification of the increase in income or assets and notify the individual and the MR/DD Waiver Program office of termination of the medical card. The Service Coordinator is responsible for monitoring the member's assets and is also the responsible party for reporting when the member's income or assets exceed the limits specified in Section 513.3.2. The Service Coordinator may request information from the member's payee or member's legal representative to ensure that financial eligibility is not "lost" throughout the year due to excessive assets or other reasons.
- The evaluations, which are used by the MR/DD Waiver Program to determine a member's level of care (medical eligibility), demonstrate that he/she no longer requires an ICF/MR level of care and therefore, is not medically eligible for the MR/DD Waiver Program. The State MR/DD Waiver office will notify the member of termination of services and of his/her right to appeal.
- A member and/or his/her legal representative choose to terminate Waiver services. The Service Coordination provider agency must request the member and/or legal representative review and sign the Informed Consent (DD-7) indicating the choice to obtain other services and the Service Coordination provider agency must convene or participate in developing the IPP to transition the member to the new services. A copy of the DD-7 and the Exit/Transfer form (DD-16) must be sent to the state MR/DD Waiver Program office. (The State's MR/DD Waiver Program must be notified if the member and/or his/her legal representative do not want the Service Coordination provider agency to participate in the transition). **The DD-16 must also be signed by the member and/or legal representative.**
- Any time a member loses eligibility or chooses to leave the MR/DD Waiver Program, both the local DHHR office and the State MR/DD Waiver Program office must be informed of the date of the member's discharge from MR/DD Waiver services. The termination of MR/DD Waiver services may be appealed through the appeals process outlined in Section 513.6 of this chapter.
- Anytime a member successfully demonstrates increased competencies in daily independence, the member's IDT team may develop a transition plan that titrates the member's services in order to move to a lesser restricted level of care. When members transition from the Waiver program in this manner, the transition period may not exceed a six month time frame.

513.6 RIGHT TO APPEAL

If an applicant/member is determined not to be medically eligible by the State MR/DD Waiver office, a Notice of Decision and a Request for Hearing form will be issued to the applicant/member. The decision/denial may be appealed directly through the fair hearing process.



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Appeal of a Denial of Service by the State MR/DD Waiver Program Office

The Statement of Rights is available at the State MR/DD Waiver Office, behavioral health providers, and local DHHR offices. The Statement of Rights is a detailed description of their right to apply for MR/DD Waiver services, receive a timely response and to be informed of their appeal rights. This document is included in the Application Information Packet.

If the appeal is not resolved by the State MR/DD Waiver Program Coordinator to the satisfaction of the appellant, the person may then appeal in writing to the Bureau for Behavioral Health and Health Facilities (BHFF), MR/DD Waiver Program, 350 Capitol Street Room 350, Charleston, WV 25301. BMS will arrange a hearing to resolve the matter.

If MR/DD Waiver services are terminated or reduced by the State, the member will receive a Notice of Decision and a Request for Hearing form. The termination and/or reduction of services may be appealed through the fair hearing process.

90 Days to Request a Hearing: The member has ninety (90) days to request a hearing after a Notice of Decision regarding eligibility has been received. Any member or authorized legal representative may request a hearing and must do so either by a written request or by using the “Request for Hearing” form (refer to Request for Fair Hearing form in Section 513.14: Attachment 1: MR/DD Waiver Documents).

When the member requests a hearing, the member has 13 Days to submit a request to BHFF to continue services. If services are terminated by the State and a hearing is requested, services will continue until a hearing decision is rendered. If an applicant/member wishes to appeal a decision they must submit the request for a hearing or pre-hearing conference within 13 days of receipt of the “Notice of Decision” to continue to receive services in the interim. When a member chooses to petition the appellate court following the final appeal decision on an MR/DD Waiver hearing, services are not continued while petitioning the appellate court.

Upon notice of denial, the Service Coordinator must arrange for an emergency IDT meeting to develop a “back-up” plan for transition. If the decision regarding eligibility (Level of Care) for the program is upheld by the hearing officer, on the date of the hearing decision, services under the MR/DD Waiver Program will cease. It is essential that upon notice of denial, that the Service Coordinator must arrange for the emergency IDT meeting to develop a “back-up” plan for transition. If the applicant/member is eligible financially for Medicaid services without the MR/DD Waiver program, other services may be available for the individual.

Any applicant/member who requests a fair hearing shall be entitled to a final administrative action within ninety (90) days of the date of the request for hearing, unless the applicant waives his or her request for a final administrative action within ninety (90) days.

If the applicant/member was denied MR/DD Waiver Program services, the applicant shall have the right to a second medical or psychological examination at the expense of the WV DHHR. Any additional documents pertinent to the condition affecting eligibility must be submitted 10 working days prior to the hearing.

The applicant/member shall have the right to access their waiver application file and copies shall be provided free of charge by BHFF.



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If needed, BHHF will coordinate or assist in arranging transportation to the hearing.

If the decision regarding eligibility (Level of Care) for the program is reversed by the hearing officer, the person is eligible for enrollment into the program on the date of the written hearing provided an allocation (slot) is available.

Appeal of an Individual Program Plan (IPP)

If a team member disagrees with any aspect of the IPP, he/she may sign the plan but indicate his/her disagreement. The rationale for that disagreement shall be recorded on the relevant form. If a team member other than the participant wishes to appeal, permission must be obtained from the participant and/or his/her legal representative in order to initiate the appeal process.

If a team member chooses to appeal either the contents or lack of implementation of the IPP, the appeal shall be filed in accordance with the Service Coordination provider agency's (or other agency providing/denying the service) appeal process. If the person does not appeal the IPP, it can be implemented without any changes as prepared.

If the appeal is not resolved at the agency level to the satisfaction of the appellant, the person may then appeal in writing to the State MR/DD Waiver Program Coordinator within 5 working days of written notification of the decision from the local agency. The MR/DD Waiver Program Coordinator will review the IPP, the relevant evaluations and the written decision from the local agency to determine the appropriateness of the services and implementation as described in the IPP.

If the appeal is not resolved satisfactorily by the State MR/DD Waiver Program Coordinator, the person may then appeal to BHHF for a Medicaid fair hearing. The appeal should be forwarded to the Bureau for Behavioral Health and Health Facilities (BHHF), MR/DD Waiver Program, 305 Capitol Street Room 350, Charleston, WV 25301. Board of Review will arrange for a hearing to resolve the matter.

During the appeal process, only those services being appealed will continue as outlined in the previous IPP. All other services will be provided according to the most current IPP. If services being appealed are part of an initial IPP and have not previously been offered, the service being appealed cannot be offered to the member.

Appeal of a Budget Allocation by the Administrative Service Organization

The IDT must make every effort to purchase services within the budget allocated by the ASO. If the IDT cannot purchase all needed services within the budget, the Service Coordinator may contact the ASO with rationale for the need to negotiate a new budget. If negotiation is unsuccessful, the Service Coordinator may request a Second Level Negotiation with the ASO. Only the member or the member's guardian or healthcare surrogate may request a fair hearing.

513.7 DESCRIPTION OF COVERED SERVICES



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Except for the limitations and exclusions listed below, BMS will pay for the following medically necessary and medically appropriate MR/DD Waiver Program Services provided to eligible Medicaid members by MR/DD Waiver Program provider agencies.

513.7.1 INDEX OF COVERED SERVICES

| Procedure Description | Procedure Code | Section |
|--|----------------|---------|
| Individual Program Development, Social Worker | T2024 -AJ | 513.7.2 |
| Individual Program Development, Service Coordinator | T2024-HN | |
| Individual Program Development, Skills Specialist, Residential Setting | T2024-UA-UH | |
| Individual Program Development, Skills Specialist, Day Setting | T2024-UA-UF | |
| Individual Program Development, Behavioral Specialist, Residential Setting | T2024-UB-UH | |
| Individual Program Development, Behavioral Specialist, Day Setting | T2024-UB-UF | |
| Individual Program Development, Behavioral Analyst, Residential Setting | T2024-UC-UH | |
| Individual Program Development, Behavioral Analyst, Day Setting | T2024-UC-UF | |
| Individual Program Development, Registered Nurse | T2024-TD | |
| Individual Program Development, Psychologist | T2024-AH | |
| Individual Program Development, Registered Dietician | T2024-AE | |
| Individual Program Development, Occupational Therapist | T2024-GO | |
| Individual Program Development, Physical Therapist | T2024-GP | |
| Individual Program Development, Speech Therapist | T2024-GN | |
| Individual Program Development, Physician | T2024-AM | |
| Service Coordination | T1016-HI | 513.7.3 |
| Transportation per mile | A0160-HI | 513.7.4 |
| Transportation per trip | A0120-HI | |
| Respite Care Contracted Level 1 1:1 ratio | T1005 | 513.7.5 |
| Respite Care Contracted Level 1 1:2 ratio | T1005-UN | |
| Respite Care Contracted Level 1 1:3 ratio | T1005-UP | |



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| Procedure Description | Procedure Code | Section |
|--|----------------|------------|
| Respite Care Agency Level 2 1:1 ratio | T1005-U4 | |
| Respite Care Agency Level 2 1:2 ratio | T1005-U3 | |
| Respite Care Agency Level 2 1:3 ratio | T1005-U2 | |
| Residential Habilitation Community | T2017-UA | 513.7.6.1 |
| Residential Habilitation Agency 1:1 ratio | T2017-U4 | 513.7.6.2 |
| Residential Habilitation Agency 1:2 ratio | T2017-U3 | |
| Residential Habilitation Agency 1:3 ratio | T2017-U2 | |
| Residential Habilitation Agency 1:4 ratio | T2017-U1 | |
| Adult Companion Contracted Level 1 1:1 ratio | S5135 | 513.7.7 |
| Adult Companion Contracted Level 1 1:2 ratio | S5135-UN | |
| Adult Companion Contracted Level 1 1:3 ratio | S5135-UP | |
| Adult Companion Agency Level 2 1:1 ratio | S5135-U4 | |
| Adult Companion Agency Level 2 1:2 ratio | S5135-U3 | |
| Adult Companion Agency Level 2 1:3 ratio | S5135-U2 | |
| Day Habilitation 1:1 ratio | T2021-U4 | 513.7.8 |
| Day Habilitation 1:2 ratio | T2021-U3 | |
| Day Habilitation 1:3 ratio | T2021-U2 | |
| Day Habilitation 1:4 ratio | T2021-U1 | |
| Pre Vocational Training Individual | T2015 | 513.7.9 |
| Pre Vocational Training Group | T2015-HQ | |
| Supported Employment Individual | T2019 | 513.7.10 |
| Supported Employment Group | T2019-HQ | |
| Therapeutic Consultative Services Skills Specialist, Day | T2021-U7-UF | 513.7.11.1 |
| Therapeutic Consultative Services Skills Specialist, Residence | T2021-U7-UH | 513.7.11.1 |
| Therapeutic Consultative Services Behavioral Specialist, Day | T2021-U8-UF | 513.7.11. |



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| Procedure Description | Procedure Code | Section |
|--|----------------|------------|
| | | 2 |
| Therapeutic Consultative Services Behavioral Specialist, Residence | T2021-U8-UH | 513.7.11.2 |
| Therapeutic Consultative Services Behavioral Analyst, Day | T2021-U9-UF | 513.7.11.3 |
| Therapeutic Consultative Services Behavioral Analyst, Residential | T2021-U9-UH | 513.7.11.3 |
| Therapeutic Consultative Services Behavior Analyst, Psychologist, Day | T2021-U6-UF | 513.7.11.3 |
| Therapeutic Consultative Services Behavior Analyst, Psychologist, Residential | T2021-U6- UH | 513.7.11.3 |
| Extended Professional Services Registered Dietician | 97802-AE-HI | 513.7.12 |
| Extended Professional Services Physical Therapist | 97530-GP-HI | |
| Extended Professional Services Occupational Therapist | 97530-GO-HI | |
| Extended Professional Services Speech Therapist (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual) | 92507-GN-HI | |
| Extended Professional Services Speech Therapist (Treatment of Swallowing dysfunction and/or oral function for feeding) | 92526 -HI | 513.7.12 |
| Extended Professional Services Licensed Psychologist (Consult) | T2025-HI | 513.7.12 |
| Skilled Nursing Services LPN 1:1 ratio | T1003-HI-U4 | 513.7.13 |
| Skilled Nursing Services LPN 1:2 ratio | T1003-HI-U3 | |
| Skilled Nursing Services LPN 1:3 ratio | T1003-HI-U2 | |
| Nursing Services RN 1:1 ratio (restricted to skilled nursing services that can only be performed by a registered nurse) | T1002- HI | |
| Crisis Services | T2034 | 513.7.14 |
| Environmental Accessibility Adaptations home | S5165 | 513.7.15 |
| Environmental Accessibility Adaptations vehicle | T2039 | |



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| Procedure Description | Procedure Code | Section |
|---|--|----------------|
| Extended Physician Services Annual Medical Evaluation | 99381-HI to 99387-HI and 99391-HI to 99397-HI | 513.7.16. 1 |
| Psychiatric Diagnostic Interview Examination | 90801-HI | 513.7.16. 2 |
| Psychological Testing with Interpretation and report | 96101-HI | 513.7.16. 3 |
| Psychological Testing – Developmental Extended | 96111-HI | 513.7.16. 4 |
| Psychological Testing Developmental Testing – Limited | 96110-HI | 513.7.16. 5 |
| Social History Social History Update | H0031-HI H0031-HI-TS | 513.13.17 |

513.7.2 INDIVIDUAL PROGRAM PLAN DEVELOPMENT (IPP)

| | | |
|------------------------|-------------|--|
| PROCEDURE CODE: | T2024-AJ | Social Worker |
| | T2024-HN | Service Coordinator |
| | T2024-UA-UF | Skills Specialist, Day Setting |
| | T2024-UA-UH | Skills Specialist, Residential Setting |
| | T2024-UB-UF | Behavioral Specialist, Day Setting |
| | T2024-UB-UH | Behavioral Specialist, Residential Setting |
| | T2024-UC-UF | Behavioral Analyst, Day Setting |
| | T2024-UC-UH | Behavioral Analyst, Residential Setting |
| | T2024-TD | Registered Nurse |
| | T2024-AH | Psychologist |
| | T2024-AE | Registered dietician |
| | T2024-GO | Occupational Therapist |
| | T2024-GP | Physical Therapist |
| | T2024-GN | Speech Therapist |
| | T2024-AM | Physician |

SERVICE UNITS: Event per specialty, minimum 2 events per IPP meeting allocated to Individualized member budget. To be considered a reimbursable event, physical attendance is required for the entire meeting.



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SERVICE LIMITS:

This service occurs during the IPP meeting only.

The service does not include reviews of data or information prior to the meeting, notification of team meetings, drafts of strategies or interventions, or distribution of the IPP outside of the team meeting.

Day habilitation, residential habilitation, community residential habilitation, prevocational, adult companion and supported employment providers who attend IDT meetings must bill the service code for the respective service.

PRIOR AUTHORIZATION:

Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Individual Program Planning is the process by which the member and his/her IDT develop a plan based on a person centered philosophy. The team should be comprised of the member and his or her "Circle of Support". The circle of support may include the Service Coordinator, professionals, direct care providers, family members, guardian, and significant individuals in the member's life with a vested interest in the member. Section 513.7.2.1 specifically addresses minimum composition requirements of the IDT. The content of the IPP must be guided by the member's needs, wishes, desires, and goals.

The team, that includes the member, participates in the IPP meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person centered plan. The Service Coordinator assumes the role of facilitator and coordinator for the meeting; however, the team is directed by the member utilizing a person centered approach to planning. IPP development occurs when the member is present.

The Individual Program Planning includes the development of the initial IPP, annual IPP and subsequent reviews or revisions of the IPP (to include quarterly reviews as warranted).

Any activity that occurs prior to the meeting or after the meeting is **not** considered Individual Program Planning. Activities provided before or after the meeting may meet the criteria for service coordination or Therapeutic Consultant service activities (see applicable sections).

SITE OF SERVICE



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Individual Program Planning development may be provided at the office of a provider agency, the member's home, a residential or day program site, clinic or physician office or any other community setting available to the member. The meeting cannot occur at one location, then continue at another location.

This service code is restricted to the site of the IDT team meeting.

DOCUMENTATION

The IPP shall serve as documentation of the IDT team meeting. The team member's signature on the IPP constitutes participation in the team meeting. Team meeting minutes should be utilized to expand discussion of the meeting or record critical issues from the meeting. The IPP must include the signature of all participants of the IPP meeting, date of the meeting and the total time spent in the meeting for each team member. A copy of the IPP will be maintained in all participating provider agency records and distributed to all team members within fourteen (14) business days of the date of the IPP team meeting. A copy of the IPP will be distributed by the Service Coordinator to all team members. Goals and objectives that have been approved by the IDT may be written on the plan or attached to the IPP.

Failure to distribute the IPP by the Service Coordinator or maintain the original IPP in the service coordination agency record or a copy of the IPP in a provider agency file can result in disallowance for IPP Development Services.

SERVICE RESTRICTIONS

Residential Habilitation, Day Habilitation, Adult Companion, Respite, Prevocational or Supported Employment Service Providers are not eligible for this service. For participation in the IPP team meeting, refer to service descriptions and service restrictions for each specified service.

PROVIDER QUALIFICATIONS

Refer to provider qualifications for specific service for MR/DD Waiver service providers.

FREQUENCY OF REVIEW OF IPP

The IPP is to be developed on an annual basis. Minimally, the annual IPP must be reviewed at a six month interval. IPP reviews should occur on a quarterly basis. For those IDT teams that do not review the annual IPP quarterly, rationale must be given for not reviewing. The IPP must be reviewed at critical junctures (refer to definitions for critical juncture).

The psychologist and the registered nurse are required to attend the annual and six month review of the IPP. MR/DD Waiver does not require the psychologist and nurse to attend the quarterly review IPP meetings. For the quarterly meetings, both the psychologist and registered nurse may send recommendations to the Service Coordinator for review at the quarterly team meetings.

A physician, psychologist or a registered nurse may attend the meeting by interactive video (MDTV or webcam) and may bill for the IDT team meeting if attending for the entire event. The physician, psychologist, or the nurse may not bill for telephone conferencing. The service must not include facility (-set-up") cost or connection cost for the MDTV or webcam.

REVIEW OF THE INDIVIDUAL PROGRAM PLAN – PROGRAM MONITORING AND CHANGE



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Once a member has been awarded a Waiver allocation, the member has 90 days to begin receiving services. The IPP should address implementation dates of services that are not to be implemented at the 90 day interval.

Situations that may warrant an earlier review include, but are not limited to:

- The member has successfully completed an objective(s) included in the IPP
- The member is regressing or losing skills already gained
- The member is failing to progress toward identified objectives after reasonable efforts have been made
- The member is being considered for training towards new objectives
- The member is having a minor or major occurrence in his/her life.
- The member experiences a critical juncture (See Section 513.1 for definition of critical juncture)

The review of the IPP needs to include:

- A summary of the treatment, training, or services provided
- Document the progress towards each objective
- Indicate problems that impeded progress, and
- Provide a decision to continue, modify, or discontinue current objectives.

513.7.2.1 INTERDISCIPLINARY TEAM (IDT) COMPOSITION

The IDT must be based on person centered philosophy. The development of the IPP by the IDT must be guided by the member's needs, wishes, desires, and goals.

At a minimum, the IDT consists of:

- The member
- His/her family and/or legal guardian as applicable
- A Service Coordinator
- At least one member of the team must be either the member's Skills Specialist or a Behavioral Specialist/Analyst
- Representatives of all agencies/providers who provide services to the individual
- A physician or registered nurse is required if the member is receiving skilled nursing services, or medical services that require RN oversight. The IDT may choose to invite the nurse and/or physician for other reasons when the team indicates that the need exists. The nurse is not required to attend quarterly meetings but may submit recommendations to the Service Coordinator for review



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at the quarterly IDT meetings. The nurse may attend the IDT meeting by interactive video (MDTV or web cam). The service does not cover the facility (–set-up”) cost or connection cost (not telephone conferencing). The nurse must not bill for telephone conferencing.

- A psychologist is required when the member has the need for specialized psychological evaluation and intervention due to co-existing (DSM IV TR Axis I diagnosis of Schizophrenia and other psychotic disorders and mood disorders) mental health disorders or behavioral needs. The only exception is if the member resides with a natural or adoptive family who addresses the DSM IV TR Axis I mental health disorder and/or behavioral needs independent of the MR/DD Waiver program through a physician/psychiatrist; and the team agrees to the exception. The psychologist is not required to attend the quarterly IDT meetings but may submit recommendations to the Service Coordinator for review at the quarterly IDT meetings. The psychologist may attend the IDT meeting by interactive video (MDTV or web cam). The service does not cover the facility (–set-up”) cost or connection cost (not telephone conferencing). The nurse must not bill for telephone conferencing.

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

- Professionals, such as a Physical Therapist, Occupational Therapist, Speech Therapist, Registered Dietician, Social Worker, etc.
- Paraprofessionals
- Direct service providers, such as Day Habilitation Program providers, Residential Habilitation providers, Respite providers, Adult Companion providers, Pre-vocational providers, Supported Employment providers, and LPN’s responsible for habilitation programs when the member receives eight (8) hours or more nursing in one day, and counselor
- Service providers from other systems such as the local education agency/public schools, DRS, or Birth to Three (provided that no duplication of service exists)
- Family Based Care Specialist (when applicable)
- Advocate (when applicable)
- Involved parties such as friends, extended family, the representative payee and the individual’s significant other

IDT MEETING ATTENDANCE

Any individual who is part of the team is very important, therefore, attendance at the IDT meeting is extremely important. The IDT meeting attendance is a responsibility of each of the team members. Strong efforts must be made in scheduling an IDT to secure the attendance of all members of the Interdisciplinary Team. The IDT should only be rescheduled for extenuating circumstances. A total of two (2) requests to re-schedule the IDT may occur when extenuating circumstances exist. The IDT **must** be rescheduled **to occur** within 30 days of the expiration date. For rescheduling of the IDT, the following conditions exist:

- The Provider agencies may request to reschedule the IDT only once for an IPP.



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- The member or member's legal representative (guardian) may request to re-schedule the IDT meeting only once for an IPP.
- The Service Coordinator is responsible for the coordination of the IDT meeting for the IDT team members.
- In extremely extenuating circumstances, family members, guardians or other team members may participate by teleconferencing if the family member, guardian or other team member does not bill for the time spent in the IDT. The member, the Service Coordinator, and the other designated members must be physically present during the IDT.
- The only exception to the IDT attendance is the registered nurse or the psychologist. The registered nurse or the psychologist may participate by interactive video (MDTV or webcam) and may bill for the service when they are present at the IDT for the entire event. All other team members may not participate or bill for the IDT event by means of interactive video (MDTV or webcam).
-

MEDICAID CANNOT REIMBURSE FOR SERVICES RENDERED WHEN THE IPP HAS EXPIRED OR IS INVALID

The IDT will convene at ninety (90) day intervals to develop, review, and update the IPP. The only exception is when the IDT has agreed to meet at longer intervals based on the needs of the member; such reviews shall occur at least every 180 days or every six (6) months. The annual, six month and quarterly IDT meetings are billable under the MR/DD Waiver Program.

REQUIRED SPECIAL MEETINGS

The IDT is also required to convene for the following events:

- **INITIAL OR TRANSFER MEETINGS**

Seven (7) Day IDT Meeting – This is a mandatory meeting when a member first receives agency or Medicaid services. This is the plan initially developed within the first seven days of the intake interview.

Thirty (30) Day IDT Meeting – The seven (7) day IPP must be finalized within thirty (30) days of the intake interview.

Transitional IDT Meeting – Mandatory meeting when a member is having a change among services or service providers. (Example: a change in where the member lives, when a new service is being added or deleted or a change is being requested for a service provider).

- **CRITICAL JUNCTURE MEETINGS**

Critical Juncture is any time that there is a significant juncture in the member's life that requires a meeting of the Interdisciplinary Team. The occurrence may require that a service needs to be decreased, increased or



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changed. A critical juncture constitutes a change in the member’s needs such as behavioral, mental health or physical health, service/service units, support, setting, or a crisis.

Crisis IDT Meeting – This type of IDT Meeting occurs when a member is experiencing a crisis (example: behavioral, medical, housing and service provision). In the event that all team members cannot be present (for a crisis IDT meeting only), a written report of the crisis IPP must be disseminated to all members within five (5) working days. When the IDT has requested a prior authorization and the approval or denial is received by the Service Coordinator, the Service Coordinator may utilize the crisis IDT format to notify the IDT team members.

- **DISCHARGE MEETING**

Discharge Planning IDT Meeting - This type of meeting must be held when a member is being discharged from MR/DD Waiver Services. This must also occur if the member is transferring to services outside of the Waiver program. (Example: discharge from MR/DD Waiver services into an ICF-MR facility).

513.7.3 SERVICE COORDINATION

| | |
|-----------------------------|---|
| PROCEDURE CODE: | T1016-HI |
| SERVICE UNITS: | 15 minutes |
| SERVICE LIMITS: | 70 units per month up to a maximum of 840 units per year. A minimum of 20 units per month will be allotted on the member’s budget. |
| PAYMENT LIMITS: | Service units shall be rounded on a monthly (not daily) basis |
| PRIOR AUTHORIZATION: | Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006, the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. |

DEFINITION

Service Coordination services are activities to establish, along with the member a life-long, person-centered, goal-oriented process for coordinating the supports (both natural and paid), range of services, instruction and assistance needed by persons with developmental disabilities. It is designed to ensure



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accessibility, accountability and continuity of support and services. This service also ensures that the maximum potential and productivity of a person with developmental disabilities in making meaningful choices with regard to his/her life and his/her inclusion in the community are achieved.

SITE OF SERVICE

The provider may provide service coordination in any location in the home or community setting which allows the service coordinator to complete all necessary duties for the member.

PROVIDER QUALIFICATIONS

- Four (4) year degree in a human service field and one or more years experience in the MR/DD field.
- Four (4) year degree in a human service field and less than one (1) year of experience in the MR/DD field. (Restrictions - must be under the supervision of the Service Coordinator Supervisor. Clinical supervision involves review of clinical activities, review of case notes and review of treatment plans for six (6) months. This must be verified by supervisory documentation once per month).
- Four (4) year degree in a non-human service field and one (1) year experience in the MR/DD field. (Restrictions - must be under the supervision of the Service Coordinator Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for six (6) months. This must be verified by supervisory documentation once per month).
- No degree or two (2) year degree and is a Licensed Social Worker grandfathered in by the WV Board of Social Worker Examiners due to experience in the MR/DD field. (Restrictions - none)
- A Registered Nurse who has one or more years of experience working in the MR/DD field (Restrictions - must be under the supervision of the Service Coordination Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for six (6) months. This must be verified by supervisory documentation once per month).
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

Providers must be a qualified mental retardation specialist. Providers must use the DD-17 for credentialing purposes. Credentials of the individual must be filed with the provider agency.

PROVIDER LIMITATIONS

- Service Coordination must not be provided by an agency that is not a Medicaid enrolled MR/DD Waiver provider.
- There is no secondary Service Coordination in the MR/DD Waiver Program. Another qualified Service Coordinator or a supervisor may act as a substitute Service Coordinator if the assigned Service Coordinator is unavailable with documentation as to the reason why substitute Service Coordination is needed. (Examples: vacation, sick leave, emergencies, etc).



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DOCUMENTATION

Service recording or progress/case notes shall include, at a minimum, the following:

- Name of MR/DD Waiver member
- Service Code
- Date of service
- Duration of service
- Start and stop times
- Type of service delivered
- Type of activity (assessment, service planning, linkage, referral, advocacy, crisis response planning, service plan evaluation and travel)
- Type of contact (face-to-face, phone, written)
- Summary of service delivered
- Outcome and/or result of service
- Signature and credentials of provider.

SERVICE COORDINATOR RESPONSIBILITIES

The Service Coordinator shall perform the following activities:

- **Service Coordination Assignment**

Each member will be assigned a single Service Coordinator.

- **Application and Eligibility Process**

- Accept referrals and provide the applicant and his/her family with the information necessary to choose between an institutional level of care in an ICF-MR facility or home and community-based services under the MR/DD Waiver Program. The Service Coordinator will conduct an interview with the applicant, his/her family, and/or legal representative to explain the choice between ICF/MR institutional and Waiver services and obtain a written informed consent for the applicant to receive Waiver services.
- Coordinate the initial medical evaluation (DD2), psychological evaluation (DD3), Social History (DD4) {if applicable and available}, IEP, psycho-educational assessment for school-age children {if applicable and available}, Birth to Three assessments {if applicable and available} as well as arrange/collect other necessary evaluations and information to establish eligibility.
- Submit the Annual Medical Evaluation (DD-2A) and psychological evaluation (DD3) {if applicable} for re-certification to the State office no later than thirty (30) days past the expiration date. Services may not be reimbursed if an individual's certification has expired past the thirty (30) day time frame.



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It is the Service Coordinator's responsibility to ensure that the member's medical and financial eligibility is monitored and determined annually.

- Ensure application for financial eligibility at the DHHR office in the county where the applicant lives or ensure that the applicant, his/her family and/or legal representative make the financial application.
- Ensure that every six (6) months thereafter that the individual, his/her family, and/or legal representative re-establish financial eligibility at the county DHHR office or annually for individuals who are currently receiving SSI.
- Ensure the completion/maintenance of all required MR/DD Waiver evaluations (Annual Medical Evaluation, DD-2A and the Psychological Evaluation, DD-3); IPP, Consents and Rights and disseminate documents to IDT members as appropriate.
- Service Coordination providers must begin the discharge process and provide linkage to services appropriate to the level of need when a member is initially found to be ineligible for MR/DD Waiver Services.
- **Linkage/Referral and Rights**

Provide oral and written information about the MR/DD Waiver Program provider agency's rights and grievance procedures for members served by the agency.

Procure all medically necessary services for children through the age of twenty one (21) within and beyond the scope of the MR/DD Waiver Program, in accordance with the Federal regulations and mandate for the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

Inform families or custodians of children less than three (3) years of age about the availability of Birth to Three Services. Medicaid will not reimburse these providers for Birth to Three Services for children enrolled in the MR/DD Waiver program. However, reimbursement may be available from other funding services.

Act as an advocate for the member. The MR/DD Waiver Program must not be substituted for entitlement programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers). Therefore, it is necessary for the Service Coordinator to advocate with these systems to obtain the required and appropriate services.

Provide education, linkage and referral to community resources.

Promote a valuable and meaningful social role for the member in the community while recognizing the member's unique cultural and personal value system.

Interface with the ASO on behalf of the member in regards to the assessment process, purchase of services, or budget process. Activities may include linkage, submission of information, coordination of choice of appropriate assessment respondents on behalf of the member, education and coordination of the most appropriate assessment setting that best meets the member's needs. The



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Service Coordinator may also conduct communication with other service providers on the IDT to allow for continuity of services/payment for services, and timely budgeting of services. These activities promote an assessment and budget that reflects the needs of the member.

- **Development of the IPP and the IDT Meeting**

Coordinate evaluations annually to be utilized as a basis of need and recommendation for services in the development of the IPP.

Notify, convene, coordinate and chair the meeting with the IDT. The Service Coordinator and the individual may wish to coordinate the annual IPP with the planning process for other service systems.

Coordinate the development of a new IPP at least annually, with a six (6) month up-date, and in accordance with the definition and requirements for IPPs stipulated in Section 513.7.2 of this chapter.

Access the necessary resources detailed in the IPP, make referrals to qualified service providers and resources, and ensure that service providers implement the instructional (behavioral) and service objectives of the IPP.

Monitor the instructional (behavioral) and service objectives to ensure that objectives are implemented according to the IPP.

Disseminate copies of the IPP to the member or member's legal representative and all provider agencies indicated on the IPP.

Disseminate evaluations or assessments to provider agencies indicated on the IPP.

- **Evaluation of the Implementation of the IPP and Services**

Ensure health and safety of the member.

Ensure the implementation of services as indicated on the IPP.

Visit the member monthly at his/her residence to personally meet with the individual and service providers to verify that services are being delivered in accordance with the IPP in a safe environment, and check that documentation of services is occurring. Visits with the individual, his/her family and/or legal representative will be utilized by the Service Coordinator to update progress towards obtaining services and resources and discuss progress towards achieving objectives contained in the IPP. The Service Coordinator will also elicit information from the member, his/her family and/or legal representative on their assessment of services, achievements, and/or unmet needs.

Visit the member at his/her day activity a minimum of every other month to verify that services are being delivered in accordance with the IPP, in a safe environment, and check that documentation of services is occurring. The Service Coordinator is encouraged to visit the supported employment setting if the visit will not be disruptive to the setting or member, assist with problem solving and engage in linkage and referral when needed.



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Advocate on behalf of the member and his/her family within the behavioral health service delivery system and community services and resources.

Provide planning and coordination before, during and after crises.

Coordinate discharge/transitional planning meetings to ensure the linkage to new service provider and access to services when transferring services from one provider agency to another. Coordination efforts will continue until the transfer of service coordination is finalized.

Travel to and from home visits, day habilitation program visits, and other locations necessary to complete duties related to the IPP.

- **Self-Direction**

Facilitate the member and/or family learning about self-directed service coordination, which they can then use to independently and fully participate in systems processes and obtain and advocate for needed resources and services.

Work with the member, his/her family, providers, and others to initiate, facilitate, and maintain collaborative working relationships among individuals and service agencies.

- **Service Restrictions**

Payee services are not reimbursable as a service coordination activity. Example: writing checks, maintaining bank account, paying the electric bill, etc. (linkage to the payee on behalf of the member is an acceptable service coordination activity).

MR/DD Waiver Service Coordinators may not provide services for more than twenty (20) people, inclusive of all people served by the Service Coordinator at any time.

The Service Coordinator must not provide Therapeutic Consultant services for members to whom they provide service coordination.

Service Coordinators may not evaluate IPP implementation by means of review of “billing or billing documentation” or other auditing activities. (The Service Coordinator may not function as a billing person/auditor. The Service Coordinator may review/monitor implemented services. The Service Coordinator is required to monitor the instructional and service objectives to ensure that objectives are implemented according to the IPP and the SC is to ensure the implementation of services as indicated on the IPP).

513.7.4 TRANSPORTATION

PROCEDURE CODE: A0120-HI: Non-emergency transportation; mini bus, mountain area transports or other transportation systems.
A0160-HI: Non-emergency transportation; per mile- case worker or social worker



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Note: Case Worker is the same as a direct care worker/Social Worker is the same as a Service Coordinator.

- SERVICE UNITS:** 1 Trip - A0120-HI, 1 mile -A0160-HI
- SERVICE LIMITS:** 6 one-way trips per day and/or A0120-HI, 77 trips per month or 700 miles per month or up to 1300 miles per month with prior approval from ASO that is based on member’s need.
- PAYMENT LIMITS:** Transportation can be billed concurrently only with Residential Habilitation, Day Habilitation, Respite, Pre-Vocational, Supported Employment, and Adult Companion.

PRIOR AUTHORIZATION: Transportation exceeding 700 miles per month must receive prior approval by the ASO. Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Transportation services are provided to a MR/DD member for the sole purpose of transporting the member **to or from a service that is reimbursed by Medicaid** such as Day Habilitation services, medical appointments, Respite Care and/or to or from specific Residential Habilitation activities which are detailed as an objective in the IPP.

Transportation services must be provided by drivers who meet the transportation provider qualifications described in this section.

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.

PROVIDER QUALIFICATIONS

Drivers must be at least eighteen (18) years of age and have a valid driver’s license (copy to be kept on file).

- Vehicles must have a valid state inspection sticker as applicable to the state and be inspected annually in accordance with State law.



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- Drivers and vehicles must be insured as required by the regulations of the WV Department of Motor Vehicles (DMV) or the state in which the vehicle is registered.
- Drivers and vehicles for agencies must be in compliance with policies for qualifications for drivers and aides, safety regulations, emergency procedures and vehicle maintenance schedules of Section 11.1 of the licensing regulations for community behavioral health providers.

SITE OF SERVICE

To and from a Medicaid reimbursable service as outlined on the member's IPP.

DOCUMENTATION

- Community Residential Habilitation, Adult Companion and Respite providers must complete the Progress Report (DD-12).
- Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form. Specific locations where the activity(ies) took place must be documented.
- The agency must develop a system to document/justify the units of transportation billed (i.e. transportation log).
- The IPP (DD-5) must specify the maximum units to be used for each Waiver service within the total units to meet the transportation service designated on the IPP (DD-5). (Example: up to one hundred (100) units per month with a maximum of sixty (60) units for Community Residential Habilitation).

SERVICE RESTRICTIONS

- Transportation may not be billed in place of school-age entitlement services.
- Transportation may not be billed out-of-state with the exclusion of transportation billed on behalf of the member, who resides in a WV state border county and allows for access to community-based habilitation and vocational needs, and is general practice for any other state citizen to cross the state borders and is directly related to the IPP (e.g., Supported employment job site or store located within thirty (30) miles of WV's state border). If destination is beyond thirty (30) miles out of state for members living in a bordering county, the member must access "non-emergency" medical transportation services and must not access Waiver transportation for this type of trip. "Non-emergency" medical transportation (NEMT) would only be applicable for medical appointments. For members who do not live in bordering counties that travel out of state for medical appointments, it will also be necessary for them to access "non-emergency" medical transportation services for this type of trip.
- **Transportation must be directly linked to an IPP goal or objective or a medical service. (Transportation to dental and vision appointments must be addressed in the ISP). The IPP must address goals or objectives or medical services requiring transportation services to access the training or medical service. The IPP must also address the specific provider(s) responsible for providing the transportation.**



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- The implementation of goals or objectives must be carried out in close proximity to the member’s residence. If a setting is available for a reimbursable activity (i.e. habilitation, adult companion, respite) close to where the member resides, this setting must be utilized. Settings may include, but are not limited to stores, banks, libraries, work site, etc. Transportation must occur where the rest of the community typically does their local shopping or conducts local business utilizing the resources available in the member’s neighborhood, town, city or county.
- Transportation must be exclusively for the member’s specific needs that are addressed in the IPP and is not intended for the personal or work activities of a staff member or family members. This includes activities such as socialization, shopping, transporting or delivery needs of the staff member or family member.
- Transportation cannot be billed when the member is **NOT** in the vehicle.
- A0120-HI and A0160 -HI cannot be billed concurrently.
- A0120-HI may not be utilized when a provider is transported in a private vehicle (car) or agency vehicle (car). Only a van or mini-bus may be utilized with A0120-HI.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.5 RESPITE CARE

| | | |
|------------------------|----------|-----------------------------------|
| PROCEDURE CODE: | T1005 | Respite Care Level I, 1:1 ratio |
| | T1005-UN | Respite Care Level I, 1:2 ratios |
| | T1005-UP | Respite Care Level I, 1:3 ratios |
| | T1005-U4 | Respite Care Level II, 1:1 ratio |
| | T1005-U3 | Respite Care Level II, 1:2 ratios |
| | T1005-U2 | Respite Care Level II, 1:3 ratios |

SERVICE UNITS: 15 minutes

SERVICE LIMITS: A Maximum combined limit of 6,912 units per IPP year for Respite Level I and Respite Level II

PAYMENT LIMITS: Specialized Family Care Providers who provide respite services may not provide respite at a 1:3 ratio.

PRIOR AUTHORIZATION:



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Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Respite Services are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver.

Respite is designed to focus on the needs of the care-giver for temporary relief and to help prevent the breakdown of the care-giver due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Care services consist of temporary care services for an individual who cannot provide for all of his/her own needs.

Respite Care Services may be billed concurrently with transportation.

RESPITE SERVICES

Respite Care may be used to:

- Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members
- Provide assistance to the primary care-giver or member in crisis and emergency situations
- Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.

Respite Care services must be provided by a Respite Care Provider who meets the Respite Care provider qualifications described in this Section. All Respite Care providers must have clinical oversight by a Therapeutic Consultant, either a Skills Specialist, or Behavior Specialist/Analyst who ensures the delivery of services in accordance with the MR/DD Waiver Program and the member's IPP.

Up to forty eight (48) units of Respite Care services per member per three (3) months may be charged, if necessary, for the purpose of training the Respite Care service provider in person-specific instruction (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Training received by the Respite Care provider must be provided by a Therapeutic Consultant, either the Skills Specialist or Behavior Specialist/Analyst.

In addition to the 48 units of training, the respite provider may utilize up to four (4) units of respite to participate in the development of the annual IPP and 4 units may be charged to participate in the 6-



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month IPP review. Billing may occur only for program planning meetings required by the MR/DD Waiver Program as outlined above.

SITE OF SERVICE

An individual may receive Respite Care services in his/her residence from a qualified Respite Care provider.

An individual may receive Respite Care services out of his/her home in the following locations:

- The home of a Specialized Family Care Provider (SFCP).
- A group home licensed by OHFLAC to deliver services to people with developmental disabilities.
- An ICF/MR group home or facility.
- A general medical hospital when the member warrants the need for additional assistance by a familiar staff person that would not otherwise be provided by hospital staff. Respite CANNOT be billed if the member is in the hospital for psychiatric treatment.
- A Day Habilitation program licensed by OHFLAC to deliver services to people with developmental disabilities (where age appropriate).
- A licensed day care program (for children only on a short-term basis). Example: ~~“Mother’s-Day-Out”~~ program when the member receives intermittent respite care at a day care program which does not occur on a daily or routine basis. When the primary care-giver works outside the home, the every day scheduled day care of the member is the responsibility of the primary care-giver and is not an eligible service activity for respite care.
- In the local public community environment.

DOCUMENTATION

Documentation shall include the following:

- Name of MR/DD Waiver member
- Content of the activity.
- Relationship of that activity to an objective on the IPP
- Actual time spent, including start and stop times for the day of service
- Date of service
- Staff to member ratio
- Signature and credentials of the staff providing the service.

The provider is required to utilize the Respite Documentation Form (DD-12). The summary on the DD-12 should discuss specifics of the task or activity and should not be a general description such as



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“completing task analysis”. Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.

SERVICE RESTRICTIONS

Respite Care services may not be used in a group home, ISS or a residence where the individual lives alone or with other service members because these settings have staff that may work shifts and are not the single primary care-giver for the individual. Respite Care services may only be used by the above settings in an emergency to allow the individual to go to another site for temporary care, or to cover services in a crisis while a new IPP is developed which covers the changes in the individual's circumstances and/or the services. As an exception, Respite Services may be utilized in a DD Crisis Respite Site location that is a BHHF contracted DD Crisis Respite site.

Respite is not intended for every day provision of care for a child or adult in the absence of a parent(s) or primary care-giver(s) when the parent(s) or caretaker(s) goes to work.

The same documentation is required for contracted services. A contract is required between the contracted provider and the provider agency.

The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

PROVIDER QUALIFICATIONS

The Therapeutic Consultant must assess and have oversight for “respite relevant training goals” only.

Respite Care Level I Providers are individuals contracted by an agency who have been chosen by the member or the member's legal representative. Providers may include Specialized Family Care Providers (SFCP) and/or biological or adoptive family members or relatives. The Respite Care Level 1 provider cannot reside with the member. Respite Care Level I is an optional service for Waiver providers.

Prior to the provision of services, the contracted Respite providers must submit verification of the following to the contracting provider:

- Contractor is a minimum of 18 years of age. Verification of age must be on file at the contracting provider agency.
- Current certification in CPR and First Aid. A copy of the certification card must be on file at the contracting provider agency.
- Training in health related issues (medication interactions, seizures, gastrostomy tubes, etc.) or respite relevant training procedures and protocols as needed by the member.
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to



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the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Respite Care Level II Providers must be employees of the behavioral health provider. The Respite Care Level II provider must not reside with the member. Respite Care Level II providers must meet the following requirements:

- Be at least 18 years of age. Verification of age must be on file at the provider agency
- High school diploma or GED
- Current certification in CPR and first aid. A copy of the certification care must be on file at the provider agency
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements

513.7.6 RESIDENTIAL HABILITATION

(RESIDENTIAL BASED SERVICES INCLUDES BOTH AGENCY RESIDENTIAL HABILITATION AND COMMUNITY RESIDENTIAL HABILITATION)

DEFINITION

Residential Habilitation Services are monitoring, support and training services delivered in a member's residence and the member's community that provide instruction and assistance to enable him/her to acquire and maintain skills which will allow him/her to live and socialize more independently. Residential Habilitation services also may include behavioral interventions to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. Residential Habilitation is a venue for active treatment.

Residential habilitation services must be developed exclusively to address the identified habilitation needs of the member. Activities should not be integrated to occur concurrently with personal or work activities of a staff member or family members. This includes such activities such as socialization, shopping, transporting or delivery needs of the staff member or family member. When a setting is available for a reimbursable residential habilitation activity in the neighborhood where the member resides, this setting must be utilized. (i.e. stores, banks, libraries, etc). Residential Habilitation services must occur where the rest of the community typically shops or conducts business utilizing the resources available in the member's neighborhood. Residential Habilitation services must be based on assessment that is person-centered/goal oriented and with meaningful/productive activities that are guided by the member's needs wishes, desires, and goals.

All Agency Residential services are provided under the supervision of a Therapeutic Consultant. Community Residential Habilitation services are provided under clinical oversight of the Therapeutic Consultant. A Therapeutic Consultant will either be a Skills Specialist or a Behavioral Specialist/Analyst.



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The Skills Specialist or the Behavioral Specialist/Analyst will work in conjunction and/or collaboration with the designated Residential Habilitation provider(s) to ensure the implementation of Residential Habilitation Services. (See Section 513.7.11 of this chapter).

Examples of skills, which may be taught include, but are not limited to:

- Personal grooming
- Dressing
- Meal preparation
- Emergency skills
- Self-medication
- Social skills
- Interpersonal skills
- Household skills
- Community access skills
- Independent travel
- Independent living skills
- Communication skills
- Self-advocacy skills
- Mobility skills
- Fine/gross motor skills

Physical assistance to assist the individual to achieve a specific instructional objective, may be included as part of the instructional plan for the activity. Physical assistance must be an integral part of an instructional plan and secondary to the learning of a skill, to be reimbursed as part of a habilitation service.

SERVICE RESTRICTION

Residential Habilitation cannot replace the routine care and supervision which would be expected to be provided by a legally responsible care taker or for activities or supervision for which payment is made by a source other than Medicaid.

No more than 8 hours of supervision and monitoring at night may be provided for members living in group homes or ISS settings (1-3 living in the home). This is not available for members who reside in family homes.

Providers for Community Residential Habilitation Services can only be reimbursed for services that are considered extraordinary via the extraordinary care assessment (DD-25).



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MR/DD Waiver services may not replace federally mandated educational services. The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.6.1 COMMUNITY RESIDENTIAL HABILITATION

PROCEDURE CODE: T2017-UA

SERVICE UNITS: 15 minutes

SERVICE LIMITS: 496 units per month Limit of 496 units per month combined with T2017-U4, T2017-U3, T2017-U2, T2017-U1 and up to 744 units per month with prior authorization)

PAYMENT LIMITS: Only those services that have been identified as necessary in the Extraordinary Care Assessment are allowable for reimbursement. Any units in excess of 496 per month up to 744 units per month must be approved by the local waiver contact person prior to November 1, 2006 and by the ASO November 1, 2006 and beyond. The local Waiver contact person cannot authorize units in excess of four (4) hours after November 1, 2006.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Residential services above 496 units per month that includes Community Residential Habilitation or a combination of Community Residential Habilitation and Agency Residential Habilitation, needs prior authorization.

DEFINITION

Community Residential Habilitation services are support services delivered in a participant's residence and in the community which provide instruction and assistance to enable him/her to acquire and maintain skills which will allow him/her to live and socialize more independently. Residential Habilitation services may also include behavioral support to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. Training must be age appropriate, functional and natural in terms of materials, location and times.



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The Extraordinary Care Assessment and service requirements associated with the assessment are not necessary for Specialized Family Care providers and parents of adult children beyond 18 years of age who have not been appointed as legal representative for the member (guardian). The assessment and requirements are intended for natural parents, adoptive parents, or legal representatives who provide community residential habilitation services to the member.

PROVIDER QUALIFICATIONS

Residential service providers must have a minimum of the following qualifications:

- Be at least 18 years old with proof of age on file
- Be a Biological/Adoptive family member, or a Specialized Family Care Provider
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements
- Certification of CPR and First Aid
- Community Residential Habilitation services must have the oversight of a Therapeutic Consultant

Up to twelve (12) hours (forty eight {48} units) of Residential Habilitation services per three (3) months per member may be charged, if necessary, for the purpose of training the Residential Habilitation service provider in member-specific instructional (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only Therapeutic Consultants, either the Skills Specialist or Behavior Specialist/Analyst may provide training to Residential Habilitation providers.

Up to 1 hour (4 units) of Residential Habilitation may be charged by the Residential Habilitation service provider to participate in the development of the annual IPP, the quarterly review or 6-month IPP review. Billing may occur only for program planning meetings outlined above and only for the actual time participating in such meetings.

SITE OF SERVICE

Community Residential Habilitation is provided in the following settings:

- Biological /Adoptive/Natural family homes that is the primary residence of the member.
- Specialized Family Care Homes certified by the SFCP administered by WV University Center for Excellence in Disabilities (WVUCED) and DHHR, Bureau for Children and Families. A foster care home or an adult family care home is not an eligible setting for Community Residential Habilitation.

DOCUMENTATION

- Residential Habilitation providers must maintain detailed documentation (e.g., progress notes, daily activity logs, task analysis) for residential sites in the center's chosen format. Documentation must include the name of MR/DD Waiver member, specific activity provided, its relationship to an IPP



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objective, task analysis, the actual time spent, including start and stop times, signatures and credentials of staff providing the service and the date of service.

- Community Residential Habilitation providers must complete the Community Residential Habilitation Documentation from (DD 12). The summary should discuss specifics of the task or activity and should not be a general description such as “completing task analysis”. Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.

SERVICE RESTRICTIONS

- It is **not** the member’s or the member’s legal representative’s responsibility to provide or arrange for Residential Habilitation services. It is the responsibility of the Service Coordination provider agency to provide or arrange for Residential Habilitation services with trained and qualified Medicaid providers.
- Routine monitoring or support is not considered assistance in community residential habilitation services. This service includes activities that are considered “active treatment”. Members may receive Community Residential Habilitation in the form of assistance as they participate in activities at home or in the local community. This assistance provides the individualized support necessary for participation in the activity during brief episodes between training steps.
- Providers for community residential habilitation can only be reimbursed for services that are considered extraordinary via the extraordinary care assessment.
- Community Residential Habilitation may only be provided to individuals who live in the home with their biological or adoptive family. This service cannot be provided to individuals living in ISS or group home settings.
- Community Residential Habilitation providers may not bill for overnight supervision and monitoring.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.6.2 AGENCY RESIDENTIAL HABILITATION

| | |
|------------------------|---|
| PROCEDURE CODE: | T2017-U4, T2017-U3, T2017-U2, T2017-U1 |
| SERVICE UNITS: | 15 minutes |
| SERVICE LIMITS: | 2616 monthly, combined service limits (Combined service limits include S5135, S5135 UN, S5135 UP Adult Companion Services Level 1-contracted and S5135-U4, S5135-U3, S5135-U2Adult Companion Services Level 2 - agency and Community Residential Habilitation T2017- UA) (Note: 507.6.1. caps Community Residential Habilitation {T2017-UA} in combination with Agency Residential habilitation {T2017 U4, T2017 U3, T2017 U2, and T2017} U1 to 496 |



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units per month without prior approval/authorization and 744 units per month with prior authorization).

Staff / Member Ratio 1:1, 1:2, 1:3, and 1:4 Residential

A member living in a natural family home who has a legally responsible adult (court appointed guardian or parent) may only receive habilitation services that have been identified as necessary in the Extraordinary Care Assessment.

PRIOR AUTHORIZATION:

Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Agency Residential Habilitation services are support services delivered in a participant's residence and in the member's community which provide instruction and assistance to enable him/her to acquire and maintain skills which will allow him/her to live and socialize more independently. Residential Habilitation services may also include behavioral support to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. Training must be age appropriate, functional and natural in terms of materials, location and times.

Agency Residential Habilitation, Staff/Member Ratio 1:1 (T2017-U4), 1:2 (T2017-U3), 1:3 (T2017-U2), and 1:4 (T2017-U1) are a combination of the above services delivered by a staff member of a behavioral health center licensed by the OHFLAC. No other ratio combinations can be considered.

Up to twelve (12) hours (forty eight {48} units) of Residential Habilitation services per three (3) months per member may be charged, if necessary, for the purpose of training the Residential Habilitation service provider in member-specific instructional (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only qualified professionals such as Therapeutic Consultant, Skills Specialist or Behavioral Specialist/Analyst may provide training to Residential Habilitation providers.

Up to one (1) hour (four {4} units) of Residential Habilitation may be charged by the Residential Habilitation service provider to participate in the development of the annual IPP, the quarterly review, or 6-month IPP review. Billing may occur only for program planning meetings outlined above and only for the actual time participating in such meetings.



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Habilitation service providers must be employed staff of the licensed behavioral health provider agency which the member has chosen to provide the service(s). This requirement assures the credentialed staff has met specific professional and training requirements and is monitored by a licensed behavioral health provider and meets the criteria establishing an employee-employer relationship as specified by the U. S. Department of Labor (DOL).

Agency Residential Habilitation services must have oversight by a Therapeutic Consultant.

PROVIDER QUALIFICATIONS

Residential service providers must have a minimum of the following qualifications:

- Be at least 18 years old with proof of age on file;
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.) to deliver services;
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member; See Section 513.2.6 Criminal Investigation Background Check for further requirements
- Certification in CPR and First Aid.

SITE OF SERVICE

Residential Habilitation is provided in the following settings:

- The member's own home or apartment that is his/her primary residence. Residential Habilitation services may not be delivered in a residence that endangers the health or safety of the member or the staff.
- Biological or adoptive family homes that is the member's primary residence.
- Specialized Family Care Homes certified by the SFCP administered by the WV University Center for Excellence in Disabilities (WVUCED) and DHHR, Bureau for Children and Families. A foster care home or an adult family care home is not an eligible setting for Agency Residential Habilitation.
- Group homes licensed by OHFLAC to serve individuals with mental retardation and/or developmental disabilities.
- Individualized Support Settings (ISS) staffed or operated by a licensed behavioral health center serving people with mental retardation and/or developmental disabilities (ISS setting is defined as a home setting with one – three (1-3) people living in the home).
- Residential Habilitation services may also be carried over in the necessary local public community environments as specified in the IPP.
- The MR/DD Waiver Program is limiting the size of agency operated group homes. It is the policy of the MR/DD Waiver Program to support living arrangements which are **not** large congregate settings. Agency operated group homes with a four (4) bed capacity or above must receive special approval from DHHR.



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DOCUMENTATION

- Residential Habilitation providers must maintain detailed documentation (e.g., progress notes, daily activity logs, task analysis) for residential sites in the center's chosen format. Documentation must include the name of MR/DD Waiver member, specific activity provided, its relationship to an IPP objective, the actual time spent, including start and stop times, task analysis, signatures and credentials of staff providing the service and the date of service. When transportation is provided in conjunction with habilitation, the transportation must be linked to a goal on the IPP.
- A weekly schedule of activities that is linked to the training goals and objectives must be available for the Agency Residential Habilitation provider. The schedule must include the activity, the place, and general time frame that the activity is to occur. The schedule provides direction for staff implementing the training and consistency of training activities. Member's preference must be included in the development of the weekly schedule.

SERVICE RESTRICTIONS

- It is not the member's or the member's legal representative's responsibility to provide or arrange for Residential Habilitation services. It is the responsibility of the Service Coordination provider agency to provide or arrange for Residential Habilitation services with trained and qualified Medicaid providers.
- Members may receive Residential Habilitation in the form of assistance by staff as they participate in activities at home or in the local community. This assistance provides the individualized support necessary for participation in the activity. Unlike Residential Habilitation training, this assistance is not presented in a training format with formal training objectives. Based upon evaluations, the IDT (1) determines if the individual requires assistance to participate in non-training residential activities; (2) identifies on the ISP those activities for which this support would be provided; and (3) specifies the amount of support (units per month). Residential Habilitation assistance is to be provided in combination with daily Residential Habilitation training. A member must have a current residential training program to qualify for the Residential Habilitation assistance and is to be maintained as described in the documentation section of Residential Habilitation.
- A maximum of 8 hours per day (32 units) of monitoring and supervision may be provided to a member for overnight supervision. Overnight supervision must be provided by alert and "awake" staff. The need for monitoring and supervision must be supported by evaluations and included in the IPP. Justification for such services may include such factors as severe challenging behaviors or life-endangering medical conditions. Residential Habilitation monitoring and supervision in a family home or a Specialized Family Care Home (SFCH) may not be provided by a family member or the SFCP.
- Providers for Community Residential Habilitation can only be reimbursed for services that are considered extraordinary via the extraordinary care assessment.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).



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513.7.7 ADULT COMPANION SERVICES

| | | | |
|------------------------|-----------|---------------------------|------------|
| PROCEDURE CODE: | S5135 | Adult Companion Level I, | 1:1 ratio |
| | S5135 UN | Adult Companion Level I, | 1:2 ratios |
| | S5135 UP | Adult Companion Level I, | 1:3 ratios |
| | S5135- U4 | Adult Companion Level II, | 1:1 ratio |
| | S5135- U3 | Adult Companion Level II, | 1:2 ratios |
| | S5135- U2 | Adult Companion Level II, | 1:3 ratios |

SERVICE UNITS: 15 minutes

SERVICE LIMITS: 2616 monthly, combined service limits (Combined service limits includes T2017-UA, T2017-U1, T2017-U2, T2017-U3 and T2017-U4 Residential Habilitation).

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Adult Companion Services are non-medical care supervision, socialization, monitoring and assistance as determined by the IDT and specified in the IPP. The purpose of Adult Companion Services is two-fold:

- To participate in “non-training” activities in the member’s local community that are planned and that do not occur during intermittent periods of time between training activities. Example: staff accompanying a member for a two (2) hour time-frame to a swimming activity at a local community pool.
- To provide assistance with activities that will not have a long-term benefit of training to the member. (Example: Staff placing groceries in a kitchen cabinet for a member who has cerebral palsy and is physically unable to reach the upper cabinets without assistance).

Adult Companion services are complimentary to, and not exclusive of Residential Habilitation, Day Habilitation, Prevocational or Supportive Employment services as specified by individual needs on the IPP.



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ADULT COMPANION SERVICES

Adult Companion services must have clinical oversight by a Therapeutic Consultant who ensures the delivery of services in accordance with the MR/DD Waiver Program and the IPPs of the members.

Adult Companion Level I Providers may be individuals contracted by an agency who have been chosen by the member or the member's legal representative. They may not reside with the member. Adult Companion Level I is an optional service for Waiver providers.

Conditions of Contracting:

Prior to the provision of services, the contracted Adult Companion Level I Provider must submit verification of the following to the contracting provider:

- The contractor is a minimum of 18 years of age;
- Current certification in CPR and First Aid. A copy of the certification card must be on file at the contracting provider agency;
- The contractor has training in health related issues (medication interactions, seizures, gastrostomy tubes, etc.) as needed per individual Waiver member;
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. **CIB is required for Level I and Level II.** See Section 513.2.6 Criminal Investigation Background Check for further requirements

Adult Companion Level II Providers must be employees of the behavioral health provider chosen for the service and:

- Have a high school diploma or Graduate Equivalency Degree (G.E.D.);
- Be at least 18 years old with proof of age on file at the provider agency;
- Current certification in CPR and first aid. A copy of the certification card must be on file at the contracting provider agency;
- The contractor has training in health related issues (medication interactions, seizures, gastrostomy tubes, etc.) as needed per individual Waiver member;
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. **CIB is required for Level I & Level II.**

SITE OF SERVICE

Adult Companion services are provided in the following locations:



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- Locations in the member's local community (local public community environment) to implement those activities which support a member's needs and choices.
- Natural or Adoptive family homes or Specialized Family Care homes in which the member resides
- Group Homes (GH) licensed by OHFLAC to serve individuals who have a diagnosis of MR/DD. (GH = 4 members in one home)
- The MR/DD Waiver Program is limiting the size of agency operated group homes. It is the policy of the MR/DD Waiver Program to support living arrangements which are **not** large congregate settings.
- Individualized Support Setting (ISS) (ISS = 3 or less members in one home)
- BHHF Development Disability (DD) funded Crisis Respite sites

DOCUMENTATION- LEVEL I AND LEVEL II

- Adult Companion services are documented on an Adult Companion Services documentation form (DD-12) by the provider and monitored and reviewed by the Service Coordinator. Documentation shall include name of MR/DD Waiver member, the content of the activity, the relationship of that activity to an objective on the IPP, the actual time spent, including start and stop times, date of service, the staff to member ratio and the signature and credentials of the staff providing the service on the Adult Companion Services Documentation form (DD-12). The summary should discuss specifics of the task or activity and should not be a general description such as "completing task analysis". Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.

SERVICE RESTRICTIONS: LEVEL I AND LEVEL II:

- Adult Companion services shall **not** be billed concurrently with Residential Habilitation (agency), Community Residential Habilitation, Respite, Day Habilitation, Pre-Vocational Training and Supported Employment services.
- The member is required to have Habilitation Services (Residential Habilitation or Community Residential Habilitation Services) to access Adult Companion services.
- Adult Companion providers shall **not** provide services to members with whom they share a residence.
- This service is **not** to be provided by a family member residing with the member in a natural, adoptive or foster family setting.
- This service is **not** to be provided by a SFCP in a specialized family care setting.
- This service is **not** to be provided by a family member of a member residing in an agency-operated or agency-staffed residential home such as an ISS or a group home.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as



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stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

- A staff member’s home is not a site of service.

513.7.8 DAY HABILITATION PROGRAM

PROCEDURE CODE T2021-U4, T2021-U3, T2021-U2, T2021-U1

SERVICE UNITS: 15 minutes

SERVICE LIMITS: 600 - 15 minute units per month up to an annual maximum of 7,200 units inclusive of staff/member ratios 1:1(U4), 1:2 (U3), 1:3 (U2), 1:4 (U1) these are the only ratios available for Day Habilitation

PAYMENT LIMITS: See below

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Day Habilitation is a structured program that is designed to promote the acquisition of skills or maintenance of skills for the member outside the residential home. Day Habilitation activities must occur during naturally occurring routines of the day for the member.

Day Habilitation activities in the plan must be developed exclusively to address the habilitation needs of the member. Activities should not be integrated to occur concurrently with personal or work activities of a staff member or family members. This includes such activities such as socialization, shopping, transporting or delivery needs of the staff member.

Day Habilitation services must be based on assessment, be person-centered/goal oriented, and with meaningful/productive activities that are guided by the member’s needs wishes, desires, and goals.



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DAY HABILITATION SERVICES

Day Habilitation services consist of programs of instruction/training, supervision and assistance, specialist services and evaluations provided by or under the direct supervision of a Therapeutic Consultant, as described in Section 513.7.11 of this Chapter.

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

- Development of self-care skills
- Use of community services and businesses
- Emergency skills
- Mobility skills
- Nutritional skills
- Social skills
- Communication and speech instruction (prescribed by a Speech Language Pathologist)
- Therapy objectives (prescribed by Physical Therapist, Occupational Therapist, etc.)
- Interpersonal skills instruction
- Functional academics such as recognizing emergency and other public signs, independent money management skills, etc.
- Citizenship, rights and responsibilities, self-advocacy, etc.
- Other habilitative services necessary for an individual to participate in activities in the community settings of his/her choice
- Self medication
- Independent living skills
- Volunteer services (volunteer work cannot replace a paid employment position).

Physical assistance to assist the individual to achieve a specific instructional objective may be included as part of the instructional plan for the activity. Physical assistance must be an integral part of an instructional plan and secondary to learning of a skill, to be reimbursed as part of a habilitation service.

When a setting is available for a reimbursable day habilitation activity (i.e. habilitation, adult companion, respite) in the neighborhood where the member resides, this setting must be utilized. (i.e. stores, banks, libraries, etc). Day Habilitation must occur where the rest of the community typically shops or conducts business utilizing the resources available in the member's neighborhood. Day Habilitation must be for the member's specific needs and is not intended for the socialization, shopping, transporting or delivery needs of a staff member or a family member. Members may participate in either community based day habilitation or facility based day habilitation. The facility based day habilitation program must be licensed by OHFLAC.



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Up to 48 units of Day Habilitation Program services per 3 months may be charged, if necessary, for the purpose of training the Day Habilitation service provider in person-specific instructional (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Training received by the Day Habilitation provider must be conducted by a Therapeutic Consultant.

Up to 4 units of day habilitation service may be charged by the Day Habilitation service provider to actively participate in the development of the annual IPP and 4 units may be charged to actively participate in the 3, 6, 9 month IPP update. Billing may occur only for program planning meetings required by the MR/DD Waiver Program as outlined above.

Day Habilitation Program services can be delivered in staff/member ratio of 1:1, 1:2, 1:3 and 1:4. No other ratio combinations can be granted. There must be sufficient numbers of competent, trained staff to provide active habilitation and to protect the individual's health and safety.

PROVIDER QUALIFICATIONS

Individuals providing Day Habilitation Program services must be employees (staff) of the licensed behavioral health provider (either community day habilitation or site-based day habilitation). This requirement assures the credentialed staff has met specific professional and training requirements, is monitored by a licensed behavioral health provider and meets the criteria establishing an employee-employer relationship as specified by the U. S. Department of Labor (DOL).

Day Habilitation Program service providers must have a minimum of the following qualifications:

- Be at least 18 years old with proof of age on file
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- Certified in CPR and First Aid
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.
- See Section 513.2.6 Criminal Investigation Background Check for further requirements

SITE OF SERVICE

Day Habilitation takes place away from a person's home and may include activities in natural community environments to facilitate skills acquisition. Day Habilitation may be provided in a licensed, certified day program site or a natural setting in the community. All facility based day program sites must be licensed by OHFLAC.

DOCUMENTATION

Day Habilitation providers (employing organization) must maintain detailed documentation (e.g. progress notes, daily activity logs) for services provided in the provider's chosen format.



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Documentation shall include name of MR/DD Waiver member, the content of the activity, the relationship of that activity to an objective on the IPP, the actual time spent, including start and stop times, date of service, the staff to member ratio, schedule, task analysis and the signature and credentials of the staff providing the service.

A weekly schedule of activities that is linked to the training goals and objects must be available for the Day Habilitation provider. The schedule must include the activity, the place, and general time frame that the activity is to occur. The schedule provides direction for staff implementing the training and consistency of training activities. Member's preference must be included in the development of the weekly schedule.

SERVICE RESTRICTIONS

- Day Habilitation Services are analogous to work or instructional classes in skills of daily living necessary to assist the individual to be involved in the community. Individuals who have aged out of school must participate in Day Habilitation, Prevocational Training or Supported Employment programs.
- Day Habilitation services may not be delivered in a residential site except in rare circumstances where the individual cannot receive Day Habilitation services outside his/her home. Approval for day habilitation in a member's home must be requested and authorized from the ASO and the following conditions must be met:

The services are overseen by a Therapeutic Consultant

All service providers meet the qualifications for delivering Day Habilitation Services

Day Habilitation and Residential Habilitation services are not delivered concurrently

The Therapeutic Consultant must ensure the training of staff on appropriate training program goals and that activities occur in a normal, community setting.

Ordered by a physician

- Day Habilitation may not take the place of federally funded educational services. Children who do not receive extended school year services may be eligible to receive Day Habilitation in the summer months. However, during the remainder of the year, school is considered the day habilitation and the child is not eligible for day activities under Waiver both during the week and on weekends (day activities include Day Habilitation, Prevocational Services and Supported Employment). The Title XIX MR/DD Waiver Home and Community Based Program cannot provide federal and state mandated education services. The only exception for this would be if Day Habilitation services would be deemed beneficial for the member directly before or directly after the traditional school day.
- Day habilitation services must be offered in the most integrated setting available. Ratios for day habilitation are 1:1, 1:2, 1:3, and 1:4. No other ratio combinations can be considered. A weekly schedule of activities that is linked to the training goals and objectives must be available for community day habilitation. The schedule must include the activity, the place, and the time that the



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activity is to occur. The schedule provides direction for staff implementing the training and consistency of training activities. Member’s preferences must be included in the development of the weekly schedule. This schedule is for the purpose of day habilitation activities only.

513.7.9 PREVOCAATIONAL TRAINING

PROCEDURE CODE: T2015-Individual, T2015-HQ-Group
SERVICE UNITS: 60 minutes
SERVICE LIMITS: 115 1-hour units per month inclusive of both Individual and Group services.

PAYMENT LIMITS: MR/DD Waiver Prevocational Training services may not be substituted for those services available through DRS through a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation of a referral to the Division of Rehabilitation Services (DRS) must be maintained by the provider agency in the individual’s record of service.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Prevocational Training Services are planned and designed to assist an individual to acquire and maintain basic work and work-related skills. The service must be an essential component of the IPP, and work activity must be a secondary or tertiary goal of the service, subordinate to the acquisition and retention of work and work-related skills.

PROVIDERS QUALIFICATIONS

- Must be at least 18 years old with proof of age on file.
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to



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the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

- Certified in CPR and First Aid
- Must be employees (staff) of the licensed behavioral health provider or the Division of Rehabilitation Services acknowledged vendor.

PREVOCATIONAL TRAINING SERVICES

Prevocational Training service activities include but are not limited to, the following:

- Training the individual to follow directions and carry out assigned duties
- Assistance to acquire appropriate attitudes and work habits, such as socially appropriate behaviors on the work site
- Assistance to adjust to the production and performance standards of the workplace
- Mobility training as related to work or work skills
- Compliance with workplace rules or procedures
- Attendance to work activity
- Assistance with workplace problem solving
- Instruction in the appropriate use of work-related facilities (e.g., rest rooms, cafeteria/lunch rooms, and break areas.)

Individual services are delivered in a staff/member ratio of 1:1. Group services are delivered in staff/member ratio of 1: 2-4. No other ratio combinations can be considered. There must be sufficient numbers of competent, trained staff to provide pre-vocational training and to protect individual's health and safety.

Prevocational training services must be provided by paraprofessionals and supervised by a Therapeutic Consultant in accordance with the provider qualification and training requirements of this chapter. Paraprofessionals must also have documented training or experience in the implementation of Prevocational Training plans of instruction.

Up to 48 units of Day Habilitation Program services per 3 months may be charged, if necessary, for the purpose of training the prevocational service provider in person-specific instructional (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Training received by the Prevocational Training provider must be conducted by a Therapeutic Consultant.

Up to four (4) units of prevocational training services may be charged by the Day Habilitation service provider to actively participate in the development of the annual IPP and four (4) units may be charged to actively participate in the 3, 6, 9 month IPP update. Billing may occur only for program planning meetings required by the MR/DD Waiver Program as outlined above.



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SITE OF SERVICE

Services may be delivered by day activity centers or adult day service programs operated by behavioral health providers which are licensed by OHFLAC, or acknowledged by a Division of Rehabilitation Services vendor prior to November 1, 2006 will be granted a grandfather status.

If any member is paid less than minimum wage the program must be certified by the Department of Labor and maintain a current sub-minimum wage certificate.

Services may be delivered by the pre-vocational provider in a community setting.

DOCUMENTATION

- Pre-vocational service providers must maintain detailed documentation (e.g., progress notes, daily activity logs) for services provided in the agency’s chosen format. Documentation shall include name of MR/DD Waiver member, the content of the activity, the relationship of that activity to an objective on the IPP, the actual time spent, including start and stop times, date of service, the staff to member ratio, task analysis and the signature and credentials of the staff providing the service.
- A weekly schedule of activities that is linked to the training goals and objectives must be available for the Pre-Vocational provider. The schedule must include the activity, the place, and general time frame that the activity is to occur. The schedule provides direction for staff implementing the training and consistency of training activities. Member’s preference must be included in the development of the weekly schedule.

SERVICE RESTRICTIONS

In order to access Pre-Vocational services under the MR/DD Waiver Program, one must determine if services are currently provided through Division of Rehabilitation Services (DRS). If services are not provided through DRS, a program funded under the Rehabilitation Act of 1973, the MR/DD Waiver Program provider agency must make a referral to DRS. A copy of the referral must be maintained by the provider agency in the individual’s record of service. MR/DD waiver pre-vocational services must not be utilized concurrently with any DRS pre-vocational services.

The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.10 SUPPORTED EMPLOYMENT

PROCEDURE CODE: T2019-Individual, T2019-HQ-Group

SERVICE UNITS: 15 minute

SERVICE LIMITS: 576 - 15 minute units per month inclusive of both Individual and Group services.



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PAYMENT LIMITS:

MR/DD Waiver Supported Employment services may not be substituted for those services available through Division of Rehabilitation Services (DRS) through a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation of referral, to DRS must be maintained by the provider agency in the individual's record of service.

PRIOR AUTHORIZATION:

Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Supported Employment Services are services that enable individuals to engage in paid, competitive employment, in integrated community settings. The services are for individuals who have barriers to obtaining employment due to the nature and complexity of their disabilities, regardless of age or vocational potential. The services are designed to assist individuals for whom competitive employment at or above the minimum wage is unlikely without such support and services and need ongoing post-employment support based upon the member's level of need.

PROVIDER QUALIFICATIONS

Supported employment service providers must meet the following criteria:

- Must be at least 18 years old with proof of age on file.
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- CPR and First Aid
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirement.

SUPPORTED EMPLOYMENT SERVICES

Supported Employment services include, but are not limited to:



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- Vocational counseling (Example: Discussion of the member's on- the- job work activities)
- Job development and placement for a specific waiver member with the member present
- On-the-job training in work and work-related skills
- Accommodation of work performance task
- Supervision and monitoring by a job coach
- Intervention to replace inappropriate work behaviors with adaptive work skills and behaviors
- Retraining as jobs change or job tasks change
- Training in skills essential to obtain and retain employment, such as the effective use of community resources
- Transportation to and from job sites when other forms of transportation are unavailable or inaccessible.

Natural work setting supports are to be considered prior to the utilization of Supported Employment. Individual services are delivered in a staff/member ratio of 1:1. Group services are delivered in a staff/member ratio of 1:2-4. No other ratio combinations can be considered. There must be sufficient numbers of competent, trained staff to provide supported employment services and to protect individual's health and safety.

Supported Employment Services must be supervised by a Therapeutic Consultant. In addition to the primary training requirements as outlined in Section 513.2.5, paraprofessionals providing supported employment must have documented training or experience in implementation of Supported Employment plans of instruction.

- Trainers or job coaches must be employees of community behavioral health providers that are licensed by OHFLAC or community rehabilitation programs that are acknowledged by a Division of Rehabilitation Services vendor prior to July, 1, 2006 will be granted a grandfather status.

SITE OF SERVICE

Integrated community work setting.

DOCUMENTATION

- Supported Employment providers must maintain detailed documentation (e.g., progress notes, daily activity logs) in the center's chosen format for services provided. Documentation shall include name of MR/DD Waiver member, the content of the activity, the relationship of that activity to an objective on the IPP, the actual time spent, including start and stop times, date of service, the staff to member ratio and the signature and credentials of the staff providing the service.
- A weekly schedule of activities that is linked to the training goals and objects must be available for the Supportive Employment provider. The schedule must include the activity, the place, and general time frame that the activity is to occur. The schedule provides direction for staff



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implementing the training and consistency of training activities. Member's preference must be included in the development of the weekly schedule.

SERVICE RESTRICTIONS

- In order to access supported employment services under the MR/DD Waiver Program one must determine if services are currently provided through DRS. If services are not provided through DRS, a program funded under the Rehabilitation Act of 1973, the MR/DD Waiver Program provider agency must make a referral to DRS. A copy of the referral must be maintained by the provider agency in the individual's record of service. MR/DD waiver supported employment services must not be utilized concurrently with any DRS pre-vocational services.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.11 THERAPEUTIC CONSULTATIVE SERVICES (Therapeutic Consultative Services Includes Skills Specialist, Behavioral Specialist, and Behavioral Analyst-)

DEFINITION

Therapeutic Consultative services are services provided by a Qualified Mental Retardation Professional to develop and monitor a plan of intervention or instruction.

ROLE OF THERAPEUTIC CONSULTANT

Although not mandated, each member may have up to three (3) Therapeutic Consultants. In the absence of the member's Therapeutic Consultant due to illness or emergencies, a substitute Therapeutic Consultant from the same provider may provide the service in the interim. Services which are provided to the member during this absence require the documentation of the reason for the substitution on the progress note.

A Behavioral Specialist/Analyst will act as the Therapeutic Consultant if significant maladaptive issues are indicated by the ICAP assessments that require positive behavioral support intervention. The Behavioral Specialist/Analyst is responsible for both the maladaptive and the adaptive portions of the plan.

A Skills Development Specialist will act as the Therapeutic Consultant if there are no significant maladaptive issues present. The residential setting may have one consultant for the member and the day setting may have one (1) consultant for the member. The day setting includes Day Habilitation, Prevocational, and Supported Employment Services. A third Therapeutic Consultant may be added only if there is a second or third provider for a day setting activity.



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An individual with Behavioral Specialist/Analyst credentials who provides therapeutic consultant services to a member whose assessments indicate no maladaptive behaviors will need to bill as a Skills Specialist.

In the event that there is more than one (1) Therapeutic Consultant, the Residential Therapeutic Consultant will act as the primary Therapeutic Consultant. Additional Therapeutic Consultants (up to two) may be necessary if the individual is also receiving services from different providers in a day setting such as day habilitation, prevocational, or supported employment services.

The Residential Therapeutic Consultant will be the primary Consultant responsible for coordinating the collaboration of the total habilitation plans and behavioral support plans, protocols, or guidelines. All habilitation plans (residential, day, prevocational/supported employment) must be developed in collaboration. The point of collaboration is the IDT.

All Therapeutic Consultant's involved with the member's habilitation plans must sign each part of the plan (residential, day, prevocational/supported employment) indicating the plans are consistent with adaptive training methodologies, strategies, areas of skill improvement and maladaptive issues or interventions. The ASO will provide ICAP adaptive and maladaptive finding to the IDT. The IDT may use these finding to assist in prioritizing the member's habilitation and training needs. Plans must be correlated with the results found in both the adaptive and maladaptive findings of the ICAP assessment. Therapeutic Consultants are responsible for the writing and collection of the habilitation plans, and training of the individuals who will be implementing the direct training with the member.

A Therapeutic Consultant must be a qualified mental retardation specialist. Providers must use the DD-17 for credentialing purposes. Any credential that the providers verify on this form must be filed with the provider agency.

SPECIALTY CONSULTANT FOR HEARING OR VISUAL IMPAIRMENT NEEDS

A provider who is certified or specially trained to provide mobility or adaptive training for an individual who is visually impaired or adaptive training for a member who is hearing impaired may be added to a member's team for consultation purposes only. Verification of the provider's qualifications as a Specialty Consultant for hearing or visual impairment must be maintained in the provider agency's files (example: certification or specialized training). This provider is a skills specialist and may bill for only skills specialist services. This provider may consult with the team for a total of **20 units per IPP year**. The Specialty Consultant may consult with the other Therapeutic Consultants on the team, assess the member, or make recommendations to the team regarding adaptations for training activities. Recommendations must be maintained in the member record in writing.

RESTRICTIONS

The Therapeutic Consultant must not be utilized as a direct care service provider for the member. The Therapeutic Consultant may coach or model the training activity as an integral part of the training of the direct service provider. Methods such as coaching or modeling are intermittent activities that do not occur over extended periods of time. However the direct service provider must be present during coaching or modeling of training activity.



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The service is face to face with the exception of a crisis which can constitute the service being provided via teleconference. Crisis services are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavioral support planning, interventions, strategies and direct care.

513.7.11.1 SKILLS SPECIALIST:

PROCEDURE CODE: T2021-U7-UF 1:1 provider to member ratio - day
T2021-U7-UH 1:1 provider to member ratio – residential

SERVICE UNITS: 15 minutes

SERVICE LIMITS: 80 units per month; up to 140 units per month with ASO approval. Limits are combined for both day and residential settings. A minimum of 20 units will be allotted per month in the member’s individual budget.

PAYMENT LIMITS: Providers without credentials for their area of specialty may not provide the service. The Residential setting consultant and the day setting consultant may collaborate no more than 8 units per calendar year for the purpose of plan development.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Skills Specialist provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational providers, supportive employment providers. Also, the Skills Specialist provides training for respite and adult companion providers (if applicable for “respite-relevant” training objectives or health or safety training objectives only). This service is provided to members with the primary need for adaptive skills training and the absence of significant maladaptive behaviors. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction.



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Skills Specialist Core Job Functions:

- Development of task analysis and person specific strategy or methodology for implementation of intervention or instruction plans for an individual (habilitation plans or staff/caretaker directions/guidelines). Example: How may the staff/caretaker create a successful environment for the person?
- Evaluate environment(s) for implementation of the plan which creates the optimal environment for learning. (TC should select the most suitable environment for the consumer's learning needs. For example, if the consumer has an aversion to noisy environments, the TC would be aware of this and would steer the consumer/team from training in such environments as possible)
- Train primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational, supported employment, adult companion, and respite providers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans or guidelines).
- Assessment, evaluation and monitoring of the effectiveness of intervention or instruction plans (habilitation plans or behavioral guidelines) for habilitation training.
- **Job placement activities with a limit of 20 units per quarter (for members receiving supported employment services only)**
- Pre-vocational and supported employment training
- Collect and evaluate data around targeted behaviors when this activity leads to a functional assessment and a behavior support plan (Skills Specialist may collect data to determine the need for a behavior specialist or a behavior analyst) Once the need for a behavior specialist/analyst is determined, the skills specialist would no longer provide the service.

PROVIDER QUALIFICATIONS

- Minimum of a Bachelor's degree in human service field such as psychology, social work, education, or counseling.
- Staff hired prior to November 1, 2006 may be grandfathered into the skills specialist position. Within one year all therapeutic consultants grandfathered into the position must have taken the "Overview of Positive Behavior Support" as developed by the WV Positive Behavior Support (PBS) network.
- Must be a qualified mental retardation professional.
- Must have one year professional experience working with individuals with mental retardation/developmental disabilities.
- Demonstrated competencies as determined by the provider that the individual can perform the core job functions of a skills specialist. Providers without one year post graduate professional experience may provide skills specialist services under the direct supervision of a QMRP professional with a Masters degree in social work, psychology or counseling or a licensed psychologist.
- Providers must have a Criminal Investigation Background Check. CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements

SITE OF SERVICE



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This service may be provided in the Skills Specialist’s office, the individual’s home or other community locations which provide the proper equipment and physical facilities to deliver the specific Skills Specialist’s service.

DOCUMENTATION

A detailed progress note or evaluation report for each service is required. The documentation should include the service code, description of the service, date, time spent, including start and stop times and signature and credentials of the Skills Specialist. All data obtained for a functional analysis must be maintained in the member’s record. Service units are to be rounded on a monthly basis, not daily or weekly.

SERVICE RESTRICTIONS

- Does not apply to the direct training of the member (cannot provide direct services).
- Skills Specialist may not provide aquatic therapy, art therapy, dance therapy, music therapy, pet therapy, aroma therapy, and equestrian therapy. Additionally, skill building instruction or activities around these types of therapies may not be provided.

513.7.11.2 BEHAVIOR SPECIALIST

| | | |
|-----------------------------|---|--|
| PROCEDURE CODE: | T2021-U8-UF | 1:1 provider to member ratio - day |
| | T2021-U8-UH | 1:1 provider to member ratio – residential |
| SERVICE UNITS: | 15 minutes | |
| SERVICE LIMITS: | 120 units per month; up to 200 units per month with ASO approval (combined with T2021U9 (Behavioral Analyst) A minimum of 20 units will be allotted per month in the member’s individual budget (combined with T2021U9) | |
| PAYMENT LIMITS: | Providers without credentials for their area of specialty may not provide the service. The residential setting consultant and the day setting consultant may collaborate no more than 8 units per calendar year for the purpose of plan development | |
| PRIOR AUTHORIZATION: | Refer to Section 513.9, 513.10.1, 513.10.2, 513.11.1, and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. | |



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Services not registered with the claims agent will not be reimbursed.

See Eligibility Criteria for the Service and prior authorization.

DEFINITION:

Behavioral Specialist provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational providers, supportive employment providers) for members *with significant maladaptive behaviors*. The plan of intervention will require a behavioral guideline, protocol, or plan dependent on the member's need. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction.

ELIGIBILITY CRITERIA FOR THE SERVICE

The following is a list of criteria that must be exhibited in order to receive this behavioral service. Once a targeted behavior is established, this service may be utilized for the purpose of behavioral tracking when the behavioral data leads to a positive behavior support plan or behavior protocol. One or more of the conditions must be met:

- Member must currently exhibit maladaptive behaviors or have a recent history of maladaptive behaviors that have occurred no more than one year from the date of implementation of the service (verification by historical evaluation, assessment behavior support plan, behavior plan or IPP only).
- Member may have a history of behaviors beyond the one year that have resulted in severe life threatening situations such as fire setting or arson or sexual assault or offending or behaviors that result in severe bodily harm to others. Eligibility for this criteria must be prior authorized by the ASO.
- Member must have identified behaviors on the IPP that require tracking of behavioral data for the functional assessment
- Member must have a functional assessment that outlines one or more specific targeted behaviors that are currently or will be addressed in a behavioral protocol or a positive behavior support plan **OR** member must have an ICAP rating of moderate, severe or critical on the maladaptive range
- Member may have an active behavior protocol in place if behaviors are infrequent or if the behaviors are not occurring at the time of implementation of the service **OR** member may have a behavior support plan in place.

Person Specific Strategies (Behavioral Guidelines)

A guideline is a written instruction for staff. Written instructions describe methods or interventions that have worked for the member in the past or methods/interventions that have not worked in the past. Written instructions may include “helpful hints” for direct support staff or family members who work directly with the member. The written instruction will address members with the following:

- Mildly challenging behaviors
- Behaviors that occur on an infrequent basis



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- Behaviors that have occurred in the past
- Behaviors that are not life threatening

Person Specific Strategies (Protocol or Positive Behavior Support Plan)

A Positive Behavior Support Plan is a written document that summarizes strategies that assist in preventing challenging behavior(s) from occurring and helps the consumer learn new skills. The plan must be developed within a 90 day time frame. Development and implementation of a plan is as follows:

- Gather information, data collection/functional analysis
- Develop hypothesis
- Build a support plan
- Human rights committee approval
- Train staff
- Implement the plan
- Evaluate effectiveness and modify support plan- review data

Behavioral Specialist Core Job Functions:

- Responsible for all aspects of positive behavior support services
- Behavioral assessment or evaluation consisting of activities such as functional analysis of targeted behavior or analysis of behavioral data
- Behavioral support plan or protocol development
- Training of providers to implement behavioral plan
- Development of behavioral protocols and behavioral guidelines for direct care staff or families
- Development of task analysis and/or methodology for implementation of intervention or instruction to an individual
- Train primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational, supported employment, adult companion, and respite providers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans, behavior plans or protocols)
- Train primary care providers in the person-specific aspects and methods of a plan of intervention or instruction- habilitation plans (i.e., family, residential habilitation providers, day habilitation providers and respite providers)
- Job placement activities with a limit of 20 units per quarter (for members receiving either prevocational or supported employment services only)
- Train primary care providers in the person specific aspects and methods of a plan of intervention or instruction (habilitation plans) who provide prevocational and supported employment services



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- Assessment, evaluation and monitoring of the effectiveness of intervention and instruction plans (habilitation plans, behavior plans, protocols)

PROVIDER QUALIFICATIONS

- Minimum of Bachelor's Degree in Human Service field such as psychology, social work, education, or counseling
- Staff hired prior to November 1, 2006 may be grandfathered into the behavior specialist position. Within one year all therapeutic consultants grandfathered into the position must have taken the "Overview of Positive Behavior Support" as developed by the WV Positive Behavioral Support (PBS) network.
- Minimum of two years professional work experience working with individuals with mental retardation and/or developmental disabilities.
- Must be a qualified mental retardation professional.
- Demonstrated competencies as determined by the provider that the individual can perform the core job functions of a skills development specialist.
- Providers must have a Criminal Investigation Background Check. CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

SITE OF SERVICE

This service may be performed at the Behavioral Specialist's office, the individual's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Behavioral Specialist's services.

DOCUMENTATION

A detailed progress note or evaluation report for each service is required. The documentation should include the service code description of the service, date, time spent, including start and stop times and signature and credentials of the Behavior Specialist. All data obtained for a functional analysis must be maintained in the member's record. Service units are to be rounded on a monthly basis, not daily or weekly. The progress note must include an analysis of the data or problem, the clinical outcome, and the plan of intervention as the result of the analysis.

SERVICE RESTRICTIONS

- Does not apply to the direct training of the member (cannot provide direct services)
- Behavior Specialist may not provide aquatic therapy, art therapy, dance therapy, music therapy, and equestrian therapy. Additionally, skill building instruction or activities around these types of therapies may not be provided.



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513.7.11.3 BEHAVIOR ANALYST

PROCEDURE CODE: T2021-U9-UF Behavior Analyst (1:1 provider to member ratio) – Day
 T2021-U9-UH Behavior Analyst (1:1 provider to member ratio) – Residential
 T2021-U6-UF Behavior Analyst – Psychologist (1:1 provider to member ratio) – Day
 T2021-U6-UH Behavior Analyst –Psychologist (1:1)

SERVICE UNITS: 15 minutes

SERVICE LIMITS 120 units per month; up to 200 units per month with ASO approval (combined with Behavioral Specialist T2021 U8)
 A minimum of 20 units will be allotted per month in the member’s individual budget (combined with T2021U8)

PAYMENT LIMITS: Providers without credentials for their area of specialty may not provide the service. The Residential setting consultant and the day setting consultant may collaborate up to 8 units per calendar year for the purpose of plan development

PRIOR AUTHORIZATION: Refer to Section 513.9, 513.10.1, 513.10.2, 513.11.1, and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

See Eligibility Criteria for the Service and prior authorization.

DEFINITION

Behavioral Analyst provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational providers, supportive employment providers). Also, the Skills Specialist provides training for respite and adult companion providers (if applicable for “respite-relevant” training objectives). This service is provided to members with the primary need for both maladaptive interventions and adaptive skills training. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction. The plan of intervention will require a behavioral guideline, protocol or plan dependent on the member’s need. The



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Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction.

ELIGIBILITY CRITERIA FOR THE SERVICE

The following is a list of criteria that must be exhibited in order to receive this behavioral service. Once a targeted behavior is established, this service may be utilized for the purpose of behavioral tracking when the behavioral data leads to a positive behavior support plan or behavior protocol. One or more of the conditions must be met:

- Member must currently exhibit maladaptive behaviors or have a recent history of maladaptive behaviors that have occurred no more than one year from the date of implementation of the service (verification by historical evaluation, assessment behavior support plan, behavior plan or IPP only).
- Member may have a history of behaviors beyond the one year that have resulted in severe life threatening situations such as fire setting or arson or sexual assault or offending or behaviors that result in severe bodily harm to others. Eligibility criteria must be prior authorized by the ASO.
- Member must have Identified behaviors on the IPP that require tracking of behavioral data for the functional assessment
- Member must have a functional assessment that outlines one or more specific targeted behaviors that are currently or will be addressed in a behavioral protocol or a positive behavior support plan **OR** member must have an ICAP rating of moderate, severe or critical on the maladaptive range
- Member may have an active behavior protocol in place if behaviors are infrequent or if the behaviors are not occurring at the time of implementation of the service **OR** member may have a behavior support plan in place

Person Specific Strategies (Behavioral Guidelines)

A guideline is a written instruction for staff. Written instructions describe methods or interventions that have worked for the member in the past or methods/interventions that have not worked in the past. Written instructions may include “helpful hints” for direct support staff or family members who work directly with the member. The written instruction will address members with the following:

- Mildly challenging behaviors
- Behaviors that occur on an infrequent basis
- Behaviors that have occurred in the past
- Behaviors that are not life threatening

Person Specific Strategies (Protocol or Positive Behavior Support Plan)

A Positive Behavior Support Plan is a written document that summarizes strategies that assist in preventing challenging behavior(s) from occurring and helps the consumer learn new skills. The plan must be developed within a 90 day time frame. Development and implementation of a plan is as follows:



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- Gather information, data collection/functional analysis
- Develop hypothesis
- Build a support plan
- Obtain Human Rights Committee approval
- Train staff
- Implement the plan
- Evaluate effectiveness and modify support plan- review data

Behavioral Analyst Core Job Functions

- Responsible for all aspects of positive behavior support services
- Behavioral assessment or evaluation consisting of activities such as functional analysis of targeted behavior or analysis of behavioral data
- Behavioral support plan or protocol development
- Training of providers to implement behavioral plan
- Development of behavioral protocols and behavioral guidelines for direct care staff or families.
- Development of task analysis and/or methodology for implementation of intervention or instruction to an individual.
- Train primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational, supported employment, adult companion, and respite providers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans, behavior plans or protocols).
- Training in the person-specific aspects and methods of a plan of intervention or instruction provided to the individual and/or primary care providers (i.e., family, residential habilitation providers, day habilitation providers and respite providers).
- Job placement activities with a limit of 20 units per quarter (for members receiving either prevocational or supported employment services only)
- Pre-vocational and supported employment training
- Assessment, evaluation and monitoring of the effectiveness of intervention and instruction plans (habilitation plans, behavior plans, protocols)

PROVIDER QUALIFICATIONS



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- Minimum of Master’s Degree in human service field with a graduate level course work in applied behavioral analysis or positive behavioral support or;
- Minimum of Bachelor’s Degree in human service field with a graduate level course work in applied behavioral analysis or positive behavioral support and;
- Minimum of three years professional work experience working with individuals with mental retardation and/or developmental disabilities and;
- Qualified Mental Retardation Professional;
- Demonstrated competencies (course work, training) in the area of positive behavior support and skills development.
- Providers must have a Criminal Investigation Background Check. CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

SITE OF SERVICE

This service may be provided at the Behavioral Analyst’s office, the individual’s home or other community locations which provide the proper equipment and physical facilities to deliver the specific Behavioral Analyst’s services.

DOCUMENTATION

A detailed progress note or evaluation report for each service is required. The documentation should include the service code description of the service, date, time spent, including start and stop times and signature and credentials of the Behavior Analyst. All data obtained for a functional analysis must be maintained in the member’s record. Service units are to be rounded on a monthly basis, not daily or weekly.

SERVICE RESTRICTIONS

- Does not apply to the direct training of the member (cannot provide direct services)
- Behavior Analyst may not provide aquatic therapy, art therapy, dance therapy, music therapy, and equestrian therapy. Additionally, Skill building instruction or activities around these types of therapies may not be provided.

513.7.12 EXTENDED PROFESSIONAL SERVICES

| | | | |
|------------------------|---|-----------|-------------|
| PROCEDURE CODE: | Occupational Therapist | 1:1 ratio | 97530-GO-HI |
| | Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes | | |
| | Physical Therapist | 1:1 ratio | 97530-GP-HI |



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Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes

Speech Therapist 1:1 ratio 92507-GN-HI

Treatment of speech, language, voice, communication, and/or auditory processing; event

Speech Therapist 1:1 ratio 92526 - HI

Treatment of swallowing dysfunction and/or oral function for feeding; event

Registered Dietician 1:1 ratio 97802-AE- HI

Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

Psychologist Consultant 1:1 ratio T2025

Consultative services to a member's Therapeutic Consultant when there are complex behavioral issues present.

SERVICE UNITS:

15 minute units of service except for Speech Therapist which is an event code

SERVICE LIMITS:

Occupational Therapist, Physical Therapist, and Registered Dietician (30 units per month up to a maximum to 360 units annually. - Combined units with Occupational Therapist, Physical Therapist, Registered Dietician), Psychologist Behavioral Consult (4) units per year). Speech Therapist (4) events per month.

PAYMENT LIMITS:

Providers without credentials for their area of specialty may not provide the service. Psychologist Behavioral Consult (T2025) is limited to four (4) units per year. This service is a consult by a licensed psychologist on the behavioral support plan and may not be utilized for the purpose of training of direct care staff, families, or other Therapeutic Consultants or Extended Professionals.

PRIOR AUTHORIZATION:

Prior to November 1, 2006 refer to Section 513.9, 513.10.1, 513.10.2, 513.11.1, and 513.12.1. (Prior Authorization process). Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget.

The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior Approval required for:



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- Occupational Therapist, Physical Therapist, and Registered Dietician: for any combined units above 30 per month.
- Speech Therapist: above 4 events per month
- Psychologist Behavioral Consult, above 4 units per year

DEFINITION

Extended Professional Services are those provided directly to the member which would not otherwise be provided by an alternative source. Extended Professional Services include Physical Therapy, Occupational Therapy, Speech/Language Therapy, Registered Dietician Services and Specialized Consultation to a Therapeutic Consultant by a Licensed Psychologist.

Professional Services:

Core Job Functions:

Must be performed by a fully licensed, certified and/or registered (e.g., physical therapist, speech/language, occupational therapist, registered dietician). A Certified Occupational Therapy Assistant (COTA) or a Licensed Physician Therapist Assistant (PTA) are not considered an Extended Professional.

Professional services must have a 1:1 ratio and consist of:

- Physical therapy
- Occupational therapy
- Speech and language therapy
- Dietary services by registered dietician.
- Specialized Consultative Services to a Therapeutic Consultant by a Licensed Psychologist (Limited to a member who has rating of moderate, severe, or critical on the annual ICAP rating of maladaptive behaviors or member is in crisis, a functional analysis may be utilized to assess the member's maladaptive behaviors).

Professional services cannot be conducted concurrently with the same member (i.e. physical therapy and occupational therapy being implemented with the member concurrently).

SITE OF SERVICE FOR ALL EXTENDED PROFESSIONAL SERVICES

This service may be provided in the Extended Professional's office, the member's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Extended Professional Services. It is the expectation of the extended professional to develop a home care plan.

DOCUMENTATION FOR ALL EXTENDED PROFESSIONAL SERVICES



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A detailed progress note or evaluation report for each service is required. The documentation should include the description of the service, date, time spent, including start and stop times and signature and credentials of the extended professional. The service must be linked to a goal on the IPP for the therapy and an assessment of progress or lack of progress addressed in the documentation. Service units are to be rounded on a monthly basis, not daily or weekly.

513.7.13 SKILLED NURSING SERVICES

DEFINITION

Nursing services are services which only a Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) can perform. Nursing services consists of nursing care which can be provided safely in the recipient's residence, day habilitation program, etc. The service must be provided by a registered nurse **under the direction of a physician** or a licensed practical nurse under the supervision of a registered nurse **and under the direction of a physician**. Services must be provided within the scope and standards of the West Virginia Nurse Practice Act.

SITE OF SERVICE

Skilled Nursing Services can be provided in the following settings:

- The participant's own home or apartment that is his/her primary residence
- Natural family homes that is his/her primary residence.
- Specialized Family Care Homes certified by the Specialized Family Care Program administered by WV University Center for Excellence in Disabilities (WVUCED) and DHHR, Bureau for Children and Families.
- Group homes licensed by OHFLAC to serve individuals with mental retardation and/or developmental disabilities.
- Individualized Support Settings (ISS) operated by a licensed behavioral health center serving people with mental retardation and/or developmental disabilities.
- Skilled Nursing services may also be carried over in the necessary local public community environments, as specified in the IPP.

Nursing services may not be delivered in a residence that endangers the health or safety of the participant or the staff. If applicable for the safety of the member there needs to be an assurance that the home has the following:

- Adequate electrical power including back-up power system (generator and/or battery);
- Adequate space for equipment and supplies;
- Adequate fire safety and adequate exits for medical and other emergencies;
- Clean environment to the extent that the individual's life and health is not at risk;



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DOCUMENTATION

A detailed progress note or evaluation report for each service is required. The documentation should include the description of the service, member name, date, time spent, including start and stop times, and signature and credentials of the Nurse. Service units are to be rounded on a monthly basis, not daily.

SERVICE RESTRICTIONS

Nursing services are not intended to replace the natural supports of the member. Nursing is considered supportive to the care provided to an individual by the individual's family, foster parents, and/or delegated care-givers, as applicable. Nursing services shall be based on medical necessity. Increases in the level of care and number of hours or visits authorized shall be based on a change in the condition of the individual, limitation of the program, and the ability of the family, foster parents, or delegated care-givers to provide care.

The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.13.1 NURSING SERVICES BY RN

PROCEDURE CODE: T1002- HI RN 1:1

SERVICE UNITS: 15 minutes

SERVICE LIMITS: 40 units per month

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective November 1, 2006, the service must be based upon the assessed need of the member, identified by the IDT, and included on the individualized Waiver budget. The ASO will register the service (s) with the claims agent. Services not registered with the claims agent will not be reimbursed. RN Services (only those services that can be completed by a RN) do not need prior authorization by the ASO.

Nursing services must be physician ordered.

DEFINITION

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



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Nursing services that may be provided by a Registered Nurse (RN) include but are not limited to:

- AMAP required RN duties
- Annual nursing assessment (all member's must have annual nursing assessment)
- Self-medication administration assessment
- Completing forms necessary for prior authorization for nursing services
- Nursing plan of care, including measurable goals/objectives
- Monthly nursing summaries
- Direct supervision of AMAPs, LPNs
- Work directly with physicians and specialists to plan medical treatment
- Train providers on client specific health and safety issues.

PROVIDER QUALIFICATIONS:

- Current WV registered nursing license
- CIB check. See Section 513.2.6 Criminal Investigation Check for further requirements.

513.7 13.2 SKILLED NURSING SERVICES LPN

| | | |
|------------------------|-------------|----------|
| PROCEDURE CODE: | T1003-HI-U4 | LPN 1: 1 |
| | T1003-HI-U3 | LPN 1: 2 |
| | T1003-HI-U2 | LPN 1: 3 |

SERVICE UNITS: 15 minutes

SERVICE LIMITS: Based upon the medical need for skilled nursing, the member may receive up to 24 hours of skilled nursing (ratios combined) per day. The nurse will also be expected to provide habilitation training (which is active treatment) when the member receives 8 hours or more of skilled nursing services per day.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with All annual IPP's conducted on or after November 1, 2006, the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior authorization required for any services over 248 units (62 hours) per month (2 hours per day)



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Nursing services must be ordered and implemented under the direction of a physician.

DEFINITION

Nursing services that must be provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) include but are not limited to: (Note: Reimbursement of these activities is at the LPN rate)

- Routine monitoring (data collection) of specific medical symptoms such as seizures, bowel habits, blood pressure, diet and exercise;
- Taking off physician orders if only nurses are administering medication;
- Ensuring physician orders are current, properly documented and communicated to direct care staff and others per agency policy;
- Direct nursing care including medication/treatment administration;
- Monitoring and review of MARs, medication storage and documentation (when no AMAPs are administering medication);
- Ensure medical appointments have been kept and information communicated to all others per agency policy;
- Assist in obtaining informed consent for medication and/or treatments;
- Facilitate procurement of and monitoring of medical equipment;
- Keeping emergency sheets updated and accurate;
- Training/education of members regarding health/medical issues.

If the member receives eight or more hours of skilled nursing services and the LPN is responsible for habilitation programs, the LPN may participate in the IPP and bill the LPN code.

PROVIDER QUALIFICATIONS:

- Current WV Nursing License
- CIB check. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

513.7.14 CRISIS SERVICES

PROCEDURE CODE: T2034 - 2:1 staff to member ratio
SERVICE UNITS: Unit = 1 hour
SERVICE LIMITS: Limit of fourteen (14) days (annually by IPP year)



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(A day is considered an event regardless of the number of hours that the crisis service was delivered)

Service may not be provided in a mental health crisis stabilization unit, psychiatric hospital, MR/DD Crisis Sites, ICF-MR facility, general medical hospital, natural family home or specialized family care home. Service may not be provided concurrently with residential habilitation, day habilitation, prevocational, supported employment, respite, or adult companion services.

PRIOR AUTHORIZATION:

Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006, the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. This service requires prior authorization by the ASO, and must meet the criteria as outlined in -Authorization" and -Behavioral Needs Criteria.

DEFINITION:

The goal of this service is to respond to a crisis immediately, assess the situation, and stabilize as quickly as possible. Crisis services are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavioral support planning, interventions, strategies and direct care. This service requires medical necessity (Refer to Behavioral Needs Criteria below). This service is a 2:1 ratio (staff to member ratio). The additional staff person is available for assurance of health and safety in the respective setting. Crisis services include formal training, informal training and behavioral support.

AUTHORIZATION:

The behavior support specialist may initiate the service by providing a written clinical justification within 48 hours or the next working day of the onset of crisis services.

A prior authorization request must be submitted within 72 hours of implementation of the service. The Service Coordinator must request the authorization from the ASO. If the crisis occurs on a Friday, the request may be submitted on a Monday.

The Service Coordinator must maintain a record of the authorization for service and clinical justification by the behavior support specialist.

Crisis Services are contingent upon the approval by the ASO. Services not approved by the ASO will not be reimbursed for payment.



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Intensive Support Requirement:

Intensive Support Requirement is when a member requires an acute level of support during periods of time when the person is presenting episodes of unmanageable behaviors that require an intense level of behavioral or psychiatric care. An individual may display extreme, maladaptive behaviors that are not anticipated, are acute in nature and are beyond the daily behaviors that are addressed through other supports. Crises of this nature may be due to medication changes, reaction to situational stressors, or environmental trauma. By providing this service, an imminent admission to a hospital or institutional facility will be avoided while protecting the person from harming themselves or others. This service is not intended to be ongoing in nature and must include a plan of titration of the level of supports.

During crisis service the following training and support activities must be conducted

- Record behavioral data as indicated by the behavioral support plan or initial data collection assessment
- Implement the behavioral support plan, behavioral protocol or behavioral guidelines
- Ensure health and safety of the member

Crisis Services staff will implement the plan(s) that are directed at reducing the maladaptive behavior(s). This service may include behavioral interventions to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. All Crisis Services are provided under the supervision of a Behavioral Specialist/Analyst as described in Sections 513.7.11.2 or 513.7.11.3 of this chapter. Crisis Services may be provided for periods of up to fourteen (14) consecutive days per episode and may not exceed fourteen days in a total calendar year provided the service has been authorized by the ASO.

Behavioral Needs Criteria for Crisis Services:

Definition

The member exhibits severe bodily harm, tissue damage, extreme property destruction or is an imminent safety concern for self or others. Member requires a behavioral support plan.

Member must have a maladaptive severity rating on the ICAP of four (4), which is described as an **extremely serious** and **critical problem**. The behavior is life threatening and the reduction in frequency of the targeted behavior requires vigilance and a highly structured environment. The ICAP must list the targeted behavior, score the frequency and score the severity of the behavior. During the transition to the ASO, members needing crisis services prior to the annual ASO ICAP assessment will require a functional assessment rather than the ICAP for this service. The functional assessment must indicate extremely serious and critical behaviors.

Member must have a functional assessment (ICAP or other functional assessment) that indicates extremely serious and critical behaviors in one (1) of the following areas in order to be eligible for crisis services.



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In the event that the member has not received the ICAP assessment, another functional assessment may be utilized to determine Level 4 maladaptive behaviors in the areas of Hurtful to Self or others, destruction to property, and socially offensive behavior.

Eligible ICAP Criteria for Crisis Services:

Acceptable categories of Maladaptive Behaviors on the ICAP assessment for crisis services are as follows (must have a four (4) in one of the following areas to be eligible for crisis services):

- Hurtful to Self
- Hurtful to Others
- Destructive to Property
- Socially Offensive Behavior

Requirement:

- The development or adaptation and implementation of a Behavioral Support Plan.
- Every occurrence of the targeted behavior must be documented.
- Documentation of the targeted behavior on the ICAP or the functional assessment must be consistent with other assessments. When inconsistencies occur, a written explanation must accompany the IPP.

PROVIDER QUALIFICATIONS

Crisis Service providers must have a minimum of the following qualifications:

- Be at least 18 years old with proof of age on file
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- Current certification in CPR and First Aid
- Training in health related issues (medication interactions, seizures, gastrostomy tubes, etc.) as needed per individual waiver member.
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.
- Individuals providing Crisis Services must be employees (staff) of the licensed behavioral health provider
- Specific training on the implementation and documentation of Positive Behavior Support plans.

SITE OF SERVICE



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Crisis Services are provided in the following settings:

- Group homes licensed by OHFLAC to serve individuals with mental retardation and/or developmental disabilities (group home is defined as a home setting where four (4) or more members reside).
- Individualized Support Settings (ISS) operated by a licensed behavioral health center serving people with mental retardation and/or developmental disabilities (ISS setting is defined as a home setting where one (1) to three (3) members reside).
- Crisis services may also be carried over into the necessary local public community environments, as specified in the IPP.
- This service may not be provided in settings such as a natural family, specialized family care and an adoptive family home.

DOCUMENTATION:

Following any use of crisis services, the individual's IPP will be reviewed and updated to reflect a plan for the prevention and interventions to ameliorate subsequent occurrences. The IPP must identify crisis early warning signals, triggers and the necessary services and supports to insure the health and safety of the individual. Any plan that involves the use of restrictive intervention will be approved by a behavior specialist or a behavior analyst and approved by the Human Rights Committee.

- Crisis Service providers must maintain detailed documentation (e.g., progress notes, daily activity logs, or behavioral data tracking forms) for residential sites in the center's chosen format. Documentation must include the name of MR/DD Waiver member, specific activity provided, its relationship to an IPP objective or targeted behavior, the actual time spent, including start and stop times, signatures and credentials of staff providing the service and the date of service.
- A written order is required by a behavioral specialist or behavioral analyst for this service.

SERVICE RESTRICTIONS:

- **This service is not intended for the use as an emergency response for routine and on-going behavioral challenges.**
- Staff/member ratio is 2:1, up to a maximum of 24 hours per day. A member may not receive residential habilitation, day habilitation, adult companion, more than 2 hours per day nursing, respite, prevocational services or supported employment services during the 24 hour day when the member is receiving crisis services. A member may only receive service coordination, Therapeutic Consultant, or transportation services during the daily 24 hour time-frame that crisis services are received.
- A maximum of 8 hours per day (32 units) of monitoring and supervision may be provided to a member. The need for monitoring and supervision must be supported by evaluations and included in the IPP.



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- Justification for such services may include such factors as severe challenging behaviors or life-endangering medical conditions.
- Crisis services may not be provided outside of an ISS (Intensive Support Setting) or group home setting. An ISS setting is defined as a 1-3 person setting
- The provision of staff as the only support to the member may not be the only intervention provided under crisis services. Clinical interventions must be present in addition to the staffing support.
- This service may not be provided in a hospital, or a facility setting.

513.7.15 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

PROCEDURE CODE: S5165 (home), T2039 (vehicle)

SERVICE UNITS: One Unit equals \$1

SERVICE LIMITS: A maximum of \$1,000 per service year (Combined service limits include S5165 & T2039).

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Environmental Accessibility Adaptations are physical adaptations to the home and/or vehicle, required by the participant's plan of care or IPP, which are necessary to ensure the health, welfare and safety of the participant. The purpose of this service is accessibility to the home or vehicle only. Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service. Additionally, these adaptations enable the participant to function with greater independence in the home and without which the participant would require a more restrictive environment. Medicaid funds will be used only after all other non-family funding sources have been exhausted. In order to access this benefit:

- The IDT must meet and determine the needs of the participant and document these needs on the participant's IPP.



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- The Service Coordinator will complete and submit a DD-19 form to the ASO to authorize the request for an Environmental Accessibility Adaptation covered by this benefit.
- Once the Agency Contact Person has reviewed the completed DD-19 form, the Service Coordinator may submit the appropriate billing to access this benefit.

Environmental Adaptations include but are not limited to:

- Supplies and installation of grab bars,
- Supplies and installation of ramp(s),
- Widening of doorways,
- Modification of bathroom facilities,
- Installation of specialized electric and plumbing systems where necessary to accommodate medical equipment and supplies,
- Vehicle modifications and/or lifts

Excluded are those adaptations or improvements to the home of general utility, and are not of direct medical or remedial benefit to the participant. For example (This is not an all inclusive list):

- Carpeting
- Roof repair
- Central air conditioning
- Capital Improvements
- Adaptations which add to the total square footage of the home

RESTRICTION

The service coordination provider agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for the cost of services must be issued to the vendor of the EAA service. The provider agency must maintain verification of payment to the vendor and a receipt verifying the service was provided.

SITE OF SERVICE

- Participant's Home – Non-agency operated residences for specific adaptations to meet the participant's needs
- Vehicle – Non-agency operated vehicles for specific adaptations to meet the participant's needs.

DOCUMENTATION

The Service Coordinator must attach the following items to the DD-19 form to be maintained in the participant's file (see Attachment 1 for DD-19):

- Copy of the IPP detailing the need for the Environmental Accessibility Adaptation.



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- Copy of any assessments detailing the need for the Environmental Accessibility Adaptation.
- Written documentation supporting the denial or exhaustion of other non-Medicaid and non-family resources; and
- Any and all receipts and/or invoices for services rendered.
- The original DD-19 form must be maintained in the participant's file with the required attachments.
- The agency contact person is responsible for maintaining a single file with a copy of all DD-19 forms completed and submitted for reimbursement. This single file must have the attachments to the DD-19 form.
- The single file maintained by the service coordination agency contact person shall be made available for review by State and Federal monitors.
- All receipts and invoices must be kept on file. It is the Service Coordinator's responsibility to verify the Environmental Accessibility Adaptations have been purchased and/or provided.

SERVICE RESTRICTIONS

- Provider agencies will be reimbursed through billing Service Coordination for arranging and processing this service, not from the requested amount.
- The Service Coordination agency contact person and the Service Coordinator are responsible for ensuring the request is for only those adaptations covered by this benefit. Any reimbursements for non-covered adaptations will result in the amount of the request being deducted from the agency's Service Coordination billing.
- Licensed sites, agency operated sites, or public housing sites are responsible for providing ADA accessible housing. Therefore, this benefit is not allowable for ADA required improvements, state Fire Marshall requirements or OHFLAC requirements.
- Licensed sites or agency operated sites are responsible for providing accessible transportation to those participants who require transportation services.
- Routine durable medical equipment or routine communication devices are not considered environmental accessibility services through Waiver. These services may be otherwise available through Medicaid state plan services.

The following is a list of exclusions from this benefit (CMS exclusions):

- Carpeting
- Roof Repair
- Central Air Conditioning
- Adaptations which add to the total square footage of the home.
- This benefit is **not** to be utilized by combining the benefit allocated for more than one (1) participant for any Environmental Accessibility Adaptations.



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- This benefit is not to be utilized by combining the benefit allocated to the member for more than one calendar year for any Environmental Accessibility Adaptations.

513.7.16 EVALUATION SERVICES

This section applies to evaluation services that are also offered outside of the Title XIX Home and Community Based Waiver Program. Extended Physician Services, Psychiatric Diagnostic Interview Examination, and Psychological Testing with interpretation and report, Psychological Testing, Developmental Testing with Interpretation and Report, and Psychological Testing Developmental Testing – Limited with Interpretation and Report (Annual Psychological Evaluation) are services that can be provided by the waiver provider if the staff member has the required credentials for the service.

513.7.16.1 EXTENDED PHYSICIAN SERVICES (Annual Medical Evaluation)

PROCEDURE CODE: 99381-HI to 99387-HI CPT codes for new member
99391-HI to 99397-HI CPT codes for established member

SERVICE UNITS: Event

SERVICE LIMITS: One evaluation annually

PAYMENT LIMITS: No one with credentials other than a medical or osteopathic physician licensed to practice in WV may perform or charge for this service.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Extended Physician Services consist of a comprehensive annual medical evaluation performed by a medical or osteopathic physician licensed to practice in WV. The comprehensive annual medical evaluation must include:

- A physical and developmental examination
- Blood levels for medications (if applicable)



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- Assessment of specialized medical care
- Recommendations for additional services.
- Diagnosis - mental and physical, with prognosis
- Recommendation, based on the examination as to ICF/MR level of care and services.
- Information should also be gathered from the individual or legal guardian on what he/she wants from services with relation to his/her goals for home life, day services, social life and/or other life areas. This service must include a recommendation that the individual requires an ICF/MR level of care and services and home and community-based services are appropriate, if the data supports such a recommendation.

This service is used when submitting an initial application packet and to re-establish medical eligibility for re-certification on an annual basis. The DD-2A must be fully completed.

Failure to submit annual medical evaluation (DD-2A) within 30 days of the expiration date for re-certification may result in the member losing eligibility for MR/DD Waiver services and the agency being responsible for non-reimbursable Waiver services.

SITE OF SERVICE

Physician's office, individual's home or other applicable community location

DOCUMENTATION

Completion of the annual medical evaluation (DD-2A) form for the evaluation

513.7.16.2 Psychological Evaluations (Triennial and Annual)

Each member must receive a psychological evaluation to determine medical eligibility. Both the DD-2 (physician's medical evaluation) and the DD-3 (psychological evaluation) are utilized in the determination of the need for ICF-MR level of care.

Specific testing instruments or assessments utilized by the psychologist are based upon the member's need. Procedure codes utilized by the psychologist are based upon the type of assessment or testing conducted by the psychologist and based upon the unique clinical needs of the member. The procedure code utilized by the psychologist is not dependent upon whether the evaluation is an annual or a triennial evaluation, but must be determined based upon the activity performed during the evaluation. Members may not have a need to utilize all service codes under Psychological Evaluations. The following codes may be utilized during the annual or the triennial psychological evaluations, provided the activity matches the code (Refer to 90801, 96101, 96111, 96110 for specific definitions and restrictions):

90801 Psychiatric Diagnostic Interview (intake)

96101 Psycho-diagnostic testing, with report



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96110 Developmental Testing, limited

96111, developmental testing, extended

GENERAL DEFINITION OF NEURO-COGNITIVE TESTING:

Cognitive functioning

Cognitive processes

Visual motor responses

Abstract abilities

Adaptive and Maladaptive behavioral functioning

Results in an Outcome:

Administration of test- generates material that is formulated into a report that includes data, analysis of the data or results of the testing, and recommendations.

- A comprehensive psychological evaluation must be completed every 3 years for all members utilizing the DD-3 format.
- The comprehensive evaluation may be updated by a psychologist, the following 2 years by interviewing the individual, checking the individual's current status, completing adaptive behavior scales and updating all recommendations for children below 18 years of age. An annual psychological evaluation is not required for adults 18 years of age and older. The DD-3 format must be utilized.

Psychological Evaluation, Triennial Services must include:

- Intellectual testing
- Measures of adaptive behavior
- Interview with the individual
- Other age appropriate and/or disability-specific evaluation methods.

This service also includes a review of current status, recommendations for instructional services to increase skills and other therapeutic interventions, diagnostic impression(s), statement supported by evaluation results indicating if the individual requires an ICF/MR level of care based on his/her need for habilitative services and recommendation supported by evaluation results that home and community-based services are appropriate.

A comprehensive psychological evaluation must be completed every 3 years for all members. The comprehensive evaluation may be updated by a psychologist, the following 2 years by interviewing the individual, checking the individual's current status, completing adaptive behavior scales and updating all recommendations for children below 18 years of age. An annual psychological update is not required for adults 18 years of age and older.



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Psychological Evaluations, Triennial services must be provided by a psychologist with at least a Master’s degree in psychology from an accredited program and licensed to practice in WV or eligible to be licensed to practice in WV and under the supervision of a WV licensed psychologist.

The Psychological Evaluation, Annual Update service must include:

- Specific scores of a standardized adaptive behavior measure
- Observation of the person
- Prognosis statement regarding how the person will function with continued ICF/MR level of care
- DSM-IV format with an ICD-9 diagnosis
- Recommendations for adaptive training and behavioral supports.

This service must include training recommendations and a clear recommendation as to an appropriate placement. If the recommendation is for an alternative level of care, specific information to support the new placement must be included.

The Adaptive Behavior Scales previously mentioned must be completed on the Adaptive Behavior Scales for adults (ABS-RC: 2) and Adaptive Behavior Scales for children ages 3 to 18 years (ABS-S: 2). Children age three and below may utilize the Vineland Adaptive Behavior Scale or other age-appropriate standardized measurements of adaptive functioning.

Psychological Evaluation, Annual Update services must be provided by a psychologist with at least a Master’s degree in psychology from an accredited program and licensed to practice in WV or eligible to be licensed to practice in WV and under the supervision of a WV licensed psychologist.

513.7.16.2.1 Psychiatric (Psychological) Diagnostic Interview Examination

| | |
|-----------------------------|--|
| PROCEDURE CODE: | 90801-HI Psychiatric Diagnostic Interview Examination. |
| SERVICE UNITS: | Session/Event |
| SERVICE LIMITS: | Completed on individual new to the provider of the service with registration. |
| PAYMENT LIMITS: | No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform the testing. |
| PRIOR AUTHORIZATION: | Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective November 1, 2006, the service must be based upon the assessed need of the member, identified by the IDT and included on the individualized Waiver budget. The ASO will |



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register the service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed one event.

DEFINITION

Psychiatric diagnostic interview examination is an all-inclusive evaluation of a member’s functional level(s), mental status, history and a disposition performed by a psychiatrist or psychologist. It may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.

NOTE: THIS CODE MAY ONLY BE USED WHEN THE MEMBER IS NEW TO THE PROVIDER.

SITE OF SERVICE

Psychologist’s office, individual’s home or other applicable community locations

DOCUMENTATION

Documentation must contain the completed evaluation (DD-3) signed by the psychiatrist or psychologist. The documentation must include place of evaluation and date of service. The license number of the psychiatrist or psychologist must also be present.

TRIENNIAL OR ANNUAL EVALUATIONS

This code may be utilized either for the triennial or annual evaluation and is dependent upon the member’s needs. This service may not be provided unless the member is new to the provider agency.

513.7.16.2.2 Psychological Testing with Interpretation and Report

- PROCEDURE CODE:** 96101-HI
- SERVICE UNITS:** 1 hour (maximum of 4 hours)
- SERVICE LIMITS:** One evaluation every three years for all members (adult and child). (Cannot be utilized within three year period with 96111)
- PAYMENT LIMITS:** No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform this service.
- PRIOR AUTHORIZATION:** Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent.



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Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed one evaluation every three years.

DEFINITION

96101 psychological testing is a service that is provided per hour of the psychologist's or physician's time face-to-face time with patient, includes the time interpreting test results and preparing the report. Psychological testing includes:

Psycho-diagnostic Assessment of the following, with interpretation and report:

- Emotionality
- Intellectual Abilities
- Personality
- Psychopathology

Examples include the MMPI, Rorschach, and the WAIS

The psychologist includes the results of the ABS assessment in his evaluation. Psychologist administers the WAIS, Wechsler Scales for the purpose of assessment of an ICF-MR level of care, adaptive training recommendations, and interpretation of testing results and report.

SITE OF SERVICE

Psychologist's office, individual's home or other applicable community locations

DOCUMENTATION

Documentation must contain the completed evaluation, signed by the qualified licensed psychologist. The psychologist license number, place of the evaluation, date of service and time spent must also be included in the documentation.

TRIENNIAL OR ANNUAL EVALUATIONS

This code may be utilized either for the triennial or annual evaluation and is dependent upon the member's needs and the testing conducted by the psychologist.

RESTRICTION

This service may not be utilized within a three year period with 96101.

If a Service Coordinator administers the ABS prior to the psychological evaluation and the Service Coordinator provides the results of the evaluation to the psychologist, the Psychologist may not bill for administering the ABS. The psychologist may include historical evaluations or assessments in the report but may not bill for an assessment he/she did not conduct. When a trained/qualified Service Coordinator administers the ABS, the Service Coordinator may bill service coordination because the ABS is an assessment. If the psychologist billed for the ABS, this would result in duplication of service/payment for the ABS activity.



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The psychologist may bill 96101 for the assessments that he/she administered during his evaluation. The psychologist may bill for the interpretation of the “raw data” from the ABS and include it in his/her report.

Psychologist includes the results of the ABS assessment in his evaluation. Psychologist administers the WAIS, Wechsler Scales for assessment of an ICF-MR level of care, adaptive training recommendations, interpretation of testing results and report.

513.7.16.2.3 Psychological Testing –Developmental Testing Extended with Interpretation and Report

| | |
|-----------------------------|---|
| PROCEDURE CODE: | 96111-HI |
| SERVICE UNITS: | Event |
| SERVICE LIMITS: | One evaluation every three years for all members (adult and child). (Cannot be utilized within three year period with 96101) |
| PAYMENT LIMITS: | No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform a psychological evaluation. |
| PRIOR AUTHORIZATION: | Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP’s conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed one evaluation every three years. |

DEFINITION

Extended developmental testing includes the administration of standardized developmental instruments utilized for the assessment of behavioral functioning, with interpretation, and report in the following areas:

- Motor skills
- Language skills
- Social skills
- Adaptive skills



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- Cognitive functioning

Examples of standardized developmental instruments include the ABS, Vineland, SIB, and others. This does not include standardized measures intellectual functioning such as the WAIS and others. This service is intended for adaptive and maladaptive behavioral assessment only. If this code is billed, the **psychologist must administer the assessment**. If the Service Coordinator administers the ABS, the psychologist may not bill this code.

SITE OF SERVICE

Psychologist’s office, individual’s home or other applicable community locations

DOCUMENTATION

Documentation must contain the completed interpretation and report, signed by the licensed psychologist. The psychologist license number, place of the evaluation, date of service and time spent must also be included in the documentation.

TRIENNIAL OR ANNUAL EVALUATIONS

This code may be utilized either for the triennial or annual evaluation and is dependent upon the member’s needs and the testing conducted by the psychologist.

513.7.16.2.4 Psychological Testing Developmental Testing – Limited with Interpretation and Report

PROCEDURE CODE: 96110-HI

SERVICE UNITS: Event

SERVICE LIMITS: One evaluation annually for children under age 18. Adults are not required to have an annual psychological update unless the condition warrants an evaluation for treatment purposes. Annual psychological evaluations are not required for level of care determination for adults over 18 years of age. Children under the age of 18 are required to submit an annual psychological update for level of care determination

PAYMENT LIMITS: No provider with credentials other than those specified for a psychologist or a psychologist under supervision may perform this service.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective With all annual IPP’s conducted on or after November 1, 2006, the services will be selected by the member in conjunction with his/her IDT. The services must be



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based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed service limits.

DEFINITION

Developmental testing; limited with interpretation and report is intended for diagnostic screening only. Once a member has a confirmed diagnosis, it is no longer necessary to screen. The psychologist may determine that it is clinically necessary to administer extended developmental testing rather than administer limited testing. The provider may not bill 96110 prior to 96111 nor may the provider bill both codes concurrently. Limited developmental testing is not a screening tool for extended developmental testing. Members may never need this assessment.

Examples: Screening Test II, Early Language Milestone Screening, GARS, with interpretation and report. .If this code is billed, the **psychologist must administer the assessment.**

SITE OF SERVICE

Psychologist’s office, individual’s home, or other applicable community locations

DOCUMENTATION

Documentation must contain the completed interpretation and report, signed by the licensed psychologist. The psychologist license number, place of the evaluation, date of service and time spent must also be included in the documentation.

TRIENNIAL OR ANNUAL EVALUATIONS

This code may be utilized either for the triennial or annual evaluation and is dependent upon the member’s needs and the testing conducted by the psychologist.

513.7.17 SOCIAL HISTORY

| | | |
|------------------------|------------------------|-------------|
| PROCEDURE CODE: | Initial Social History | H0031-HI |
| | Social History Update | H0031-HI-TS |

SERVICE UNITS: Event

SERVICE LIMITS: H0031-HI- At the time of enrollment, one comprehensive evaluation per member per provider per lifetime.
H0031-HI-TS- Annually

PAYMENT LIMITS: The initial social history service must be provided by a Therapeutic Consultant with at least Bachelor’s degree in social work from an accredited college and/or WV licensure in social work. The initial social history is required for all new enrollees of the program. An



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annual social history may be performed for evaluation and planning purposes but is not required for the annual determination of level of care (medical eligibility).

A social worker with a temporary license must be supervised by a Master's level, licensed social worker per state social work licensing policies and his/her work must be co-signed by the supervising social worker.

PRIOR AUTHORIZATION:

Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be elected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

An initial Social History is performed for the initial comprehensive evaluation and must include:

- Developmental history
- Family history and description of home and family life
- Educational history and achievements
- Functional/life/vocational skills status
- Recreational interests
- History of hospitalizations, and
- Legal status and other relevant information.

Information should also be gathered from the individual or legal guardian on what he/she wants from services with relation to his/her goals for home life, day services, social life and/or other life areas. This service must include a current social information review of historical social information, findings and assessments, recommendations and verification that the data supports such recommendations.

ANNUAL SOCIAL HISTORY

Only the Initial Social History is a requirement at the time of enrollment. Additional social history updates may be completed as indicated by the IPP team members.

SITE OF SERVICE

This service may be performed in the Social worker's office, individual's home or other applicable community location.



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DOCUMENTATION

Completion of the Social History (DD-4) dated and signed exclusively by a licensed social worker or a temporary licensed social worker under the supervision of a licensed social worker.

513.8 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

GENERAL REQUIREMENTS

- MR/DD Waiver Program provider agencies must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information; Chapter 300, Provider Participation; and Chapter 800, General Administration of the Provider Manual. This can be found at the BMS Web Site (www.wvdhhr.org/bms).
- MR/DD Waiver Program provider agencies must comply with all other documentation requirements of this chapter.
- All required documentation must be maintained for at least five (5) years in the provider's file subject to review by authorized BMS personnel or contracted agents. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five (5) years whichever is greater.
- All required documentation and records must be available upon request by BMS or federal monitors, or contracted agents for auditing and/or medical review purposes. Record retention must be in accordance with the MR/DD Waiver Record Retention Guidelines as found in Attachment 1.
- Failure to maintain all required documentation and in the manner required by BMS, may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.
- Refer to DD 26 - Record Retention Guidelines.

SPECIFIC REQUIREMENTS

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

- Each Service Coordinator Provider Agency is required to maintain all required MR/DD Waiver documentation on behalf of the State of WV and for state and federal monitors.
- All MR/DD Waiver Program forms as applicable to the policy requirement or service code requirement (forms located in the attachment at the end of the manual in Attachment 1).
- Agencies that wish to computerize any of the forms, DD-1 through DD-13, may do so. However, all basic components must be included and the name/number indicated on the form (refer to Chapter 300 for a description of general requirements for Medicaid record retention and documentation). This can be found on the BMS web site (www.wvdhhr.org/bms).



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- All providers of Waiver services must maintain service progress notes, behavioral data collection, and/or attendance records to substantiate that services billed by the MR/DD Waiver Program provider agency were provided on the dates listed and were for the actual amount of time and number of units claimed. Specific documentation requirements are detailed in Section 513.7, Description of Covered Services.
- Day to day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for said service. Monitoring and review of services as related to the IPP or monthly summary (visit) are to be maintained in the service coordination agency record. In the course of monitoring of the IPP and services, the Service Coordinator may review or request specific day to day documentation. All documentation provided must meet the criteria for documentation as indicated in the policy manual such as date, actual time of service and number of units claimed.

513.9 DUAL PROCESSES FOR TRANSITION TO INDIVIDUAL WAIVER BUDGET

The member's current IPP, along with authorizations granted by the BHHF Waiver Department, will be valid until the member's annual IPP or there is a critical juncture of treatment that requires a service to be modified or added.

On November 1, 2006:

- QMRP 1 and/or QMRP 2 will be converted to a Therapeutic Consultant (refer to Section 513.7.11) that includes the Skills Specialist and Behavioral Specialist/Analyst.
- The QMRP 1 and/or QMRP 2 service that were previously utilized for QMRP nursing will be converted to Nursing Services that can only be completed by the RN (refer to Section 513.7.13.1).
- QMRP services utilized for attendance to IDTs will be converted to Individual Program Development (refer to Section 513.7.2).
- QMRP 3 will be converted into an Extended Professional service that includes Registered Dietician, Physical Therapist, Occupational Therapist and Speech Therapist (refer to section 513.7.12).
- Attendance to IDTs by the QMRP 3 will be converted to Individual Program Development (refer to section 513.7.2).
- QMRP 3 Services utilized for mental health conditions will need to be coordinated with the ASO to be transferred to providers of mental health services.
- Units of service for QMRP services previously authorized to the member will be granted for the Therapeutic Consultation services.
- Definitions, provider qualifications, site of service, documentation requirements and service restrictions for procedure codes will be in effect unless otherwise stated.

Beginning November 1 2006, the ASO will be responsible for the granting of prior authorizations at major junctions of treatment and at the time of the IPP.



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Beginning July 1, 2006, the Administrative Service Organization (ASO) will conduct the assessments necessary to complete the member's individualized Waiver budget prior to the IPP. Each member will complete the assessment and budgeting process over the course of the year beginning July 1, 2006, and ending October 31, 2007. The assessment and budgeting process must be completed prior to the IPP. The process may be completed prior to the annual IPP. In the event that extenuating circumstances exist which prevents the member from participating in the independent assessment process conducted by the ASO, the current Prior Authorization (for services would continue until such time that the next 90 day quarterly IDT meeting is conducted (Example: IDT team may meet at the next 90 day quarterly meeting if the member is hospitalized).

The Individual Waiver Budget Process is as follows:

- Administrative Service Organization (ASO) provides member education on the process, the available services under the waiver program, available provider agencies in the area, general information on the program and the Individualized Waiver Budget
- ASO conducts an independent assessment in collaboration with the member (and member's legal representative, if applicable). The logistics of scheduling the assessment will be done in collaboration with the member and his/her legal representative if applicable, and the Service Coordinator
- Individualized Waiver Budget is developed by the ASO which is based on the objective assessed needs of the member
- ASO recommends the Individualized Waiver Budget to the Service Coordinator (with the results of the individualized assessments of the member).
- Service Coordinator reviews the budget with the IDT team and the team outlines the services, goals and objectives in the Individual Program Plan (IPP)
- Service Coordinator notifies the ASO of the specific service(s) and units of service(s) for registration with the claims agent
- Once the ASO has registered with the claims agent, the ASO will continue to register all services with the claims agent or respond to emergency requests for service changes that require registration with the claims agent.
- The ASO will monitor health and safety as it relates to requests for service authorizations (Example: Member lives in an ISS setting and cannot administer his/her own medication. The budget does not request nursing nor does the Service Coordinator identify if the home is provided with AMAP certified staff to assist the member with his/her medications)



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513.10 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual.

In order to receive payment from BMS, a provider shall comply with all prior authorization requirements. BMS in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

513.10.1 SERVICES REQUIRING PRIOR AUTHORIZATION

All services provided within the Title XIX MR/DD Waiver program must be registered with the ASO. The following services must be prior authorized before a member may receive the service or provider may bill:

- Exceeding the individual budget, **as assigned** by the ASO
- Exceeding of service limits or exceptions to service
- Waiver Nursing services that can be performed by a LPN (T1003 HI U4/U3/U2) **in excess of 248 units per month**
- Community Residential Habilitation in excess of 496 units per month with a maximum of 744 units per month
- Transportation in excess of 700 miles per month with a maximum of 1300 miles per month
- Respite in a general medical hospital (may not be provided in a psychiatric hospital or an acute care hospital with a distinct part psychiatric unit)
- In- home Day Habilitation
- Environmental Accessibility Adaptations
- Crisis Services

Prior authorization must be received from the ASO for any special requests for exceeding service caps, monthly ICF-MR cost, or service limits. Services provided without a prior authorization may not be billed and are subject to disallowance. In the event of an emergency after hours or on a weekend that constitutes a medical need for a service, the service may be offered. However, authorization must be obtained the next working day. Staffing in excess of 1:1 ratio cannot be considered except for Crisis Services.



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513.10.2 SERVICE REGISTRATION/PRIOR AUTHORIZATION PROCESS

All services provided within the Title XIX MR/DD Waiver program must be registered through the Administrative Service Organization. Services requiring prior authorization (refer to Section 513.10.1) must be submitted to the ASO within 10 working days of the IPP meeting at which the services were chosen.

The Service Coordinator is responsible for ensuring that all **service registrations/** prior authorizations for all chosen providers are forwarded to the ASO. This process should be addressed during the Interdisciplinary Team Meeting.

513.11 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, Provider Participation, of the Provider Manual and Section 513.2 of this chapter. In addition, the following limitations also apply to the requirements for payment of medically necessary and medically appropriate MR/DD Waiver Program Services described in this chapter.

- The MR/DD Waiver Program is designed to support individuals with mental retardation and/or developmental disabilities in their local communities. The program offers an alternative to placement in an ICF/MR facility.
- MR/DD Waiver services may be provided out-of-state to participants residing in border counties of the state of West Virginia. The out-of-state services provided must be located within thirty (30) miles of the West Virginia border. The service is made available with the following limitations:
 - All participants must live in West Virginia;
 - All MR/DD Waiver regulations and policies must be followed in the provision of the services. This includes the requirement that all providers be West Virginia licensed or certified as necessary;
 - The services provided must conform with the stated goals and objectives on the member's IPP; and
 - Individual Member budgets or limitations described in this manual must be followed

513.11.1 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100, General Information, of the Provider Manual, BMS will not pay for the following services:

- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).



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- Residential Habilitation payments may not be made for room and board or the cost of facility maintenance and upkeep
- Birth to Three services paid for by Medicaid for children enrolled in the MR/DD Waiver program
- MR/DD Waiver services may not be provided concurrently unless otherwise indicated in the service definition. For example Residential Habilitation services may not be provided concurrently with the individual's Day Habilitation Program, School services or Respite Care services.
- Personal care is not a habilitation service and may not be billed as such. (Personal Care is assistance in the form of hands-on assistance, as in actually performing a personal care task for the member such as personal hygiene, dressing feeding, nutrition, environmental support functions, and health-related tasks for the person).
- MR/DD Waiver services are not part of the Health Maintenance Organization's (HMO's) responsibility for coverage. They do not require Physician Assured Access System (PAAS) approval. MR/DD Waiver services provided must follow the guidelines set forth in this manual

513.11.2 MOUNTAIN HEALTH CHOICES

Members on the MR/DD Waiver program cannot be a member of the Mountain Health Choices program at this time.

513.12 BILLING PROCEDURES

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

- MR/DD Waiver Program provider agencies must bill all third party liabilities such as a member's private insurance for those services that are covered by both private insurance and the Medicaid waiver program prior to billing Medicaid. Medicaid is considered a secondary insurance to an individual's private insurance.
- Claims will not be honored for services (inclusive of service code definitions) provided outside of the scope of Chapter 513 of the MR/DD Waiver policy manual or outside of the scope of federal regulations.



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513.12.1 PAYMENT AND LIMITATIONS PAYMENT

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

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

PAYMENT LIMITATIONS

- Medicaid is the payer of last resort. Therefore, private insurance must be billed first for those services covered by both private insurance and Medicaid. The Service Coordinator must inform the member, his/her family and/or his/her legal representative of this requirement.
- MR/DD Waiver services may not be charged while an individual is receiving services as an inpatient in a hospital, nursing facility or ICF/MR. As an exception, while a member is inpatient in a non-state operated hospital, the member may receive respite services when the member requires a support staff that is familiar with the member's individualized needs provided the service is not duplicated by the hospital. This service requires approval by the ASO.
- No services may be charged prior to an applicant's discharge from an ICF/MR or state institution. The only exception is Service Coordination and training to support staff provided by a Therapeutic Consultant, which may be billed starting 30 days prior to discharge. Allowable activities for the Therapeutic Consultant are assessment, evaluation, habilitation plan development, or behavioral support plan development, and training of direct support staff assigned to provide services at the time of discharge. The State MR/DD Waiver Coordinator must be notified of the actual date on which an applicant is discharged from an ICF/MR or state institution and begins to receive MR/DD Waiver services.
- Services provided during the initial evaluation process for completion of the application packet, such as Evaluations and Service Coordination, may be billed when the following criteria is present:
 - An allocation (*slot*) is available to the member
 - The psychological evaluation is within 90 days
 - The IPP is current and includes the services
 - The member is both medically and financially eligible
 - The date of service is not before the initial date of eligibility on the Medical card
- Ongoing services such as residential habilitation or day habilitation may be billed when the following criteria is in place:
 - An allocation (*slot*) is available to the member
 - Medical and financial eligibility are confirmed



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- Medically necessary assessments have been completed and indicate a medical necessity for the service
- Services requiring a prior authorization have been prior authorized before the provision of service or submission of claims for said service.
- Registration by the ASO.

513.13 HOW TO OBTAIN INFORMATION

For information concerning procedure codes and diagnosis codes, refer to Chapter 100, General Information. In addition forms utilized by the waiver program may be located in Attachment 1.

513.14 ATTACHMENT 1: MR/DD WAIVER DOCUMENTS

The MR/DD Waiver Forms are as follows:

- DD-2A Annual Medical Evaluation
- DD-3 Comprehensive Psychological Evaluation
- DD-4 Social History
- DD-5A Initial Individual Program Plan
- DD-5 Individual Program Plan
- DD-7 Informed Consent (Choice of ICF/MR and MR/DD Waiver)
- DD-7A Informed Consent (Choice of Providers and Services)
- DD-9 Monthly Home Visit Report
- DD-9A Day Habilitation Visit Report
- DD-12 Documentation - Monthly Progress Report
- DD-13 Certification of Training for Habilitation Providers
- DD-14 Application
- DD-16 Member Exit/Transfer
- DD-17 Therapeutic Consultant Credentialing Form
- DD-19 Environmental Accessibility Adaptations Form
- DD-20 Mortality Notification
- DD-24 Request For Nursing
- DD-25 Extra-ordinary Care Instrument
- DD-26 Record Retention and Storage

**CHAPTER 513
MR/DD WAIVER SERVICES
NOVEMBER 1, 2007**

**ATTACHMENT 1
MR/DD WAIVER DOCUMENTS
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DD- 2A

ANNUAL MEDICAL EVALUATION

**West Virginia Department of Health and Human Resources
ICF/MR Level of Care Evaluation**

Initial **Annual Renewal** **Title XIX MR/DD Waiver** **ICF/MR**

Service Coordination Agency: _____

Address: _____

Service Coordinator: _____

Contact Person: _____

Date: _____

I. DEMOGRAPHIC INFORMATION (MAY BE COMPLETED BY SERVICE COORDINATOR OR FAMILY MEMBER)

| | | | | | |
|--|----------------------|---|---------------------------------------|---|--|
| 1. Individual's Full Name | | 2. Sex: <input type="checkbox"/> F <input type="checkbox"/> M | | 3. Medicaid # (Required) | |
| 4. Address (including Street/Box, City, State & Zip) | | | | | |
| _____ | | | | | |
| _____ | | | | | |
| Phone: () | | | | | |
| 5. County | 6. Social Security # | 7. Birthday (MM/DD/YY) | 8. Age | 9. Phone | |
| 10. Spouse's Name | | | 11. Address (if different from above) | | |
| 12. Check if applicant has any of the following: | | | | | |
| a. <input type="checkbox"/> Guardian | | d. <input type="checkbox"/> Power of Attorney | | g. <input type="checkbox"/> Other _____ | |
| b. <input type="checkbox"/> Committee | | e. <input type="checkbox"/> Durable Power of Attorney | | | |
| c. <input type="checkbox"/> Medical Power of Attorney | | f. <input type="checkbox"/> Living Will | | | |
| Name & Address of Representative: | | | | | |
| _____ | | | | | |
| _____ | | | | | |
| Phone: () | | | | | |
| 13. Living Arrangement | | | | | |
| <input type="checkbox"/> Natural/adoptive family | | <input type="checkbox"/> ISS – One person (Intensive support setting) | | | |
| <input type="checkbox"/> Specialized family care provider | | <input type="checkbox"/> ISS – Two person (Intensive support setting) | | | |
| <input type="checkbox"/> Group Home (4 or more persons) | | <input type="checkbox"/> ISS – Three person (Intensive support setting) | | | |
| 14. Description of current living arrangements, including formal and informal support(i.e. family, friends, other services) | | | | | |
| _____ | | | | | |
| _____ | | | | | |
| _____ | | | | | |
| 15. Significant Health History – (include recent hospitalization(s) and/or surgery(s) with dates, history of infectious disease) | | | | | |
| _____ | | | | | |
| _____ | | | | | |
| _____ | | | | | |
| _____ | | | | | |

II. MEDICAL ASSESSMENT (MUST BE COMPLETED BY PHYSICIAN) **NAME:** _____

DATE: _____

| 16. Height | Weight | BP | P | R | T |
|-----------------------|--------|----|---|---|---|
| 17. Allergies: | | | | | |

CODE: √ = NORMAL N = NOT DONE (PLEASE EXPLAIN WHY) NA = NOT APPLICABLE X = ABNORMAL (PLEASE DESCRIBE)

| | | |
|---------------------------------|--|--|
| SKIN | | |
| EYES/VISION | | |
| NOSE | | |
| THROAT | | |
| MOUTH | | |
| SWALLOWING | | |
| LYMPH NODES | | |
| THYROID | | |
| HEART | | |
| LUNGS | | |
| BREAST | | |
| ABDOMEN | | |
| EXTREMETIES | | |
| SPINE | | |
| GENITALIA | | |
| RECTAL (MALES INCLUDE PROSTATE) | | |
| BI-MANUAL VAGINAL | | |
| VISION | | |
| DENTAL | | |
| HEARING | | |
| NEUROLOGICAL | | |
| ALERTNESS | | |
| COHERENCE | | |
| ATTENTION SPAN | | |
| SPEECH | | |
| SENSATION | | |
| COORDINATION | | |
| GAIT | | |
| MUSCLE TONE | | |
| REFLEXES | | |

NAME _____

DATE _____

MEDICAL ASSESSMENT II, CONT.

Problems requiring Special Care (check all appropriate blanks)

| | | | | | |
|---------------------------|-------|---------------------------------|-------|-----------------------|-------|
| <u>MOBILITY</u> | | <u>CONTINENCE STATUS</u> | | <u>FEEDING</u> | |
| Ambulatory | _____ | Continent | _____ | Feeds self | _____ |
| Ambulatory w/human help | _____ | Incontinent | _____ | Needs assistance | _____ |
| Ambul. W/mechanical help | _____ | Not Toilet trained | _____ | Needs to be fed | _____ |
| Wheelchair self propelled | _____ | Catheter | _____ | Gastric/J tube | _____ |
| Wheelchair w/assistance | _____ | Ileostomy | _____ | Special Diet | _____ |
| Wheelchair/electric | _____ | Colostomy | _____ | | |
| Transfer w/assistance | _____ | | | | |
| Bedfast | _____ | | | | |

| | | | |
|--|-------|--|-------|
| <u>PERSONAL HYGIENE/SELF CARE</u> | | <u>MENTAL , BEHAVIORAL AND OTHER DIFFICULTIES</u> | |
| Needs total care | _____ | Alert | _____ |
| Independent | _____ | Confused/Disoriented | _____ |
| Needs Assistance | _____ | Irrational behavior | _____ |
| | | Needs close supervision | _____ |
| | | Self-injurious behavior | _____ |
| | | EPS/Tardive Disconesia | _____ |
| | | Communicates with sign | _____ |
| | | Communicates assistive device | _____ |
| | | Communicates hearing aid | _____ |
| | | Unable to communicate | _____ |
| | | Limited communication | _____ |

ADDITIONAL RECOMMENDATIONS

| | | | | | |
|---------------------|-------|---------------------|-------|-----------------|-------|
| VISION THERAPY | _____ | OXYGEN THERAPY | _____ | IV FLUIDS | _____ |
| SPEECH THERAPY | _____ | SUCTIONING | _____ | SKILLED NURSING | _____ |
| OCUPATIONAL THERAPY | _____ | TRACHEOSTOMY | _____ | | |
| PHYSICAL THERAPY | _____ | VENTILATOR | _____ | | |
| SOAKS, DRESSINGS | _____ | DIAGNOSTIC SERVICES | _____ | | |
| TRACTION, CASTS | _____ | | | | |

LABS
ORDERED _____

Please Complete All Sections Below to Ensure Certification for the Program

DIAGNOSTIC SECTION

AXIS I: (List all Emotional and/or psychiatric conditions)

AXIS II: (List all Cognitive, Developmental conditions and personality disorders)

AXIS III: (List ALL medical conditions)

PROGNOSIS:

I certify that this patient's developmental disability, medical condition and related health needs are as documented above AND the patient requires the level of care and services provided in an "INTERMEDIATE CARE FACILITY" for individuals with mental retardation and/or related conditions
 YES _____ NO _____

(Note: ICF/MR level of care means the Individual needs a high level of habilitation training and supervision. This level of care does not have to occur in an institution and can be provided in a community setting.)

DATE _____ PHYSICIAN'S SIGNATURE _____ LICENSE # _____

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

Approved for ICF/MR Level of Care _____ Yes _____ No _____

Name of Reviewer: _____ Date _____

DD- 3

Comprehensive Psychological Evaluation

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)**

NAME: _____

EVALUATION DATE: ___/___/___

BIRTHDATE: ___/___/___

AGENCY/FACILITY: _____

REASON FOR EVALUATION: _____

I. RELEVANT HISTORY:

- A. Prior Hospitalization/Institutionalization
- B. Prior Psychological Testing
- C. Behavioral History

II. CURRENT STATUS:

- A. Physical/Sensory Deficits
- B. Medications (Type, frequency and dosage)
- C. Current Behaviors
 - 1. Psychomotor
 - 2. Self-help
 - 3. Language
 - 4. Affective
 - 5. Mental Status
 - 6. Others (Social interaction, use of time, leisure activities)

III. CURRENT EVALUATION

- A. Intellectual/Cognitive:
 - 1. Instruments used:
 - 2. Results:
 - 3. Discussion:
- B. Adaptive Behavior:
 - 1. Instruments used: ABS I & II Others (list)
 - 2. Results:
 - 3. Discussion:
- C. Other:
 - 1. Instruments used:
 - 2. Results:
 - 3. Discussion:
- D. Indicate the individual's level of acquisition of these skills commonly associated with need for active treatment.
 - 1. Able to take care of most personal care needs. yes no
 - 2. Able to understand simple commands. yes no

- | | | |
|-----|--|--|
| 3. | Able to communicate basic needs and wants. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 4. | Able to be employed at a productive wage level without systematic long term supervision or support. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 5. | Able to learn new skills without aggressive and consistent training. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 6. | Able to apply skills learned in a training situation to other environments or settings without aggressive and consistent training. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 7. | Able to demonstrate behavior appropriate to the time, situation or place without direct supervision. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 8. | Demonstrates severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 9. | Able to make decisions requiring informed consent without extreme difficulty. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 10. | Identify other skill deficits or specialized training needs which necessitates the availability of trained MR personnel, 24 hours per day, to teach the person to learn functional skills. | yes <input type="checkbox"/> no <input type="checkbox"/> |
-

E. Developmental Findings/Conclusions

IV. RECOMMENDATIONS:

- A. Training
- B. Activities
- C. Therapy/Counseling/Behavioral Intervention

V. DIAGNOSIS:

VI. PROGNOSIS:

VII. PLACEMENT RECOMMENDATIONS:

Signature of Supervised Psychologist

Signature of Licensed Psychologist

Title

License #/Title

Date

Date

DD-3 - COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)
REVISED JULY 1, 2004
PAGE 2 OF 2

DD- 4

Social History

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
SOCIAL HISTORY**

PARTICIPANT NAME: _____ **DATE:** _____

I. DEVELOPMENTAL HISTORY:

Provide information summarizing personal growth from infancy through adolescence with attention to the development of his/her physical, social, and emotional competencies. As outlined below, if development is delayed, describe the circumstances or conditions associated with the delay and date of onset. If more space is needed, use back of this sheet and identify information by Roman numeral and letter.

- a) Physical
- b) Social
- c) Emotional

II. FAMILY:

List parents, spouse, children, siblings, significant others, and type of relationships, i.e., are they an available source of support and/or resources. Include description of family's socio-economic circumstances, and family composition. Past and current living arrangements, special problems, such as alcohol, substance abuse, and mental illness should be included.

III. EDUCATION/TRAINING:

Describe education and training experiences, identify schools and programs attended, relationships with peers and teachers, any adjustment problems, levels of accomplishment and any other pertinent information.

IV. FUNCTIONAL STATUS:

Describe levels of functioning relating to employment capabilities, work-related experiences, and assessment of skills relevant to the activities of daily living and self-care skills. Is applicant/participant now, or ever been gainfully employed? Indicate level of care recommendation.

V. RECREATION/LEISURE ACTIVITIES:

Identify and describe recreational and leisure time activities, frequencies, accessibility, and degree of involvement.

VI. HOSPITALIZATIONS:

List medical and psychiatric hospital dates and reason for admissions.

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
SOCIAL HISTORY**

VII. FAMILY MEDICAL HISTORY (Identify relationship to the participant):

| | | | |
|----------------|-----------------|--------------------|-------------------|
| MR/DD | Cerebral Palsy | Autism | Mental Illness |
| Heart Disease | Diabetes | Tuberculosis | Hepatitis |
| Kidney Disease | Cancer | Hypertension | Metabolic Disease |
| Allergies | Thyroid Disease | Muscular Dystrophy | Epilepsy |
| Other _____ | | | |

Deceased Siblings (Cause of Death) _____

VIII. LEGAL STATUS:

Guardianship, committee, custody).

IX. OTHER RELEVANT INFORMATION:

(Family medical history; applicant/participant military service; religious preference; or significant events or circumstances not covered in other sections).

DATE

DATE

SIGNATURE OF TEMPORARY LSW

SIGNATURE/CO-SIGN OF DEGREED/LSW

LICENSE #/DEGREE

LICENSE #/DEGREE

DD- 5A

Initial Individual Program Plan

DD- 5

Individual Program Plan

PROMPTS FOR “MY GOALS/DREAMS” AND “MY CIRCLE OF SUPPORT”

The following is a series of questions or prompts for the service coordinator to begin facilitation of the development of the overall goals/dreams of the participant and identification of the participant's circle of support. This section (page 2 only) is for discussion at the annual IPP team meeting and may be prepared prior to the team meeting, then, reviewed with the remainder of the team members. No other section of the IPP may be completed prior to the team meeting. This series of prompts must be provided or billed as a service coordination activity and must not be provided or billed as an IPP team meeting activity.

What I did last year: *(Include achievements, special events, progress on goals, etc.)*

I like to spend time with: *(This could be a family, friends, church members, employers, providers, classmates, etc. Include how contact is made such as on the phone, visiting, or letters, and also how to assist the person in their contact with others – what supports are needed.)*

During my leisure time I like to: *(Include continuing and developing new leisure activities and any club affiliations, also include activities specific to an individual's culture.)*

The things that I am good at are: *(My strengths and abilities are. List things I do well, that I can do, or enjoy doing, or that others feel I am good at doing.)*

To be more independent, I would like to continue working on and/or learn how to: *(This may include things taught through a variety of sources such as the school, community, enrichment programs; or include independent living skills such as hygiene, cooking, or skills for community access, or skills for achieving vocational interests. Include what assistance is needed – how can the team support such goals?)*

Things that are extremely important to me are: *(List possessions and activities specific to an individual's culture and religious practices.)*

The things I never want in my life are: *(There may be things or situations that make me mad, sad, scared or confused. It might be people I don't want to be around, fear of animals, foods that I don't like, or anything that would cause me undue stress.)*

People who help me and support me: *Include natural supports, friends, family members, or professionals providing evaluation or support.)*

What I want to do in the next year and who I would like to help me: *(Include things like taking a trip with my family and/or provider, earning money, learning to self-medicate; get a piece of special equipment.)*

My long-term goals for the future are:

(What would make me happy? What do I want to work toward the most? What would make my life better? These are things I want to do in the future.)

If I could change things in my life, what would I change?

(Include things like guardian changes, change in residence, and change in school.)

What community activities will enable me to pursue interests in a positive way? *(What are my interests? What do I like to do? Where do I like to go? What activities make me smile?)*

WHAT ARE MY DREAMS/GOALS IN THESE AREAS?



COMMUNITY PARTICIPATION



HOME AND SUPPORTS



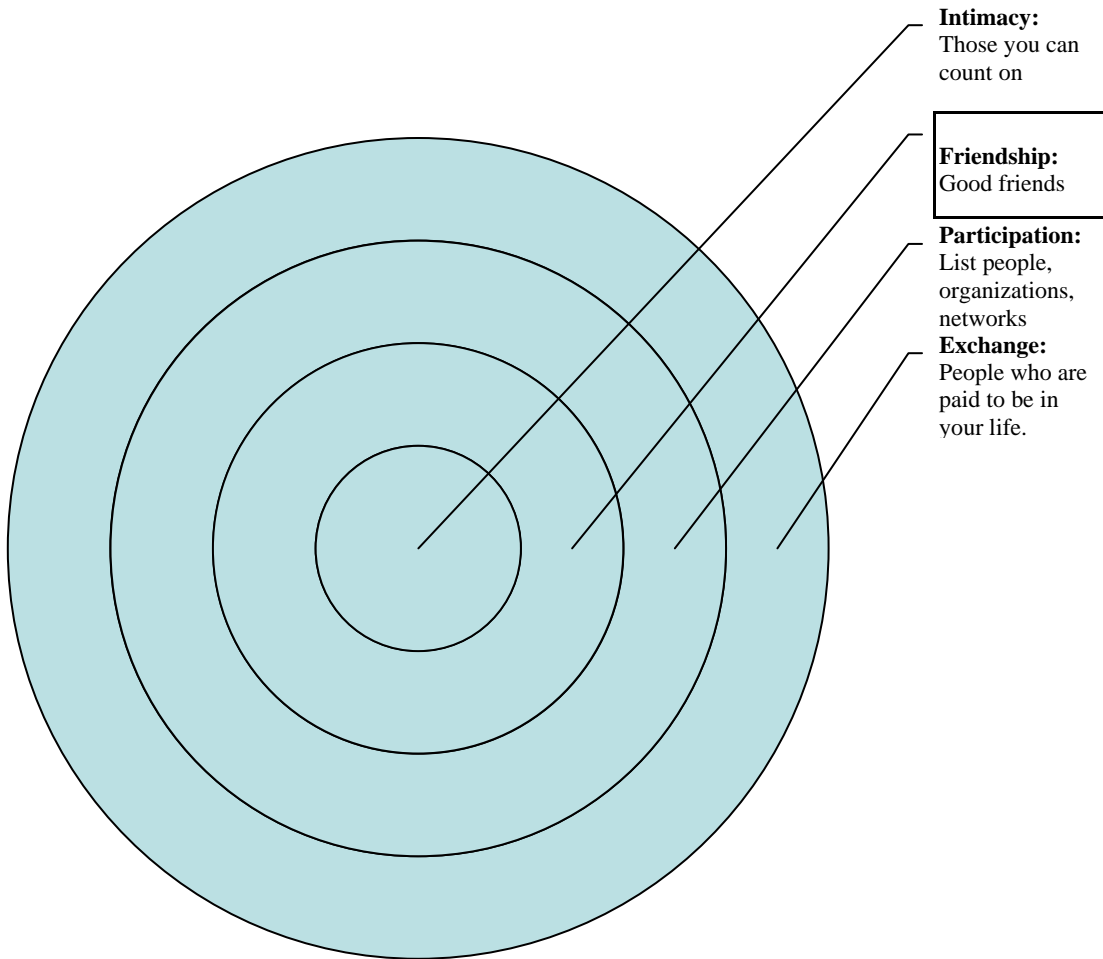
**MAKING MY OWN FRIENDS AND
KEEPING FRIENDSHIPS**



SUPPORT NETWORK (FAMILY, FRIENDS, ETC.)

Note: Use the findings from page 2 to assist in the identification of goals/dreams

CIRCLE OF SUPPORT



Who can I count on?

Who is a good friend?

List people, organizations, or networks you are involved with:

People who are paid to be in my life (staff):

Who would you like to participate in developing your plan?

The Team will need to review above information with the person to determine how to develop support systems and increase participation in their communities.

Assessment and Evaluation Information Summary of Recommendations

| Evaluation | Date of Evaluation | Summary of Priority Recommendations |
|-------------------------------|--------------------|-------------------------------------|
| DD-2A | | |
| DD-3 | | |
| DD-4 | | |
| PT | | |
| OT | | |
| ST | | |
| Other Testing | | |
| Extraordinary Care Assessment | | |
| Nursing Assessment | | |
| ICAP | | |
| SIS | | |
| Other | | |
| | | |
| | | |
| | | |
| | | |

Individual Services Plan

May Utilize More Than One Page

| Service | Availability/Accessibility | Provider | | | | |
|----------------------|--|---------------------|--|----|--|--|
| | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Yes</td> <td style="width: 85%;"></td> </tr> <tr> <td>No</td> <td></td> </tr> </table> | Yes | | No | | |
| Yes | | | | | | |
| No | | | | | | |
| Frequency of Service | Plan of Action | Start Date/End Date | | | | |
| | | | | | | |
| Service | Availability/Accessibility | Provider | | | | |
| | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Yes</td> <td style="width: 85%;"></td> </tr> <tr> <td>No</td> <td></td> </tr> </table> | Yes | | No | | |
| Yes | | | | | | |
| No | | | | | | |
| Frequency of Service | Plan of Action | Start Date/End Date | | | | |
| | | | | | | |
| Service | Availability/Accessibility | Provider | | | | |
| | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Yes</td> <td style="width: 85%;"></td> </tr> <tr> <td>No</td> <td></td> </tr> </table> | Yes | | No | | |
| Yes | | | | | | |
| No | | | | | | |
| Frequency of Service | Plan of Action | Start Date/End Date | | | | |
| | | | | | | |
| Service | Availability/Accessibility | Provider | | | | |
| | <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Yes</td> <td style="width: 85%;"></td> </tr> <tr> <td>No</td> <td></td> </tr> </table> | Yes | | No | | |
| Yes | | | | | | |
| No | | | | | | |
| Frequency of Service | Plan of Action | Start Date/End Date | | | | |
| | | | | | | |

HABILITATION OBJECTIVE PAGE
Use as many of these sheets as necessary

| | | | |
|--------------------|--|-----------------|--|
| Member Name | | Provider | |
|--------------------|--|-----------------|--|

My goal is: _____ **Start Date:** _____ **Target Date:** _____

| Goal Number | My Objective is | Method(s) |
|--------------------|------------------------|------------------|
| | | |

What is needed for me to meet my objective?

My Goal is: _____ **Start Date:** _____ **Target Date:** _____

| Goal Number | My Objective is | Method(s) |
|--------------------|------------------------|------------------|
| | | |

What is needed for me to meet my objective?

NOTE: ATTACH TASK ANALYSIS/METHOD FORMS, CRISIS PLAN, BEHAVIORAL SUPPORT PLAN, BEHAVIORAL PROTOCOL, OR BEHAVIORAL GUIDELINES TO THE PLAN

SIGNATURES

| Relationship | Signature | Date Attended/Time | Agree | Disagree |
|---|-----------|--------------------|-------|----------|
| Consumer | | | | |
| Parent/Guardian | | | | |
| Service Coordinator | | | | |
| RN/Physician | | | | |
| Psychologist | | | | |
| Other (Circle of Support, Advocate, PT, OT, ST, etc.) | | | | |
| Other (Circle of Support, Advocate, PT, OT, ST, etc.) | | | | |
| Other (Circle of Support, Advocate, PT, OT, ST, etc.) | | | | |
| Other (Circle of Support, Advocate, PT, OT, ST, etc.) | | | | |
| Other (Circle of Support, Advocate, PT, OT, ST, etc.) | | | | |
| Other (Circle of Support, Advocate, PT, OT, ST, etc.) | | | | |
| Other (Circle of Support, Advocate, PT, OT, ST, etc.) | | | | |

****IDT member has disagreed with the plan. The rationale is attached.***

Rationale for Disagreement with the Plan

Signature: _____ Date: _____

DD- 7

Informed Consent to a Choice of Alternatives Between
Institutional and Waiver Home and Community-Based
Services

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
INFORMED CONSENT TO A CHOICE OF ALTERNATIVES BETWEEN
INSTITUTIONAL AND WAIVER HOME AND COMMUNITY-BASED SERVICES**

NAME: _____

AGENCY/FACILITY: _____

*(**Indicate that information has been provided by initialing each area covered)*

- _____ 1. The findings and results of the evaluations and needs have been discussed with the participant and/or family or legal representative.
- _____ 2. Alternative plans for providing services to meet the participant's needs have been discussed and a choice of services between ICF/MR and community-based MR/DD Waiver services has been presented to the participant and/or family or legal representative.
- _____ 3. The participant and/or family or legal representative have chosen ___ICF/MR ___Community-based MR/DD Waiver as described by the Service Coordinator.
- _____ 4. The participant and/or family or legal representative have requested that an Individual Program Plan be developed for their approval.
- _____ 5. The right to a fair hearing and the agency and state appeal process have been discussed with the participant and/or family or legal representative.
- _____ 6. A copy of the MR/DD Waiver Manual has been offered to the participant and/or family or legal representative and he/she has _ accepted _ refused the copy of the handbook.

I, _____, consent for the state DHHR to disclose Case Status Information and/or Eligibility Information to Behavioral Health Providers for Treatment, Payment, Administrative Service Organization and Health Care Operations as is necessary to assist in the provision of Title XIX MR/DD Waiver Services.

Participant Date Parent or Legal Guardian Date

Service Coordinator Date SC Supervisor Date

Witness Date

DD- 7A

Informed Consent
Choice of MR/DD Waiver Providers
and
MR/DD Waiver Services

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
NOTIFICATION OF CHOICE OF
MR/DD WAIVER PROVIDERS AND MR/DD WAIVER SERVICES**

NAME: _____

AGENCY/FACILITY: _____

*(**Indicate that information has been provided by initialing each area covered)*

- _____ 1. The right to choose among all qualified providers has been discussed with the participant and/or family or legal representative.
- _____ 2. All enrolled service coordination agencies in the participant's catchment area have been discussed with the participant, family and/or legal representative.
- _____ 3. The participant and/or family or legal representative have chosen _____ as their service coordination agency.
- _____ 4. The right to choose among all available MR/DD Waiver services to meet the participant's needs have been discussed with the participant and/or family or legal representative.
- _____ 5. The participant, family and/or legal representative has been informed of their right to a fair hearing if denied service(s) and the provider(s) of their choice.
- _____ 6. A copy of the MR/DD Waiver Reference Guide to Providers has been offered to the participant, family and/or legal representative have ____accepted ____ refused a copy of the Reference Guide.

Participant _____ Date _____

Parent or Legal Guardian _____ Date _____

Service Coordinator _____ Date _____

SC Supervisor _____ Date _____

Witness _____ Date _____

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)**

NAME: _____

EVALUATION DATE: ___/___/___

BIRTHDATE: ___/___/___

AGENCY/FACILITY: _____

REASON FOR EVALUATION: _____

I. RELEVANT HISTORY:

- A. Prior Hospitalization/Institutionalization
- B. Prior Psychological Testing
- C. Behavioral History

II. CURRENT STATUS:

- A. Physical/Sensory Deficits
- B. Medications (Type, frequency and dosage)
- C. Current Behaviors
 - 1. Psychomotor
 - 2. Self-help
 - 3. Language
 - 4. Affective
 - 5. Mental Status
 - 6. Others (Social interaction, use of time, leisure activities)

III. CURRENT EVALUATION

- A. Intellectual/Cognitive:
 - 1. Instruments used:
 - 2. Results:
 - 3. Discussion:
- B. Adaptive Behavior:
 - 1. Instruments used: ABS I & II Others (list)
 - 2. Results:
 - 3. Discussion:
- C. Other:
 - 1. Instruments used:
 - 2. Results:
 - 3. Discussion:

D. Indicate the individual's level of acquisition of these skills commonly associated with need for active treatment.

- | | | |
|-----|--|--|
| 1. | Able to take care of most personal care needs. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 2. | Able to understand simple commands. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 3. | Able to communicate basic needs and wants. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 4. | Able to be employed at a productive wage level without systematic long term supervision or support. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 5. | Able to learn new skills without aggressive and consistent training. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 6. | Able to apply skills learned in a training situation to other environments or settings without aggressive and consistent training. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 7. | Able to demonstrate behavior appropriate to the time, situation or place without direct supervision. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 8. | Demonstrates severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 9. | Able to make decisions requiring informed consent without extreme difficulty. | yes <input type="checkbox"/> no <input type="checkbox"/> |
| 10. | Identify other skill deficits or specialized training needs which necessitates the availability of trained MR personnel, 24 hours per day, to teach the person to learn functional skills. | |
-

E. Developmental Findings/Conclusions

IV. RECOMMENDATIONS:

- A. Training
- B. Activities
- C. Therapy/Counseling/Behavioral Intervention

V. DIAGNOSIS:

VI. PROGNOSIS:

VII. PLACEMENT RECOMMENDATIONS:

Signature of Supervised Psychologist

Signature of Licensed Psychologist

Title

License #/Title

Date

Date

DD- 9

MONTHLY HOME VISIT REPORT
RESIDENTIAL HABILITATION FOR
ISS/GROUP HOME

MR/DD Waiver
Monthly Service Coordination Visit
Residential Habilitation for ISS/Group Home

I. WAIVER PARTICIPANT INTERVIEW

NAME OF WAIVER PARTICIPANT: _____ age _____
ADDRESS: _____

- 1) Is the participant safe, neat and clean? **YES** **NO**
1a) If no, list intervention: _____
- 2) Do you have any concerns or recommendations about your services? **YES** **NO**
2a) If yes, list: _____
- 3) List next months community integration events or special plans you have: _____
- 4) What has improved over the last month for you? _____

II. HABILITATION PROVIDER INTERVIEW

- 1) Describe the overall status report of the participant given by the provider: _____
1a) List any concerns with sleep patterns: _____
1b) List any concerns with appetite: _____
1c) List any concerns with behaviors: _____
- 2) List dates and outcomes of past months medical and/or other therapy appointments.
(Include any hospitalizations, diagnostic changes, needs for referral for prior authorization, side effect monitoring, illnesses....)
2a) _____
2b) _____
2c) _____
- 3) Were there any medication changes over the month? **YES** **NO**
3a) List if yes: _____
3b) If yes, was the Waiver RN and IDT team notified? **YES** **NO**
- 4) List Dates/Purposes of Upcoming Appointments: _____
- 5) Has the participant progressed in any areas? **YES** **NO** *Specify:* _____
- 6) Has the participant regressed in any areas? **YES** **NO** *Specify:* _____
- 7) Is there a current, complete, and signed copy of the IPP on site? **YES** **NO**
- 8) Is liaison work requested between the day and residential habilitation settings? **YES** **NO**
7a) If yes, state purpose: _____
- 9) Do you have the necessary equipment/ materials to provide active treatment services? **YES** **NO**
9a) If no, list needed items: _____
- 10) Is all adaptive equipment in working condition? **YES** **NO** *Specify:* _____
10a) If no, targeted resolution date: _____

III. OVERSIGHT AND ACCOUNTABILITY OBSERVATION

- 1) List any concerns with staffing/services: _____
 1a) Specify plans for resolution of any concerns: _____
- 2) Is there a back up plan in the event of habilitation provider and/or participant illness? **__ YES __ NO**
 2a) If no, specify plans for resolution: _____

IV. STATUS OF LAST MONTHS REQUESTS FOR SC FOLLOW-UP

- SC Task #1: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task #2: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task #3: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task # 4: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____

V. ADDITIONAL REQUESTS FOR SC FOLLOW UP

- 1) _____ 2) _____
- 3) _____ 4) _____

VI. ENVIRONMENTAL ASSESSMENT

- 1) Is the home sanitary and safe? **__ YES __ NO**
 1a) Specify any needed improvements: _____
 1b) Targeted Resolution Date: _____ Other: _____
- 2) Are any environmental modifications needed? **__ YES __ NO**
 2a) If yes, then specify: _____
 2b) Targeted Resolution Date: _____ Other: _____
- 3) Does the person have adequate crisis prevention, intervention and response plans? **__ YES __ NO**
 3a) If no, then specify plans for improvement: _____
 3b) Targeted Resolution Date: _____ Other: _____
- 4) Are there effective evacuation and disaster response plans in place? **__ YES __ NO**
 4a) If no, then specify plans for improvement: _____
 4b) Targeted Resolution Date: _____ Other: _____

VII. SERVICE TIME

Travel TO Start Time: _____ : _____ Travel TO End Time: _____ : _____
 Visit START Time: _____ : _____ Visit END Time: _____ : _____
 Travel FROM Start Time: _____ : _____ Travel FROM End Time: _____ : _____
 TOTAL Number of Miles: _____ TOTAL Number of Minutes: _____

VIII. SIGNATURE SECTION

| | | | |
|-------------------------------|-------|--|-------|
| Participant Signature | Date: | Habilitation Provider Signature | Date: |
| | | (Check One) <input type="checkbox"/> Witness or <input type="checkbox"/> Guardian | |
| Service Coordinator Signature | Date: | Signature | Date: |

DD- 9A

MONTHLY HOME VISIT REPORT
RESIDENTIAL HABILITATION FOR
NATURAL FAMILY –
SPECIALIZED FAMILY CARE PROGRAM

I. WAIVER PARTICIPANT INTERVIEW

NAME OF WAIVER PARTICIPANT: _____ age _____
ADDRESS: _____

- 1) Is the participant safe, neat and clean? **YES** **NO**
1a) If no, list intervention: _____
- 2) Do you have any concerns or recommendations about your services? **YES** **NO**
2a) If yes, list: _____
- 3) List next months community integration events or special plans you have: _____
- 4) What has improved over the last month for you? _____

II. HABILITATION PROVIDER OR PARENT/GUARDIAN INTERVIEW

- 1) Describe the overall status report of the participant given by the provider: _____
1a) List any concerns with sleep patterns: _____
1b) List any concerns with appetite: _____
1c) List any concerns with behaviors: _____
- 2) List dates and outcomes of past months medical and/or other therapy appointments.
(Include any hospitalizations, diagnostic changes, needs for referral for prior authorization, side effect monitoring, illnesses....)
2a) _____
2b) _____
2c) _____
- 3) Were there any medication changes over the month? **YES** **NO**
3a) List if yes: _____
3b) If yes, was the Waiver RN and IDT team notified? **YES** **NO**
- 4) List Dates/Purposes of Upcoming Appointments: _____
- 5) Has the participant progressed in any areas? **YES** **NO** Specify: _____
- 6) Has the participant regressed in any areas? **YES** **NO** Specify: _____
- 7) Is there a current, complete, and signed copy of the IPP on site? **YES** **NO**
- 8) Is liaison work requested between the day and residential habilitation settings? **YES** **NO**
7a) If yes, state purpose: _____
- 9) Do you have the necessary equipment/ materials to provide active treatment services? **YES** **NO**
9a) If no, list needed items: _____
- 10) Is all adaptive equipment in working condition? **YES** **NO** Specify: _____
10a) If no, targeted resolution date: _____

III. OVERSIGHT AND ACCOUNTABILITY OBSERVATION

- 1) List any concerns with staffing/services: _____
 1a) Specify plans for resolution of any concerns: _____
- 2) Is there a back up plan in the event of habilitation provider and/or participant illness? **__ YES __ NO**
 2a) If no, specify plans for resolution: _____

IV. STATUS OF LAST MONTHS REQUESTS FOR SC FOLLOW-UP

- SC Task #1: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task #2: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task #3: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task # 4: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____

V. ADDITIONAL REQUESTS FOR SC FOLLOW UP

- 1) _____ 2) _____
- 3) _____ 4) _____

VI. ENVIRONMENTAL ASSESSMENT

- 1) Is the home safe? **__ YES __ NO**
 1a) Specify any needed improvements: _____
 1b) Targeted Resolution Date: _____ Other: _____
- 2) Are any environmental modifications needed? **__ YES __ NO**
 2a) If yes, then specify: _____
 2b) Targeted Resolution Date: _____ Other: _____
- 3) Does the person have adequate crisis prevention, intervention and response plans? **__ YES __ NO**
 3a) If no, then specify plans for improvement: _____
 3b) Targeted Resolution Date: _____ Other: _____
- 4) Are there effective evacuation and disaster response plans in place? **__ YES __ NO**
 4a) If no, then specify plans for improvement: _____
 4b) Targeted Resolution Date: _____ Other: _____

VII. SERVICE TIME

Travel TO Start Time: _____ : _____ Travel TO End Time: _____ : _____
 Visit START Time: _____ : _____ Visit END Time: _____ : _____
 Travel FROM Start Time: _____ : _____ Travel FROM End Time: _____ : _____
 TOTAL Number of Miles: _____ TOTAL Number of Minutes: _____

VIII. SIGNATURE SECTION

| | | | |
|-------------------------------|-------|--|-------|
| Participant Signature | Date: | Habilitation Provider Signature | Date: |
| | | (Check One) <input type="checkbox"/> Witness or <input type="checkbox"/> Guardian | |
| Service Coordinator Signature | Date: | Signature | Date: |

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Documentation – Monthly Progress Report

Community Residential Habilitation, Respite or Adult Companion - Documentation Form

Participant Name/Client Number _____

Service Coordinator _____

Provider Name _____

Month/Year _____

CHECK ONE: Community Residential Habilitation Adult Companion I Adult Companion II Respite I Respite II

PER CONTINUOUS BLOCK OF TIME: (utilize back of this form or another sheet of paper if necessary)

| | | | | | | |
|-------|-------|-------------|------------|-------------|----------------------------------|---|
| Date: | Code: | Start Time: | Stop Time: | Total Time: | Training/Objective(s) # __N/A | Transportation: yes__ no __ Total Miles: |
|-------|-------|-------------|------------|-------------|----------------------------------|---|

Summary: _____

Mileage: FROM: _____ TO: _____

Mileage: FROM: _____ TO: _____

Signature/Title of Provider: _____

PER CONTINUOUS BLOCK OF TIME: (utilize back of this form or another sheet of paper if necessary)

| | | | | | | |
|-------|-------|-------------|------------|-------------|--|---|
| Date: | Code: | Start Time: | Stop Time: | Total Time: | Training/Objective(s) # __N/A (No Training) | Transportation: yes__ no __ Total Miles: |
|-------|-------|-------------|------------|-------------|--|---|

Summary: _____

Mileage: FROM: _____ TO: _____

Mileage: FROM: _____ TO: _____

Signature/Title of Provider: _____

PER CONTINUOUS BLOCK OF TIME: (utilize back of this form or another sheet of paper if necessary)

| | | | | | | |
|-------|-------|-------------|------------|-------------|--|---|
| Date: | Code: | Start Time: | Stop Time: | Total Time: | Training/Objective(s) # __N/A (No Training) | Transportation: yes__ no __ Total Miles: |
|-------|-------|-------------|------------|-------------|--|---|

Summary: _____

Mileage: FROM: _____ TO: _____

Mileage: FROM: _____ TO: _____

Signature/Title of Provider: _____

PER CONTINUOUS BLOCK OF TIME: (utilize back of this form or another sheet of paper if necessary)

| | | | | | | |
|-------|-------|-------------|------------|-------------|--|---|
| Date: | Code: | Start Time: | Stop Time: | Total Time: | Training/Objective(s) # __N/A (No Training) | Transportation: yes__ no __ Total Miles: |
|-------|-------|-------------|------------|-------------|--|---|

Summary: _____

Mileage: FROM: _____ TO: _____

Mileage: FROM: _____ TO: _____

Signature/Title of Provider: _____

Instructions for Completing Community Residential Habilitation, Respite or Adult Companion Documentation Form

1. Complete top portion of the form.

Participant Name/Client Number

Service Coordinator

Provider Name

Month/Year

2. Check type of service being provided. **Only one type of service may be entered/recorded on a form for each continuous block of time. (example date is 01-01-2006 - 6:00 a.m. to 9:00 a.m. is one continuous block of time - 10:00 a.m. to 12:30 p.m. is another continuous block of time - 6:30 p.m. to 9:30 p.m. is another continuous block of time)*

Check One: Community Residential Habilitation Adult Companion I Adult Companion II Respite I Respite II

3. Enter the date of the service.

| | | | | | | | |
|--------|--|--|--|--|--|--|--|
| Date: | | | | | | | |
| 1/1/06 | | | | | | | |

4. Enter the code of the service.

| | | | | | | | |
|---------|--|--|--|--|--|--|--|
| Code: | | | | | | | |
| T2017UA | | | | | | | |

SERVICE CODES: Residential Habilitation

Transportation

T2017-UA= Community Residential Habilitation

A0160=Transportation I A0120=Transportation II

Adult Companion

Respite

S5135-UAU4= Adult Companion Level I, 1:1 ratio

T1005-UAU4= Respite Care Level I, 1:1 ratio

S5135-UAU3= Adult Companion Level I, 1:2 ratio

T1005-UAU3= Respite Care Level I, 1:2 ratio

S5135-UAU2= Adult Companion Level I, 1:3 ratio

T1005-UAU2= Respite Care Level I, 1:3 ratio

S5135-UBU4= Adult Companion Level II, 1:1 ratio

T1005-UBU4= Respite Care Level II, 1:1 ratio

S5135-UAU3= Adult Companion Level II, 1:2 ratio

T1005-UBU3= Respite Care Level II, 1:2 ratio

S5135-UBU2= Adult Companion Level II, 1:3 ratio

T1005-UBU2= Respite Care Level II, 1:3 ratio

5. Enter the time service session begins (Start Time). ** If two (2) sessions are done in one day, there are to be two (2) Start Times.* This refers to blocks of continuous time for each specific code – You may complete more than one objective during the “continuous” block of time.

| | | | | | | | |
|--|--|---------------------|--|--|--|--|--|
| | | Start Time: 9:30 am | | | | | |
| | | Start Time: | | | | | |

6. Enter the time service session ends (Stop Time). **If two (2) sessions (time lapse between continuous blocks of time) are done in one day, there are to be two (2) Stop Times.*

| | | | | | | | |
|--|--|---------------------|--|--|--|--|--|
| | | Stop Time: 11:00 am | | | | | |
| | | Stop Time: | | | | | |

7. Enter the full time it takes to complete the session (Total Time). **If two (2) sessions are done in one day, there are to be two (2) Total Times.*

| | | | | | | | |
|--|--|------------------|--|--|--|--|--|
| | | Total Time: 1:30 | | | | | |
| | | Total Time: | | | | | |

8. Enter the number(s) of the training objective(s) worked on during the service session. If no training is done, mark “N/A”.

| | | | | | | | |
|--|--|--|--|-----------------------------|--|--|--|
| | | | | Training/Objectives # 1,5,6 | | | |
| | | | | N/A (No Training) | | | |

9. Mark “yes” if transportation was provided to the participant and the total miles used. Mark “no” if no transportation was provided.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| | | | | | | Transportation: yes <input checked="" type="checkbox"/> no <input type="checkbox"/> | |
| | | | | | | Total Miles: 10 | |

10. Write a brief note describing the service session.

Summary: **Josh completed his shopping, purchasing, and choice training programs this morning at the (give specific locations activity(ies) were implemented). He was attentive and did well except with making change. Completed all programs.**

Signature/Title of Provider: **Joe Staff, Res Hab**

11. Mileage (from) initial starting point (be specific – list “address” instead of “home” (to) specific destination where activity(ies) occurred – list specific site “Mercer County Public Library” instead “Library”, “Hometown Grocery Store – 10th Street” instead of “store”, Hometown Restaurant – 6th Street ” instead of restaurant.

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Certification of Training for Habilitation Providers

**MR/DD WAIVER PROGRAM
CERTIFICATION OF TRAINING FOR HABILITATION PROVIDERS**

Name of Participant: _____ Date: _____

Service Coordination Agency: _____

Name of Subcontracting Agency (If applicable): _____

Name of Location: GH ISS/Semi-I/Apt Day Pro SFCH NF Home

Period for Which Training is Valid: From _____ To _____

Trained on the Following Program Objectives:

- | | |
|----------|-----------|
| 1. _____ | 9. _____ |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | 16. _____ |

* Note: Specific procedure/techniques/methods may be found attached to the program plan. Amount of time spent training is documented in the QMRP case notes.

I certify that I have received training on the program objectives listed above. I will contact the service coordinator or Therapeutic Consultant if additional training is needed.

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature and Credentials of Trainer

Date

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MR/DD Waiver Application

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Member Exit/Transfer Form

Therapeutic Consultant Credentialing
Form
DD-17

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Environmental Accessibility Adaptations Form

**MR/DD WAIVER PROGRAM
REQUEST FOR ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS**

TO BE COMPLETED BY THE SERVICE COORDINATOR:

Date _____

Participant Name _____

Medicaid Recipient # _____

Living Situation: Natural Family SFCP ISS Group Home

Service Coordination Agency _____

Service Coordination Agency Address _____

Service Coordination Phone Number _____

Service Coordinator Name _____

Brief Description of the Environmental Accessibility Adaptation Needed: _____

Total Cost of the Environmental Accessibility Adaptation: \$ _____

Has the Participant utilized this service in the current calendar year? YES NO

If yes, what is the total amount of funding utilized in the current calendar year? \$ _____

ATTACH THE FOLLOWING DOCUMENTATION:

- IPP recommendations**
- Documentation of denials or exhaustion of non-Medical and non-family resources**
- Purchase order detailing costs and description for the Environmental Accessibility Adaptations.**

Service Coordinator Signature/Date _____

Agency Contact Person Signature/Date _____

****All Original Documentation (form and attachments) must be maintained in the participant's file. A copy of this form must be maintained in a single file by the Agency Contact Person.****

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Mortality Notification

MR/DD WAIVER NOTIFICATION OF PARTICIPANT DEATH
 (This form is only used to report deaths of participants who reside in a 24 hour staffed setting.)

TO: Office of Behavioral Health Services
MR/DD Waiver Program
350 Capitol Street, Room 350
Charleston, West Virginia 25301-3702

FROM: _____

INFORMATION ON THE DECEASED:

Name _____ Gender _____ Age _____

Date of Birth ____/____/____ Address _____

City _____ Medicaid Number _____

DIAGNOSIS AND MEDICAL CONDITION:

Axis I

Axis II

Axis III

Medications: (Use additional paper if necessary)
List all current medications prescribed and non-prescribed.

| <u>Medication</u> | <u>Dosage/Frequency</u> | <u>Purpose of Medication</u> |
|-------------------|-------------------------|------------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Date of Death ____/____/____ Time of Death _____ a.m. / p.m. (Circle One)

Location of Death

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Request for Nursing Services

**TITLE XIX MR/DD WAIVER PROGRAM
REQUEST FOR NURSING SERVICES**

TO BE COMPLETED BY SERVICE COORDINATOR:

CLIENT NAME _____

DATE OF BIRTH _____

WEST VIRGINIA MEDICAID RECIPIENT # _____

MR/DD Waiver status verified by _____ Date client enrolled in MR/DD Waiver _____

LIVING SITUATION: With Parents/SFCP
 ISS
 Group Home
 Other (describe) _____

AGENCY NAME _____

WV MEDICAID PROVIDER _____

AGENCY ADDRESS _____

AGENCY PHONE # _____

SERVICE COORDINATOR _____

LIST OF ALL MEDICAID SERVICES CURRENTLY PROVIDED TO CLIENT: (also list provider)

PRINCIPAL DIAGNOSIS: _____

Other pertinent diagnoses: _____

HAS THERE BEEN CHANGE IN THIS CLIENT'S CONDITION IN THE LAST YEAR? Yes No

If yes, please explain

**MR/DD WAIVER NURSING REQUEST
PAGE 2**

CLIENT NAME _____

MEDICAID # _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN:

Brief description of client's medical status: _____

Has family/care giver been trained to adequately care for client? Yes No

List/Describe exactly what procedures this client requires that must be performed by a licensed nurse:

List all medications and treatment orders: _____

Patient Name: _____

RX:

I certify that this patient is in need of skilled nursing services @ ___ hours per day/___ days per week. The patient is under my care and requires the skilled procedures as listed above. Unless otherwise indicated this authorization covers a one year period, unless there is a change in the patient's condition.

Physician's Signature: _____

Date Signed: _____

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Extra-ordinary Care Instrument

**TITLE XIX MR/DD HOME & COMMUNITY BASED WAIVER
ASSESSMENT TO DETERMINE EXTRAORDINARY CARE**

| MOTOR SKILLS | Not-Applicable | Independent | Semi-Independent | Minimal Assistance | Moderate Assistance | Total Assistance | AVERAGE SCORE |
|--|---|------------------------------|--|--|--|---|----------------------|
| | Not – applicable is not included in the average | Completes without assistance | May require assistance of a device without personal assistance | Intermittent physical assistance of another person | Requires physical assistance of another person to accomplish | Unable to complete without constant physical assistance of another person | |
| | N/A | 0 | 1 | 2 | 3 | 4 | |
| Ambulation and mobility (n/a 0-20 months of age) | | | | | | | |
| Transfers (example from bed to chair) (n/a 0- 24 months of age) | | | | | | | |
| Positioning (bed mobility) (n/a 0-9 months of age) | | | | | | | |
| TOTAL MOTOR SKILLS Average of 3.0 and above is “extraordinary” | | | | | | | |

| PERSONAL CARE SKILLS | Not-Applicable | Independent | Semi-Independent | Minimal Assistance | Moderate Assistance | Total Assistance | AVERAGE SCORE |
|--|---|------------------------------|--|---|--|---|----------------------|
| | Not – applicable is not included in the average | Completes without assistance | Sometimes needs verbal prompt to complete task | Verbal prompt required to complete task | Physical prompt and/or repeated instructions required to complete task | Unable to complete without constant physical assistance of another person | |
| | N/A | 0 | 1 | 2 | 3 | 4 | |
| Dressing (n/a 0-48 months of age) | | | | | | | |
| Grooming (hair) (n/a 0 48 months of age) | | | | | | | |
| Bathing (n/a 0- 48 months of age) | | | | | | | |
| Oral hygiene (n/a 0 48 months of age) | | | | | | | |
| Eating with utensils (n/a 0 36 months of age) | | | | | | | |
| Simple Meal Preparation (n/a 0 -120 months of age) | | | | | | | |
| Household Skills (adult only) | | | | | | | |
| Toileting (n/a 0- 36 months of age) | | | | | | | |
| TOTAL PERSONAL CARE SKILLS Average of 3.0 and above is “extraordinary” | | | | | | | |

| DAILY LIVING SKILLS | Not-Applicable | Independent | Semi-Independent | Minimal Assistance | Moderate Assistance | Total Assistance | AVERAGE SCORE |
|---|---|------------------------------|--|---|--|---|----------------------|
| | Not – applicable is not included in the average | Completes without assistance | Sometimes needs verbal prompt to complete task | Verbal prompt required to complete task | Physical prompt and/or repeated instructions required to complete task | Unable to complete without constant physical assistance of another person | |
| | N/A | 0 | 1 | 2 | 3 | 4 | |
| Ability to engage in and complete age appropriate routine tasks or routines of the day for a child below age 5 (task in the home that would be age appropriate) | | | | | | | |
| Ability to cross nearby residential street in own neighborhood or recognize traffic safety (n/a 0 -84 month) | | | | | | | |
| Ability to ride public transportation (n/a 0- 14 years) | | | | | | | |
| Ability to make simple purchases in own neighborhood (n/a 0 - 84 months) | | | | | | | |
| Age appropriate ability to recognize dangers such as “hot, electrical, falls, or sharp objects (i.e. hot stove, electrical outlets, stairs, etc.) n/a 0-36 months | | | | | | | |
| TOTAL DAILY LIVING SKILLS Average of 3.0 and above is “extraordinary” | | | | | | | |

| COMMUNICATION SKILLS | Not-Applicable | Independent | Semi-independent | Minimal Assistance | Moderate Assistance | Total Assistance | AVERAGE SCORE |
|---|---|------------------------------|---|---|--|--|----------------------|
| | Not – applicable is not included in the average | Completes without assistance | Sometimes needs verbal prompt or assistance to complete | Verbal prompt or assistance required to complete task | Physical prompt and/or repeated instructions required to complete task | Unable to complete without constant physical assistance of another | |
| | N/A | 0 | 1 | 2 | 3 | 4 | |
| Ability to communicate basic wants and needs (n/a 0-36 months) | | | | | | | |
| Ability to understand simple directives, instructions (n/a 0-48 months) | | | | | | | |
| Ability to initiate age appropriate social contacts with peers in own neighbor (n/a 0-84 months) | | | | | | | |
| Ability to understand very basic reading and writing (i.e. ability to recognize basic signs and written communication) (n/a 0-84 months) | | | | | | | |
| TOTAL COMMUNICATION SKILLS Average of 3.0 and above is “extraordinary” | | | | | | | |

| MALADAPTIVE ISSUES (will require a formal guideline, protocol or plan) | | | | | | | AVERAGE SCORE |
|--|---|----------------------------|------|----------|---------|---------|--------------------------|
| | Not – applicable is not included in the average | This is not a problem – | Mild | Moderate | Serious | Extreme | |
| | N/A | 0 | 1 | 2 | 3 | 4 | |
| Participates in Self – Injurious Behaviors | | | | | | | |
| Participates in destruction of property | | | | | | | |
| Participates in behavior physically hurtful to others | | | | | | | |
| Participates in behaviors that interferes with activities of others | | | | | | | |
| Demonstrates unusual or repetitive habits | | | | | | | |
| Participates in behavior that is offensive to others | | | | | | | |
| Demonstrates verbal aggression | | | | | | | |
| TOTAL MALADAPTIVE ISSUES 2.0 or above on any item would be reason to evaluate for a guideline or protocol or plan – Has to be linked to ICAP assessment. (Follow the Protocol for ICAP for guidelines, protocols or BSP) | | | | | | | |

| SPECIALIZED PHYSICAL, MEDICAL AND THERAPEUTIC NEEDS | Not-Applicable | Independent | Semi- independent | Minimal Assistance | Moderate Assistance | Total Assistance | AVERAGE SCORE |
|---|---|------------------------------|--|---|--|--|--------------------------|
| | Not – applicable is not included in the average | Completes without assistance | Sometimes needs verbal prompt to complete task | Verbal prompt required to complete task | Physical prompt and/or repeated instructions required to complete task | Unable to complete without constant physical and/or verbal assistance of another | |
| | N/A | 0 | 1 | 2 | 3 | 4 | |
| Ability to carry out specific therapeutic exercises (i.e. Physical, Occupational, Speech- Hearing – Language Plans) | | | | | | | |
| Ability to manage own medication (adults only 18 years of age and above) | | | | | | | |
| TOTAL SPECIALIZED Score of 3.0 on either item | | | | | | | |

Payments will not be made for the routine care and supervision which would be expected to be provided by the care taker, or for activities or supervision for which payment is made by source other than Medicaid. Medicaid does not cover these components.

Services that are provided by legally responsible relatives will not cost more than equivalent services from customary providers.

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**MR/DD WAIVER RECORDS
RETENTION AND STORAGE**

MR/DD WAIVER RECORDS RETENTION AND STORAGE CLINICAL/MEMBER RECORDS

Please find the requirements for documentation requirements in MR/DD Waiver service settings.

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

1. Current complete IPP including current psychological, social and physical evaluations and IEP if there is one
2. Current behavior support plans as appropriate including necessary data sheets, info necessary for day to day behavior management implementation
3. Activity schedule
4. Current doctor's orders for every medication administered at that site, even if the client self administers
5. Nurse's notes (may be archived after 90 days)
6. Daily residential habilitation documentation or staff notes for past 60 days (may then be archived)
7. Current MARs for past 90 days
9. Copies of other pertinent medical or evaluative information relevant to treatment.
10. Monthly summary of medications, doctor's orders, nursing concerns, progress, problems supplied by service coordination agency.

Day Habilitation/Day Treatment

1. Personal identification/demographic sheet and emergency contacts including guardian contacts (Revised DD1)
2. Current complete IPP including current psychological, social and physical evaluations and IEP if there is one
3. Current behavior support plans as appropriate including necessary data sheets, info necessary for day to day behavior management implementation
4. Programmatic data collection for past 60 days (may then be archived)
5. Monthly summary of medications, doctor's orders, nursing concerns, progress, problems supplied by service coordination agency
6. Current incident reports and APS forms relating specifically to the client, with other consumer names coded (past 12 month's worth)
7. MARs for past 90 days as necessary for medications administered on Day Program site
8. Activity schedule

Community Day Habilitation

1. Personal identification/demographic sheet and emergency contacts including guardian contacts kept in sealed envelope and updated monthly
2. Appropriate data collection sheets

Natural Family Locations

1. Behavior Support Plans if indicated, along with appropriate data sheets if any
2. Complete IPP and IEP if there is one, supplied by service coordinator
3. Community Residential Habilitation documentation
4. MARs and doctor's orders, if medications are administered by agency staff

The natural family is entitled to any and all information upon request, current psychological, social and physical evaluations, activity schedules, copies of the monthly summary by the Service Coordinator, medical records, etc.

Note: This summary of clinical records does not include any information the facility may be required to keep in an administrative file or in a location on site. For example, each home/facility (other than natural family) will be required to maintain a central file of incident reports, divided by client, with copies of internal investigations and actions taken as a result of investigation attached. Additionally, each facility will be required to train staff regarding sensitivity to security and confidentiality of consumer records and discrete storage of each consumer's clinical records (such that they cannot be reviewed by non-eligible individuals).