CHAPTER 513 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES WAIVER (IDDW)

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BACKGROUND

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

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

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

This waiver is administered by the West Virginia DoHS under the provisions of Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code.

PROGRAM DESCRIPTION

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

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

Services are available through the Participant-Directed Option (*Personal Options*) to members who are eligible and who choose to direct some or all of the services available through this option. These include person-centered support, respite (in-home and out-of-home), transportation, speech therapy, occupational therapy, physical therapy, dietary therapy, environmental accessibility adaptations home and vehicle, and goods and services. For more information refer to Section 513.9.2 Participant-Directed Services Option. Members may choose all of their services through the Traditional Option, or the member may choose to mix Traditional Option services and Participant-Directed Option services.

All required documentation forms are available on the Bureau for Medical Services website.

HOME AND COMMUNITY-BASED SETTINGS REQUIREMENTS

In January 2014, the Centers for Medicare & Medicaid Services promulgated a final federal rule (2014 Home and Community Based Services Final Rule. CMS-2249-F and CMS 2296-F) to ensure that individuals receiving long-term services and supports through home and community-based services (HCBS) programs under 1915(c) and 1915(i) have full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal finances, and receive services in the community to the same degree as individuals not receiving Medicaid HCBS.

The West Virginia Home and Community Based Services Statewide Settings Transition Plan is a document that is several years in the making and is West Virginia's response to how West Virginia will meet the standards in the final federal rule. Over the past eight years, West Virginia has put this document out for public comment seven times, adding to the plan each time and making revisions. This final plan is divided into four sections – Phase I is Planning, Phase II is Initial Research and Discovery, Phase III is Analysis of Research and Phase IV is Steps Going Forward. In an effort to make the document less voluminous much of the research, analysis and public comments have been moved to the West Virginia's Statewide Transition Plan webpage.

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Human Resources (DoHS) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters.

West Virginia underwent the process of developing a transition plan pursuant to 42 CFR 441.301(c)(6) that contained the actions the State took to bring all West Virginia waivers into compliance with requirements set forth in 42 CFR 441.301(c) (4-5). West Virginia has three HCBS waivers that are affected by this Rule: Aged and Disabled Waiver (ADW), Intellectual and/or Developmental Disabilities Waiver (IDDW), and Traumatic Brain Injury Waiver (TBIW). The Children with Severe Emotional Disorders Waiver (CSEDW) provides services in foster and natural homes and these settings must be compliant before any services can be provided in these settings.

All members and settings for all of the Waiver programs will be reviewed annually using the following protocols.

Member-Controlled Settings

Member-controlled settings are defined as home or apartments owned or leased by a HCBS member or by one of their family members. 92% of the members on all three Waiver programs own or lease their own homes. Individual, privately-owned homes (privately-owned or rented homes and apartments in which the individual receiving Medicaid-funded home and community-based services live independently or with family members, friends, or roommates) are presumed to be in compliance with the regulatory criteria of a home and community-based setting. The state includes private residences as part of the overall quality assurance framework when implementing monitoring processes for ongoing compliance

with the settings criteria, as well as any oversight provisions in the approved HCBS waivers or State Plan Amendments.

The member's case manager must assess the setting annually, up to 90 days prior to the member's Anchor Date, to ascertain that the member continues to reside in a setting with the characteristics of a member-controlled setting and that the setting continues to meet the standards as described below:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. 42 CFR 441.301(c)(4)(i)/441.710(a)(1)(i)/441.530(a)(1)(i)
- The setting is selected by the individual from among setting options including non-disability specific settings. The settings options are identified and documented in the person-centered plan and are based on the individual's needs, preferences 42 CFR 441.301(c)(4)(ii)/ 441.710(a)(1)(ii)/441.530(a)(1)(ii)
- The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. 42 CFR 441.301(c)(4)(iii)/ 441.710(a)(1)(iii)/441.530(a)(1)(iii)
- The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices including but not limited to daily activities, physical environment, and with whom to interact. 42 CFR 441.301(c)(4)(iv)/ 441.710(a)(1)(iv)/441.530(a)(1)(iv)
- The setting facilitates individual choice regarding services and supports, and who provides them. 42 CFR 441.301(c)(4)(v) 441.710(a)(1)(v)/441.530(a)(1)(v)

Any member residing in a setting that does not meet these standards will be referred to their case management agency for remediation to attempt to attain compliance. These remediation attempts will be monitored by BMS, and assistance provided if needed. If the setting cannot be remediated to meet the standard, then the member will be referred to transition to an approved setting. If this transition is not successful, then, as a last resort, the member will be discharged from the program.
The member-controlled setting assessment may be found on the Resource page of the Statewide Transition Plan website.

The case manager must complete mandatory training on the Statewide Transition Plan prior to completing the member-controlled assessments. Direct-support professional staff must also receive mandatory training on the Statewide Transition Plan. Members will receive educational information on the Statewide Transition Plan from their case managers.

Provider-Controlled Settings

Provider-controlled settings are settings where a member resides with a paid unrelated caregiver or with an agency provider who provides HCBS services for the majority of the day. Any day settings such as IDDW facility-based day habilitation sites are defined as provider-controlled settings.

In the IDDW program, specialized family care homes are considered provider-controlled settings and 24 hour intensively supported settings and group homes with four or more members are also considered in this category.

All provider-controlled settings and members who receive services in these settings will be evaluated at least annually by the BMS or its designee to ascertain that the setting continues to exhibit the characteristics of a provider-controlled setting and that the setting meets the standards as described below:

- The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities, and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each IDDW member, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law. [42 CFR 441.301(c)(4)(vi)(A)]
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. [42 CFR 441.301(c)(4)(vi)(B)(3)]
- Any modification of the additional conditions, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. [42 CFR 441.301(c)(4)(vi)(F)]
- The setting was selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- The individual participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services.
- The individual has opportunities to seek employment and work in competitively integrated settings and engage in community life.
- The individual has his/her own bedroom or shares a room with a roommate of choice.
- The individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan.
- The individual controls his/her personal resources.
- The individual chooses when and what to eat and may have access to food at any time.
- The individual chooses with whom to eat or to eat alone.
- Individual choices are incorporated into the services and supports received.
- The individual chooses from whom they receive services and supports.
- The individual has access to make private telephone calls/text/email at the individual's preference and convenience.
- Individuals are free from coercion and restraint.
- The individual, or a person chosen by the individual, has an active role in the development and update of the individual's person-centered plan.
- The setting does not isolate individuals from individuals not receiving Medicaid HCBS in the broader community.
- State laws, regulations, licensing requirements, or facility protocols or practices do not limit individuals' choices.
- The setting is an environment that supports individual comfort, independence and preferences.
- The individual has unrestricted access in the setting.

- The physical environment meets the needs of those individuals who require supports.
- Individuals have full access to the community.
- The individual's right to dignity and privacy is respected.
- Individuals who need assistance to dress are dressed in their own clothes appropriate to the time of day and individual preferences.
- Staff communicate with individuals in a dignified manner.
- The individual can have visitors of their choosing at any time.
- The individual's unit has an entrance door that is lockable by the individual, with only appropriate staff having keys to doors.

Any provider-controlled setting that does not meet these standards will be referred to BMS or its designee for remediation to attempt to attain compliance. If the setting cannot be remediated to meet all of these standards, then the setting will be removed from approved provider listing and the member(s) will be referred to transition to an approved setting. If this transition is not successful, then, as a last resort, the member will be discharged from the program.

The provider-controlled setting assessment may be found under the Resource page of the Statewide Transition Plan website.

The case manager and the direct-support professional staff must complete mandatory training on the Statewide Transition Plan. Members will receive educational information on the Statewide Transition Plan from their case managers.

In addition, all waiver agencies will be contacted annually to verify the settings owned, leased or operated by the provider agency. It is the responsibility of the agency to notify BMS within 15 days of any change in status, i.e., sites are added or removed. When a new setting is added, BMS or its designee, must review the site to ascertain the site is in compliance before any HCBS services may be billed.

All HCBS Settings

All home and community-based settings must have all of the following qualities, and such other qualities based on the needs of the individual as indicated on their person-centered plan:

- The setting is integrated in and supported full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitively integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- The setting ensures the individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.
- The setting facilitates individual choice regarding services and supports, and who provides them.

Heightened Scrutiny Overview

As the State reviewed each distinct setting/address, settings were sorted into one of five categories:

1. The setting meets the HCBS characteristics and is compliant.
2. The setting does not currently meet HCBS characteristics but intends to become compliant.
3. The setting cannot meet the HCBS characteristics.
4. The setting is presumptively institutional and is determined incompatible with HCBS.
5. Settings that are intermediate care facilities for individuals with intellectual disabilities (ICF/IID), institutions for mental disease (IMD), nursing facility, or hospitals do not provide HCBS and were not subject to transition.

The State of West Virginia worked with Waiver providers to monitor their plans to come into compliance. If a setting is unable or unwilling to become compliant with remediation, as determined by on-site review of the setting, then the state will initiate the process for resolution of beneficiary concerns when in a setting that will not be compliant.

Some settings may be presumptively non-HCBS settings that isolate, and these are described below:

- Settings that are located in a building that is also a publicly or privately-operated facility that provides inpatient institutional support treatment,
- Settings that are located in a building on the grounds of, or immediately adjacent to, a public institution, or
- Any other settings that have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS, including:
    - Where members have limited, if any, opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid funded HCBS
    - Where the setting restricts member choice to receive services or to engage in activities outside of the setting
    - Where the setting is physically located separate and apart from the broader community and does not facilitate member opportunity to access the broader community and participate in community services, consistent with the member's person-centered service plan.

These settings will be subject to heightened scrutiny process. These are those settings that the state has determined are presumed institutional and that the state has determined to have or will overcome the institutional presumption and comply with the settings criteria by the end of the transition period. In such cases, the setting would be submitted to CMS for a heightened scrutiny review. Evidence compiled by the State will accompany this submission. This evidence will include review documents, stakeholder interviews and comments and other evidence as necessary.

At present there are no such determined settings. West Virginia does not have any Waiver settings that are in a building that provides inpatient institutional treatment. West Virginia does not have any Waiver settings on the grounds of, or adjacent to, a public institution. All settings where Waiver services are provided have been evaluated through the Setting Review Process for each respective Waiver and all provide integration into the broader community. Data analysis from these evaluations can be found on the West Virginia Statewide Transition Plan website.

Transition of Members

When a case manager or the BMS' designee discovers a setting that no longer meets the standards of the Integrated Settings Rule, the case manager will work with the provider to develop a remediation plan within 30 days of this discovery. This plan may include transfer to another setting that complies. The provider will have 30 additional days to complete the remediation plan and the case manager will have an additional 30 days to make a visit to the setting to ensure the plan is completed. If, after the total 90-day period, the setting is not in compliance, then it shall be determined that the setting does not meet the characteristics necessary for HCBS and remediation efforts have been unsuccessful. At this point, the setting will be dis-enrolled from the Medicaid program. Notification to the provider will be by certified mail as well as electronically. The provider is responsible for notification of members, with all correspondence or contacts copied to the BMS.

BMS will also notify the individual members five working days after the provider notification, to assure that all stakeholders are notified of the dis-enrollment. This Information will include material on transition assistance and extensions and will be provided through 1) the specific time frame letter sent to each member by letter and 2) through the general informational meetings for members as noted below.

While the transitions of members to other providers or settings will begin as soon as the provider is notified, the provider will have 90 calendar days from the date of the notification to assist individuals to transition to other services and/or settings that do comply with the Rule. The provider will have 10 calendar days from the date of its notification of disenrollment to notify all participants of the disenrollment and actions the provider will take to ensure person centered planning. BMS will be copied on all provider to member correspondence. The operating agency or utilization management contractor will also notify the member within 10 calendar days of the date of notification.

Individuals may remain at the setting, but HCBS services may not be billed for that individual. Individual team meetings will be held and the individual and their legal representative (if applicable) will make the final choice of available settings/sites. Provider disenrollment will occur at the end of the 45 days or when all members are successfully transitioned.

Within 30 working days of the date of the notification, the provider will submit to BMS an Agency Transition Plan. This plan will list 1) setting location which is non-compliant; 2) the member(s) by name and Medicaid number; 3) the service(s) provided to each listed member; 4) the date for the Critical Juncture transition meeting for each listed member; 5) The result of the meeting including setting/location of services that do comply with the rule; 6) The date of the change of provider/setting. The provider will submit updates to the agency's Transition Plan weekly to the BMS, completing items 4-6 as these events occur. This plan update will be provided to the BMS until all member transitions are complete.

The BMS shall be copied on all correspondence with members and/or families.

Members will also be encouraged to call the BMS should they have any questions with the BMS contact information made available to all affected members at Critical Juncture meetings and on the BMS website.

Should an individual member request assistance beyond that given by the provider, the BMS will assist the member in the timely transition to another provider and/or setting. Requests should be made by phone, email or

letter. In isolated instances, the BMS may extend the 90-day transition period for an individual member to assure that there is no interruption of services to the individual member. It is anticipated that approximately 10% of members in an affected setting would have need of some mode of direct intervention from the BMS.

This procedure would also apply to a provider which concurs with the setting review that the site is not HCBS compliant.

PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

513.1 BUREAU FOR MEDICAL SERVICES (BMS) CONTRACTUAL RELATIONSHIPS

The BMS contracts with a Utilization Management Contractor (UMC). The UMC acts as an agent of BMS and administers the operation of the IDDW program. The UMC processes initial eligibility determination packets and conducts the annual functional assessment to establish re-determination of medical eligibility and to calculate individualized budgets. The UMC conducts education for IDDW providers, members, advocacy groups, and DoHS. The UMC provides a framework and a process for the purchase of waiver services based on individualized budgets. At times, the UMC, in collaboration with BMS, will provide answers to policy questions which will serve as policy clarifications. These policy clarifications will be posted on the BMS IDDW website under Policy Clarifications.

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

BMS contracts with a Medical Eligibility Contracted Agent (MECA) to determine initial and re-determination eligibility of prospective and active members and to recruit and train licensed psychologists to participate in the Independent Psychologist Network. The UMC and the MECA work together to process initial applications and re-determination packets.

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

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

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

513.2 PROVIDER ENROLLMENT AND RESPONSIBILITIES

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

- Receive a Certificate of Need (CON) approval from the West Virginia Health Care Authority through the full-length CON process or through the Summary Review process. Note that, in order

to contract with extended professionals to provide dietary therapy, occupational therapy, physical therapy, and/or speech therapy services, the applicable service(s) must be included on the provider agency's CON.

- Obtain and maintain a behavioral health license through the DoHS Office of Health Facility Licensure and Certification (OHFLAC). NOTE: This requirement does not apply to case management-only agencies.
- Obtain and maintain a provider certification through the UMC, as described in section 513.2.4. NOTE: This requirement **only** applies to case management-only agencies.
- Meet and maintain all BMS enrollment requirements including a valid provider agreement on file that is signed by the IDDW provider and BMS, as well as a valid Medicaid enrollment agreement.
- Ensure that a member or agency staff are not discharged, discriminated, or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process that involves the IDDW provider.
- Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services the member needs to another provider(s) and is agreed upon by the member and/or their legal representative and the receiving provider(s).
- Meet and maintain the standards established by the Secretary of the U.S. Department of Health and Human Services (DHHS), and all applicable state and federal laws governing the provision of these services.
- Ensure that services are delivered, and documentation meets regulatory and professional standards before the claim is submitted.
- Ensure that all required documentation is maintained at the agency on behalf of the State of West Virginia and accessible for state and federal audits.
- Begin the mandatory IDDW Program training for all agency staff on the first day of employment and document all mandatory training on the Certificate of Training Form (WV-BMS-IDD-06).
- Ensure that all agency staff providing direct care services are fully trained in the proper care of the member to whom they will be providing services prior to billing for services. Health and Safety training must be conducted by a registered nurse (RN), behavioral support professional (BSP), or case manager. Fully trained agency staff must be available until newly hired agency staff or qualified support workers are fully trained.
- Ensure that specific goals based on assessments and designed to maintain the optional adaptive functioning of the individual, are implemented. Goals shall have related measurable objectives, have an expected achievement date, and, when appropriate, outcomes for discharge.
- Hire and retain a qualified workforce.
- Subcontract with licensed individual or group practices of the behavioral health profession as defined by OHFLAC, if contracting occurs.
- Maintain evidence of implementing a utilization review and quality improvement process which includes verification that services have been provided and the quality of those services meets the standards of the IDDW Program and all other applicable licensing and certification bodies.
- Provide an assigned agency IDDW contact person whose duties include:
    - Review of home and day services visits to assure compliance with Waiver policy;
    - Oversight of agency staff implementing the Individual Program Plans (IPPs) of all members in the IDDW Program; and
    - Communicating with BMS and the UMC.

- Implement the IDDW Quality Improvement System as further defined under Section 513.2.3 Quality Improvement System.
- Provide each member with maximum choice of IDDW services within their individualized budgets available in each of the Service Delivery Models and a choice of Service Delivery Models.
- Employ or contract with extended professional agency staff who meet all the training and credentialing requirements listed under this section and its subparts, as well as the individual service definitions of this chapter.
- Maintain a record of the training verification or recertification on each agency staff.
- Participate in quarterly training sessions and routine conference calls provided by the UMC.
- Ensure that all residential sites (leased or rented by the IDDW provider) provide a safe environment for the members and agency staff.
- Assist the member receiving services in securing safe housing.
- Provide appropriate auxiliary aids and services when necessary to ensure effective communication with members and/or legal representatives when natural or other supports are not available. This includes the use of qualified sign language interpreters, documents in Braille or large print, audio recordings, etc.
- Comply with all American with Disabilities Act (ADA) requirements if applicable.
- Comply with all Social Security Administration (SSA) requirements for serving as a representative payee, if applicable, including maintaining documentation for a minimum of two years.
- Maintain written policies and procedures to avoid conflict of interest (if agency is providing case management and other services).

All agency staff, except contracted extended professional staff, having direct contact with members must meet the following qualifications:

- Approved criminal background checks as defined in Section 513.2.1 Criminal Background Checks.
- Are not listed on the list of excluded individuals maintained by the Office of the Inspector General (OIG) as defined in Section 513.2.1 Criminal Background Checks.
- Be over the age of 18.
- Have the ability to perform the tasks.
- Training on Emergency Procedures, such as Crisis Intervention and restraints upon hire and thereafter only if deemed necessary by the interdisciplinary team (IDT) based on the assessed needs of the member;
- Documentation of competency-based training initially and annually as mandated by OHFLAC and the IDDW manual. For all trainings but CPR/First Aid (which expire as indicated by the date on the card), annually is defined as within the month the training expires. These trainings include:
    - Training on treatment policies and procedures, including confidentiality training;
    - Training on rights of members;
    - Training on Emergency Care to include member-specific Crisis Plans and Emergency Disaster Plans;
    - Training on Infectious Disease Control;
    - Documented training on First Aid by a certified trainer from an approved agency listed on the BMS IDDW website to include always having current First Aid certification upon hire and as indicated per expiration date on the card;

- Documented training in Cardiopulmonary Resuscitation (CPR) by an approved agency listed on the BMS IDDW website to include always having current CPR certification upon hire and as indicated per expiration date on the card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the agency staff);
- Training on member-specific needs (including health, behavioral health other needs);
- Training on direct-care ethics for direct-support professionals, day services, Person-Centered Support licensed practical nurse (LPN), and respite that minimally addresses:
  - Focus on the member, including commitment to person-centered supports as best practice;
  - Promoting the physical and emotional well-being of the member;
  - Integrity and responsibility;
  - Confidentiality;
  - Justice, fairness, and equity;
  - Respect;
  - Relationships;
  - Self-determination; and
  - Advocacy.
- Training on Recognition of, Documentation of and Reporting of suspected abuse, neglect and exploitation, including injuries of unknown origin; and
- Completion of the facilitated West Virginia Association for Positive Behavior Support (WV APBS) Overview of Positive Behavior Support or the West Virginia University's Center for Excellence in Disabilities (WVUCED) Positive Behavior Support Direct-Care Overview.

- Documentation must include training topic, date, the beginning time of the training, the ending time of the training, the location of the training, the signature of the instructor, and the signature of the trainee. Internet training must include the person's name, the name of the internet provider, and a certificate of completion or other documentation showing successful completion. All documented evidence of training for all staff persons who deliver IDDW services must be kept on file and available upon request.
- Prior to using an internet provider for training purposes, the name, web address, and course names must be submitted to the UMC for review. The UMC will respond in writing whether the training meets training criteria.
- Qualifications must be verified initially as current and updated as required.
- Agency staff who function as Approved Medication Assistive Personnel (AMAP) must have high school diplomas or the equivalent and be certified AMAPs.
- Case managers are also required to receive initial and annual training in Conflict-Free case management.
- Any staff person who provides transportation services must have a valid driver's license, proof of current vehicle insurance and registration. In addition, any staff person who provides transportation services must abide by local, state, and federal laws regarding vehicle licensing, registration, and inspections upon hire and checked annually thereafter.
- Though not a requirement, ***BMS strongly urges providers to obtain an Approved Protective Services Record Check and consider the results.*** Please see the form at Bureau for Children and Families (BCF) website.

Conflicts of Interest

CMS requires that services be free of conflicts of interest. The BMS has implemented a system that allows members to receive services in a conflict-free manner. Agencies that provide case management services to a member **cannot** provide any other IDDW or Home and Community Based Services to that member if provision of those services would result in financial gain, potential financial gain, or job security, whether those services be funded by Medicaid or an alternative funding source. Conflicts of interest are prohibited. A conflict of interest is when the Case manager who represents the member who receives services has competing interests due to affiliation with a provider agency, combined with some other action.“ Affiliated” means has either an employment, contractual or other relationship with a provider agency such that the Case manager receives financial gain or potential financial gain or job security when the provider agency receives business serving IDDW clients.

At no time shall an agency or person affiliated with an agency provide services to a member while serving as their landlord, except in the case in which the home in which the tenet resides and rents from their agency or person affiliated with the agency has been licensed by OHFLAC. Conflicts of interest are prohibited for members accessing IDDW services, regardless of the service and funding source involved.

If a case manager influences the Freedom of Choice of the member, a conflict of interest occurs. To ensure complete impartiality, the case manager and other agency personnel, with the exception of the legal representative of the member being assessed or the Specialized Family Care provider, will be excused when the Freedom of Choice form is completed during the annual functional assessment. If the member has a legal representative who is not in attendance, the legal representative must sign the Freedom of Choice within 10 days. case managers must always ensure any affiliation with a provider agency does not influence their actions with regard to seeking services for the member they represent. Failure to abide by this Conflict of Interest policy will result in the loss of provider IDDW certification for the provider involved in the conflict of interest for a period of one year and all current people being served by the suspended provider will be transferred to other case management agencies. Additionally, any case manager who takes improper action as described above will be referred to their professional licensing board for a potential violation of ethics. (BMS notes that whether any action is taken would be within the sole discretion of the particular licensing board and depend upon its specific ethical rules). Reports of failure to abide by this Conflict of Interest policy will be investigated by the UMC and the results of this investigation will be reported to BMS for review and possible action.

Electronic Visit Verification

As required by the Cures Act, BMS will implement an Electronic Visit Verification (EVV) system to verify in-home visits for Personal Care Services (Participant-Directed Support) providers by March 1, 2021 and Home Health Care Services (HHCS) providers by January 1, 2023. The EVV system will verify:

- Type of service performed;
- Individual receiving the service;
- Date of the service;
- Location of service delivery;
- Individual providing the service; and
- Time the service begins and ends.

For services requiring EVV, direct-care staff and case managers will use the system to check-in at the beginning of the visit. After the visit, the member or authorized representative will use the system to verify

the correct visit has been provided. BMS will ensure the EVV solution is secure, minimally burdensome, and does not constrain member selection of a caregiver or the manner of care delivery. BMS will provide training and an EVV guide that will be available when the system is implemented.

513.2.1 Criminal Background Checks

Refer to *Chapter 700 West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for criminal background check information.

513.2.2 Office Criteria

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

- Must be physically located in West Virginia.
- An agency office site can serve no more than eight contiguous counties in West Virginia as designated in the application. IDDW providers wishing to make changes in the approved counties they serve must make the request in writing to the UMC. The UMC will make a determination on the request and inform the provider in writing. No change in counties served can be made unless approved by the UMC.
- Changes can only be made annually unless it is a request for a provider to expand their service area by the BMS.
- Meet ADA requirements for physical accessibility (Refer to 28 CFR 36, as amended) including but not limited to:
    - Maintains an unobstructed pedestrian passage in the hallways, offices, lobbies, bathrooms, entrance and exits
    - The entrance and exit has accessible handicapped curbs, sidewalks and/or ramps
    - The restrooms have grab bars for convenience
    - A telephone is accessible
    - Drinking fountains and/or water made available as needed
- Be readily identifiable to the public.
- Maintain a primary telephone number that is listed with the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone.)
- Maintain an agency secure Health Insurance Portability and Accountability Act (HIPAA) compliant e-mail address for communication with BMS and the UMC for all staff.
- Do not use personally identifiable information in the subject line of a secure email.
- Personal electronic devices are prohibited when using personally identifiable information.
- Referencing people receiving IDDW Services on social media in any manner is strictly prohibited.
- At a minimum, must have access to a computer, fax, email address, scanner, and internet.
- Utilize any database system, software, etc., compatible with/approved and/or mandated by BMS.
- Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.

- Contain space for securely maintaining program and personnel records. (Refer to *Chapter 100, General Administration and Information*, and *Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
- Maintain a 24-hour contact method.
- Any authentication method for electronic and stamped signatures must meet the following basic requirements:
    - Unique to the person using it
    - Capable of verification
    - Under the sole control of the person using it, and
    - Linked to the data in such a manner that if the data is changed, the signature is invalidated.

513.2.3 Quality Improvement System (QIS)

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

The QIS is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met; and ensure the active involvement of interested parties in the quality improvement process.

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

The CMS mandates the IDDW program guarantee the following quality assurances:

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

Data is collected and analyzed for all the quality assurances and sub-assurances based on West Virginia's Quality Performance Indicators, as approved by CMS. The primary sources of discovery include IDDW provider reviews, Incident Management Reports, complaints and/or grievances of members or their

legal representatives, OHFLAC reviews, abuse and neglect reports, administrative reports, oversight of delegated administrative functions and interested party input.

513.2.3.2 Quality Improvement Advisory (QIA) Council

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

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

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

513.2.3.3 IDDW Provider Reviews

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

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

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

- Payment to BMS within 60 days after BMS notifies the provider of the overpayment; or

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

If the IDDW provider disagrees with the final report, the IDDW provider may request a document/desk review may be requested within 30 days of receipt of the final report pursuant to the procedures in *Chapter 100, General Administration and Information* of the West Virginia Medicaid Provider Manual. The IDDW provider must still complete the written repayment arrangement within 30 days of receipt of the final report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed, and set forth in detail the items in contention. **The letter must be addressed to:**

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

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

Reviews of Participant-Directed services are included in Section 513.9.2 for *Personal Options*.

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

513.2.3.4 Plan of Correction

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

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

513.2.3.5 Training and Technical Assistance

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

513.2.3.6 Self-Reviews

IDDW agencies are required to submit evidence to the UMC every year to document continuing compliance with all certification requirements as specified in this manual. This evidence report must include a signed attestation from an appropriate official of the provider agency (e.g. executive director, Board Chair, etc.). The report may be sent from a provider's human resources (HR) system, as an excel spreadsheet or as other report that includes all applicable fields and documents the employee's training dates. This form must be submitted electronically to the UMC. This self-review tool allows providers to incorporate into their Quality Assurance and Improvement processes a method to ensure quality services occur and CMS Quality Assurances are met.

Each provider will be required to submit a self-review in January of each year. The exact due date will be communicated to the provider at least two months prior to the due date.

513.2.3.7 Utilization Guidelines for IDDW

Each agency must put into place a set of Utilization Guidelines (UG) to ensure that each member who receives IDDW services receives the authorized services and supports at the right time, in the right amount, and for as long as the services are needed. UG is a person-centered process that starts with person-centered planning. The purpose of UG is to monitor claims submission and ensure that services provided are in compliance with the IDDW Manual and existing authorizations, and to ensure that the services requested and utilized for the member are within the annual individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2, Service Authorization Process.

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

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

- Staff training;
- Education of staff on how services will be delivered throughout the service year. This education should minimally include the following:
    - Tentative schedule of the member (daily, weekly, monthly)
    - Units of service authorized
    - Averages of usage (daily/monthly)
    - Individualized training (as needed)
    - Requirements and limitations of the particular service provided
- Empowering and educating members and families so that they are able to make informed choices about their services and supports;
- Assessing needs of the member:

  - Service requests are based on identified need for the coming service year, therefore additional units may not be requested for contingency purposes;
- Choosing services based on the member's assessed needs and within the annual individualized budget;
- Monitoring service utilization throughout the service year;
- Monitoring the needs of the member and updating services as needed;
- Delivering services based on:
  - Assessed need and within the individualized budget;
  - Agreement by the IDT;
  - IDDW service caps and limitations;
  - Documentation on the IPP; and
  - The individualized Waiver budget

513.2.4 Provider Agency Certification (Case Management-Only)

IDDW provider agencies that are only providing case management services must be certified by the UMC. A certification application must be completed and submitted to the UMC.

To be certified as an IDDW case management-only agency, applicants must meet and maintain the following requirements:

- A business license issued by the state of West Virginia;
- A Federal Tax Identification Number (FEIN);
- An organizational chart;
- A list of the Board of Directors (if applicable);
- A list of all agency staff that includes their qualifications;
- A Quality Management Plan for the agency;
- Written policies and procedures for processing complaints and grievances, from staff or members, that:
  - Addresses the process for submitting a complaint;
  - Provides steps for remediation of the complaint including who will be involved in the process;
  - Includes steps for notifying the member/staff of the findings and recommendations;
  - Provides steps for advancing the complaint if the member/staff does not feel the complaint has been resolved;
  - Ensures that a member or agency staff are not discharged, discriminated against, or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted, or who has participated in an investigation process that involves an IDDW provider.
- Written policies and procedures for the use of personally- and agency-owned electronic devices which includes, but is not limited to:
  - Prohibiting using personally identifiable information in text messages and subject lines of emails;
  - Prohibiting the use of personally identifiable information in the body of emails unless the email is sent securely through a Health Insurance Portability and Accountability Act (HIPAA) compliant connection;

  - Prohibiting the use of personally identifiable information being posted on social media sites;
  - Prohibiting using public Wi-Fi connections;
  - Informing agency employees that, during the course of an investigation, related information on their personal cell phone is discoverable;
  - Requiring all electronic devices be encrypted.
- Written policies and procedures for members who wish to transfer services to another agency;
- Written policies and procedures for the discontinuation of a member's service;
- Written policies and procedures to avoid conflict of interest, including education of case managers on general conflict of interest/professional ethics with verification:
  - Annual signed Conflict of Interest Statement for all case managers and the agency director;
  - Process for investigating reports on conflict of interest complaints;
  - Process for reporting to BMS;
  - Process for reporting complaints to professional licensing boards for ethics violations.
- Office space that allows for confidentiality of the member;
- An Agency Emergency Plan for members and office operations that includes:
  - Office Emergency Back-up Plan ensuring office staffing and facilities are in place during emergencies such as floods, fires, etc. NOTE: Temporary facilities must meet all requirements and the UMC must be notified within 48 hours of the emergency relocation;
  - Process for notification of members of the Emergency Back-up Plan.
- Accept referrals in the UMC's web portal within five business days or forfeit the referral;
- Develop and implement policies and procedures for people with limited English proficiency and/or accessible format needs that culturally and linguistically appropriate to ensure meaningful access to services;
- Provide computer(s) for staff with HIPAA secure email accounts, UMC web portal access, internet access, and current (within the last five years) software for spreadsheets;
- Hire and retain a qualified workforce;
- Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services that the member needs to another provider(s) and is agreed upon by the member and/or their legal representative and the receiving provider(s).
- Ensure that services are delivered, and that documentation meets regulatory and professional standards before claims are submitted;
- Participate in all mandatory training sessions.

Agencies will be reviewed by the UMC within six months of initial agency certification, and annually thereafter. (See *Chapter 300, Provider Participation Requirements*).

Providers will be held accountable for information contained in all Medicaid common chapters. Providers are encouraged to contact the UMC for training needs and technical assistance at any time.

513.3 STAFF QUALIFICATIONS AND TRAINING REQUIREMENTS

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

513.3.1 Behavior Support Professional (BSP) Agency Staff Qualifications

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

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

- At a minimum have a Bachelor of Arts (BA) or Bachelor of Science (BS) degree in a human services field or a Board of Regents degree, one-year professional experience in the I/DD field, completion of the WV APBS facilitated three hour Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview, and completion of an approved WVAPBS curriculum.
- Agency staff employed as therapeutic consultants prior to 12/1/15 with a degree in a non-human service field, one-year professional experience in the IDD field, completion of the WV APBS facilitated three-hour Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview and the completion of an approved WV APBS curriculum.

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

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

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

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

- Be a Board Certified Behavior Analyst (BCBA) - Master's degree or Board Certified Behavior Analyst Doctoral Level (BCBA-D) – Doctoral degree and completion of either the WVAPBS facilitated Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview, three years professional experience working with individuals with IDD; or
- Have a Master of Arts (MA) or Master of Science (MS) degree, three years professional experience working with individuals with IDD, and have a Positive Behavior Support endorsement by a recognized APBS Network or Positive Behavior Support Board of Review; or
- Have a Bachelor of Arts (BA), Bachelor of Science (BS) degree, Board of Regents degree or Board Certified Assistant Behavior Analyst (BCaBA) credential, three years professional experience working with individuals with IDD, and have a Positive Behavior Support endorsement by a recognized APBS Network or a Positive Behavior Support Board of Review.

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

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

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

513.3.2 Crisis Services Agency Staff Qualifications

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

513.3.3 Dietary Therapist Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, agency staff providing dietary care services must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

If the dietitian is not agency staff but is contracted by the IDDW provider to provide services in their specialty, then the dietitian must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

513.3.4 Facility-Based Day Habilitation Agency Staff Qualifications

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

513.3.5 Job Development Agency Staff Qualifications

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

513.3.6 Occupational Therapist Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, agency staff providing occupational therapy services must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

If the occupational therapist is not agency staff but is contracted by the IDDW provider to provide services in their specialty, then the occupational therapist must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

513.3.7 Person-Centered Support Agency Staff Qualifications

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

513.3.8 Physical Therapist Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, agency staff providing physical therapy services must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

If the physical therapist is not agency staff but is contracted by the IDDW provider to provide services in their specialty, then the physical therapist must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

513.3.9 Pre-Vocational Agency Staff Qualifications

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

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

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

- Must be 18 years of age or over;
- Have the ability to perform the participant-specific required tasks;
- Have documentation of initial and renewal of training requirements:
    - Documented training on Emergency Procedures, such as Crisis Intervention and restraints upon hire and annually thereafter;
    - Documented training on Emergency Care such as a Crisis Plan, Emergency Worker Back-up Plan and Emergency Disaster Plan upon hire and on an as needed basis thereafter;
    - Documented training on Infectious Disease Control upon hire and annually thereafter;
    - Documented training on First Aid by a certified trainer from an approved agency listed on the BMS IDDW website to include always having current First Aid Certification upon hire and as indicated per expiration date on the card;
    - Documented training in CPR by an approved agency listed on the BMS IDDW website to include always having current CPR certification upon hire and as indicated per expiration date on the card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the QSW);
    - Documented training on member-specific needs (including special needs, health and behavioral health needs) upon hire and on an as needed basis thereafter; and
    - Documented training in recognition of documentation of and reporting of suspected abuse, neglect and exploitation upon hire and annually thereafter.
- Qualifications must be verified initially upon hire as current and updated as necessary.
- The QSW may be responsible for certain costs, i.e. CPR and First Aid certifications, criminal background checks through WV CARES.

Any qualified support worker who provides transportation services must have a valid driver's license in addition to abiding by local, state, and federal laws regarding vehicle licensing, registration and

inspections upon hire and checked annually thereafter. Providers may screen workers' driving records through the WV CARES automated WV Department of Motor Vehicles registry.

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

513.3.11 Respite Agency Staff Qualifications

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

513.3.12 Case Management Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, each staff employed by agencies providing case management services must complete and pass Conflict Free Case Management (CFCM) training and certification. All case managers must meet one of the following requirements listed below.

- Four-year degree in a human service field and one or more years' experience in the IDD field.
- Four-year degree in a human service field and less than one year of experience in the IDD field. (Restrictions - must be under the supervision of the case manager supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for six months. This must be verified by supervisory documentation once per month).
- Four-year degree in a non-human service field and one year experience in the IDD field. (Restrictions - must be under the supervision of the case manager Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for six months. This must be verified by supervisory documentation once per month).
- No degree or two-year degree and is a licensed social worker (LSW) grandfathered in by the West Virginia Board of Social Worker Examiners due to experience in the IDD field. (Restrictions - none)
- RNs with a two-year RN degree employed prior to December 1, 2015.

513.3.13 Skilled Nursing Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, agency staff providing skilled nursing services must be an LPN in the State of West Virginia or a licensed RN in the State of West Virginia. The nursing license must include a CPR/First Aid component, or the nurse must have a separate and current CPR/First Aid card.

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

513.3.14 Speech Therapist Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, agency staff providing speech therapy services must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

If the speech therapist is not agency staff but is contracted by the IDDW provider to provide services in their specialty, then the speech therapist must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

513.3.15 Stand-By Intervention Agency Staff Qualifications

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

513.3.16 Supported Employment Agency Staff Qualifications

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

513.3.17 Transportation Services Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, the provider is required to maintain documentation at all times verifying that agency staff providing transportation services have a valid driver's license, proof of current vehicle insurance, inspection and registration.

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

513.4 REPORTING REQUIREMENTS

Anyone providing IDDW services who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 64 Series 11), West Virginia State Code§ 9-6-1, § 9-6-9, and § 49-6A-2 to report the incident. Reports of abuse and/or neglect may be made anonymously by calling 1-800-352-6513, seven days a week, 24 hours day.

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

If the member is also a Medley class member, the member's advocate must also be notified.

IDDW providers must utilize the West Virginia Incident Management System to track the types of incidents listed below for anyone the agency provides services to.

- **Simple Incidents -** any unusual event occurring to a member that needs to be recorded and investigated for risk management or quality improvement purposes. Examples would be a minor assault by another member with injury resulting; seizures in an individual not prone to seizures; injuries of unknown origin; high rates of uncharacteristic self-injurious behavior with no significant negative outcome; suicidal threats or gestures without significant injury; medication error with minimal or no negative outcome; etc.
- **Critical Incidents -** those incidents with a high likelihood of producing real or potential harm to the health and well-being of the member or members served but not involving abuse or neglect.

- **Abuse, Neglect and Exploitation Incidents -** those incidents which meet the following definitions of abuse, neglect, or exploitation:
    - Abuse means any physical motion or action (hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs. It includes use of corporal punishment as well as the use of any restrictive intrusive procedure to control inappropriate behavior for purposes of punishment.
    - Abuse also includes psychological abuse which means humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.
    - Abuse also includes verbal abuse which means use of oral, written, or gestured language by which abuse occurs. This includes demeaning and derogatory terms to describe persons with disabilities. Verbal abuse includes, but is not limited to yelling or using demeaning, derogatory, vulgar, profane or threatening language; threatening tones in speaking; teasing, pestering, molesting, deriding, harassing, mimicking or humiliating a person in any way; and making sexual innuendo.
    - Neglect means a negligent act or pattern of actions or events that caused or may have caused injury or death to person or may have placed a person at risk of injury or death that was committed by an individual responsible for providing services. Neglect includes, but is not limited to a pattern of failure to establish or carry out a member's individualized program plan or treatment plan that placed or may have placed a member at risk of injury or death; a pattern of failure to provide adequate nutrition, clothing or health care; failure to provide a safe environment; and failure to maintain sufficient, appropriately trained staff.
    - Exploitation means the unlawful expenditure or willful dissipation of the funds or assets owned or paid to or for the benefit of an incapacitated individual.

All incidents must be entered into the West Virginia Incident Management System (WV IMS) within 24 hours of the provider becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day.

The agency whose staff observe, are involved in, or are informed of the incident should report it in the WV IMS. In the event the individual receives case management from another agency, or self-directs via the Personal Options Service Delivery model, the residential/day service agency or resource consultant, as applicable, is responsible for notifying the CM of the incident, as well as for completing follow-up in the IMS. That agency or resource consultant, as applicable, must also provide the CM with copies of all related documentation. If the incident occurs in a residential or day setting where the individual also receives CM services, the observer can notify the CM, who can then enter the incident.

The IDDW provider must also comply with any other reporting required for mandatory reporters or as part of their behavioral health license.

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

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

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

The case manager is required to notify the UMC of a member's transfer to another case management provider or if the member chooses another service delivery system within two working days. The case manager must transfer the member in the UMC's web portal by the effective date of the transfer. The effective date must fall on the 1st of a month.

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

513.5 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

General Requirements

- IDDW Program provider agencies must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information*; and *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual. IDDW
- Program provider agencies must comply with all other documentation requirements of this chapter.
- All required documentation must be maintained by the IDDW provider for at least five years in the member's file subject to review by authorized BMS personnel or contracted agents. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years whichever is greater.
- All required documentation and records must be available upon request by BMS or federal monitors, or contracted agents for auditing and/or medical review purposes.
- Failure to maintain all required documentation and in the manner required by BMS, may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.

Specific Requirements

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

- Each IDDW provider is required to maintain all required IDDW documentation on behalf of the State of West Virginia and for state and federal monitors, including all IDDW Program forms as applicable to the policy requirement or service code requirement.
- Agencies that wish to computerize any of the forms may do so. All basic components must be included, and the name/number indicated on the form (refer to *Chapter 300, Provider*

Participation Requirements, for a description of general requirements for Medicaid record retention and documentation).

- All providers of Waiver services must maintain service progress notes, behavioral data collection, and/or attendance records to substantiate that services billed by the IDDW Program provider agency were provided on the dates listed and were for the actual amount of time and number of units claimed. Specific documentation requirements are detailed under Section 513.9 Description of Service Options *and its subparts as* well as each service definition in this Chapter.
- Day to day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for said service. Monitoring and review of services as related to the IPP or monthly summary (visit) are to be maintained in the case management provider record. In the course of monitoring of the IPP and services, the case manager 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.
- The original physical copy of the annual assessment completed by the member, his/her guardian and/or his/her IDT. Once the annual assessment is completed, and the member or his/her guardian has signed the document attesting to its accuracy and completeness, it will be the duty of the primary Service Provider to ensure that the document is not altered, copied, or distributed in any manner. However, the primary Service Provider must make the original physical copy annual assessment available to the member, his/her guardian and his/her IDT at the Service Provider's offices, upon request, to review only. The case manager provider agency may store the document electronically but must be able to make the document available upon request of the member or their legal representative.
- Required on-site documentation may be maintained in an electronic format as long as the documentation is accessible to individuals who may need to access it. In addition to all documentation required by other state agencies (OHFLAC), the IDDW provider must disseminate this information to the member when they reside in their natural family home. The IDDW provider must ensure that the following is maintained in the member's home when the member resides in an Unlicensed Residential or Licensed Group Home setting:
    - Personal demographic/emergency contact information. If community activities are planned, a copy will be taken in a sealed envelope for emergency use only.
    - Current complete IPP including current psychological, social, and physical evaluations (if applicable), current Behavior Support plan, activity schedule, Crisis Plan, IHP, and IEP. The IPP must be attached in the UMC's web portal prior to the UMC making decisions on requests for prior authorization for IDDW services.
    - Current doctor's orders for every medication administered at that site, even if the member self-administers.
    - Current daily direct support documentation, task analysis and/or staff notes.
    - Current Medication Administration Records (MARs).
    - Copies of other pertinent medical or evaluative information relevant to treatment.
- Electronic health record and electronic signature requirements described in *Chapter 100, General Administration and Information* of the BMS Provider Manual.

ELIGIBILITY AND ENROLLMENT

513.6 APPLICANT ELIGIBILITY AND ENROLLMENT PROCESS

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

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

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

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

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

513.6.1 Application Process

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

513.6.1.1 Initial Eligibility Determination Process

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

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

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

Psychologists in the IPN are identified and placed on a list following documented training by the MECA. The IP is responsible for completing an Independent Psychological Evaluation (IPE) and uploading it to

the required internet site within 60 days of the receipt date of the IPN Response Form. The evaluation includes assessments which support the diagnostic considerations offered and relevant measures of adaptive behavior.

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

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

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

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

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

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

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

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

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

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

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

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

513.6.2 Initial Medical Eligibility

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

Evaluations of the applicant must demonstrate:

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

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

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

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

513.6.2.1 Diagnosis

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

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

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

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

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

513.6.2.2 Functionality

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

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

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

the narrative descriptions contained in the documentation submitted for review, i.e., psychological report, the IEP, occupational therapy evaluation, etc. if requested by the IP for review.

513.6.2.3 Active Treatment

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

513.6.3 Initial Financial Eligibility

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

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

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

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

513.6.3.1 Determination of Initial Financial Eligibility

The applicant must meet the following financial eligibility criteria:

Income:

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

- Only the applicant's personal income is considered for determination.

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

Assets:

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

513.6.4 Slot Allocation Referral and Selection Process

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

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

Once an IDDW slot is available, the enrollee will receive an informational packet up to 90 days prior to the slot being awarded. A Freedom of Choice form (WV-BMS-I/DD-2) on which the enrollee must indicate the wish to receive Home and Community Based services as opposed to services in an ICF/IID, his/her chosen Service Delivery Model (Traditional or Traditional and Participant-Directed) as well as the chosen case management provider will be included and must be returned to the UMC within 30 days of receipt of the informational packet.
The enrollee must access IDDW direct care services within 180 days when the funded slot becomes available or the enrollee will be discharged from the program.
Upon receipt of the complete and signed Freedom of Choice form, the UMC will refer the member to his/her chosen case management provider and if indicated, *Personal Options* FMS. The case manager (CM) provider may reject the referral only if:

- It appears to have been received in error;
- The CM provider is unable to meet the referred member's medical and/or behavioral needs.

Case management providers that reject referrals due to internal service capacity policies may not receive future referrals until the capacity/service issues are resolved.

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

513.6.5 Eligibility Effective Date

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

- The date of initial medical eligibility which is established by the MECA **or**

- The date on which the applicant was approved for financial eligibility at a local/county DoHS office. The applicant will receive a letter from DoHS (ESNL-A) stating the date the applicant is financially eligible for the program.

513.7 ANNUAL RE-DETERMINATION OF ELIGIBILITY PROCESS

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

513.7.1 Annual Re-determination of Medical Eligibility

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

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

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

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

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

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

If the member is determined to be medically eligible as a result of a Medicaid Fair Hearing, then services will continue if the member or their legal representative requested this within 13 days of the receipt of the Notice of Decision Letter. If services were terminated due to the member or their legal

representative not requesting their continuance within 13 days of the receipt of the Notice of Decision letter, then services will begin again on the date of the Hearing Officer's decision of reversal.

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

513.7.2 Annual Re-determination of Financial Eligibility

All members utilizing IDDW services must have financial eligibility re-determined annually by their local or county DoHS. Members who are found financially eligible will receive documentation from the DoHS (ESNL-A) which the member needs to present to their case management provider. The member must provide their Notice of Decision letter re-establishing their medical eligibility to the DoHS before financial eligibility can be established.

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

POLICY

513.8 INDIVIDUAL PROGRAM PLAN (IPP)

Central to the services that a member receives through the IDDW Program is the member's IPP. Developing the IPP is the process by which the member is assisted by the Interdisciplinary Team (IDT) which consists of their legal representative (when applicable), their advocate (when applicable) other natural supports the member who is receiving services chooses to invite, as well as attendees required by the IDDW Program policy manual. This team meets to decide what needs to be done, by whom, when and how and to document the decisions made by this planning team.

The content of the IPP must be guided by the member's assessed needs, wishes, desires, and goals but the requested services cannot exceed the member's individualized budget. If the member and/or the team believes that the member requires services in excess of the individualized budget, the team may list those additional services in the separate section of the IPP set aside for this purpose. However, in order for the member to begin receiving any services under the IPP, the case manager must submit a list of services that can be purchased within the member's individualized budget, making sure all direct care service needs are purchased first. Only services that can be purchased within the budget may be authorized and all other service needs must be covered by natural or unpaid supports or from programs other than the IDDW, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

If a member has had a documented change in need since the annual functional assessment was conducted, then a Critical Juncture should occur immediately to discuss the need for additional services.

All IPP meetings should be scheduled at a time and location that takes into consideration the schedule and availability of the member receiving services and the other members of the team.

The member must attend the IPP. If the member has a legal representative, the legal representative must attend the IPP in member or by teleconferencing in extenuating circumstances.

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

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

- All components in the WV-BMS-IDD-05
    - Cover/demographics
    - Meeting minutes
    - Circle of support/goals and dreams
    - Summary of assessment and evaluation results
    - Medications
    - Individual Service Plan
        - IDDW Services*
        - Non-IDDW Services and Natural Supports
    - Individual Habilitation Plan and Task Analysis if the member receives formal training
    - Tentative Weekly Schedule (including both paid and unpaid supports and any other programs providing any type of service, i.e. personal care, private duty nursing, etc.)
    - Signature Sheet (and rationale for disagreement if necessary)
    - Behavior Support Plan or Protocol, if applicable, with signatures of developer and member/legal representative (must indicate consent by member/legal representative)
        - Dates that plan was approved and, initiated will be reviewed. If the plan includes restrictive measures, then approval by the IDDW Provider's Human Rights Committee must be attached. The Human Rights Committee (HRC) must monitor plans with adverse procedures at least annually.
        - The member or their legal representative must sign off on their agreement prior to the development of the plan.
    - Crisis Plan to include Emergency Disaster Plans
    - Individual Spending Plan (when available) if a member is self-directing any of the Participant-Directed Services
    - The names of individuals providing Participant-Directed, Person-Centered Support, In-Home Respite and Out-of-Home Respite

*IDDW services must be purchased in the following order so that the health and safety of the member receiving services is ensured:

- Case management services must be purchased first, followed by direct-care services in the following order, if the IDT wishes to purchase any of these services: person-centered support services, day services, electronic monitoring, direct-LPN services and respite services.
- Professional services may be purchased next in the following order if the IDT wishes to purchase any of these services: RN, BSP, Indirect LPN, any of the specialty therapies (speech therapy (ST), physical therapy (PT), occupational therapy (OT) and developmental therapy (DT)), Transportation.

If a finalized IPP needs any changes, the team must complete an addendum IPP to reflect those changes before service requests will be considered.

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

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

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

In extenuating circumstances (i.e. legal representative living out of state or inclement weather), IDT members may participate by teleconferencing. Team members who attend by teleconference may not bill for the time spent in the IDT and the case manager must note on the signature sheet that they attended by phone. If the legal representative attends by telephone, the case manager must obtain their signature within 10 days. When a member has been admitted to a Crisis Site, then the case manager may attend and bill for their services while conducting the IPP over the telephone. A WV-BMS-IDD-12 should be

submitted and after 30 days this individual must be discharged from the IDDW Program unless there has been additional days approved by the UMC/BMS.
An IPP includes the completed IPP (WV-BMS-IDD-5) and the following attachments: Crisis Response Plan, Behavior Support Plan/Protocols (if applicable), tentative weekly schedule, budgeted cost of planned services, spending plans if the member self-directs eligible services, and meeting minutes.

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

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

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

Medicaid cannot reimburse for services rendered when the IPP has expired, has not been reviewed within required timelines, and/or does not include required signatures or services.

513.8.1 The Interdisciplinary Team (IDT)

The IDT participates in the IDT meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support outline of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan within the member's individualized budget. The IDT must make every effort to purchase IDDW services with the individualized assessed budget. The IDT must consider all supports available, both paid and unpaid, both IDDW waiver and non-IDDW. In circumstances when individuals wish to live in 24-hour supported settings (intensively support setting (ISS) and group home (GH)), the individualized budget must be considered before signing leases, renting apartments, living in family-owned homes or homes left in trust to the member. The member and the legal representative may want the member to live in a certain setting or even live alone, but if the individualized assessed budget does not provide enough supports for these settings, then the member or the legal representative need to look at alternatives – roommates, more natural support, supplemental funding from family or trusts, etc. Any services that cannot be purchased within budget must be supported from unpaid or natural supports or services from another program other than the IDDW, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

IDT meetings should be held in a manner that is convenient to the member and ensures the confidentiality of the member. Restaurants or other public locations are not appropriate sites to conduct IDP meetings. If the member, their legal representative and members of the IDT agree, meetings may be held virtually through a secure platform. All direct support services must be purchased first before professional services. This is to ensure the health and safety of the member. The direct-care support services must be purchased in the following order of importance: all types of person-centered supports,

facility-based day habilitation, pre-vocational, job development, supported employment, electronic monitoring, LPN services and respite services.

At a minimum, the IDT consists of:

- The member;
- Their legal representative as applicable;
- The member's case manager;
- Representatives of all IDDW providers that provide services to the individual; and
- A Medley Advocate if the member is a Medley Class member.

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

- Natural supports the member chooses to invite;
- Professionals such as BSP, RN or LPN, physical therapist, occupational therapist, speech therapist, registered dietician, etc.;
- Direct service workers, such as day services providers, person-centered support workers and respite workers;
- Service providers from other systems such as the local education agency/public schools, Division of Rehabilitation Services (DRS), or Birth to Three (provided that no duplication of service exists);
- Family Based Care Specialist (when member resides in a specialized family care home); and
- Advocate (when applicable).

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

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

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

513.8.1.1 Seven-Day IDT Meeting

This meeting is mandatory when a member receives an IDDW slot. This is the initial meeting that occurs within the first seven calendar days of admission/intake by a new provider agency and must include IDDW services as well as other support services a member needs to live successfully in the community. This IPP document must reflect a full range of planned services: Medicaid, non-Medicaid, and natural supports. This meeting must be documented on the Initial IPP (WV-BMS-IDD-4) by the member's case manager. If services can be finalized at this meeting and a full range of planned services are documented, then the 30-day IDT meeting will not be necessary.

Additionally, a seven-day meeting is required if a member who lives in an ISS or Group Home Setting transfers to a new residential provider. As with the Initial IPP above, if services can be finalized at this meeting and a full range of planned services are documented on the Annual IPP form (WV-BMS-IDD-5), the 30-day IDT meeting will not be necessary.

513.8.1.2 30-Day IDT Meeting

This meeting is only required if a full range of planned services were not finalized at the seven-day IPP meeting for Initial IPPs and the IPP for members who've transferred residential providers. If this meeting is necessary, the resulting IPP (WV-BMS-IDD-5) must be completed by the case manager and will serve as the annual IPP. It must be reviewed every 180 days.

513.8.1.3 Transfer/Discharge IDT Meeting

This meeting is held when a member transfers from one IDDW provider to another, chooses a different service delivery model or when the member no longer meets medical or financial eligibility. The transfer-from agency is responsible for coordinating the meeting and documenting the transfer. The member or their legal representative, as well as the transfer-to agency, must agree to the transfer. The transfer-from agency must send the resulting IPP to the transfer-to agency within 14 calendar days. The transfer-from agency must also submit a transfer via the UMC's web portal and attach Transfer/Discharge Form (WV-BMS-IDD-10) to the UMC within seven calendar days. If the resulting IPP is found to be not valid because necessary team members did not attend, or necessary services were not addressed during the transfer, then the authorizations may be rolled back to the transfer-from agency until a valid IPP is held.

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

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

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

513.8.1.4 Critical Juncture IDT Meeting

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

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

- All team members do not agree with services or service mix;
- A new goal will be implemented for the member;
- The team is discussing implementation of a Positive Behavior Support plan, where one was not previously required;
- The member changes residential setting (example: moves from Natural Family to a Licensed Group Home or an Unlicensed Residential Home);
- The member who lives in an Unlicensed Residential Home, Licensed Group Home or specialized family care home moves to a different location;
- The member goes into crisis placement;
- The member has a change in legal representative status;
- The primary caregiver changes or passes away;
- The member elects to change Service Delivery Model;
- The member receives a new service not previously received.
- The member receiving services has had a documented change in need between the time the annual functional assessment was conducted, and the budget letter was received. The case manager, in consultation with the member or their legal representative and the IDT, should conduct a Critical Juncture meeting whenever the need is identified. For additional information on service authorizations refer to Section 513.25.4 Appeals and Service Authorizations.

513.8.1.5 Annual, Quarterly, and Six-Month IDT Meetings

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

513.9 DESCRIPTION OF SERVICE OPTIONS

Two service options are offered in the IDDW:

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

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

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

513.9.1 Traditional Service Option

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

It is required that case management be accessed through the Traditional Service Option by all members who receive services.

The following services are available via the Traditional Service Option:

- Behavior Support Professional
- Crisis Services
- Electronic Monitoring
- Environmental Accessibility Adaptations
- Extended Professional Services
    - dietary therapy
    - occupational therapy
    - physical therapy
    - speech therapy
- Facility Based Day Habilitation
- Job development
- Person-centered support
- Pre-vocational services
- Respite
- Case management
- Skilled nursing
    - RN services
    - LPN services
- Supported employment
- Transportation

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

Once the team determines the array of services that may be purchased within the individualized budget, the case manager documents on the IPP (WV-BMS-IDD-5) and requests the units agreed upon in the UMC web portal.

The hourly wage of agency staff employed by an IDDW provider is determined solely by the agency that employs the staff person. Agency providers must at all times comply with all local, state, and federal wage

and hour employment laws and regulations, including, but not limited to, the West Virginia Wage and Hour Act, Fair Labor Standards Act (FLSA) and Internal Revenue Service (IRS) laws and regulations. IDDW providers are solely responsible for making their own determination as to whether an individual performing work for the agency is an employee or independent contractor under applicable state and federal laws and regulations. Provider agencies should not interpret this as an opportunity to misclassify workers as independent contractors. Provider agencies are solely responsible for any liability resulting from misclassification of workers. BMS reserves the right to dis-enroll any IDDW provider which is found to have misclassified employees by the U.S. Department of Labor, IRS, or any other applicable state or federal agency. All agency staff hired by an IDDW provider must meet the requirements listed in the applicable Agency Staff Qualifications in Section 513.3.

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

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

513.9.2 Participant-Directed Service Option

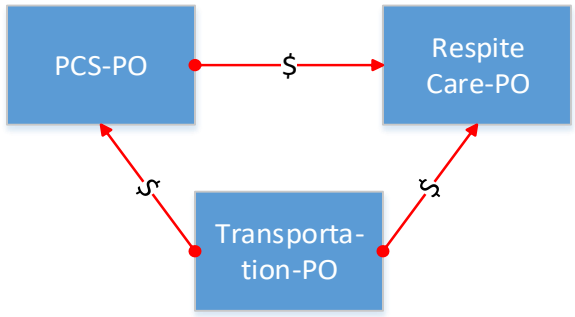
The Participant-Directed Service Delivery Model is available to every member except for those living in OHFLAC licensed residential settings. Based on assessments the IDT identifies needed services and addresses those on the IPP.

If the member chooses this Service Option, he/she has the opportunity to exercise choice and control over the participant-directed services they choose and the individuals and organizations who provide them (employer authority); and/or how the portion of their individualized budget associated with participant-directed services (i.e., their participant-directed budget) is spent (budget authority). The participant-directed services over which members have the opportunity to exercise choice and control are Family/Home-Based Person-Centered Support, Unlicensed Residential Person-Centered Support, In-Home Respite, Out-of-Home Respite, Participant Directed Goods and Services, and Transportation. (Note that Participant-Directed Goods and Services and Transportation can only be participant-directed if at least one of either a Person-Centered Support and/or a Respite service is also participant-directed.) The maximum amount of a participant-directed budget is the equivalent monetary value of Person-Centered Support service units, Respite service units, Participant-Directed Goods and Services, and Transportation service units available, based on the age, residential setting, needs of the member, and units available. When a member is accessing Person-Centered Support, Respite, Participant-Directed Goods and Services, and/or Transportation services, whether via the Traditional or Participant-Directed Service Option, the total dollar amount of the services must be added together and may not exceed the service limits in both Service Options combined.

All services purchased must be within the individualized budget. Both Family Person-Centered Support: *Personal Options* and Transportation Miles: *Personal Options* monies may be transferred into Respite: *Personal Options* to increase this service. Transportation Miles: *Personal Options* monies may also be transferred to Family Person-Centered Supports: *Personal Options* to increase this service. Respite: *Personal Options* monies may not be transferred into Family Person-Centered Support: *Personal Options* or Transportation Miles: *Personal Options*. Participant-Directed Goods and Services monies may not be

transferred into Respite: *Personal Options,* Family Person-Centered Supports: *Personal Options* or to Transportation Miles: *Personal Options*, nor may any of these service monies be transferred into Participant-Directed Goods and Services.

I/DDW Allowable Financial Authority Exchanges



Only those $$ exchanges indicated with an arrow are allowed. All others are prohibited.

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

The *Personal Options* vendor assigns a *Personal Options* resource consultant to assist and support each self-directing member to develop and monitor monthly spending plans. The Resource Consultant will ensure the member/representative is aware of service utilization so that the member/representative can make adjustments to the spending plan if the budget amount allows for modifications.

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

Members who choose to participant-direct their IDDW services will do so with the support of an FMS called *Personal Options.* If utilizing *Personal Options,* the member is the common law employer, or employer of record, of the QSW hired.

To assist with functions related to being the common law employer, the member may appoint a representative. A representative may not be a paid employee providing *Personal Options* IDDW services to the member.

As the common law employer, the member is responsible to:

- Elect the participant-directed option;

- Work with their resource consultant to become oriented and enrolled in the Participant-Directed Service Delivery Model, enroll QSWs, develop a spending plan for the participant-directed budget, and create an emergency QSW's back-up plan to ensure staffing, as needed;
- Recruit and hire their QSWs;
- Provide required training to QSWs, including training on needs specific to the member;
- Determine QSWs' work schedule and how and when the Qualified Support Workers should perform the required tasks;
- Determine qualified support worker(s)' daily activities;
- Evaluate QSWs' performance;
- Review, sign, and submit QSWs' timesheets to the *Personal Options* FMS;
- Maintain documentation in a secure location and ensure employee confidentiality;
- Discharge QSWs, when necessary; and
- Notify the service coordinator of any changes in service need.

The *Personal Options* FMS acts as the fiscal/employer agent to the member, and is therefore responsible to:

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

The *Personal Options* FMS is not the common law employer of the qualified support worker(s) of the members. Rather, the *Personal Options* FMS assists the member/common law employer in performing all that is required of an employer for wages paid on their behalf and all that is required of the payer for requirements of back-up withholding, as applicable. The *Personal Options* FMS operates under §3504 of

the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and Medicaid program rules, as required.

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

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

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

If the Participant-Directed Service Delivery Model is selected by the member, the, *Personal Options* FMS, rather than the case manager, provides I&A service that includes:

- Providing or linking common law employers with program materials in a format that they can use and understand;
- Providing and assisting with the completion of enrollment packets for common law employers;
- Providing and assisting the common law employer with employment packets;
- Discussing and/or helping determine the participant-directed budget with the common law employer;
- Presenting the common law employer with the *Personal Options* FMS' role in regard to payment for services;
- Assisting common law employers with determining participant-directed budget expenditures (hiring);

- Assisting with the development of an individualized spending plan based upon the annual participant-directed budget;
- Making available to the member/representative a process for voicing complaints/grievances pertaining to the *Personal Options* FMS' performance;
- Providing additional oversight to the common law employer as requested or needed;
- Monitoring and reporting information about the utilization of the participant- directed budget to the member, representative, CM, and BMS; and
- Explaining all costs/fees associated with participant-directing to the member. The costs/fees are for the criminal investigation background check, CPR, and First Aid for QSWs. The cost for the FMS does not come out of the individual's budget.

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

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

513.10 BEHAVIOR SUPPORT PROFESSIONAL SERVICES

513.10.1 Behavior Support Professional I and II (Traditional Option)

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

- Develops training plans that include member-specific aspects and methods of intervention or instruction;
- Provides training to staff members who will implement the training plans on aspects and methods of intervention (i.e., family, person-centered support, facility-based day habilitation, supported employment, and crisis direct-support professionals);
- Provides training for direct-support professionals who provide respite services if applicable for respite-relevant training objectives or health/safety training objectives only;
- Evaluates/monitors the effectiveness of the training plans through analysis of programming results that occurs at least monthly;
- Follows-up once training plans have been implemented to observe progress/regression; and
- Revises training plans as needed.

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

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

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

The BSP may also perform the following functions:

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

Procedure Code: T2021-HN Level I
T2025-HO Level II
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, any Unlicensed Residential Home, a licensed IDDW provider agency office, a licensed day program facility, a licensed pre-vocational site, licensed crisis sites, public community locations, and a member's supported work site.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The amount of service must be identified on the IPP.
- The maximum annual units of BSP services cannot exceed 768 units/192 hours per IPP year.
- Staff members providing BSP services may not live in the home of the member.
- If the assigned BSP is unavailable due to an emergency or illness, another BSP may provide services in their absence.
- BSP Level I services may only be provided by a staff person who meets the criteria in Sections 513.2 - 513.2.1, and Section 513.3.1.1 Behavior Support Professional I (BSP I) Agency Staff Qualification Requirements.
- BSP Level II services may only be provided by a staff person who meets the criteria in Sections 513.2 - 513.2.1, and Section 513.3.1.2 Behavior Support Professional II (BSP II) Agency Staff Qualification Requirements.
- Direct-care services provided by the BSP must be billed utilizing the appropriate direct care service code.
- BSP services may not be billed for traveling to complete BSP activities.
- BSP services cannot be billed for completing administrative activities to include these listed below.
    - HR activities such as staff supervision, monitoring, and scheduling.
    - Routine review of a member's file for quality assurance purposes.
    - Staff meetings for groups or individuals.
    - Monitoring of a licensed group home (fire drills, hot water heater temperature checks, etc.).
    - Filing, collating, writing notes to staff.
    - Phone calls to staff.
    - Observing staff while training individuals without a clinical reason.

- Administering assessments not warranted or requested by the member or their legal representative.
- Making plans for a parent for a weekend visit.
- Working in the home while providing direct care staff coverage.
- Sitting in the waiting room for a doctor or medical appointment.
- Conducting a home visit routinely and without justification—only case managers are required to make monthly home visits.

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

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

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

Procedure Code: T2024-HI Level I
T2025-HI Level II
Service Units: Unit = Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual function assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.

- The maximum annual combined units of BSP IPP Planning (both BSP I and BSP II) cannot exceed four Events per member's annual IPP year.
- BSP may attend all planning meetings, either face-to-face or by teleconference, but in order to bill the IPP code, the professional must be physically present for the duration of IPP meeting.
- IPP cannot be billed for preparation prior to or for follow-up performed after the IPP meeting.
- Staff providing BSP services may not be an individual who lives in residence of the member.

513.11 CRISIS SERVICES

513.11.1 Crisis Services (Traditional Option)

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

Procedure Code: T2017 2:1 ratio
Service Units: Unit = 15 minutes

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

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

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed Group Home, an Unlicensed Residential Home, and public community locations.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Crisis Services cannot exceed 1,344 units/336 hours per IPP year.
- This service may be billed concurrently with case management, BSP, and Transportation.
- This service may not be billed concurrently with Person-Centered Support, Facility-Based Day Habilitation, LPN, Respite, Pre-vocational, Job Development, and Supported Employment.
- The ratio of agency staff to member receiving services is 2:1 for this service.
- Direct-Support Professionals providing Crisis Services may not live in in the home of the member.
- This service is not intended for use as emergency response for ongoing behavioral challenges.

513.12 EXTENDED PROFESSIONAL SERVICES

513.12.1 Dietary Therapy (Traditional Option)

Dietary Services may be provided to directly members 21 years of age and older by a registered dietary therapist that is a licensed in West Virginia and an enrolled Medicaid provider. Services may include:

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

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

Procedure Code: 97802-AE 1:1 ratio
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided.
Prior authorizations are based on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an Unlicensed Residential Home, a licensed day program facility or pre-vocational center, and crisis sites.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of dietary therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: physical therapy and occupational therapy.
- The ratio of agency staff to member receiving services is 1:1 for this service.
- Agency staff providing dietary therapy services may not be an individual who lives in the member's home.
- Agency staff may not bill dietary therapy for completing administrative activities.

513.12.2 Occupational Therapy (Traditional Option)

Occupational Therapy is provided directly to members 21 years old and over by an occupational therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Evaluation and training services in the areas of gross and fine motor function;
- Self-care;
- Sensory and perceptual motor function;
- Screening and assessments;
- Planning and reporting;
- Direct therapeutic intervention;
- Design, fabrication, training and assistance with adaptive aids and devices;
- Consultation or demonstration of techniques with other service providers and family members; and

- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or legal representative.

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

Procedure Code: 97530-GO 1:1 ratio
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, any unlicensed residential home, a licensed day program facility or pre-vocational center, and crisis sites.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- This service is limited to members 21 years old and over. Members under 21 may access this service through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of occupational therapy may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: physical therapy and dietary therapy.
- The ratio of agency staff to member receiving services is 1:1 for this service.

- Agency staff providing occupational therapy services may not be an individual who lives in the member's home.
- Agency staff providing occupational therapy services may not bill for administrative activities.

513.12.3 Physical Therapy (Traditional Option)

Physical therapy is provided directly to members 21 years old and over by a physical therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

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

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

Procedure Code: 97530-GP 1:1 ratio
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed GH, an unlicensed residential home, a licensed day program facility or pre-vocational center, and crisis sites.

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

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

- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- This service is limited to members 21 years old and over. Members under 21 may access this service through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of physical therapy may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: occupational therapy and dietary therapy.
- The ratio of agency staff to member receiving services is 1:1 for this service.
- Agency staff providing physical therapy services may not be an individual who lives in the member's home.
- Agency staff providing physical therapy services may not bill for administrative activities.

513.12.4 Speech Therapy (Traditional Option)

Speech therapy is provided directly to members 21 years old and over by a speech pathologist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

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

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

Procedure Code: 92507-GN 1:1 ratio
Service Units: Unit = 1 Event

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

services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre-vocational site, and crisis sites.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- This service is limited to members 21 years old and over. Members under 21 may access this service through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 96 units/96 events per member's annual IPP year for members below age 24.
- 48 units/48 events per member's annual IPP year for members age 24 and over.
- The ratio of agency staff to member is 1:1 for this service.
- Agency staff providing speech therapy services may not be an individual who lives in the member's home.
- Agency staff may not bill speech therapy services for completing administrative activities.

513.12.5 Dietary Therapy (Participant-Directed Option, *Personal Options Model*)

Dietary Therapy is provided directly to members 21 years old and over by a dietary therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Nutritional assessment and therapy for diseases that have a nutrition component;
- Preventive health and diet assessment;
- Weight management therapy;
- Design of menus;

- Screening;
- Assessments;
- Planning and reporting;
- Direct therapeutic intervention;
- Consultation or demonstration of techniques with other service providers and family members; and
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or legal representative.

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

Procedure Code: 97802-AE-UG 1:1 ratio
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre-vocational center and crisis sites.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.

- The maximum annual units of dietary therapy services may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: physical therapy and occupational therapy.
- The ratio of staff to member receiving services is 1:1 for this service.
- Staff providing physical therapy services may not be an individual who lives in the member's home.
- Staff providing physical therapy services may not bill for administrative activities.

513.12.6 Occupational Therapy (Participant-Directed Option, *Personal Options Model*)

Occupational Therapy is provided directly to members 21 years old and over by an occupational therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Evaluation and training services in the areas of gross and fine motor function;
- Self-care;
- Sensory and perceptual motor function;
- Screening and assessments;
- Planning and reporting;
- Direct therapeutic intervention;
- Design, fabrication, training and assistance with adaptive aids and devices;
- Consultation or demonstration of techniques with other service providers and family members; and
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or legal representative.

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

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

Procedure Code: 97530-GO-UG 1:1 ratio
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, any Unlicensed Residential Home, a licensed day program facility or pre-vocational center and crisis sites.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- This service is limited to members 21 years old and over. Members under 21 may access this service through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of occupational therapy may not exceed 416 units/104 hours per IPP year. This is in combination with the following services:
    - Physical therapy and dietary therapy.
- The ratio of staff to member receiving services is 1:1 for this service.
- Staff providing physical therapy services may not be an individual who lives in the member's home.
- Staff providing physical therapy services may not bill for administrative activities.

513.12.7 Physical Therapy (Participant-Directed Option, *Personal Options Model*)

PT is provided directly to members 21 years old and over by a physical therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Screening and assessments;
- Treatment and training programs designed to preserve and improve abilities for independent functioning, such as gross and fine motor skills, range of motion, strength, muscle tone;
- Activities of daily living;
- Planning and reporting;
- Direct therapeutic intervention;
- Training and assistance with adaptive aids and devices;
- Consultation or demonstration of techniques with other service providers and family members; and

- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or their legal representative.

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

Procedure Code: 97530-GP-UG 1:1 ratio
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed GH, an unlicensed residential home, a licensed day program facility or pre-vocational center, and crisis sites.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- This service is limited to members 21 years old and over. Members under 21 may access this service through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of physical therapy may not exceed 416 units/104 hours per IPP year. This is in combination with the following services: occupational therapy and dietary therapy.
- The ratio of staff to member receiving services is 1:1 for this service.

- Staff providing physical therapy services may not be an individual who lives in the member's home.
- Staff providing physical therapy services may not bill for administrative activities.

513.12.8 Speech Therapy (Participant-Directed Option, *Personal Options Model*)

Physical Therapy is provided directly to members 21 years old and over by a physical therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

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

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

Procedure Code: 92507-GN-UG 1:1 ratio
Service Units: Unit = 1 Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an Unlicensed Residential Home, a licensed day program facility or pre-vocational site and crisis sites.

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

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

- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- This service is limited to members 21 years old and over. Members under 21 may access this service through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 96 units/96 events per member's annual IPP year for members below age 24.
- 48 units/48 events per member's annual IPP year for members age 24 and over.
- The ratio of staff to member receiving services is 1:1 for this service.
- Staff providing physical therapy services may not be an individual who lives in the member's home.
- Staff providing physical therapy services may not bill for administrative activities.

513.13 ELECTRONIC MONITORING

513.13.1 Electronic Monitoring (Traditional Option)

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

- This service is only to be utilized when there is no paid staff in the member's home.
- This service may be installed in residential settings in which residing adult members, their legal representatives (if applicable) and their IDT teams request such surveillance and monitoring in place of paid staff.
- All electronic monitoring systems or companies used or contracted by the IDDW provider meet the standards set by the BMS and must be pre- approved by the BMS before providing any services and approved annually thereafter.
- The IDDW provider must have written policies and procedures approved by BMS that define emergency situations and details how remote and stand-by staff will respond to each (Ex. Fire, prolonged power outage, medical crisis, stranger in the home, violence between members, any situation that appears to threaten the health and welfare of the member).
- The electronic monitoring system or company must receive notification of smoke/heat activation at each member's home.

- The electronic monitoring system or company must have two-way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of the members in each home, including emergency situations when the participant may not be able to use the telephone.
- The electronic monitoring system or company must allow the monitoring base staff to have visual (video) oversight of areas in the member's home deemed necessary by the IDT.
- At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of members at the remote living site.
- The monitoring base staff will assess any urgent situation at a member's living site and call 911 emergency personnel first if that is deemed necessary, then call the stand-by staff.
- The monitoring base staff will stay engaged with the participant(s) at the living site during an urgent situation until the stand-by staff or emergency personnel arrive.
- Any member wishing to access this service must first be assessed using the identified Risk Assessment and approved by the IDDW provider's HRC to ensure that the member's health and welfare would not be harmed by accessing this service. The approval of the HRC must be documented and attached to the member's IPP.
- After the approval of the HRC is obtained, the member and their legal representative (if applicable) and the IDT must give informed consent and document the approval of such support in place of on-site staff or natural supports on the member's IPP.
    - The member, their legal representative and all IDT members are made aware of both the benefits and the risks of the operating parameters and limitations. Benefits may include increased independence and privacy and risks may include not having on-site staff in case of an emergency.
- The residential agency conducts a programmatic review of the system as well as a drill at seven days of implementation, again at 14 days and at least quarterly thereafter. The drill will consist of testing the equipment and response time.
- The case manager reviews the continued usage of this service at every home visit and during every IPP and makes the IDT aware of any problems or concerns encountered with the use of this system, all of which is documented on the IPP.
- The number of members served by one stand-by intervention staff for on-site response is determined by the IDT and based upon the assessed needs of the members being served in specifically identified locations.
- The IDDW provider has stand-by intervention staff who meet the following standards:
    - Responds by being at the member's residential living site within 20 minutes or less from the time an incident is identified by the remote staff and the stand-by staff acknowledges receipt of the notification by the remote staff. The IDT has the authority to set a shorter response time based on the individual member's need.
    - Assists the member in the home as needed to ensure the urgent need/issue that generated a response has been resolved.
    - Each time an emergency response is generated, an incident report must be submitted to the WV IMS by the IDDW provider.

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

Service Units: Unit = 1 Hour

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the adult member's family residence, a licensed Group Home and in an unlicensed residential home.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to people over the age of 18.
- The electronic monitoring/surveillance staff to member ratios for this service are 1:1, 1:2, 1:3 and 1:4 and authorizations will be based on the number of IDDW members residing within the residence.
- The maximum annual units of electronic monitoring for individuals who live in licensed group homes or unlicensed residential homes is 5,840 units per IPP year and this is in combination with all other types of direct care services (person-centered support, facility-based day habilitation, pre-vocational, supported employment, job development, crisis and LPN services).
- The maximum annual units of electronic monitoring for individuals who live in natural family homes is 2,920 units per IPP year and this is in combination with all other types of direct care services (person-centered support, facility-based day habilitation, pre-vocational, supported employment, job development, crisis and LPN services).
- Only electronic monitoring/surveillance systems approved by BMS may be used.
- The member will not be charged for installation costs related to video and/or audio equipment.
- The electronic monitoring/surveillance system may not be used in specialized family care homes.
- The electronic monitoring/surveillance system may not be used to monitor direct care staff.
- The electronic monitoring/surveillance system serves as a replacement for direct care staff, thus no other direct care service may be billed at the same time for the member receiving services or for any other people receiving IDDW services residing in the home.

513.14 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

513.14.1 Environmental Accessibility Adaptations Home (Traditional Option)

Environmental Accessibility Adaptations-Home (EAA-Home) are physical adaptations to the private residence of the member or the member's family home which maximize the member's physical accessibility to the home and within the home. EAA-Home must be documented in the member's IPP and

must include the specific item requested. Additionally, these adaptations enable the member to function with greater independence in the home. This service is used only after all other funding sources have been exhausted.

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

Procedure Code: S5165
Service Units: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home or an unlicensed residential home.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- EAA-Home is not intended to replace the member's, member's family, or landlord's responsibility for routine maintenance and upkeep of the home. These include but are not limited to cleaning, painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and heating, plumbing, electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

- Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the member's need. Appliances compliant with the American Disabilities Act (ADA) are sufficient to meet this requirement.
- The specific item(s) must be documented on the IPP.
- Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service.
- Adaptations made to rental residences or to specialized family care homes must be portable.
- $1000 available per member's annual IPP year in combination with Traditional and Personal Options Environmental Accessibility Adaptations - Vehicle and/or Participant-Directed Goods and Services.
- The case management agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.14.2 Environmental Accessibility Adaptations Vehicle (Traditional Option)

Environmental Accessibility Adaptations-Vehicle (EAA-Vehicle) are physical adaptations to the vehicle including paying for accessibility adaptations to a vehicle that is the member's primary mode of transportation. EAA-Vehicle is documented on the member's IPP and must include the specific item requested. The purpose of this service is to maximize the member's accessibility to the vehicle only. All EAA requests must be submitted by the case management provider to the UMC for approval. If approved, the case management provider is responsible for ensuring the adaptation to the vehicle is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation including dated and itemized receipts of the completed adaptation must be maintained by the case management provider.

Procedure Code: T2039
Service Unit: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- $1000 available per member's annual IPP year in combination with Traditional and Personal Options EAA - Home and/or PDGS.
- The specific item(s) must be documented on the IPP.
- This service may not be used for adaptations or improvements to the vehicle that are of general utility (such as running boards) , and are not of direct medical or remedial benefit to the individual.
- This service may not be used to purchase or lease a vehicle.
- This service may not be used to adapt a vehicle owned or leased by an IDDW provider agency.
- This service may not be used for regularly scheduled upkeep, maintenance, and repairs of a vehicle except upkeep and maintenance of the modifications.
- The case management agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.14.3 Environmental Accessibility Adaptations Home (Participant-Directed Option, *Personal Options Model*)

EAA-Home are physical adaptations to the private residence of the member or the member's family home which maximize the member's physical accessibility to the home and within the home. EAA-Home must be documented in the member's IPP and must include the specific item requested. Additionally, these adaptations enable the member to function with greater independence in the home. This service is used only after all other funding sources have been exhausted.
All EAA requests must be submitted by the case management provider to the UMC for approval. If approved, the *Personal Options* vendor is responsible for ensuring the adaptation to the home is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation including dated and itemized receipts of the completed adaptation must be maintained by the case management provider and the *Personal Options* vendor.

Procedure Code: S5165-UG
Service Units: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home or an unlicensed residential home.

Documentation: IDDW provider must maintain all of the following documentation in the member's file and the Case Manager informed the service was completed:

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- EAA-Home is not intended to replace the member's, member's family, or landlord's responsibility for routine maintenance and upkeep of the home. These include but are not limited to cleaning, painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and heating, plumbing, electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the member's need. Appliances compliant with the ADA is not sufficient to meet this requirement.
- The specific item(s) must be documented on the IPP.
- Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service.
- Adaptations made to rental residences or to specialized family care homes must be portable.
- $1000 available per member's annual IPP year in combination with Traditional and Personal Options Environmental Accessibility Adaptations - Vehicle and/or PDGS.
- The personal options vendor must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.14.4 Environmental Accessibility Adaptations Vehicle (Participant-Directed Option, *Personal Options Model*)

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

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

Procedure Code: T2039-UG
Service Unit: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- $1000 available per member's annual IPP year in combination with Traditional and Personal Options Environmentally Accessibility Adaptations - Home and/or Participant-Directed Goods and Services.
- The specific item(s) must be documented on the IPP.
- This service may not be used for adaptations or improvements to the vehicle that are of general utility (such as running boards) , and are not of direct medical or remedial benefit to the individual.
- This service may not be used to purchase or lease a vehicle.
- This service may not be used to adapt a vehicle owned or leased by an IDDW provider agency.
- This service may not be used for regularly scheduled upkeep, maintenance, and repairs of a vehicle except upkeep and maintenance of the modifications.
- The case management agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.15 DAY SERVICES

513.15.1 Facility-Based Day Habilitation (Traditional Option)

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

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

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

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

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

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

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

Procedure Code:	T2021-U5 1:1-2 ratio T2021-U6 1:3-4 ratio T2021-U7 1:5-6 ratio
Service Unit:	Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Facility-Based Day Habilitation cannot exceed 6,240 units/1560 hours (Average six hours/day) per member's IPP year. When the member accesses other direct care services, these units are counted toward the daily cap of all direct care services (all other types of Person-Centered Support, other Day Services, LPN, Crisis Intervention, and Electronic Monitoring).
- This service may not be billed concurrently with any other direct care services.
- Agency staff members to member ratios for this service are 1:1-2, 1:3-4, and 1:5-6.
- Agency staff providing Facility-Based Day Habilitation services may not be an individual who lives in the member's home.
- Only members 18 years of age and over may access this service.

513.15.2 Pre-Vocational (Traditional Option)

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

disabilities. These services should enable each member to attain the highest level of work in a setting matched to the individual's strengths, interests, priorities, and abilities.

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

Tasks of a benefit to a provider are those tasks, performed by a member, for which the provider would otherwise have to pay an employee to complete. A member taking out trash generated by the whole room or setting (not just the member's personal trash) would be an example of a task benefiting the provider. A member being trained to clean up after him/her self would not fall in this category.

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

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

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

Members receiving pre-vocational services must have employment-related goals on the IPP and general habilitation activities must be designed to support such employment goals. Members may receive minimum wage. If the IDDW provider benefits from the member's labor, then the member must be paid.

Pre-vocational direct-support professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the member or their legal representative.

Procedure Code: T2021-U1 1:1-2 ratio
T2021-U2 1:3-4 ratio
T2021-U3 1:5-6 ratio
Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess

of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

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

Limitations/Caps:

- The amount of service is limited by the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- The maximum annual units of Pre-vocational services cannot exceed 6,240 units/1,560 hours (average six hours/weekday) per IPP year. This is in combination with all other direct care services (Participant-Directed Support, other day services, LPN, Crisis Intervention, and electronic monitoring).
- This service may not be billed concurrently with any other direct support services.
- The ratios of staff members to member are 1:1-2, 1:3-4, and 1:5-6 for this service.
- Direct-support professionals providing pre-vocational services may not live in the home of the member.
- The amount of pre-vocational services must be identified on the IPP.
- Only members 18 years of age and over may access this service.
- Only BSPs or RN may bill for providing training to pre-vocational staff.

513.15.3 Job Development (Traditional Option)

Job development services are designed for analysis, situational assessments, and supports in either acquiring or maintaining competitive employment. These services should enable each member to attain and maintain employment at the highest level of work in a setting matched to the individual's strengths, interests, priorities, and abilities.

Job development services must be supervised by a supported employment services supervisor or a BSP. In addition to the standard training requirements, paraprofessionals providing job development must have documented training or experience in implementation of Supported Employment Plans of Instruction.

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

Job development services include, but are not limited to, such concepts as:

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

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

Job development direct-support professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the member or their legal representative.

Procedure Code: T1019-HB 1:1 ratio
Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided community settings, and/or integrated employment setting.

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

- Name of the member
- Service code including modifier to indicate ratio of staff member to member
- Date of service
- Start time

- Stop time
- Total time spent
- Task Analysis
- Transportation log (if applicable)
- Signature of the staff member

Limitations/Caps:

- The amount of service is limited by the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Job Development services cannot exceed 6,240 units/1,560 hours (average six hours/weekday) per IPP year. This is in combination with all other direct care services (Participant-Directed Support, other Day Services, LPN, crisis intervention, and electronic monitoring).
- This service may not be billed concurrently with any other direct-support services.
- The ratios of staff members to member are 1:1
- Direct-support professionals providing Job Development services may not live in the home of the member.
- The amount of Job Development services must be identified on the IPP.
- Only members 18 years of age and over may access this service.
- Only BSPs or RN may bill for providing training to Job Development staff.

513.15.4 Supported Employment (Traditional Option)

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

- Vocational counseling (Example: Discussion of the member's on-the-job work activities);
- On-the-job training in work and work-related skills;
- Accommodation of work performance task;
- Supervision and monitoring by a job coach;
- Intervention to replace inappropriate work behaviors with adaptive work skills and behaviors;
- Retraining as jobs change or job tasks change;
- Training in skills essential to obtain and retain employment, such as the effective use of community resources;
- Transportation to and from job sites when other forms of transportation are unavailable or inaccessible.

Natural work setting supports are to be considered prior to the utilization of supported employment.

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

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

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

Procedure Code: T2019 1:1 ratio
T2019-HQ 1:2-4 ratio
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service must be provided in an integrated community work setting unless the member is self-employed, and may not be provided in any setting owned or leased by an IDDW provider agency. An integrated setting requires that most of the member's co-workers in the setting do not have disabilities.

Documentation: Documentation must include all of the following items.

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- Agency staff providing Supported Employment services may not be an individual who lives in the member's home.
- The maximum annual units of supported employment cannot exceed 8,320 units/2080 hours per member's annual IPP year. This is in combination with all other direct-care services (Participant-Directed Support, other day services, LPN, crisis intervention, and electronic monitoring).
- This service may not be billed concurrently with any other direct-care services.
- Group services for this service have an agency staff to member ratio of 1:2-4.

513.16 GOODS AND SERVICES

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

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

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

Procedure Code: T2028-SC
Service Unit: Unit = $1.00

Prior Authorization: Prior authorizations are based on assessed need and services must be within the member's individualized participant-directed budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

Documentation:

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

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan. If a member is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 1000 units ($1,000) per member's IPP year in combination with Traditional and Personal Options EAA - Vehicle and Home.
- The *Personal Options* vendor must not pay PDGS funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the PDGS service.
- To access Participant-directed Goods and Services the member must also access at least one other type of participant-directed service during the budget year—i.e. Participant-Directed Support or Respite.
- PDGS monies may not be transferred into Family Person-Centered Supports: *Personal Options,* Respite: *Personal Options* or Transportation Miles: *Personal Options.*
- The following represents non-permissible goods and services:
    - Goods, services and supports available through another source;
    - Goods, services or supports provided to or benefiting persons other than the member;
    - Room and board;
    - Personal items and services not related to the qualifying disability;
    - Gifts for workers/family/friends, payments to someone to serve as a representative,
    - Clothing, food(including nutritional supplements) and beverages;
    - Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the member's need. Appliances compliant with the American Disabilities Act (ADA) is not sufficient to meet this requirement.
    - Air purifiers, humidifiers or air conditioners unless individual has a documented respiratory/allergy condition or diagnosis;
    - Electronic entertainment equipment;
    - Utility payments;
    - Generators unless used for medical equipment only (cannot be for the entire house);

- Swimming pools, hot tubs and spas or any accessories, repairs or supplies for these items;
- Railings for decks and porches;
- Outdoor recreational equipment unless specifically adapted for the individual's needs;
- Costs associated with travel;
- Household furnishings such as comforters, linens, drapes and furniture;
- Furniture unless it is a lift chair for someone with mobility issues;
- Vehicle expenses including running boards, routine maintenance and repairs, insurance and gas money;
- Medications, vitamins, and herbal supplements;
- Illegal drugs or alcohol;
- Experimental or investigational treatments;
- Computers, monitors;
- Communication devices/tablets for children under the age of 21;
- Communication devices/tablets for adults over the age of 21 unless specifically recommended by a licensed speech therapist;
- Computer software;
- Fax machines;
- Copiers;
- Scanners;
- Printers or ink cartridges;
- Landline telephones or cell phones;
- Car seats and strollers that do not require modifications;
- Monthly internet service;
- Yard work;
- Household cleaning supplies;
- Home maintenance including paint and replacement of flooring, appliances, doors, furnaces, hot water tank, roof and windows (unless the item needs modified such as a window that is large enough for an adult to use to exit in case of a fire);
- Fences, gates, half-doors;
- Driveway or walk way repairs or supplies unless specifically to exit or enter home to and from vehicle;
- Covered awnings;
- Pet/pet care including service animals, veterinary bills, food and training;
- Respite and/or Direct-Care Services (Person-Centered Support, LPN, Supported Employment, Facility-Based Day Habilitation, etc.);
- Spa services;
- Public education or items needed for public educational purposes;
- Personal hygiene items;
- Summer camps;
- Day care;
- Discretionary cash; and
- Home alarm and monitoring systems.

- PDGS is not intended to replace the responsibility of the member, their family, or their landlord for routine maintenance and upkeep of the home. These include but are not limited to cleaning,

painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and heating, plumbing and electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

513.17 PERSON-CENTERED SUPPORT

There are five types of Person-Centered Support services available under the Traditional Option and three types of Person-Centered Support services available under the Personal Options model. Each is described in detail in its specific section, below. The five types are:

- Family Person-Centered Support - Traditional
- Home-Based Person-Centered Support - Traditional
- Licensed Group Home Person-Centered Support - Traditional
- Unlicensed Residential Person-Centered Support - Traditional
- Crisis Site Person-Centered Support – Traditional
- Person-Centered Support – Personal Options
    - Provided by staff that do not live in the member's home
    - Provided by staff that do live in the member's home
- Unlicensed Residential Person-Centered Support – Personal Options

513.17.1 Family Person-Centered Support

513.17.1.1 Family Person-Centered Support (Traditional Option)

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

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

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

Family Person-Centered Support services must be assessment based and outlined on the IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs.

Family Person-Centered Support services may include training specific to the member, attendance, and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC.

Direct-support professionals providing Family Person-Centered Support must be a family member living in the home of the member or a certified specialized family care provider providing this service in a certified specialized family care home. For the purposes of providing Family Person-Centered Support services, family members include biological/adoptive parents or step-parents, biological/adoptive adult siblings or step-siblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/-uncles only. Spouses of members are excluded from providing services.

Procedure Code: S5125-U5 1:1 ratio
S5125-U6 1:2 ratio
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified in the annual functional assessment and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the family residence of the member, a specialized family care home, and/or in the local public community.

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

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

Limitations/Caps:

- The amount of service is limited by the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Family Person-Centered Support services cannot exceed 7,320 units/1,830 hours (based upon average of five hours per day) per IPP year for natural family/specialized family care home settings for members under age 18. This is in combination with the following direct support services: all other types of Person-Centered Support and crisis intervention.
    - The maximum annual units of Family Person-Centered Support services cannot exceed 11,680 units/2,920 hours (based upon average of eight hours per day) per IPP year for natural family/specialized family care home settings for members aged 18 and older. This is in combination with the following direct support services: all other types of Person-Centered Support, LPN, crisis intervention, and electronic monitoring.
    - All direct-support services cannot exceed an average of 12 hours per day on days when facility-based day habilitation, job development, pre-vocational, and/or supported employment services are provided.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff members to members who receive services are 1:1 and 1:2 for this service.
- The amount of Family Person-Centered Support provided must be identified on the IPP.
- Family Person-Centered Support is not available while the member is hospitalized in a Medicaid certified hospital except for members who live in a specialized family care home when behavioral needs of the member arise due to the temporary to change in environment.
- Family Person-Centered Support is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.
- Family Person-Centered Support cannot replace the routine care, and supervision which is expected to be provided to biological, adoptive or foster children or adults by a parent or a Specialized Family Care provider.
- Family Person-Centered Support may not substitute for federally mandated educational services.
- Spouses are excluded from providing Family Person-Centered Support services

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

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

Person-Centered Support: *Personal Options* services are available to members living in the following types of residential settings: the family home of the member and specialized family care homes.

Person-Centered Support: *Personal Options* may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

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

Person-Centered Support: *Personal Options* services must be assessment based and outlined on the member's spending plan. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs.

Person-Centered Support: *Personal Options* services may include training specific to the member. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is permitted if requested by the member or their legal representative.

Procedure Code: S5125-UA 1:1 ratio (provided by staff that do not live in the member's home)
S5125-UA-UK 1:1 ratio (provided by staff that live in the member's home)
Service Units: Unit = 15 minutes

Prior Authorization: All units of Person-Centered Support – Personal Options are purchased and authorized under the S5125-UA service code. The F/EA vendor will be responsible for claiming services provided by staff that live in the member's home by including the UK modifier on service claims.

All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the family residence of the member, a specialized family care home, and/or in the local public community.

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

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

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

Limitations/Caps:

- The amount of service is limited by the individualized participant-directed budget and spending plan, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units Person-Centered Support: *Personal Options* services are limited to the equivalent monetary value of 7,320 units/1,830 hours (based upon average of five hours per day) of Traditional Family Person-Centered Support per IPP year for members under age 18 when transferring funds from the annual budget allocation to the Participant-Directed budget. This is in combination with the following direct-support services: all other types of Person-Centered Support and crisis intervention.
- The maximum annual units of Person-Centered Support: *Personal Options* services are limited to the equivalent monetary value of 11,680 units/2,920 hours (based upon average of eight hours per day) of Traditional Family Person-Centered Support per IPP year for members aged 18 and older when transferring funds from the annual budget allocation to the Participant-Directed budget. This is in combination with the following direct support services: all other types of Person-Centered Support, LPN, crisis intervention, and electronic monitoring.
- Units/funds of authorized Unlicensed Residential Person-Centered Support: Personal Options may not be used to access additional Extended Therapies: *Personal Options*, Environmental Accessibility-Vehicle and Home: *Personal Options* or PDGS.
- Units/funds of authorized Person-Centered Support: Personal Options may not be used to access additional Extended Professional Therapies: *Personal Options*, Environmental Accessibility-Vehicle and Home: *Personal Options* or Participant-Directed Goods and Services.
- All direct-support services cannot exceed the equivalent monetary value of an average of 12 hours per day on days when Facility-Based Day Habilitation, Job Development, Pre-vocational, and/or Supported Employment services are provided.
- The equivalent monetary value for Respite services cannot be used to access additional Person-Centered Support: *Personal Options* services; however, if additional Respite units are needed, the equivalent monetary value of Person-Centered Support: *Personal Options* services may be used to access additional Respite services.
- The equivalent monetary value for Person-Centered Support: *Personal Options* services may be used to increase Respite: *Personal Options* but cannot be used to increase Transportation: *Personal Options,* Environmental Accessibility Adaptations: *Personal Options,* Dietary Therapy: *Personal Options,* Occupational Therapy: *Personal Options,* Speech Therapy: *Personal Options,* Physical Therapy: *Personal Options* or Participant-Directed Goods and Services.
- This service may not be billed concurrently with any other direct support service.
- The ratio of staff member to member is 1:1 for this service.

- Person-Centered Support: *Personal Options* is not available while the member is hospitalized in a Medicaid certified hospital except for members who live in a specialized family care home when the behavioral needs of the member arise due to the temporary to change in environment.
- Person-Centered Support: *Personal Options* is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.
- Person-Centered Support: *Personal Options* cannot replace the routine care, and supervision which is expected to be provided to biological, adoptive or foster children or adults by a parent or a Specialized Family Care Provider.
- Person-Centered Support: *Personal Options* may not substitute for federally mandated educational services.
- A member's representative may not be a paid employee providing *Personal Options* IDDW services to the member.
- Spouses are excluded from providing Person Centered Support: *Personal Options* services.

513.17.2 Home-Based Agency Person-Centered Support

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

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

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

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

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

Home-Based Agency Person-Centered Support services must be assessment based and outlined on the IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs and within their individualized budget.

Home-Based Agency Person-Centered Support services may include training specific to the member.

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

Home-Based Agency Person-Centered Support Direct-Support Professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the member or their legal representative.

Procedure Code: S5125-U7 1:1 ratio
S5125-U8 1:2 ratio
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the family residence of the member, a specialized family care home, and/or in the local public community. This service may not be provided in a direct-support professional's home.

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

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

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

Home-based Agency Person-Centered Support Direct-Support Professionals will be subject to usage of the EVV utilization and all corresponding requirements.

Limitations/Caps:

- The amount of service is limited by the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Home-Based Agency Person-Centered Support services cannot exceed 7,320 units/1,830 hours (based upon average of five hours per day) per IPP year for natural family/specialized family care home settings for members under age 18. This is in combination with the following direct support services: all other types of Person-Centered Support and crisis intervention.
- The maximum annual units of Home-Based Agency Person-Centered Support services cannot exceed 11,680 units/2,920 hours (based upon average of eight hours per day) per IPP year for natural family/specialized family care home settings for members aged 18 and older. This is in combination with the following direct support services: all other types of Person-Centered Support, LPN, crisis intervention, and electronic monitoring.
- All direct support services cannot exceed an average of 12 hours per day on days when Facility-Based Day Habilitation, job development, pre-vocational, and/or supported employment services are provided.
- This service may not be billed concurrently with any other direct support service.
- The ratios of staff members to member are 1:1 and 1:2 for this service.
- The amount of Home-Based Agency Person-Centered Support provided must be identified on the IPP.
- Direct-support professionals providing Home-Based Agency Person-Centered Support services may not live in the home of the member.
- Home-Based Agency Person-Centered Support is not available while the member is hospitalized in a Medicaid-certified hospital, except for members who live in an Unlicensed Residential Home, Licensed Group Home or specialized family care home when behavioral needs of the member arise due to the temporary to change in environment.
- Home-Based Agency Person-Centered Support is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.
- Home-Based Agency Person-Centered Support services cannot replace the routine care, and supervision which is expected to be provided to biological, adoptive or foster children or adults by a parent or Specialized Family Care Provider. The IDT must make every effort to meet the assessed needs as identified on the annual functional assessment, of the member through natural supports.
- Home-Based Agency Person-Centered Support may not substitute for federally mandated educational services.
- Spouses are excluded from providing Home-based Agency Person-Centered Support services.

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

Licensed Group Home Person-Centered Support is provided to adults aged 18 and older who live in a site licensed by the Office of Health and Health Facility Licensure and Certification (OHFLAC) by awake and alert Direct Support Professionals and consists of individually tailored training and/or support activities that enable the person who receives services to live and inclusively participate in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person who receives services to have greater independence and personal choice, and to allow for maximum inclusion into their community.
This service is limited to not more than four individuals per setting. Eight licensed group homes have been grandfathered in under the new Integrated Settings Rule and these eight sites may continue to serve more than four individuals. Contact BMS for a list of those specific sites.
Licensed GH, Person-Centered Support may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for independent living.

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

Licensed GH, Person-Centered Support services must be assessment based and outlined on the IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs.

Licensed GH, Person-Centered Support services may include on-site training specific to the member. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is permitted if requested by the member or their legal representative.

Licensed Group Home Person-Centered Support direct-support professionals may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the member are not compromised.

Staff providing Licensed GH, Person-Centered Support cannot be a family member of the member. For the purposes of providing Licensed GH, Person-Centered Support services, family members include biological/adoptive parents or step-parents, biological/adoptive adult siblings or step-siblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/-uncles only. Spouses of members are excluded from providing services.

Procedure Code: S5125-U1 1:1 ratio

S5125-U2 1:2 ratio
S5125-U3 1:3 ratio
S5125-U4 1:4 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

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

Limitations/Caps:

- The amount of service is limited by the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to adults aged 18 and older.
    - The maximum annual units of Licensed Group Home Person-Centered Support services cannot exceed 35,040 units/8,760 hours (based upon average of 24 hours per day) per IPP year. This is in combination with the following direct support services: all other types of

Person-Centered Support, LPN, Crisis Intervention, Facility-Based Day Habilitation, Pre-vocational, job development, supported employment, and electronic monitoring.
    - All requests for more than an average of 12 hours per day of 1:1 service require BMS approval. Approval of this level of service will be based on demonstration of assessed need not a particular residential placement.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff members to members are 1:1, 1:2, 1:3, and 1:4 for this service.
- The amount of Licensed GH, Person-Centered Support provided must be identified on the IPP.
- Licensed Group Home Person-Centered Support is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.
- All people residing together in one of these settings must be served by the same IDDW residential provider.

513.17.4 Unlicensed Residential Person-Centered Support

513.17.4.1 Unlicensed Residential Person-Centered Support (Traditional Option)

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

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

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for independent living.

Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED.

Unlicensed Residential Person-Centered Support services must be assessment based and outlined on the IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs and within their individualized budget.

Unlicensed Residential Person-Centered Support services may include on-site training specific to the member. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is permitted if requested by the member or their legal representative.

Unlicensed residential person-centered support direct-support professionals may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the member are not compromised.

Unlicensed residential person-centered support direct-support professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the member or their legal representative.

Direct-support professionals providing Unlicensed Residential Person-Centered Support cannot be a family member of the member. For the purposes of providing Unlicensed Residential Person-Centered Support services, family members include biological/adoptive parents or step-parents, biological/adoptive adult siblings or step-siblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/-uncles only. Spouses of members are excluded from providing services.

Procedure Code:	S5125-HI 1:1 ratio S5125-UN 1:2 ratio S5125-UP 1:3 ratio
Service Units:	Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
Site of Service: This service may be provided in an Unlicensed Residential Home and/or in the local public community.

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

- Name of the member
- case management provider name
- Month of Service
- Year of Service
- Day of Service
- Service Code including modifier to indicate staff to member ratio
- Start time

- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff member

Limitations/Caps:

- The amount of service is limited by the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to adults aged 18 and older.
    - The maximum annual units of Unlicensed Residential Person-Centered Support services cannot exceed 35,040 units/8,760 hours (based upon average of 24 hours per day) per IPP year. This is in combination with the following direct support services: all other types of Person-Centered Support, LPN, Crisis Intervention, Facility-Based Day Habilitation, Pre-vocational, job development, supported employment, and electronic monitoring.
    - All requests for more than an average of 12 hours per day of 1:1 services require BMS approval. Approval of this level of service will be based on demonstration of assessed need not on a particular residential setting.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff members to members are 1:1, 1:2, and 1:3 for this service.
- The amount of Unlicensed Residential Person-Centered Support provided must be identified on the IPP.
- Unlicensed Residential Person-Centered Support is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.
- This service is limited to no more than three individuals per setting; note that, other than siblings, individuals must be non-related.
- Unlicensed Residential Person-Centered Support cannot be provided in a setting owned or leased by an IDDW provider.
- All people residing together in one of these settings must be served by the same IDDW residential provider.

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

Unlicensed Residential Person-Centered Support: *Personal Options* is provided to adults aged 18 and older in an Unlicensed Residential Home and/or in the local public community. Unlicensed Residential Person-Centered Support: *Personal Options* is provided by awake and alert staff who **do not live in the home with the member** and consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in their community. The activities and environments are

designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence and personal choice, and to allow for maximum inclusion into their community.

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

- Self-care;
- Receptive or expressive language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for independent living.

Unlicensed Residential Person-Centered Support: *Personal Options* services must be assessment based and outlined on the IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs.

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

Unlicensed Residential Person-Centered Support: *Personal Options* staff may compile data collected in daily documentation during their shift for later review by the BSP, as long as safety/health and oversight of the member are not compromised.

Staff providing Unlicensed Residential Person-Centered Support: *Personal Options* cannot be a family member of the member. For the purposes of providing Unlicensed Residential Participant-Directed Support services, family members include biological/adoptive parents or step-parents, biological/adoptive adult siblings or step-siblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/-uncles only. Spouses of members are excluded from providing services.

Procedure Code: S5125-UD 1:1 ratio
Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

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

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

Limitations/Caps:

- The amount of service is limited by the individualized participant-directed budget and spending plan except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2..
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to adults aged 18 and older.
    - The maximum annual units of Unlicensed Residential Person-Centered Support: *Personal Options* services cannot exceed 35,040 units/8,760 hours (based upon average of 24 hours per day) per IPP year. This is in combination with the following direct support services: all other types of Person-Centered Support, LPN, crisis intervention, Facility-Based Day Habilitation, pre-vocational, job development, supported employment, and electronic monitoring.
    - All direct-support services cannot exceed the equivalent monetary value of an average of 12 hours per day on days when Facility-Based Day Habilitation, Job Development, Pre-vocational, and/or Supported Employment services are provided.
    - All requests for more than an average of 12 hours per day of 1:1 services require BMS approval. Approval of this level of service will be based on demonstration of assessed need.
- This service may not be billed concurrently with any other direct care service.
- The ratio of staff member to member is 1:1 for this service.
- The amount of Unlicensed Residential Person-Centered Support: *Personal Options* provided must be identified on the IPP.
- Units/funds of authorized Unlicensed Residential Person-Centered Support: Personal Options may not be used to access additional Extended Therapies: *Personal Options*, Environmental Accessibility-Vehicle and Home: *Personal Options* or PDGS.
- Unlicensed Residential Person-Centered Support: *Personal Options* is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities located either within or outside of a medical hospital.

- This service is limited to no more than three individuals per setting; note that, other than siblings, individuals must be non-related.
- Unlicensed Residential Person-Centered Support: *Personal Options* cannot be provided in a setting owned or leased by an IDDW provider.

513.17.5 Crisis Site Person-Centered Support (Traditional Option)

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

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

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

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

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

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

Procedure Code:	T1005-U7 1:1 ratio
	T1005-U8 1:2 ratio
	T1005-U9 1:3 ratio
Service Unit:	Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on specific assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

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

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

Limitations/Caps:

- The amount of service is limited by the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- Prior authorization will only be provided for up to 2,880 units/720 hours (based upon an average of 24 hours per day for 30 days) at a time.
- The maximum annual units of Crisis Site services may not exceed 17,280 units/4,320 hours (based upon an average of 24 hours per day for 180 days) per IPP year. This is in combination with the following direct support services: *Person-Centered Support, Day Services, LPN, Crisis Intervention and Electronic Monitoring*.
- An equivalent reduction in other authorized Direct-Support Professional services must be made in UMC's web portal to off-set the number of units of Crisis Site services requested.
- Form WV-BMS-IDD-12 must be submitted by the case manager to the UMC within 72 hours of admission.
- The ratios of staff members to member are 1:1, 1:2, and 1:3 for this service.
- This service may not be billed concurrently with any other direct support service.
- Crisis Site services must be prior authorized by the UMC. Under emergent circumstances which place the health and safety of the member or others at risk, Crisis Site services may be immediately implemented without prior authorization up to a maximum of 72 hours.

513.18 RESPITE

There are two types of Respite services available under the Traditional Option, each of which is described in detail in its specific section, below. Not all forms of respite are paid services. The two types are:

1. In-Home Respite*
2. Out-of-Home Respite*

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

513.18.1 In-Home Respite

513.18.1.1 In-Home Respite (Traditional Option)

In-Home Respite services provided by awake and alert Direct-Support Professionals are specifically designed to provide temporary substitute care normally provided by a family member or a specialized family care provider. The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. In-Home Respite services consist of temporary care services for an individual who cannot provide for all of their own needs. Members providing In-Home Respite services may participate in person-centered planning.
In-Home Respite services may be used to:

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

Direct-support professionals providing In-Home Respite services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the member or their legal representative.

Procedure Code: T1005-UA 1:1 ratio
T1005-UB 1:2 ratio
Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the family residence of the member, a specialized family care home where the member resides, and public community locations.

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

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

If a BSP is involved in training plans carried out by the Respite staff member, documentation is completed through those training plans per the IPP. This documentation must be maintained by the member/employer and provided to the BSP as needed for oversight of training programs.
In-home Respite direct-support professionals will be subject to usage of the EVV utilization and all corresponding requirements.

Limitations/Caps:

- The amount of service is limited by the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of In-Home Respite service may not exceed 3,650 units/912 hours (based upon average of 2.5 hours/ day) per IPP year. This is in combination with the following direct support services: Out-of-Home Respite, In-Home Respite: *Personal Options,* and Out-of-Home Respite: *Personal Options*.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff member to member are 1:1 and 1:2 for this service.
- The amount of In-Home Respite must be identified on the IPP.
- Direct-support professionals providing In-Home Respite services may not live in the home of the member.
- In-Home Respite is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities located either within or outside of a medical hospital.

- In-Home Respite services are not available to members living in unlicensed residential home or licensed GH settings.
- In-Home Respite services may not be provided by a spouse of a member or any other individual living in the home of the member.
- In-Home Respite services are not to replace natural supports, and cannot be provided by biological or adoptive parents or step-parents.
- In-Home Respite services may not be provided in an ICF/IID facility.
- The primary caregiver may not provide Respite for any other member at the same time that the member the primary caregiver is responsible for is also receiving services. For example: Primary Caregiver A is responsible for Member B. Primary Caregiver C is responsible for Member D. Primary Caregiver A cannot provider respite to Member D while Primary Caregiver C provides respite for Member B.

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

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

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

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

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

Procedure Code: T1005-UD 1:1 ratio
Service Unit: Unit = 15 minutes

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

services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2. The annual budget for participant-directed services is determined following the purchase of Traditional services.

Site of Service: This service may be provided in the family residence of the member, a specialized family care home where the member resides, and/or public community locations.

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

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

If a BSP is involved in training plans carried out by the Respite staff member, documentation is completed through those training plans per the IPP. This documentation must be maintained by the member/employer and provided to the BSP as needed for oversight of training programs.
In-home Respite direct-support professionals will be subject to usage of the EVV utilization and all corresponding requirements.

Limitations/Caps:

- The amount of service is limited by the individualized participant-directed budget and spending plan.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of In-Home Respite*: Personal Options* services are limited to the equivalent monetary value of 3,650 units/912 hours (based upon average of 2.5 hour per day) per IPP year. This is in combination with the following direct support services: Out-of-home Respite, In-home Respite, and Out-of-Home Respite: *Personal Options*.
- This service may not be billed concurrently with any other direct-support service.
- The ratio of staff member to member is 1:1 for this service.
- The amount of In-Home Respite: *Personal Options* must be identified on the IPP.
- In-Home Respite service units/funds may not be transferred to access additional units of any other Personal Options service except Out-of-Home Respite – *Personal Options*.
- Staff providing In-Home Respite: *Personal Options* may not live in the home of the member or within the specialized family care home where the member resides.

- In-Home Respite: *Personal Options* is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities located either within or outside of a medical hospital.
- In-Home Respite: *Personal Options* services are not available to members living in unlicensed residential home or licensed GH settings.
- In-Home Respite: *Personal Options* services may not be provided by a spouse of a member or any other individual living in the home of the member.
- In-Home Respite: *Personal Options* services are not to replace natural supports, and cannot be provided by biological or adoptive parents or step-parents.
- In-Home Respite: *Personal Options* services may not be provided in an ICF/IID facility.
- The primary caregiver may not provide Respite for any other member receiving services at the same time that the member the primary caregiver is responsible for is also receiving services. For example: Primary Caregiver A is responsible for Member B. Primary Caregiver C is responsible for Member D. Primary Caregiver A cannot provider respite to Member D while Primary Caregiver C provides respite for Member B.
- The equivalent monetary value for In-Home Respite: *Personal Options* services cannot be used to access additional units of any other Personal Options service except for Out-of-Home Respite: *Personal Options.*

513.18.2 Out-of-Home Respite

513.18.2.1 Out-of-Home Respite (Traditional Option)

Out-of-Home Respite services are provided out of the home where the individual resides and are provided by awake and alert direct-support professionals are specifically designed to provide temporary substitute care normally provided by a family member or a specialized family care provider. Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the member, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the member is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver. Not all forms of respite are paid services. Anytime the primary caregiver can get a break from providing care, then this a form of respite. The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Out-of-Home Respite services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing Out-of-Home Respite services may participate in person-centered planning.

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

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

Direct-support professionals providing Out-of-Home Respite services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the member or their legal representative.

Procedure Code: T1005-U1 1:1 ratio
T1005-U5 1:2 ratio
T1005-U6 1:3 ratio
Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in a specialized family care home in which the member **does not** reside, licensed facility-based day programs, licensed pre-vocational centers, and/or public community locations.

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

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

Out-of-home respite direct-support professionals will be subject to usage of the EVV and NPI number utilization and all corresponding requirements.

Limitations/Caps:

- The amount of service is limited by the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Out-of-Home Respite service may not exceed 3,650 units/912 hours (based upon average of 2.5 hours/ day). This is in combination with the following direct support services: In-Home Respite, In-Home Respite: *Personal Options,* and Out-of-Home Respite: *Personal Options*.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff member to member are 1:1, 1:2, and 1:3 for this service.
- The amount of Out-of-Home Respite must be identified on the IPP.
- Direct-support professionals providing Out-of-Home Respite services may not live in the home of the member.
- Out-of-home respite is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities located either within or outside of a medical hospital.
- Out-of-home respite services are not available to members living in an unlicensed residential home or licensed GH settings.
- Out-of-home respite services may not be provided by a spouse of a member or any other individual living in the home of the member.
- Out-of-home respite services are not to replace natural supports, and cannot be provided by biological or adoptive parents or step-parents.
- Out-of-home respite services may not be provided in an ICF/IID facility.
- Out-of-home respite services may not be provided to individuals under the 18 years of age in a Facility-Based Day Habilitation program or a Pre-Vocational Center.
- The primary caregiver may not provide respite for any other member receiving services at the same time that the member the primary caregiver is responsible for is also receiving services. For example: Primary Caregiver A is responsible for Member B. Primary Caregiver C is responsible for Member D. Primary Caregiver A cannot provider respite to Member D while Primary Caregiver C provides respite for Member B.

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

Out-of-Home Respite: *Personal Options* services provided out of the home where the member resides by awake and alert staff are specifically designed to provide temporary substitute care normally provided by a family member or a specialized family care provider. Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the member, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the member is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver. Not all forms of respite are paid services. Anytime the primary caregiver can get a break from providing care, then this a form of respite. The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Out-of-Home Respite: *Personal*

Options services consist of temporary care services for an individual who cannot provide for all of their own needs. Persons providing Out-of-Home Respite: *Personal Options* services may participate in person-centered planning.

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

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

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

Procedure Code: T1005-UC 1:1 ratio
Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment, and services must be within the individualized budget of the member, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2. The annual budget for participant-directed services is determined following the purchase of Traditional services.

Site of Service: This service may be provided in a specialized family care home in which the member **does not** reside and/or public community locations.

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

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

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

Out-of-Home Respite Direct-Support Professionals will be subject to usage of the EVV and National Provider Identifier (NPI) number utilization and all corresponding requirements.

Limitations/Caps:

- The amount of service is limited by the individualized participant-directed budget and spending plan.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Out-of-Home Respite: *Personal Options* services are limited to the equivalent monetary value of Traditional Respite of 3,650 units/912 hours (based upon average of 2.5 hour per day) per IPP year when transferring funds from the annual budget allocation to the Participant-Directed budget. This is in combination with the following direct support services: Out-of-Home Respite, In-Home Respite, and In-Home Respite: Personal Options.
- This service may not be billed concurrently with any other direct support service.
- The ratio of staff member to member is 1:1 for this service.
- The amount of Out-of-Home Respite: *Personal Options* must be identified on the IPP.
- Out-of-Home Respite service units/funds may not be transferred to access additional units of any other Personal Options service except In-Home Respite – *Personal Options*.
- Staff providing Out-of-Home Respite: *Personal Options* may not live in the home of the member or within the specialized family care home where the member resides.
- Out-of-Home Respite: *Personal Options* is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities located either within or outside of a medical hospital.
- Out-of-Home Respite: *Personal Options* services are not available to members living in an unlicensed residential home or licensed GH settings.
- Out-of-Home Respite: *Personal Options* services may not be provided by a spouse of a member or any other individual living in the home of the member.
- Out-of-Home Respite: *Personal Options* services are not to replace natural supports, and cannot be provided by biological or adoptive parents or step-parents.
- Out-of-Home Respite: *Personal Options* services may not be provided in an ICF/IID facility.
- Out-of-Home Respite: *Personal Options* services may not be provided to individuals under the 18 years of age in a Facility-Based Day Habilitation program or a Pre-Vocational Center.
- The primary caregiver may not provide Respite for any other member at the same time that the member the primary caregiver is responsible for is also receiving services. For example: Primary Caregiver A is responsible for Member B. Primary Caregiver C is responsible for Member D. Primary Caregiver A cannot provider respite to Member D while Primary Caregiver C provides respite for Member B.
- The equivalent monetary value for Out-of-Home Respite: *Personal Options* services cannot be used to access any other Personal Options services except for In-Home Respite: *Personal Options.*

513.19 CASE MANAGEMENT

513.19.1 Case Management (Traditional Option)

Case Management services establish, along with the member, a life-long, person-centered, goal-oriented process for coordinating the supports (both natural and paid), range of services, instruction and

assistance needed by persons with developmental disabilities. It is designed to ensure accessibility, accountability and continuity of support and services. This service also ensures that the maximum potential and productivity of a member is utilized in making meaningful choices with regard to their life and their inclusion in the community. All IDDW services purchased, however, must be within their annual individualized budget.

Once the member/legal representative has chosen a case management provider from the available IDDW providers, the agency assigns a case manager to the member. The member/legal representative may request the assignment of a specific case manager and when possible, the agency honors the request. The member/legal representative may choose to transfer to a different case management provider for any reason and the transfer will be effective on the first of a following month. The member will have choice of case management agency and choice of provider agency(s). Unless prior approval is granted, no case management agency may provide other Home and Community Based Services (HCBS) for a member, whether those services are funded by Medicaid or another funding source. A case management agency may be approved to provide other HCBS services only when there is no other willing and qualified case management providers with capacity within a 25 mile radius of the member's home or there are no other willing and qualified case management providers who have a common language or cultural background with the member. Religion is not considered a reason for approval of a cultural background exception.

The case manager must inform the member or their legal representative of all licensed IDDW agency providers who serve the region where the member resides. This is to ensure the member, or their legal representative, have a free choice of providers. At the annual functional assessment, the UMC will inform the member and their legal representative of case management agencies that serve the county in which the member lives.

The following safeguards must be in place to ensure that service plan development is conducted in the best interests of the member when an IDDW agency has been approved to provide both case management and other HCBS to a member:

- The agency must have separate files for case management and other HCBS. It is the responsibility of the agency director to ensure separate file maintenance.
- The case management offices are in a separate location from the other HCBS services (may be in same building, but physically separated).
- There shall be no sharing of supervisory staff between the case management and HCBS services.
- The case manager may not provide any other HCBS services to the member.
- The case manager must have documentation from BMS or their designee for the approved request due to 25-mile radius, language or cultural background.
- West Virginia will monitor the conflict free services through quality reviews conducted by the Administrative Services Organization (ASO).
- Case managers must remain neutral during the development of the IPP and including the requirement that the IDD agency separate HCBS from case management services into distinct functions, with separate oversight.
- IDDW agencies must have a policy to ensure how the agency ensures that the case manager is free from influence of other HCBS service providers regarding member Plans of Care.
- Any case manager working for an agency that will also be providing other HCBS services will sign a Conflict of Interest Assurance form and the completed form must be placed in the case

manager's personnel file. Failure to have the form in the file when reviewed will result in sanctions including disallowance of units billed.
- Evidence of administrative separation on organizational chart that includes position titles and names of staff must be available to BMS or their designee during quality reviews or upon request.

The agency owner/administrator must also sign an Attestation/Conflict of Interest Application for Home and Community Based Waiver services that includes, at a minimum, the following:

- The agency has administrative separation of supervision of case management and HCBS.
- Members are offered choice for HCBS between and among available service providers. Members are not limited to HCBS provided only by this agency.
- Members are free to choose or deny HCBS without influence from the case management or HCBS staff.
- Members choose how, when, and where to receive their approved HCBS in accordance with the person-centered service planning process and plan.
- Members are free to communicate grievance(s) regarding Case Management or HCBS delivered by the agency.
- The grievance/complaint procedure is available, clear and understood by members and legal representatives.
- Grievances/complaints are resolved in a timely manner by giving the member the opportunity to file a grievance/complaint with the Agency. If the grievance/complaint is not resolved, then the member is given the opportunity to present their case to the UMC for resolution.

Conflict of Interest standards and policy apply to all agents, individuals and agency entities, public or private. At a minimum, the agency case manager, and the agency owner cannot be related by blood or marriage to the member or to any paid caregiver of the member, cannot be financially responsible for the member, cannot be empowered to make financial or health decisions for the member, and cannot hold financial interest in any entity paid to provide services to the member. Failure to abide by Conflict of Interest policy and standards will result in the loss of case management certification for the provider involved in the conflict of interest for a period of one year and all current members being served by the suspended provider will be transferred to other case management agencies. Any case manager who knowingly violates Conflict of Interest policy or standards will be referred to their professional licensing board for a potential violation of ethics. (BMS notes that whether any action is taken would be within the sole discretion of the particular licensing board and depend upon its specific ethical rules). Reports of failure to abide by this Conflict of Interest policy will be investigated by the UMC and the results of this investigation will be reported to BMS for review and possible action. Additionally, cooperating agencies must have an MOU that addresses liability issues.
The case manager must, at a minimum, perform the following activities listed below.

- Assist the member and/or legal representative with re-determination of financial eligibility as required at the DoHS office in the county where the member lives.
- Begin the discharge process and provide linkage to services appropriate to the level of need when a member is found to be ineligible for IDDW Services during annual eligibility or financial redetermination.
- Assist with procurement of Person-Centered services that are appropriate and necessary for each member within and beyond the scope of the IDDW Program including annual medical and other evaluations as applicable to the member.

- Act as an advocate for the member. The IDDW Program must not be substituted for entitlement programs funded under other Federal public laws such as Special Education under P.L.99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers). Therefore, it is necessary for the case manager 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 UMC on behalf of the member in regard to the assessment process, purchase of services and budget process. Activities may include linkage, negotiation of services, submission of information, coordination of choice of appropriate assessment respondents on behalf of the member, education and coordination of the most appropriate assessment setting that best meets the member's needs.
- Purchase services to obtain authorizations or modify existing authorizations within 7 days of the IDT meeting or team's approval of a service plan addendum.
- Communicate with other service providers on the IDT to allow for continuity of services and payment of services.
- Coordinate necessary evaluations to be utilized as a basis of need and recommendation for services in the development of the IPP.
- Coordinate with and notify IDT members at least 30 days in advance of meeting.
- Support the member as necessary to convene and conduct IDT meetings using Person-Centered thinking and planning strategies.
- Document all services, both paid and unpaid, from any and all programs on the IPP.
- Review schedules of all programs used by the member to ensure that times and tasks do not overlap or duplicate.
- Coordinate the development of IPPs at least annually. The IPP must be reviewed and approved by the IDT at least every 90 days unless otherwise specified in the plan, but shall not exceed 180 days. NOTE: Services cannot be provided without a valid IPP. In the event that an IDT cannot meet within required timeframes, an exception can be requested by submitting form WV-BMS-IDD-12 to the UMC. Exceptions will be approved for member-related reasons, such as hospitalization, illness, or other emergency. Without an approved exception, services may not be provided without an authorization.
- Access the necessary resources detailed in the IPP, make referrals to qualified service providers and resources, and monitor that service providers implement the instructional, behavioral and service objectives of the IPP.
- Disseminate copies of all IPPs to the IDT members and Participant-Directed service Option providers (if applicable) within 14 calendar days of the IDT meeting.
- Upload any required documentation into the UMC's web portal within 14 calendar days of the IDT meeting. NOTE: No services will be prior authorized until the current IPP is loaded into the web portal.
- Upload into the UMC's web portal any additional documentation requested by BMS or the UMC.
- Disseminate copies of the budget sheet from the IDDW CareConnection© website, once finalized.
- Monitor to ensure that the member's health and safety needs are addressed.

- Comply with reporting requirements of the WV IMS for members on their caseload.
- Personally, meet monthly with the member and their paid or natural supports that are present with the member the time of the visit at the member's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented. The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the case manager Home/Day Visit Form (WV-BMS-IDD-03).
- Check with the BMS fiscal agent monthly to verify financial eligibility.
- Personally meet at least quarterly month with the member and their support staff at the member's facility-based day program or pre-vocational center (if applicable). The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identification of unmet needs. The visit is documented on the case manager Home/Day Visit Form (WV-BMS-IDD-03).
- The case manager is responsible for the development of the Crisis Plan which is to identify the entity/individual responsible for responding to each type of crisis reflected in the plan, and notify all appropriate parties if a member is admitted to a crisis site or state institution.
- Process Freedom of Choice forms (WV-BMS-IDD-2) in the UMC's web portal within two business days any time a member requests a change of case management agency, service provider agency, and/or Service Delivery Models.
- Coordinate Transfer/Discharge meetings to ensure the linkage to a new case management agency, service provider agency, or Service Delivery Model and access to services when transferring services from one provider agency to another or to another type of service delivery model. Coordination efforts must continue by the current case management provider until the transfer of services is finalized.
- Travel as necessary to complete case management activities related to the IPP.
- Provide information and assistance regarding participant-directed services during annual IPP meetings and upon request by the member or legal representative.
- Inform the member, in writing, of their rights at least annually.
- Attend and participate in the annual functional assessment for eligibility conducted by UMC.
- Monitor any restrictive measures approved by the HRC to ensure the measures are implemented properly and reviewed at least annually by the HRC and by the IDT at every IDT meeting.
- Attend and contribute to Futures Planning sessions, including, but not limited to, PATHs and MAPs.

Failure to consistently carry out the required Case Management activities may result in sanctions against the agency including referral/admissions ban, reduction in case load size, and disenrollment as an IDD waiver provider.

Procedure Code: G9002-U3 case management Natural Family & SFC
G9002-U4 case management ISS & Group Home
Service Unit: Unit = Per member/Per month

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

Documentation: A progress log for each service is required each month, including when any type of IDT meeting is held. Documentation must include all of the following items.

- Case management agency
- Member name
- Date of service
- Start time
- Stop time
- Summary of the service provided
- Signature and credentials of the agency staff
- Service code

Case managers will be subject to usage of the EVV utilization and all corresponding requirements to record monthly home visits.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 12 units/12 events (one per month) per member's annual IPP year.
- A member may only have one case manager assigned at one time. In the event of a transfer from one case management provider to another case management provider, the effective date of the transfer must fall on the 1st day of the month following the "transfer-to" agency's acceptance of the referral. The "transfer from" agency must finalize documentation related to member services but will not be able to bill during this time.
- Agency staff providing case management services may not be an individual who lives in the member's home.
- Case management cannot be billed for the entire calendar month if a home visit did not occur within that calendar month unless an approved WV-BMS-IDD-12 is on file.
- The case management agency cannot provide any direct care services for the member for whom they provide case management services.

513.20 SKILLED NURSING

513.20.1 Skilled Nursing Licensed Practical Nurse (Traditional Option)

LPN services listed in the service plan must be within the scope of West Virginia's Nurse Practice Act, ordered by a physician and are provided by an LPN under the supervision and monitoring of a RN actively licensed to practice in the State. LPN services are available to people who are aged 21 or older,

as children with significant medical issues can access Private Duty Nursing via the Medicaid State Plan. This service can only be used for activities that require a nurse to complete according to the WV Nurse Practice Act, however, any medication administration and performance of health care maintenance tasks as described in W. Va. CSR §64-60-1 et seq. should be provided by a trained Approved Medication Assistive Personnel. If the LPN performs these tasks, then the LPN must drop down and bill the appropriate direct care code for Person-Centered Support or Day Services. Nursing services that must be provided by an awake and alert LPN include but are not limited to:

- Verifying and documenting physician orders if only RNs or LPNs are administering medication (no AMAPS are administering medications);
- Order medications per physician orders;
- Reviewing and verifying physician orders are current, properly documented and communicated to direct care staff and others per IDDW provider policy;
- Direct nursing care including medication/treatment administration unless the medications/treatments are described in W. Va. CSR § 64-60-1 et seq.;
- Review of Medication Administration Records (MARs), medication storage and documentation (when no AMAPs are administering medication);
- Review scheduled medical appointments before occurrence and communicate this information to others per IDDW provider policy;
- Facilitate procurement of and monitoring of medical equipment;
- Train members on individualized medical and health needs, such as wound-care, medically necessary diets, etc.;
- Collect medical data for RN assessment (seizure logs, sleep logs, food logs, etc.);
- Obtain informed consent;
- Update emergency sheets; and
- Consult with RN regarding member specific issues when a medical need arises.

Note: If these services are provided by an RN, then the LPN code must be billed for reimbursement unless it is a service that may be provided by an AMAP then it must be billed at the Person-Centered Support rate.

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

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

Procedure Code:	T1003-U4 1:1 ratio
	T1003-U3 1:2 ratio
	T1003-U2 1:3 ratio
Service Unit:	Unit = 15 minutes

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

must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2. A complete and accurate DD-9 must be submitted to the UMC for all skilled nursing prior authorization requests. A checklist and instructions are provided on the IDD Waiver website.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed GH, an unlicensed residential home, a licensed day program facility or pre-vocational center, crisis sites and public community locations.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is only available for adults aged 21 and older. If an individual 18 years of age and older receives any type of Day Services or resides in an ISS or licensed GHs then the service is also available.
- This service can only be used for activities that require a nurse to complete according to the WV Nurse Practice Act and may not be provided by an approved AMAP.
- The maximum annual units of LPN services cannot exceed 2,920 units/730 hours (based upon an average of two hours per day) per member's annual IPP year of which 240 units may be used to complete indirect tasks for individuals over the age of 18 and attending day services and/or residing in an ISS/GH setting. Indirect tasks are defined as scheduling doctor appointments, pulling off doctor orders, etc. Under extraordinary circumstances documented on WV-BMS-IDD-09, the LPN units may be approved up to 11,680 units/2920 hours (average eight hours/day) per member's annual IPP year or the monetary equivalent of 8 hours of 1:1 LPN service when alternate LPN service ratios are used. This is in combination with all other direct care services (Person-Centered Support, Day Services, Crisis Intervention and Electronic Monitoring).
- All LPN services provided must be within the scope of practice for Licensed Practical Nurses. If an LPN provides a service that is not within the scope of the WV Nurse Practice Act (such as taking vital signs, providing personal hygiene, comfort, nutrition, ambulation and environmental safety and protection), it will be considered a Person-Centered Support or Respite service and must be billed as such.
- This service may not be billed concurrently with any other direct care services.
- Agency staff to member ratio codes are 1:1, 1:2 and 1:3.
- Staff members providing Skilled Nursing LPN services may not be an individual who lives in the member's home.
- LPN services may not be billed for completing administrative activities, including:
    - Attempting phone calls when the line is busy or leaving a message.
    - Nursing assessments required by the IDDW provider but not the IDD Waiver manual.
    - Waiting at a physician's office.
    - Conducting group training on general medical topics.
    - Orientation training that is not member-specific.

- Reviewing incident reports.
- Travel.

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

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

513.20.2 Skilled Nursing Licensed Registered Nurse (Traditional Option)

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

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

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

The RN may attend and participate in the IPP and the annual functional assessment for eligibility conducted by UMC based upon the member or their legal representative's request.
Direct-care services provided by the RN must be billed utilizing the appropriate direct care service code.

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

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

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

Procedure Code: T1002-HI 1:1 ratio
Service Unit: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2. A complete and accurate WV-BMS-IDD-09 must be submitted to the UMC for all skilled nursing prior authorization requests. A checklist and instructions are provided on the IDD Waiver website.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed GH, an unlicensed residential home, a licensed day program facility or pre-vocational center, crisis sites and public community locations.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 480 units/120 hours per member's annual IPP year.
- The agency staff to member ratio for this service is 1:1.
- If the RN provides a skilled nursing service that is within the scope of practice for an LPN, the RN must utilize the LPN code/rate.
- Agency staff providing Skilled Nursing RN services may not be an individual who lives in the member's home.
- RN services may only be billed 30 days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/IID or another WV waiver program for planning purposes.
- Only RNs may bill to complete a WV-BMS-IDD-09.
- RN services may not be billed for completing administrative activities including these listed below.
    - Attempting phone calls when the line is busy or leaving a message.
    - Nursing assessments required by the IDDW provider but not the IDDW manual.
    - Waiting at a physician's office.
    - Reading LPN notes.
    - Conducting group training on general medical topics.
    - Orientation training that is not member-specific.
    - Reviewing incident reports.
    - Assessing LPN competency and providing support.
    - Travel.

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

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

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

Procedure Code: T2024-TD 1:1 ratio
Service Units: Unit = Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- Four Events per member's annual IPP year.
- Professional must attend all planning meetings, either face-to-face or by teleconference, but in order to bill the IPP Planning code, the professional must be physically present for the duration of IPP meeting. IPP cannot be billed for preparation prior or follow-up performed after the IPP meeting.
- Staff providing Skilled Nursing RN IPP services may not be an individual who lives in the member's home.
- Only one RN may bill for this service during an IDT meeting.

513.21 TRANSPORTATION

Members who receive IDDW services are required to access Non-Emergency Medical Transportation (NEMT) for non-IDDW Medicaid services, including doctor appointments. NEMT must be arranged through the state's contracted NEMT vendor.

513.21.1 Transportation Miles (Traditional Option)

Transportation: Miles services are provided to the IDDW member for trips to and from the member's home, licensed IDD Facility-based Day Habilitation Program, pre-vocational centers, job development activities or supported employment activities, or to the site of a planned activity or service which is addressed on the IPP and based on assessed need identified on the annual functional assessment.

This service may be billed concurrently with person-centered support services, respite, LPN, RN, supported employment and all day services.

Procedure Code: A0160-U1
Service Units: Unit = 1 mile

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

- Member's name
- Service code
- Date of service
- "From" location (Specific Site: example member's home)
- "To" location (Specific Site: example Beckley Walmart)
- Purpose of trip
- Total number of miles per trip

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

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Transportation: Miles cannot exceed 9,600 miles per member's annual IPP year (based on average of 800 miles per month).
- Member must be present in vehicle if mileage is billed. If more than one member is present in the vehicle, then the total mileage will be divided between the number of members present in vehicle.

- Must be related to a specific activity or service based on an assessed need as identified on the annual function assessment and documented in the IPP.
- May utilized up to 30 miles beyond the West Virginia border by members living in a West Virginia county bordering another state.

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

Transportation: Miles services are provided to the IDDW member for trips to and from the member's home, licensed IDD Facility-based Day Habilitation Program, pre-vocational, job development activities or supported employment activities, or to a community-based planned activity or service which is based on assessed need. This service may be billed concurrently with Person-Centered Support Services: *Personal Options* option or Respite: *Personal Options* option. The number of miles per service must be included on the member's IPP.

Procedure Code: A0160-U3
Service Units: Unit = 1 mile

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized participant-directed budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2. The annual budget for participant-directed services is determined following the purchase of Traditional Services.

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

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

- Member's name
- Date of service
- "From" location (Specific Site: example member's home)
- "To" location (Specific Site: example Beckley Walmart)
- Purpose of trip
- Total number of miles for the trip

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The program representative may not be billed to provide transportation services.

- The maximum annual units of transportation miles: *Personal Options* services are limited to the equivalent monetary value of Traditional Transportation Miles of 9,600 units (based upon average of 800 miles per month) per IPP year when transferring funds from the annual budget allocation to the Participant-Directed budget.
- The amount of transportation provided to a member directing their transportation services must be identified on the spending plan.
- The equivalent monetary value for Transportation Miles: *Personal Options* may be used to increase access to Person-Centered Support: *Personal Options* and Respite: Personal Options, but not Participant-Directed Goods and Services
- Member must be present in vehicle if mileage is billed. If more than 1 member is present in the vehicle, then the total mileage will be divided between the number of members present in vehicle.
- Must be related to an assessed need identified on the annual functional assessment and documented in the IPP.
- May be within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of West Virginia.

513.21.3 Transportation Trips (Traditional Option)

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

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

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

Procedure Code: A0120-HI
Service Units: Unit = 1 Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.

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

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

- Member's Name
- Service code

- Date of service
- "From" location (Specific Site: example member's home)
- "To" location (Specific Site: example Beckley Walmart)
- Purpose of trip
- Total number of miles for the trip

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

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum units of Transportation Trips cannot exceed two one-way trips per day or 520 trips annually.
- Member must be present in Agency-owned mini-van or mini-bus if trips are billed.
- A trip must be related to a specific activity or service based on an assessed need identified on the annual functional assessment and documented in the IPP.
- A trip may be billed concurrently with Person-Centered Support Services, Respite and any Day Services.

513.22 PRIOR AUTHORIZATIONS

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

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

513.23 BILLING PROCEDURES

Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement the amount of time documented in minutes must be totaled and divided by the minutes in a unit of service to arrive at the number of units billed. After arriving at the number of billable

units, billing must take place on the last date in the service range. Billing cannot be rounded more than once within a calendar month. **The billing period cannot overlap calendar months.**

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

513.24 PAYMENTS AND PAYMENT LIMITATIONS

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

With the exception of Case Management services, IDDW services may not be billed while an individual is receiving services as an inpatient in an ICF/IID facility, a state institution, nursing facility, rehabilitation facility, or psychiatric facility. Billing of Case Management when a member is temporarily in a facility and/or has been placed on hold status in order to facilitate returning to their home/community is limited to three months unless additional Case Management units have been prior approved.

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

513.25 RIGHTS AND RESPONSIBILITIES OF MEMBERS/LEGAL REPRESENTATIVES

513.25.1 Rights

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

- Members and/or their legal representatives have the right to choose between home and community-based services as an alternative to institutional care and a choice of Service Delivery Models by the UMC through the completion of a Freedom of Choice form (WV-BMS-IDD-2) upon enrollment in the program and at least annually thereafter.
- Members and/or their legal representatives have a choice of IDDW providers however, members must choose a Case Management agency that is separate from the agency(s) that provide other HCBS services unless a geographic, cultural background or common language exception is granted.
- Members and/or their legal representatives have a choice of Service Delivery Models.
- Members and/or their legal representatives have the right to address dissatisfaction with services through the IDDW provider's grievance procedure.

- Members directing their services through *Personal Options* will also have the right to address dissatisfaction regarding FMS. The *Personal Options* Vendor must have a procedure for responding to and tracking member complaints.
- Members or their legal representatives have the right to access the Medicaid Fair Hearing process consistent with state and federal law.
- Members have the right to be free from abuse, neglect and financial exploitation.
- Members and/or their legal representatives have the right to be notified and attend any and all of their IDT meetings, including critical juncture meetings.
- Members and/or their legal representatives have the right to choose who they wish to attend their IDT meetings, in addition to those attendees required by regulations.
- Members and/or their legal representatives have the right to obtain advocacy if they choose to do so.
- Members and/or their legal representatives have the right to file a complaint with the UMC regarding the results of their functional assessment.
- Members and/or their legal representatives have the right to have all assessments, evaluations, medical treatments, budgets and IPPs explained to them in a format they can understand, even if they have a legal representative making the final decisions in regard to their health care.
- Members and/or their legal representative have the right to make decisions regarding their services.
- Members have the right to receive reasonable accommodations afforded to them under the ADA.

513.25.2 Responsibilities

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

- To be present during IDT meetings. In extremely extenuating circumstances, the legal representative or other team members may participate by teleconferencing if they do not bill for the time spent in the IDT. The member **must** be present and stay for the entire meeting if they do not have a legal representative;
- To understand that this is an optional program and that not all needs may be able to be met through the services available within this program and a member's annual individualized budget.
- To participate and supply correct information in the annual assessments for determination of medical eligibility and individualized budget;
- To purchase services within their annual individualized budget or utilize natural or unpaid supports for services unable to be purchased, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2;
- To participate in re-determination of financial eligibility at their local DoHS as required;
- To comply with all IDDW policies including monthly home visits by the case manager;
- To implement the portions of the IPP for which they have accepted responsibility; and
- To maintain a safe home environment for all service providers; and
- To provide their case manager with income information so financial eligibility can be monitored; and

- To notify their case manager immediately if the member's living arrangements change, the member's needs change, the member is hospitalized or if the member needs to have a critical juncture meeting.

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

513.25.3 Grievances/Complaints

A member receiving services has the right to obtain oral and written information on the provider agency's (or F/EA if self-directing) rights and grievance policies. If the member or their legal representative is dissatisfied with the quality of services or the provider of service, it is recommended that they follow the IDDW provider agency's grievance process. If the issue is not resolved at this level, the member or legal representative may file a formal complaint with the UMC. The UMC will complete an investigation and report the results to BMS and to the member or their legal representative.

513.25.4 Appeals and Service Authorizations

513.25.4.1 Medical Re-Determination Eligibility Appeals

If a member is determined not to be medically eligible, then the UMC sends by certified mail to the member or their legal representative: a written Notice of Decision (termination), a Request for Hearing form that includes free legal resources and the results of the functional assessment. A notice is also sent to the member's case manager through the UMC's web portal. The termination may be appealed through the Medicaid Fair Hearing process if the Request for Hearing form is submitted to the Board of Review within 90 days of receipt of the Notice of Decision. If the member or legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted within 13 days of the member or their legal representative's receipt of the Notice of Decision. If the Request for Hearing form is not submitted within 13 days of the member or legal representative's receipt of the Notice of Decision, reimbursement for all IDDW services will cease.

After filing a request for a Medicaid Fair Hearing, the member receiving services, or their legal representative may also request a second medical evaluation (IPE). The second medical evaluation must be completed within 60 days by a member of the IPN. The case manager, upon notification of the eligibility decision, must begin the discharge process by arranging for a Transfer/Discharge IDT meeting to develop a "back-up" plan for transition because reimbursement for IDDW services will cease on the 13th day after receipt of the written Notice of Decision letter if the member or their legal guardian does not submit a Request for Hearing form.

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

A pre-hearing conference may be requested by the member or their legal representative any time prior to the Medicaid Fair Hearing and the UMC will schedule. If the member or the legal representative has obtained legal counsel, the BMS' legal counsel will conduct the pre-hearing. At the pre-hearing

conference, the member and/or their legal representative and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination.
If the denial of medical eligibility is upheld by the hearing officer, services that were continued during the appeal process must cease on the date of the hearing decision. If the member is eligible financially for Medicaid services without the IDDW Program, other services may be available for the individual. If the termination based on medical eligibility is reversed by the Hearing Officer, the individual's services will continue with no interruption.

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

513.25.4.2 Service Authorization Process

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

If determined medically eligible, the member or their legal representative and case management provider will receive an individualized budget calculated pursuant to the methodology which is available on BMS website

Once the member's budget has been calculated, the member will receive a notice each year that sets forth the member's individualized budget for the IPP year and an explanation for how the individualized budget was calculated.

The UMC, the member, the legal representative, the case manager, and any other members of the IDT that the member wishes to be present will attend the annual assessment. The UMC will work with the member and his or her team to complete three forms: the Inventory for Client and Agency Planning (ICAP), the Adaptive Behavior Assessment System II (ABAS II) and the Structured Interview.

The member and/or his legal representative shall sign an acknowledgment that they participated in the assessment, and were given the opportunity to review and concur with the answers recorded during the assessment. If the member or his legal representative declines to sign the acknowledgment for any reason (e.g., he or she does not believe the answers were recorded accurately), the member or their legal representative shall notify the UMC through their case manager within 5 days of the assessment date, and the UMC shall resolve the issue by conferring with the member and/or the legal representative to come to an agreement on the answers on the assessment. If the member or their legal representative still disputes the answers on the assessment, then the issue can be appealed through a Medicaid Fair Hearing. The Assessment Data Modification Request (WV-BMS-IDD-13) form must be fully completed must cite the items in question.

The member will receive notice of his or her budget calculation, which will include an explanation for how the budget was calculated and instructions for seeking services that cost in excess of the budget. The budget calculation is not a decision about the services the member will be eligible to receive.

The IDT must initially make every effort to purchase services for the member within the budget allocated by the UMC. As part of this effort, the IDT should consider, among other things, substituting less expensive services for more expensive services; accessing Medicaid services offered outside of the IDDW program; and determining whether any services covered by private insurance may be helpful to the member.

Once the member receives his or her budget letter, the IDT team will meet with the member to develop the annual IPP. If the member and/or the IDT team develop an IPP that is within budget and otherwise compliant with DoHS policies (e.g., all services are within the service-specific caps), DoHS or their designated UMC will approve the IPP and authorize services consistent with the IPP.

Redetermination Requests

Within 14 days of receiving a budget, if the member or their legal representative believes that a technical error was made (e.g., a typographical error on the assessment); or there has been a change in circumstances since the assessment that is documented pursuant to a critical juncture Meeting under Section 513.8.1.4, then the member or their legal representative will direct the case manager to notify the UMC. The UMC will review the redetermination request to determine if there has been a technical error in the assessment process or a change in circumstances warranting a critical juncture. A decision will be made within 20 business days after a redetermination request The UMC may communicate with the case manager and request additional information from the member, legal representative, or case manager, if necessary. If the UMC determines there was a technical error in the assessment or in applying the budget methodology, or if a critical juncture meeting is warranted the UMC may re-calculate the budget. If the UMC finds in a redetermination that a documented change pursuant to a critical juncture meeting under Section 513.8.1.4 of this manual has occurred, and that, as a result, the member's budget should be increased, the UMC should as soon as possible send this finding to BMS with a recommendation for the budget increase. BMS will make the final determination as to whether the member's individualized budget should be increased.

The UMC does not have authority to change or increase the member's individualized budget during a redetermination, unless it finds that there was an error in the member's assessment or in BMS's application of its budget methodology. Otherwise, authorizing services in excess of the individualized budget can only be done by BMS through the "exceptions process".

If the UMC determines there was no technical error and no change in circumstances, the first level redetermination will be closed. The UMC will inform the individual or his or her legal guardian in writing that the redetermination has been closed and explain the procedures for receiving services within the member's budget and for pursuing the "exceptions process" with BMS.

If the IDT continues to believe that the UMC has made an error in the member's assessment or in applying BMS's budget methodology, the individual may request a Medicaid Fair Hearing on this limited issue. The individual may not, at this juncture, request a Medicaid Fair Hearing on any other issues, including on the sufficiency of the individualized budget in meeting the member's needs. Before

requesting a Fair Hearing on other issues, the member must first complete the “exceptions process” described below.

Exceptions Process

The IDT has an obligation to make every attempt to purchase services it deems necessary within the individualized budget. If the IDT determines after careful consideration that funds beyond the individualized budget are still necessary to avoid a risk of institutionalization, the member and/or the legal representative (or the case manager on their behalf), after consultation with the IDT, may submit a request for services in excess of the budget to BMS through the UMC web portal, along with any supporting documentation.

If the member or his or her legal representative believe services in excess of the budget are necessary, they will fill out an additional section of the IPP that reflects all the additional services that member or his or her legal representative believes the member needs. Even if the IDT believes that services in excess of the budget are necessary, the IDT must complete the primary section of the IPP and specify services that can be purchased within the member’s individualized budget. No services for the IPP year will be authorized unless this primary section is completed. The member or their legal representative must sign off on the request for services in excess of the budget. Services requested in excess of the budget, described in the additional section of the IPP, cannot be authorized unless and until an exception is approved through the exceptions process.

An “exceptions process” request for services exceeding the member’s individualized budget is clinically researched and reviewed by BMS. Such request may also be negotiated between the member or their legal representative, the case manager/IDT and BMS. A panel of three individuals employed by DoHS or its contractor will review the “exceptions” request to determine if any errors were made in the service authorization process, including if any technical errors were made in the assessment, and/or if funds in excess of the budget are needed to purchase clinically appropriate services necessary to prevent a risk of institutionalization. At least one individual on the panel will have medical training. A decision will be made by the Exceptions Panel within 20 business days after the Exceptions Panel has received submission explaining the basis for the exceptions request with any/all supporting documentation.

The individual seeking additional services through the “exceptions process” has the burden of showing that services in excess of the individualized budget are necessary to avoid a risk of institutionalization. To make this showing, the member or his legal representative must provide a clear explanation on the “exceptions process” request as to which additional services are requested and why they are necessary to prevent a risk of institutionalization, and may provide documentation to support his or her position. All documentation must be attached/enclosed/provided if the member would like BMS to consider such documents in making its decision during the “exceptions process.” Referring to documents on the “exceptions process” form is NOT sufficient; any documents the member would like BMS to consider must be attached to the ”exceptions process” form and specific sections highlighted for BMS to review

In determining whether the member has met his or her burden to receive services in excess of the budget, the three-person panel shall consider, among other things:

- The member’s most recent ICAP, Structured Interview, and all IPPs from the current year.
- Any information provided by the member in his or her application for an exception.

- The feasibility of rearranging services within the member's budget.
- The availability of less expensive services that can be substituted for more expensive services.
- The availability of services covered outside the IDDW program by Medicaid or by private insurance.
- The natural supports (if any) available to the member, and limitations on those supports.

If BMS concludes that the member has demonstrated that funds in excess of the individualized budget are necessary to prevent a risk of institutionalization, BMS will authorize funds in excess of the budget to the extent necessary to keep the member safe and healthy and avoid a risk of institutionalization, and the IPP will be finalized. If BMS determines that the member did not demonstrate that funds in excess of the individualized budget are necessary to avoid a risk of institutionalization, BMS will not authorize funds in excess of the budget. If BMS determines that an error was made in the service authorization process, it will take steps necessary to correct the error.

If, during the "exceptions process, BMS determines there was not an error, or that the requested additional services and funding are not warranted, a Letter of Denial will be sent to the member or their legal representative, which will include an explanation as to why the services(s) and funding were denied, how to file for a Medicaid Fair Hearing and free legal services available. All decisions during the "exceptions process" shall be reviewed and/or issued by BMS.

As is stated in the Letter of Denial, a member will have the ability to appeal the decision made through the exceptions process by requesting a Medicaid Fair Hearing. The hearing officer will apply the same standard applied by BMS's exceptions process panel, *i.e.*, whether the member has met his or her burden of showing that services in excess of the individualized budget are necessary to avoid a risk of institutionalization.

513.26 DISCHARGE

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

- A member's income or assets exceed the limits specified in Section 513.6.3.1 of this chapter. The county DoHS office must be contacted, in addition to the UMC, any time an individual's income or assets exceed the limits.
    - The county DoHS office closes the Medicaid file upon notification of the increase in income or assets and notifies the individual and the UMC of termination of the Medicaid card. The case manager 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 513.6.3.1 of this Chapter. The case manager may request information from the member or the member's payee or member's legal representative to ensure that financial eligibility is not "lost" throughout the year due to excessive assets or other reasons.
- The annual functional assessment which is used by the MECA to determine a member's medical eligibility demonstrates that they are no longer medically eligible for the IDDW Program. The UMC notifies the member or their legal representative and the member's

case manager of termination of services and of their right to appeal as outlined in Section 513.25.4.

- A member or their legal representative voluntarily terminates Waiver services by signing the Transfer/Discharge form (WV-BMS-IDD-10). The case manager must convene the IDT in the development of the IPP to transition the member to the new services when applicable.
- A member becomes deceased. The case manager must complete and submit the Notification of Member Death (WV-BMS-IDD-11) and notify OHFLAC within 24 hours and submit the completed form to the UMC within seven days.
- A member or their legal representative fails to comply with all IDDW policies including monthly home visits by case manager, participation in required assessments, IDT meetings and IPP development, and then the member may be discharged from the IDDW Program following consultation and approval from the UMC.
- A member does not access or utilize at least one IDDW Service each month (with the exception of case management). Individuals who are hospitalized for medical reasons will be considered for an exception. If the member or their legal representative signed a Transfer/Discharge Form (WV-BMS-IDD-10), then it is effective on the date of signature and this rule does not apply.

The case manager must transfer/discharge the member in the CareConnection© by the effective date of the valid transfer/discharge.

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

IDDW case management providers may not discharge a member if the member chooses to self-direct part or all of their services through either of the Participant-Directed service options.

513.27 TRANSFER

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

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

513.28 SERVICE LIMITATIONS AND SERVICE EXCLUSIONS

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

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

513.29 HOW TO OBTAIN INFORMATION

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

GLOSSARY

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

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

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

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

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

Approved Medication Assistive Personnel (AMAP): An unlicensed staff member who meets the eligibility requirements to become an AMAP, has successfully completed the required training and competency testing and has been deemed competent by the RN to administer medications to residents in the covered facilities in accordance with AMAP policy.

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

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

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

Conflict of Interest: When the case manager who represents the member has competing interests due to affiliation with a service provider agency.

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

Days: Calendar days unless otherwise specified.

Developmental Disability: Members with related conditions who have a severe, chronic disability that meets all of the following conditions: It is attributable to cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually or developmentally disabled 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 the Code of Federal Regulations 42 CFR 435.1010).

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

Extended Professional Staff: West Virginia licensed dietitians, occupational therapists, physical therapists and speech therapists who are enrolled Medicaid providers who contract with an IDDW provider to provide services in their specialty.

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

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

Home and Community Based Services (HCBS): Services which enable individuals to remain in the community setting rather than being admitted to an institution.

Human Services Field Degree: Four year degree from accredited college or university in one of the following fields: Psychology; Criminal Justice; Board of Regents; Recreational Therapy; Political Science; Nursing; Sociology; Social Work; Counseling; Teacher Education; Behavioral Health; Liberal Arts or other degree approved by the West Virginia Board of Social Work Examiners.
Incident: Any unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes.

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

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

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

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

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

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

Integrated Work Setting Site: A site where an individual receiving IDDW Job Development or Supported Employment services are employed where not more than 75% of the people with the same job description are diagnosed with an intellectual or developmental disability.

Intellectual Disabilities and Developmental Disabilities Waiver (IDDW) Program: The program funded by the Center for Medicare and Medicaid and administered by the Bureau for Medical Services. This program offers a comprehensive scope of services and supports to eligible IDDW Program members. Authorized services, if applicable, must be rendered by enrolled IDDW providers within the scope of their licenses and in accordance with all state and federal requirements. BMS also contracts with an UMC to perform waiver operations including annual functional assessment for eligibility and budget determinations for active program members, prior authorization of services, and quality assurance/improvement functions. BMS contracts with a MECA to assess and determine initial medical eligibility for program applicants as well as review and approve annual re-determination of eligibility for waiver services. BMS contracts with a Claims Agent to process Medicaid claims. BMS also contracts with

one Fiscal Employer Agent (F/EA) known as *Personal Options* to provide Financial Management Services to waiver members who choose to direct their own services through the participant-directed service options. *Personal Options* also provides Information and Referral services to members choosing that Participant-Directed Option. The Office of Health Facility Licensure and Certification (OHFLAC) provides monitoring and supervision of members' health and welfare through oversight of IDDW providers.

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

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

Intensively Supported Setting (ISS): A residential home that is not licensed by the Office of Health Facility Licensure and Certification (OHFLAC) with one to three people receiving services who lease, own or rent the home.

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

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

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

Licensed Group Home (GH): A residential setting that is licensed by the Office of Health Facility Licensure and Certification (OHFLAC) with one to four people receiving services. The site is leased or owned by an IDDW agency provider.

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

Medicaid Fair Hearing: The formal process by which a member or applicant may appeal a decision if the individual feels aggrieved by an adverse action that is consistent with state and federal law, including

eligibility denials, eligibility terminations or when denied a covered benefit or service. This process is conducted by an impartial Board of Review Hearing Officer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

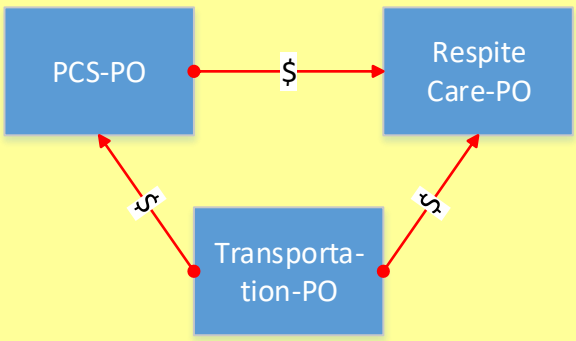
CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Intellectual and Developmental Disabilities Waiver (IDDW)	December 1, 2015
Entire Chapter	Intellectual and Developmental Disabilities Waiver (IDDW)	February 1, 2018
Throughout the Entire Chapter	, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.	February 1, 2018
Throughout the Entire Chapter	CareConnection® has been changed to UMC web portal.	February 1, 2018
Throughout the Entire Chapter	Member has been replaced by the word "person" wherever possible.	February 1, 2018
Program Description	This sentence was removed from this section: There is one Participant-Directed Financial Management Services available to assist persons with self-directing these services: *Personal Options Model.* This sentence was added to this section: Personal Options is the Participant-Directed Financial Management Services	February 1, 2018

	model available to assist persons with self-directing their services.	
Section 513.2	Training on Direct-Care Ethics for Direct Support Professionals, Day Services, Person-Centered Support, LPN, and Respite that minimally addresses: Focus on the person who receives services, including commitment to person-centered supports as best practice; Promoting the physical and emotional well-being of the person; Integrity and responsibility; Confidentiality; Justice, fairness, and equity; Respect; Relationships; Self-determination; and Advocacy.	February 1, 2018
Section 513.2	This bullet was changed to read: Any staff person who provides transportation services must have a valid driver's license. In addition, the agency must maintain documentation that any staff person who provides transportation services via personal vehicle abides by local, state, and federal laws regarding maintaining current vehicle licensing, insurance, registration, and inspections.	February 1, 2018
Section 513.2	To ensure complete impartiality, the Service Coordinator and other agency personnel, with the exception of the legal representative of the person being assessed or the Specialized Family Care Provider, will be excused when the Freedom of Choice form is completed during the annual functional assessment. If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days.	February 1, 2018
Section 513.2.3	The Quality Improvement System (QIS) is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met; and, ensure the active involvement of interested parties in the quality improvement process.	February 1, 2018
Section 513.2.3.6	IDDW agencies are required to submit evidence to the UMC every year to document continuing compliance with all certification requirements as specified in this manual. This evidence report must include a signed attestation from an appropriate official of the provider agency (e.g. Executive Director, Board Chair, etc.). The report may be sent from a provider's HR system, as an excel spreadsheet or as other report that includes all applicable fields and documents the employee's training dates. This form must be submitted	February 1, 2018

	electronically to the UMC. This self-review tool allows providers to incorporate into their Quality Assurance and Improvement processes a method to ensure quality services occur and CMS Quality Assurances are met. Each provider will be required to submit a self- review annually. The exact due date will be communicated to the provider at least two months prior to the due date.	
Section 513.3.17	This section was changed to read: In addition to meeting all requirements for IDDW Staff in *Sections 513.2 - 513.2.1*, the provider is required to maintain documentation that agency staff providing transportation services have a valid driver's license. If a personal vehicle is used, the provider must maintain documentation of proof of current vehicle insurance, inspection, and registration. Staff must also abide by local, state, and federal laws regarding vehicle licensing, registration, and inspections.	February 1, 2018
Section 513.4	All incidents must be entered into the WV IMS within 24 hours of the provider becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day.	February 1, 2018
Section 513.5	The original physical copy of the annual assessment completed by the person, his/her guardian and/or his/her IDT. Once the annual assessment is completed, and the person or his/her guardian has signed the document attesting to its accuracy and completeness, it will be the duty of the Service Provider to ensure that the document is not altered, copied, or distributed in any manner. However, the Service Provider must make the original physical copy annual assessment available to the person, his/her guardian and his/her IDT at the Service Provider's offices, upon request, to review only. The Service Coordinator provider agency may store the document electronically but must be able to make the document available upon request of the person or their legal representative.	February 1, 2018
Section 513.5	Two bullets under the Specific Requirements section were combined into one bullet: • Each IDDW provider is required to maintain all required IDDW documentation on behalf of the State of West Virginia and for state and federal monitors, including all IDDW Program The names of forms as applicable to the policy requirement or service code requirement.	February 1, 2018

Section 513.8	Bullets were added to the required components of the WV-BMS-IDD-05: • Tentative Weekly Schedule (including both paid and unpaid supports and any other programs providing any type of service, i.e. Personal Care, Private Duty Nursing, etc.) • The names of the individuals providing PCS Family, In-Home Respite and Out-of-Home Respite (both Traditional and Personal Options) This sentence was added to this section: If a finalized IPP needs any changes, the team must complete an addendum IPP to reflect those changes before service requests will be considered.	February 1, 2018
Section 513.9.2	Both Family Person-Centered Support: *Personal Options* and Transportation Miles: *Personal Option* monies may be transferred into Respite: *Personal Options* to increase this service. Transportation Miles: *Personal Options* monies may also be transferred to Family Person-Centered Supports: *Personal Options* to increase this service. Respite: *Personal Options* monies may not be transferred into Family Person-Centered Support: *Personal Options* or Transportation Miles: *Personal Options*. Participant-Directed Goods and Services monies may not be transferred into Respite: *Personal Options,* Family Person-Centered Supports: *Personal Options* or to Transportation Miles: *Personal Options* nor may any of these service monies be transferred into Participant-Directed Goods and Services	February 1, 2018

	I/DDW Allowable Financial Authority Exchanges  Only those $$ exchanges indicated with an arrow are allowed. All others are prohibited.	
Section 513.9.2	This paragraph was added: There are many reasons why a person may not use their entire allocated budget (hospitalization, periodic increase of informal/non-paid supports, etc.). Any unused funds from one month may not be carried over to later months within the person's annual budget period. The Personal Options vendor assigns a Personal Options Resource Consultant to assist and support each self-directing person to develop and monitor monthly spending plans. The Resource Consultants will ensure the person/representative is aware of under-utilization and/or any attempts to over spend the monthly spending plan.	February 1, 2018
Section 513.10	This paragraph was changed to read: Any Qualified Support Worker who provides transportation services must have a valid driver's license. If using a personal vehicle, the agency must ensure the QSW has proof of current vehicle insurance and registration and abides by local, state, and federal laws regarding vehicle licensing, registration, and inspections.	February 1, 2018
Section 513.14.1	Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the person's need. Appliances compliant with the American Disabilities Act (ADA) is not sufficient to meet this requirement.	February 1, 2018
Section 513.14.2	This service may not be used for adaptations or improvements to the vehicle that are of general utility (such as running boards), and are not of direct medical or remedial benefit to the individual.	February 1, 2018

Section 513.15.1	This was removed: This service will only be available for three years following the implementation date of this manual and upon purchase of this service in the UMC portal for the individual receiving services. It is expected that after this service ends that transition to Pre-Vocational services, Job Development services, Supported Employment services, or Person-Centered Services will occur for persons receiving services.	February 1, 2018
513.15.1	This sentence was added: Medications and health care maintenance tasks may be performed by LPNs or AMAPs at this site.	February 1, 2018
Section 513.15.2	This was added: Tasks of a benefit to a provider are those tasks, performed by a person, for which the provider would otherwise have to pay an employee to complete. A person taking out trash generated by the whole room or setting (not just the person's personal trash) would be an example of a task benefiting the provider. A person being trained to clean up after him/her self would not fall in this category. This was removed: Services are expected to occur over a two-year period, with integrated employment at a competitive wage being the specific outcome. It is expected that after two years, transition to Supported Employment will take place. • After two years of access, a transition from this service to Job Development or Supported Employment must occur. This was added: • Accessing and managing any personally available funds. Persons may receive minimum wage. If the IDDW provider benefits from the person's labor, then the person must be paid The words "and community settings" were removed from this sentence: **Site of Service:** This service may be provided in a licensed IDD Facility-Based Day Program facility and community settings.	February 1, 2018
513.15.2	This sentence was added: Medications and health care maintenance tasks may be performed by LPNs or AMAPs at this site.	February 1, 2018
Section 513.15.3	This was removed: Services are expected to occur over a two-year period, with attaining and maintaining integrated	February 1, 2018

	employment at a competitive wage being the specific outcome. It is expected that on or before two years, transition to Supported Employment will take place or Job Development Services will cease.	
Section 513.15.4	**Site of Service:** This service may be provided in an integrated community work setting and may not be provided in any setting owned or leased by an IDDW Provider agency. Most of the member's co-workers in the setting do not have disabilities.	February 1, 2018
Section 513.16.1	PDGS monies may not be transferred into Family Person-Centered Supports: *Personal Options,* Respite: *Personal Options* or Transportation Miles: *Personal Options.* Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the person's need. Appliances compliant with the American Disabilities Act (ADA) is not sufficient to meet this requirement.	February 1, 2018
Section 513.17.1.2	The equivalent monetary value for Family PCS: *Personal Options* services may be used to increase Respite: *Personal Options* but cannot be used to increase Transportation: *Personal Options* or Participant-Directed Goods and Services.	February 1, 2018
517.17.3	These sentences have been removed: IDDW providers who currently serve more than four individuals per setting must submit a transition plan to BMS for approval by June 30, 2016. This transition plan must include timelines for transitioning the setting to four or less people before March 2019. BMS will consider the plan and approve it if it is feasible to complete the transition in a timely manner that is reasonable and appropriate for the people involved. This sentences have been added: Eight licensed group homes have been grandfathered in under the new Integrated Settings Rule and these 8 sites may continue to serve more than 4 individuals. Contact BMS for a list of those specific sites.	February 1, 2018
Section 513.17.3	Staff providing Licensed Group Home PCS cannot be a family member of the person who receives services. For the purposes of providing Licensed Group Home PCS services, family members include: biological/adoptive parents or step-parents, biological/adoptive adult siblings or step-siblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/-uncles only.	February 1, 2018

	Spouses of persons who receive services are excluded from providing services. All people residing together in one of these settings must be served by the same IDDW residential provider.	
Section 513.17.4.1	All people residing together in one of these settings must be served by the same IDDW residential provider.	February 1, 2018
Section 513.17.4.2	Unlicensed Residential PCS: *Personal Options* cannot be provided in a setting owned or leased by an IDDW provider.	February 1, 2018
Section 513.18.1.2	Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the person, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the person is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver. • The equivalent monetary value for Respite: *Personal Options* services cannot be used to access additional Transportation Miles: *Personal Options* services, Person-Centered Supports: Family Personal Options or Participant-Directed Goods and Services.	February 1, 2018
Section 513.18.2.1	Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the person, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the person is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver.	February 1, 2018
Section 513.18.2.2	Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the person, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the person is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver. • The equivalent monetary value for Respite: *Personal Options* services cannot be used to access additional	February 1, 2018

	Transportation Miles: *Personal Options* services, Person-Centered Supports: Family Personal Options or Participant-Directed Goods and Services.	
Section 513.20.1	This paragraph was added: ***Effective July 1, 2018 or the individual's next anchor date, whichever is later, any medication administration and performance of health care maintenance tasks as described in W. Va. CSR §64-60-1 et seq. should be provided by a trained Approved Medication Assistive Personnel (AMAP). If an RN or LPN performs AMAP tasks, then the RN or LPN must bill the appropriate direct care code for Person-Centered Support and will be reimbursed at the Person-Centered Support rate.**	February 1, 2018
Section 513.21.1 and 513.21.2	This bullet was changed to read: Person must be present in vehicle if mileage is billed. If more than one person receiving IDDW services is present in the vehicle, then the total mileage will be divided between the number of persons present in vehicle.	February 1, 2018
Section 513.21.2	The equivalent monetary value for Transportation Miles: Personal Options may be used to increase access to Family PCS: *Personal Options* and Respite: Personal Options, but not Participant-Directed Goods and Services.	February 1, 2018
513.21.3	This sentence was added: The driver must have a valid driver's license.	February 1, 2018
Section 513.25.4.2	The entire section has been changed.	February 1, 2018
Entire Chapter	"Service coordination" terminology is changed to "case management" throughout the chapter.	April 1, 2021
Entire Chapter	"Person(s) who receives services" terminology changed to "member" throughout the chapter.	April 1, 2021
Entire Chapter	Hyperlinks have been added to link forms and websites throughout entire document.	April 1, 2021
Entire chapter	"Participant Directed Supports" changed to "Person Centered Supports" throughout chapter	April 1, 2021
513.2	Provider Enrollment and Responsibilities: Added language to second bullet: "NOTE: This requirement does not apply to case management-only agencies."	April 1, 2021
513.2	Addition of Electronic Visit Verification as required by 21st Century CURES Act	April 1, 2021
513.3.10	Addition of option for providers to screen workers' driving records through the WV CARES automated WV Department of Motor Vehicles registry.	April 1, 2021
513.3.12	Addition of CFCM certification to CM staff qualifications	April 1, 2021
513.4	Incorporation of policy clarification 91 into section	April 1, 2021

513.4	Removal of case management case load limit and requirement to notify BMS when limit is exceeded.	April 1, 2021
513.4	Addition of reporting requirements and responsibilities within the IMS system	April 1, 2021
513.4	Addition of revised purchase order for IDDW services	April 1, 2021
513.6.4	Removal of language pertaining to maximum service capacity related to case management.	April 1, 2021
513.8.1	Addition of the option to hold IDT meetings virtually if member, legal representative and team agree.	April 1, 2021
513.8.1.1 and 513.8.1.2	Addition of language to clarify 7 and 30-day IDT meeting processes	April 1, 2021
513.9.2	Removal of limitation from *Personal Options* services which prevents members from accessing unused funds to put toward future months' services.	April 1, 2021
513.12.1 and 513.12.5	Addition of Limitation/Cap stating agency staff may not bill dietary therapy for completing administrative activities	April 1, 2021
513.12.1, 2, 3 and 4	Removed public community location from site of service.	April 1, 2021
513.12.5	Addition of dietary therapy (Participant-Directed Option, *Personal Options Model)* Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021
513.12.6	Addition of occupational therapy (Participant-Directed Option, *Personal Options Model*) Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021
513.12.7	Addition of physical therapy (Participant-Directed Option, *Personal Options Model*) Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021
513.12.8	Addition of speech therapy (Participant-Directed Option, *Personal Options Model)* Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021
513.13.1	Updated language to state the residential provider is responsible for the initial testing of electronic monitoring equipment.	April 1, 2021
513.14.3 and 513.14.4	Language updated to state that the case manager must be informed that the EAA service was completed Changed "IDDW provider" to "Personal Options vendor."	April 1, 2021
513.14.3	Addition of Environmental Accessibility Adaptations Home (Participant-Directed Option, *Personal Options Model*) Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021

513.14.4	Addition of Environmental Accessibility Adaptations Vehicle (Participant-Directed Option, *Personal Options Model*) Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021
513.15.4	Changed language to "This service must be provided in an integrated community work setting unless the member is self-employed, and may not be provided in any setting owned or leased by an IDDW provider agency. An integrated setting requires that most of the member's co-workers in the setting do not have disabilities."	April 1, 2021
513.17.1.2	Addition of Person Centered Support: *Personal Options* service, formerly Family Person Centered Support *personal options* S5125-UA to be billed by staff living in the member's home S5125-UA-UK to be billed by staff living outside the member's home.	April 1, 2021
513.17.3	Removal of outdated information pertaining to transition plan	April 1, 2021
513.18	Removal of language describing forms of respite other than paid IDDW respite services.	April 1, 2021
513.19.1	• Removed Service Coordination code T1016 HI and replaced with G9002-U3 case management Natural Family & SFC and • G9002-U4 case management ISS and Group Home. These per-member-per-month event codes replace the previous 15 minute unit Service Coordination code • Specified that member transfers from one Case Management agency to another case management agency are to be effective on the first of a following month. • Added detail regarding conflict-free Case Management. • Changed case manager visits to day program settings from every other month to quarterly • Added that case manager is required to purchase services within seven days of the IDT meeting/IPP addendum. • Sanctions outlined for consistent poor performance of case management agencies. • Removed non-billable activities for Case Management • Added that Case Management can be billed when member is temporarily in a facility or has hold status. • Removal of required progress "note" and addition of required progress "log" for case management services	April 1, 2021

	• Removal of “clinical outcome” requirement for Case Management log requirements and addition of service code • 1st bullet under Limitations/Caps changed to, “transfer from agency must finalize documentation related to member services but will not be able to bill during this time” Removal of language requiring WV-BMS-IDD-12 to be submitted within the month the Home Visit did not occur.	
513.19.1	Addition of MOU requirement to address liability issues between agencies.	April 1, 2021
513.21	Removal of odometer reading from mileage documentation requirements.	April 1, 2021
Home and Community-Based Settings Requirements	Addition of HCBS Settings Requirements	December 21, 2023
Home and Community-Based Settings Requirements	Added missing text to *Provider-Controlled Settings* (first 3 bullets) and changed references to "member" to "setting” in *Transition of Members* Updated logos and DHHR refences to DoHS	September 25, 2024