I/DD Waiver Policy Clarifications
(Policy Effective 12/1/15—4/3/25)

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Approved Medication Assistive Personnel (AMAP)

Q9: Can the RN code be billed for supervision and training of AMAP staff?

A9: [12/3/15] AMAPs have been used for many years by many agencies. The RN code has not been allowed to be billed for supervision or training of AMAP staff. I/DD Waiver reimburses for specific services to be provided to an individual recipient. Supervision of AMAP/LPN staff is not a member-specific service, rather it is an agency responsibility to ensure that personnel providing services are properly monitored.

Q10: Is there an administrative billing code for AMAP services? The manual is unclear.

A10: [12/3/15] There is no code for AMAP, rather Person-Centered Support staff are trained to function as AMAPs also.

Q103: What is the deadline for AMAP background checks via WV CARES? The original date for compliance of all other submissions was May 31, 2016, however, there were issues with AMAP submissions that were not resolved by that time.

A103: [11/03/2016] According to WV CARES, background checks for AMAPs will be processed when a staff person is reprinted for their regular cycle. Those for prospective new staff will be processed upon initial submission.

Q138: Where are AMAPs allowed to pass medications and provide health maintenance tasks?

A138: [3/1/18] AMAPs are permitted by state code and rule to administer medications and carry out health maintenance tasks in any location wherever a person is receiving services. Day program, work, gym, mall, etc.

Q139: If an AMAP changes employment, do they have to go through the entire 40 hour training again with the new agency?

A139: [3/1/18] Not necessarily. The AMAP or provider agency can request a copy of their certificate for $20.00 from the OHFLAC vendor and the RN at the new agency can administer the recertification test and based on the results, may deem the AMAP approved. The AMAP will, of course, need individualized training on member-specific needs.

Q160: Can a staff person who is not a nurse and not AMAP certified administer an Epi-pen if needed?

A160: [12/6/18] Yes, in emergency situations, non-nursing staff who are not AMAP certified can administer an Epi-pen if they have been trained by a nurse and have written permission from the member's legal representative to do so.

Behavior Support Professional

Q8: How does a BSP become board certified and can current BSPs be grandfathered in as BSP II?

A8: [Updated 12/17/15] A process has been in place for three months (dated 12/3/15) that allows individuals to submit their applications to have a PBS endorsement by a recognized APBS Network for PBS Board of Review. The WV APBS Network is meeting next week and have an expedited process, but have very few applications to review. Additional information can be found at: http://wvapbs.blogspot.com/.

Some provider agencies and staff have received PBS endorsements from other states; information on PBS endorsement in other states was previously provided. Since the opportunity to become PBS endorsed has been available, BMS will not grandfather BSP staff.

Current TC/BSP staff can bill BSP I if this service is authorized for individuals who have transitioned to "new" services. BMS will allow staff who are not currently credentialed as BSP I a Period of one year to become credentialed, during which time BSP I can be billed. In addition, BSP I can be provided by staff with a non-human services degree if they were hired prior to 12/1/15.
If a BSP I qualifies for a PBS endorsement and meets all other requirements for BSP II and the budget allows, the team can request to replace BSP I with BSP II services.

BSP II cannot be provided until the clinician meets the requirements to bill that service as described in the policy manual.

Q20: According to the Quarterly Provider Training in May 2015 and the document on the BMS website, labeled "2015 Draft I/DD Waiver Comments and Responses," a transition period of one year was documented to allow current TCs and BSPs to obtain BSP I and BSP II certification. The Policy Manual, however, indicates that the time-period is six months. Please clarify.

A20: [Updated 2/18/16] BMS will allow a transition period of one year for a Therapeutic Consultant to become certified as a Behavior Support Professional, as communicated in May 2015 and in the comments and responses document. During this time, the Therapeutic Consultant can bill BSP I, as there is no other code available. Note that this does not apply to BSP II—in order to bill BSP II, the clinician must meet the requirements as described in the policy manual.

Q28: The current policy manual says that, in order to be approved to train on a curriculum, the trainer must 1—be a BCBA, 2—be the developer of the approved course, or 3—have documentation that certifies completion of an approved training course (though not necessarily the course for which they are the trainer). What is considered an "approved training course" in option 3?

A28: [1/7/16] An "approved training course" is any curriculum that was approved by the WV APBS Network.

Q40: Are professional staff (TCs, RNs, SCs, and BSPs) required to receive person-specific training?

A40: [1/7/16] No. These professionals can familiarize themselves by reviewing clinical documentation for the individual as appropriate.

Q52: Can video-conferencing such as Omnijoin or Go To Meeting be used for BSPs and RNs to attend IDT meetings?

A52: [2/4/16] These professionals can attend IDT meetings using such services; however RN IPP Planning and/or BSP IPP Planning can only be billed by the professional when he/she is physically present.

Q53: Can BSPs bill to develop the tentative schedule? This task is not identified in the policy manual as something that the BSP can do.

A53: [2/4/16] Yes, it is the responsibility of the BSP to develop the tentative schedule, therefore this is a billable activity.

Q56: Section 513.3 of the policy manual states: "all staff must be trained to provide IDDW services in a culturally and linguistically appropriate manner." Since this section is separate from the training requirements in Section 513.2, please clarify who is required to receive this training.

A56: [1/7/16] All staff who provide Medicaid services to persons who receive I/DD Waiver services must receive this training.

Q70: For purposes of the definition of Human Services degree in the policy manual, what constitutes a Liberal Arts degree?

A70: [4/7/16] At least 15 credit hours in Human Services classes are required for a degree to be considered Liberal Arts.

Q84: Can Service Coordination and/or Behavior Support Professional be billed while an individual is in the hospital, for purposes of discharge planning?

A84: [8/4/16] These services cannot be billed while a person is in the hospital, or at any time when services are on hold. When a member is hospitalized, it is the responsibility of the hospital social worker to arrange for discharge planning. Note, this does not apply to when a person is in a Crisis PCS site and their status is Member Hold-Extension in CareConnection©.

Q113: We have a BSP who was unable to get certified and will not be able to do so by the deadline of November 30, 2016. Can an extension be granted?

A113: [12/1/16] BMS will not be able to grant extensions for anyone unable to complete the course by November 30, 2016.

[Updated 1/5/17] BMS will not be able to grant extensions for anyone unable to successfully complete an approved curriculum by November 30, 2016. Those who have not successfully completed an approved curriculum will be unable to provide Behavior Support Professional Services of any kind to any I/DD Waiver member. This does not apply to new hires—all new hires have 6 months from the date of hire to receive the certification. Providers are welcome to contact KEPRO to obtain a list of curriculums that are approved.

Q119: The policy manual indicates that "new hires of individual agencies that have not completed an approved WVAPBS curriculum must successfully do so within the first six months of employment and be under ongoing clinical supervision by a Behavior Support Professional". Does this policy extend to someone who has been working for an agency in a different capacity, such as service coordination, and therefore is considered a "new hire" to the position but not the agency?

A119: [2/2/17] No. Only someone newly hired by the agency and under a BSP's supervision can bill BSP I for six months while getting certified. Those already employed by the agency wishing to provide BSP services in a new role, must be fully certified before they can bill. The "6-months provision" does not apply to staff already employed by the agency.

[Updated 2/9/17] BMS has clarified and will allow all current agency staff the same "6-months provision" to complete a WVAPBS approved curriculum under the condition that the BSP providing services is supervised by someone who is already a credentialed BSP.

Q147: Can a BSP bill to provide person centered training for an LPN on Behavior Support Plans and/or behavioral guidelines?

A147: [7/5/18] If an LPN is providing direct care services for any shift 3 hours or longer (in excess of 2,920 units of direct care nursing services per service year) and the person has a PBSP and/or behavioral guidelines then this is acceptable. This should only be done on an as-needed basis rather than completed as a matter of routine.

Q152: Can a professional serve as a person's SC and BSP simultaneously?

A152: [8/2/18] No, this is not allowed at any time.

Q186: Is a formal meeting with team agreement required to begin the development of a Functional Behavioral Assessment (FBA)?

A186: [11/18/20] Yes. The FBA is a part of the Positive Behavior Support Plan process and team agreement is required after discussing the implementation of all areas of the Positive Behavior Support Plan process.

CareConnection©

Q25: What sections of the I/DD-5 are required to be uploaded to CareConnection©?

A25: [1/7/16] The entire IPP (I/DD-5) must be uploaded to CareConnection© before requesting prior authorization for services. APS and BMS must have access to the entire document in order to review when considering requests.

Q72: A request for prior authorization for a person new to the program was recently submitted by our agency using the "initial" option in CareConnection©. We were advised that this function should not be used and that initial requests should actually be made using the "annual" option. Is this correct?

A72: [5/5/16] Yes, this is correct. The initial feature only provides an authorization for a period of 30 days. If an authorization is needed for a 30-day period, this can be received using the "annual" option, which can later be modified to reflect the units needed for the entire service year.

Q126: Is it necessary for the specific DHHR guardian listed in CareConnection© to sign the I/DD-5 or can any DHHR guardian sign the document in order to obtain prior authorization for services?

A126: [6/1/17] Any DHHR guardian can sign in place of the one listed in CareConnection©; however the circumstances surrounding the alternate attendee should be noted in the meeting minutes for the sake of clarity.

Q130: Is it necessary for the person's IPP to address all maladaptive behaviors listed on the ICAP in order for service requests to be approved by KEPRO?

A130: [8/3/17] Registration Coordinators at KEPRO will review the necessary documentation to ensure that health and safety needs are sufficiently addressed in a person's IPP. If it is unclear in the documentation submitted, then the Registration Coordinators will request additional information in order to make a clinical determination.

Q133: Pertaining to I/DDW Discharges due to death – If the SC enters an Effective Discharge Date into CareConnection© *after* an actual date of death, can the provider still bill for services until the Effective Discharge Date? For example, a SC may need to acquire the death certificate.

A133: Services cannot be billed after a date of death. Molina will reject any claims submitted for services provided after the date of death.

Q167: It was previously indicated that "Requests for authorization for January anchor dates that are submitted after 1/1/19 and go over budget will be closed." Does this mean that the rate changes only affect those with 1/1/19 anchor dates and forward or do the changes apply to any request submitted after 1/1/19?

A167: [3/7/19] The rates changes apply to any services provided 1/1/19 and later. Requests for authorization that exceed budget due to the rates change will be closed and the provider will be advised to resubmit, taking the rates changes into consideration when determining the overall cost of services for the year.

Q176: Are providers required to attach a signature page in CareConnection© that is signed by all IDT members for an addendum in order to gain approval?

A176: [8/1/19] In general, a signed signature page is not required for authorizations through CareConnection©. A signature page indicating verbal agreement from all IDT members would suffice until the physical signatures are obtained and included in the member's file. However, there are circumstances in which the physical signatures will be required that include, but are not limited to, when multiple agencies are involved, any circumstance(s) having an impact on the integrity of the documentation, and/or if the IDT decides not to pursue a Medicaid Fair Hearing (MFH), but chooses to make modifications during the timeframe in which a MFH could be requested.

Q184: How long does an agency have to accept or reject a consumer referral in CareConnection©?

A184: [10/1/20] Agencies must accept or reject all referrals within seven calendar days of receiving the notification in CareConnection©.

Q211: Can service providers request an exception to modify services after the member's service year has concluded if the Case Manager did not request the modification in CareConnection©?

A211: [1/6/22] Yes. Authorizations can be provided up to 15 days after the anchor date without an I/DD-12, if the budget, or previously approved overage, is not exceeded. Authorizations via the I/DD-12 may be provided for days 16-30 after the anchor date based on individual circumstances. I/DD-12s submitted for this purpose can only be submitted when the member receives other services from an agency that does not also provide Case Management or from a same or sister agency. Any request submitted beyond 30 days of the member's previous service year cannot be considered for review.

Further, the affected agency must submit documentation supporting their efforts to request the CM agency make modifications on their behalf. Documentation should show due diligence by the service provider and should demonstrate that requested modifications were made in a timely manner, that the service provider made attempts to follow-up with the CM agency, and that the request was necessary to the meet the unexpected changes in member's needs. This may include emails, progress notes, etc. that support the provider's request. Under these circumstances, a budget worksheet must also be provided to ensure budget/service limits are not exceeded. Requests to exceed the budget will not be considered and requests that lack clarity and/or that do not demonstrate sound utilization management practices will not be approved.

[Updated 12/1/22] Rather than waiting until the end of the member's service year, an I/DD-12 may be submitted at any time beyond the first 30 days of member's service year utilizing the same methods described in the original response. Interagency agreements must also be utilized per OHFLAC policy, and these agreements should clearly outline expectations for both parties involved.

Q217: When a member transfers CM services in CareConnection©, can the transfer-from CM still access the member's record once the identified transfer date has passed? If not, how can the transfer-from CM attach the necessary documentation as required?

A217: [1/5/23] No. Once the transfer date that has been identified in CareConnection© has past, the transfer-from CM will no longer be able to access the member's record in the system. The I/DD-5 and I/DD-10 must be attached to the member's record within 14 calendar days of the meeting date. However, it is also the responsibility of the transfer-from CM to prioritize uploading all documentation to the member's record in CareConnection© prior to the identified transfer date.

Direct Care Service (Day Services, Person-Centered Support)

Q2: Given that 1:3 and 1:4 ratios are not available for Home-Based Person-Centered Support, what ratios should be billed when an individual is receiving services in the community while attending Facility-Based Day Habilitation?

A2: [12/3/15] The provider should bill the appropriate Facility-Based Day Habilitation code.

Q3: If an individual turns 18 during his/her service year, will they be eligible at that time to receive authorization for direct support services at the limits specified in the policy manual for those age 18 and older?

A3: [12/3/15] Yes, if the request is supported by the individualized budget and is clinically necessary.

Q6: If, at the Facility-Based Day Habilitation/Pre-vocational site, one staff person is working with four individuals and two of those are focused on day hab related tasks and two are focused on pre-voc related tasks, what code and what ratio does the staff person bill?

A6: [12/3/15] Under the circumstance described, the staff person would bill the 1:3-4 Facility-Based Day Habilitation code for the individuals focused on day hab tasks and 1:3-4 Pre-vocational code for individuals focused on pre-voc tasks. [Updated 5/5/16]

Q10: Is there an administrative billing code for AMAP services? The manual is unclear.

A10: [12/3/15] There is no code for AMAP, rather Person-Centered Support staff are trained to function as AMAPs also.

Q23: If an agency does not wish to integrate a Facility-Based Day Program into the community, can Person-Centered Support services be billed while individuals attend the program?

A23: [12/17/15] The allowable sites for any type of Person-Centered Support are: the residence of the individual or the local public community. The definition of local public community in the glossary section of the Policy Manual is: "Any community setting open to the general public, such as libraries, banks, stores, post offices, etc. Facility-Based Day Programs and Pre-vocational sites are not considered public community locations." As such, Person-Centered Support services cannot be provided at the former site of a Facility-Based Day Habilitation program or within the offices of an IDDW provider.

Q24: Our agency wants to set up an additional company to pay individuals who will work in our office and we will bill Supported Employment. Is this acceptable?

A24: [12/17/15] The allowable sites for Job Development and Supported Employment are local public community settings and integrated employment settings. The definition of an integrated employment setting in the glossary section of the Policy Manual is: "A site where an individual receiving IDDW Job Development or Supported Employment services is employed where not more than 75% of the people with the same job description are diagnosed with an intellectual or developmental disability." The provider will be required to apply this standard to the individuals employed; if 75% or more individuals with the same job description are diagnosed with an intellectual or developmental disability, it will not be considered an integrated setting and neither Job Development nor Supported Employment may be billed under this circumstance.

Q30: The ISP section of the new I/DD-5 requires that the name of the staff person be indicated in the section for provider. Is it permissible to indicate the agency in this space instead of the staff person's name for those who live in ISS and for those who attend agency day services? Frequent turnover in these particular settings would require very frequent updates to the IPP document.

A30: [1/7/16] For Licensed Group Home PCS, Unlicensed Residential PCS, Facility-Based Day Habilitation, Pre-vocational Training, Job Development, and Supported Employment, it is acceptable to indicate the name of the agency that will supply the staff. For all other services, the name of the staff person must be indicated.

[Updated 7/6/16] This is also acceptable if Out-of-Home Respite is provided through a licensed facility-based day habilitation site.

Q35: BMS has indicated that the annual service limit for direct care services has been changed to 35,280 to accommodate "indirect" LPN activities. Should this number be changed to 35,376 due to leap year?

A35: [1/7/16] Yes, this limit has been changed to 35,376.

[Updated 2/6/19] This also applies to the 2020 leap year.

[Updated 3/1/19] The annual service limit accommodation due to the leap year only applies to those living in ISS/GH settings.

Q36: When are agencies required to stop billing for LPN travel time?

A36: [1/7/16] LPN travel may be billed for each individual until they transition to new services. Once the transition occurs, travel for LPN services can no longer be billed.

Q38: The policy manual says that providers cannot have any other responsibilities when providing 1:1 PCS services. With parent providers, does this apply to other children living in the home, caring for another family member, grandchild etc?

A38: [1/7/16] Yes. When a person is receiving 1:1 PCS services, he/she must be the only person receiving care. In the event that the person who receives I/DD Waiver services has siblings who require care at the same time, the parent may elect to have someone else provide care to the siblings while PCS Family services are provided, or can choose to have another provider deliver PCS services.

Q49: Can I/DD Waiver mileage/trips be used for transport to Facility-Based Day Habilitation facilities and/or Supported Employment sites, or must NEMT be used?

A49: [1/21/16] I/DD Waiver mileage/trips can be used for this type of transport. Individuals can access NEMT for transportation to these types of facilities if the I/DD Waiver mileage/trips authorizations are exhausted.

Q50: There have been several issues when calling the number provided to verify financial eligibility. Either the operator will not provide the requested information because they require the guardian to call, or there is no answer. The same information can be obtained via Molina's website. Can a printed confirmation that eligibility is verified via the website be maintained in the member file instead of calling?

A50: [1/21/16] Yes, or the Service Coordinator may verify the month's eligibility during the monthly home visit by viewing the actual Medicaid card.

Q57: Can a person who attends Facility-Based Day Habilitation or Pre-vocational be paid to perform services while FBDH or Pre-vocational is being billed?

A57: [3/3/16] It is not permissible for individuals who are receiving Facility-Based Day Habilitation services to receive payment while that service is being billed. For those receiving Pre-vocational or Job Development services, agencies may pay "piece-rate" or sub-minimum wage with Department of Labor approval certificate.

[Updated 7/6/17] If an agency does not have the Department of Labor certificate, they must pay the individual at least minimum wage. Gift cards are not allowable. If the agency sells the product being made then the member must be reimbursed for their services either by using the "piece rate" or minimum wage standard.

Q60: When an individual is receiving job coaching through the Division of Rehabilitation Services (DRS), is it required to also have that IDDW staff person bill Supported Employment, Person-Centered Support, or Respite?

A60: [3/3/16] No. Because DRS is paying an agency to provide job coaching services to the individual, it would be a duplication of services to also bill Medicaid Waiver at the same time and is thus fraudulent.

Q61: Can Occupational, Speech, and Physical Therapy be considered direct care services for individuals who live in natural family settings for the purposes of the rule that requires individuals to receive direct care services at least once every 30 days?

A61: [3/3/16] Yes, BMS has determined that individuals who receive Occupational, Speech, and/or Physical Therapy will not be subject to discharge, even if no other direct care services are provided.

Q69: If a community employer pays an I/DD Waiver member at a rate other than minimum wage (for example, "piece-rate,"), can Supported Employment be billed or must the agency bill Pre-vocational services?

A69: [4/7/16] The agency should bill Pre-vocational services in this case.

Q87: Can individuals access Supported Employment without a referral to the Division of Rehabilitation Services (DRS)?

A87: [9/1/16] In order to access Supported Employment services via an I/DD Waiver provider, the Service Coordinator must make a referral to DRS. As long as documentation showing that the referral has been made is maintained in the file, the agency can bill Supported Employment services for the individual.

Q93: If an individual receives Day Habilitation services at two different locations with two separate agencies, should the SC complete visits at each location every other month?

A93: [9/1/16] No. The SC should alternate. For example, if the individual receives Day Habilitation services at Agency A and Agency B, the SC would conduct a visit at Agency A in August and Agency B in October.

Q94: Please provide some clarification to [old] PC #133 that states "someone who lives in an ISS cannot receive PCS-Agency or PCS-Family on weekends in a Specialized Family Care Home." With new policy, ISS have been replaced by Licensed Group Home and Unlicensed Residential settings. Can someone who resides in a Licensed Group Home or Unlicensed Residential setting be eligible to receive Home-Based Person Centered Supports as it seems to fit within the description of the service and the site of service outlined in the manual?

A94: [9/1/16] Individuals who live in ISS or GH are not eligible to receive Home-Based Person Centered Support services.

Q102: In order to bill to provide I/DD Waiver services, does the legal representative have to be related to the person who receives services?

A102: [10/6/16] Yes, with the exception of Specialized Family Care Providers, in order to be paid to provide I/DD Waiver services, the legal representative is required to be a family member of the person who receives services.

Q116: If a person lives in an ISS and routinely accesses Unlicensed Residential PCS services at home, can family/friends bill for services if the member visits them for the weekend, holiday, etc.?

A116: [2/2/17] No. If a person accessing Unlicensed Residential PCS services is staying in the home of their family/friends, then the family/friends cannot bill I/DD Waiver services during the visit. The visit would be considered natural support. If staff takes the member for a short visit, as a community outing, the staff would bill the authorized Unlicensed Residential or Licensed Group Home PCS code while support is provided to the member during the visit.

Q122: If an individual attends school or is otherwise away from home for one or more weeks at a time, is it acceptable for the person to receive more than the daily average of PCS and/or Respite units while the person is home in order to utilize units that were not able to be billed due to the member being away from home?

A122: [4/6/17] No, if a person is receiving services in any facility away from home, his/her needs are met during that time by the facility. Only the daily average of PCS and/or Respite units may be billed during the time the member is at home.

Q135: What service should be utilized while transporting a member to/from the person'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?

A135: [3/1/18] Transportation Miles, Transportation Miles-PO, and Transportation Trips can be utilized. Transportation Miles (Traditional Options) services may be billed concurrently with Person-Centered Support Services, Respite, LPN, RN, Supported Employment and all Day Services. Transportation Miles (PO) may be billed concurrently with Person-Centered Support Services: Personal Options or Respite Personal Options. Transportation Trips (Traditional Option) may be billed concurrently with Person-Centered Support Services, Respite and any Day Services. While it is true that transportation services (including non-emergency medical transportation) can be billed concurrently with direct support services, the IDT must agree upon a safe and responsible plan that takes the person's medical and/or behavioral needs into consideration.

Q151: Can both Home-Based Person Centered Support and Respite services be billed by a Specialized Family Care Provider (SFCP) while a person is under the routine care and supervision of the SFCP? For example, would it be appropriate for the SFCP to bill Home-

Based Person Centered Support while taking the person(s) out into the local, public community rather than billing Respite services?

A151: [7/5/18] Home-Based PCS may only be provided by staff providing services in the person's home. SFC Providers who are providing services in their own homes may only bill Out of Home Respite for the person who is there for respite.

Q158: Can Job Development services be billed at an agency's office since some considered it a public community location?

A158: [11/1/18] No. An agency's office is a private business and not a public community location.

Q160: Can a staff person who is not a nurse and not AMAP certified administer an Epi-pen if needed?

A160: [12/6/18] Yes, in emergency situations, non-nursing staff who are not AMAP certified can administer an Epi-pen if they have been trained by a nurse and have written permission from the member's legal representative to do so.

Q163: Can NEMT be billed for more than one appointment per day?

A163: [1/3/19] Policy allows for one trip per household per day, so if a member requires transportation to more than one appointment per day, those must be done during one round trip in order for NEMT to be utilized.

Q164: Are members who live in ISS/Group Home subject to the NEMT "one trip per household per day" rule? Sometimes more than one person in the home has appointments on the same day.

A164: [1/3/19] The agency provider should notify Logisticare that the address is that of an ISS or Group Home. Logisticare will classify the address as "group home" in their system, which will allow more than one trip per day for those residents.

Q165: Can transportation services be billed to visit relatives, either in-state of out-of-state, or to locations outside of the person's local public community?

A165: The transportation sections 513.21.1 and 513.21.2 state under Site of Service that "This service may be billed to and from any activity or **service outlined on the person's IPP** and based on assessed need." The purpose of paying transportation is to transport individuals **to and from Medicaid-approved services**, which allows the individual to become more independent in **their local community.**

Visiting relatives is a family activity that is covered under natural support for individuals living with their families—the entire family benefits from visits to grandparents, etc. As such, it is only allowable for transportation services to be billed for a member to visit with relatives if the visit occurs in the member's local public community, they are going to and from a Medicaid-approved service, and it is documented in the person's IPP.

[1/2/19] An exception would be if the member lives in an ISS/GH or SFCP. If the member will be transported to visit his/her family, it is billable to do so as long as all other requirements for the service are followed. Keep in mind that transportation services cannot be billed outside the state except for those who live in border counties and for services provided within 30 miles.

Q166: Can a day program deny admission or discharge an IDDW member if they are unable to meet that person's needs?

A166: [2/7/19] This is allowed if the particular day program does not have capacity to serve the member or is unable to meet his/her needs. The reason for the denial/discharge must be clearly documented on the IPP. Agencies that cite capacity may not accept any referrals until the capacity issues are resolved. If the program cannot meet the member's needs, the IPP must clearly document what those needs are and why the agency is unable to meet them. Additionally, the IPP must include the IDT's alternative plan for meeting the identified need, and if applicable, how the member will be assisted in developing the skills needed in order to attend at a later date. For example, if the member's problem behaviors preclude him/her from attending, the IPP must identify how the behaviors that are preventing attendance are being addressed and when the team anticipates that the member may be able to attend if he/she still wishes to do so.

Q170: Section 513.15.2 Pre-Vocational (Traditional Option) under the site of service definition states, "This service **may** be provided in a licensed IDD Facility-Based Day Program facility." Does this mean that this service may be provided in a location other than a Facility-Based Day Program or can these services only be provided in a Facility-Based Day Program?

A170: [3/7/19] Pre-Vocational services can only be provided in a licensed Facility-Based Day Program and may not be provided in any other setting.

Q174: Can PCS services be billed for providing services while a member works or volunteers at a provider-owned site?

A174: [8/1/19] No. Per policy, the site of service for PCS is "in the family residence of the person who receives services, a Specialized Family Care Home, and/or in the local public community." Settings owned or leased by the provider are not considered local public community.

Q178: Can an agency bill URPCS/LGHPCS in a ratio other than what was provided? For example, if a member does not have a roommate but has an authorization for 1:2 services, can the 1:2 ratio be billed when 1:1 services are actually provided?

A178: Billing for a ratio other than that which was provided is not allowed; however, members may pursue authorizations of services identified by the IDT via the exceptions process.

[Updated 4/9/20] BMS reversed their decision and providers can bill lesser ratios than what were actually provided. Ex. Can bill 1:2 if 1:1 services were actually provided, but cannot bill 1:1 if 1:2 services were actually provided.

Q189: In regards to EVV usage, how would a DCS clock-in if services do not begin in the member's home? An example could be picking up a school-aged member from the school or at the bus stop.

A189: [12/17/20] DCS can clock-in in the community through EVV using the app on their cell phone. The system will flag that the worker was not at the member's home and the agency will have the opportunity to review this prior to claims being submitted. Please note that waiver services are not to duplicate services from an entitlement program including school transportation.

Q193: Would it be considered a conflict of interest if a member receives services from the same agency that employs a relative of the member?

A193: [3/18/21] If a member receives services from a provider that also employs a relative of the member, then it would not be considered a conflict of interest as long as the relative does not provide or is not involved in the provision of the actual service(s) provided to the member. It would be considered a conflict of interest if the member receives services directly from their relative or if the relative was involved in the provision of the actual service(s) provided to the member. The only services that can be provided by family members are Respite, Family PCS, and/or transportation.

[Updated 5/2/24] Services that can be provided by family members also includes Home-Based PCS. As outlined in section 513.17.2, services are not reimbursable if the DCS lives in the home with the member and/or if services are provided while the member is in the DCS's home.

Q205: Section 513.19.1 indicates that Case Managers must "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)". This is also not mentioned in the change log, so is this an intentional change?

A205: Yes. BMS will require that Case Managers personally meet each quarter with the member and their support staff at the member's facility-based day program or pre-vocational center as applicable.

[Updated 8/19/21] The expectation is that there will be one visit each quarter for a total of four visits per service year. For the time-being, it is expected that the CM performs a day service contact/visit for any member that has returned to day services.

Q208: All sections of the manual describing I/DD-07 documentation requirements indicate that the case management agency is to be included as part of the progress note. The I/DD-07 has a section for the provider agency to be completed. Is the expectation that the case management agency is noted here or should the DCS provider, if separate from CM, note their own agency in this section?

A208: [10/14/21] This is an oversight in the manual. The expectation is that the direct care provider agency is noted in this section of the I/DD-07, rather than the case management agency.

Q223: The manual indicates that LPN services are "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." Would this also apply to members that access Crisis Site PCS or would private duty nursing services be more appropriate due to the member's age?

A223: [1/4/24] The site of service definition includes crisis sites so this is allowable and will be included in future policy.

Electronic Monitoring

Q12: The Electronic Monitoring service information states that an incident report has to be entered in the IMS every time an emergency response is generated. Is there an exception to this if the response is a false alarm? If there is not an exception, is there a specific code that needs to be used in the IMS for this?

A12: [12/17/15] Even if the response is a false alarm, an incident report must still be completed in the IMS. It should be entered as a "simple" incident.

Q111: For individuals who receive Electronic Monitoring services, how often must the DD-17 be submitted? This is not specified in the policy manual.

A111: [11/03/16] The DD17 is required annually and should be uploaded with the DD-5 when authorization for the service is requested. For those who currently receive the

service, the DD-17 can be uploaded the next time the team meets and again at the annual juncture.

Extended Professional Services

Q37: The manual indicates that all agency staff, except extended professional staff, having direct contact with persons who receives services must meet all of the qualifications in that section. Does this apply to janitorial, clerical, and other staff who do not provide Medicaid services to individuals?

A37: [1/7/16] No. The requirements in Section 513.2 Provider Enrollment and Responsibilities, must be met by those who provide Medicaid services to persons who receive services. WV CARES will further clarify whether staff who do not provide Medicaid services are required to receive a Criminal Background Check.

[Updated 4/7/16] Only those who provide Medicaid services are required to receive the Criminal Background Check.

[Updated 6/2/16] WV CARES has clarified that direct access means physical contact with a resident, member, beneficiary, or client of a covered provider or covered contractor, or access to their property, personally identifiable information, protected health information, or financial information. As the requirement is for all direct access personnel to undergo a background check, agencies must maintain such on all employees who fit the definition. Any employee who has received a fingerprint-based background check within the last 3 years are covered until the expiration date of those 3 years. Those who have not received a background check in the past 3 years are required to submit an application in the WV CARES system and be fingerprinted.

Q61: Can Occupational, Speech, and Physical Therapy be considered direct care services for individuals who live in natural family settings for the purposes of the rule that requires individuals to receive direct care services at least once every 30 days?

A61: [3/3/16] Yes, BMS has determined that individuals who receive Occupational, Speech, and/or Physical Therapy will not be subject to discharge, even if no other direct care services are provided.

Q89: Is Hippo (Equestrian) Therapy a billable I/DD Waiver service?

A89: [9/1/16] Hippo Therapy can be provided via I/DD Waiver only when an Occupational Therapist utilizes equestrian therapy as the venue through which to deliver occupational therapy. Equestrian therapy alone would not be a billable I/DD Waiver service. Participant-Directed Goods and Services may also be used for this service, as long as

medical necessity is met, the individual self-directs, and there is money in the budget to accommodate.

Q177: Are persons allowed to access only therapy services, and no other IDDW services, through an IDDW agency that contracts with a therapy provider?

A177: [10/3/19] Yes. Agencies are not allowed to refuse services to any IDDW members, including therapies provided via a "pass-through" contract.

Q182: If the only service an agency provides to a member is an extended professional service as a pass-through, is a representative from that agency required to be present at IDT meetings?

A182: [8/6/20] No; while a representative from that agency is not required to attend the IDT meeting, the pass-through agency must ensure that recommendations and utilization for the particular extended professional service are provided to the SC for discussion at that meeting.

[Updated 4/6/23] This also applies to any agency that provides any service (not just extended professional services) as a pass-through. It is the responsibility of the CM to reach out to the pass-through agency prior to the member's meeting in order to get the utilization necessary for inclusion.

Q224: Section 513.16 of the policy manual indicates, "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." Does this logic also apply to accessing Environmental Accessibility Adaptions (EAA) and therapy services via the participant directed option?

A224: [2/1/24] Yes. In order to access EAA and/or any therapy service through the participant-directed option, the member must also access a PCS and/or Respite service through the participant-directed option.

Financial Eligibility

Q50: There have been several issues when calling the number provided to verify financial eligibility. Either the operator will not provide the requested information because they require the guardian to call, or there is no answer. The same information can be obtained via Molina's website. Can a printed confirmation that eligibility is verified via the website be maintained in the member file instead of calling?

A50: [1/21/16] Yes, or the Service Coordinator may verify the month's eligibility during the monthly home visit by viewing the actual Medicaid card.

Q68: Our local DHHR economic service worker indicated that cases for individuals who "have full coverage SSI related Medicaid with no other benefits require no maintenance" with respect to financial eligibility. For I/DD Waiver members to whom this applies, what needs to be maintained in the file?

A68: [4/7/16] Per the Income Maintenance Manual, both medical and financial eligibility must be determined annually. If county DHHRs indicate that it is not necessary to determine financial eligibility annually, please send their name and county to Pat Nisbet or Taniua Hardy for follow-up.

Q85: Does financial eligibility for I/DD Waiver members who have SSI need to be re-determined annually?

A85: [8/4/16] Yes, they do, per Income Maintenance Manual 17.32: "…..SSI…….must complete the DFA-LTC-5 to evaluate any annuities, trusts, and/or other potential resources or transfers when determined medically eligible for I/DD and at each annual redetermination."

Q173: Recent slot allocation letters indicate a specific slot release date for the person, but also specify that services can begin to be provided as soon as financial eligibility has been established and medical eligibility has been re-determined. If a person has completed these requirements prior to their slot release date, can services be provided prior to a person's slot release date or does the IDT need to wait until the identified slot release date for services to commence?

A173: [6/6/19] A person can access services as soon as both requirements are met, however, this does not happen often. There are several channels this information must pass through in order for these requirements to be met entirely, including the necessary coordination from DHHR, KEPRO, PC&A, and DXC Technology (formerly Molina Medicaid Solutions). Any provider that believes an individual has met all of these requirements prior to their slot release date is encouraged to contact the Lead Service Support Facilitator with KEPRO in order to confirm that the individual is active in all systems, prior to providing and billing for services provided. It should also be noted that any person with a July slot release date is prohibited from accessing services prior to their slot release date, due to the rollover of the new fiscal year.

Q207: Section 513.26 Discharge indicates that 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. What exactly does a case management agency do to demonstrate compliance with this requirement and what should the case manager do if a member they serve is determined to be financially ineligible?

A207: [9/30/21] In the event a member is determined to be financially ineligible by DHHR, the Case Manager would assist the member/legal representative as needed and notify all IDDW agencies that provide services to the member. The amount of assistance a case manager is responsible for will vary from member to member. The CM can verify eligibility monthly by calling 888-482-0793. Recent assets/income could also be discussed during the WV ABLE account discussion that takes places during the monthly contact. Also, the I/DD Waiver Financial Eligibility Helpful Hints document that was presented during the August 2019 Quarterly Provider Meeting contains additional details for demonstrating compliance.

Hold/Extension Requests

Q83: Section 513.26 of the I/DD Policy Manual says a person may be discharged from the program if "a person does not access or utilize at least one IDDW Service each month (with the exception of Service Coordination)." So that agencies know when it is appropriate to submit a DD-12, how is the term "month" applied—every 30 days or within the calendar month?

A83: [8/4/16] The term "month" here refers to within the calendar month. For example, if a person does not or will not receive services during the month of July, a DD-12 should be submitted identifying the reason services were not/will not be accessed and requesting an extension.

Q84: Can Service Coordination and/or Behavior Support Professional be billed while an individual is in the hospital, for purposes of discharge planning?

A84: [8/4/16] These services cannot be billed while a person is in the hospital, or at any time when services are on hold. When a member is hospitalized, it is the responsibility of the hospital social worker to arrange for discharge planning. Note, this does not apply to when a person is in a Crisis PCS site and their status is Member Hold-Extension in CareConnection©.

Q98: If a person who receives services passes away, does the SC need to submit a DD-12 if the home visit/day visit was not completed?

A98: [10/6/16] No, this is not required.

Q125: Can Waiver services be provided to persons who are incarcerated?

A125: [6/1/17] No. I/DD Waiver services cannot be provided while someone is incarcerated. In the event that a member is jailed or imprisoned, the SC should submit an I/DD-12 to KEPRO and request an eligibility extension.

[Updated 5/31/17] If a person has gone or will go a calendar month without accessing a direct care service, the SC **must** submit an I/DD-12 to KEPRO as soon as they become aware of the person's circumstances.

Q196: What are the procedures for accessing end of the service year modifications?

A196: [4/15/21] The details of the policies and procedures for accessing end of the service year modifications can be found in the IDDW UM Training document dated 2.18.21 that was sent to the IDDW Distribution List on 2.17.21.

Q200: Can Case Management services be purchased for an individual who is in hold status and whose treatment plan is out of date due to the individual being hospitalized/committed when due for an IDT meeting?

A200: [7/1/21] Yes.

[Updated 7/22/21] Requests for Case Management services can be approved under these circumstances with an approved I/DD-12 that includes details of the service(s) provided or to be provided while the member is in hold status.

[Updated 8/5/21] While Case Management services can be approved and billed while a member is in hold status, it may not be done for members who reside in an ICF. It is the responsibility of the ICF social worker to complete all Case Management activities, including securing housing and associated tasks.

Providers are advised that, if the member does not have a budget and service plan, Case Management services can be authorized with an approved I/DD-12 describing what activities will be performed. It will also be necessary to maintain Case Management Logs while the member is on hold. Note that payment is not guaranteed in the event that the member is not determined to be medically eligible and that no billing can occur when the member is out of state. Further, billing Case Management services while the member is on hold is an option, but is not a requirement and should only be provided if the member needs the service. If the IPP cannot be developed while on the member is on hold, Case Management services can only be billed with an approved I/DD-12.

[Updated 8/19/21] This is allowable in any living arrangement except for members residing in an ICF. For individuals who are already on hold, if the IDT determines that CM units need to be requested, a new DD-12 must first be submitted and approved. Do not resubmit if there is no intention to bill CM while the member is on hold. Note that a brief summary of what services the CM intends to provide is all that is necessary.

Q201: Can Case Management services be billed for an individual who is hospitalized or receiving inpatient services if Case Management services were provided?

A201: [7/1/21] Effective 4/1/21, Case Management services can be billed while a member's status in CareConnection© reflects "Member Hold - Extension" if the member's needs warrant. Proper documentation, either the DD-3 and/or the Case Manager Log as applicable, must be maintained.

Q222: When can CM services be billed while a member's status in CareConnection© is listed as Member-Hold Extension?

A222: [11/15/23] Providers are able to bill Case Management services while on hold with an approved I/DD-12 under the following scenarios:

- **CM services ***WILL NOT* **be billed:** The CM will only need to submit an I/DD-12 for the Eligibility extension. This will also cover any missed visits/meetings. Additional requests for other exceptions while the member is on hold will not be required.
- **CM services, including HVs, ***WILL* **be provided:** The CM will submit an I/DD-12 for the Eligibility extension, as well as request permission to bill CM services while on hold. Under these circumstances, CM services can only be requested and approved for 3 months at a time.
- **CM ***WILL* **be provided (holding meetings, transition planning, etc.), but ***NOT* **HVs:** The CM will submit an I/DD-12 for the Eligibility extension and HV exceptions. This can be completed on a single I/DD-12 and can only be requested and approved for 3 months at a time.

Incident Management System (IMS)

Q12: The Electronic Monitoring service information states that an incident report has to be entered in the IMS every time an emergency response is generated. Is there an exception to this if the response is a false alarm? If there is not an exception, is there a specific code that needs to be used in the IMS for this?

A12: [12/17/15] Even if the response is a false alarm, an incident report must still be completed in the IMS. It should be entered as a "simple" incident.

Q66: If an individual self-directs their services, who is responsible for entering incidents into the IMS?

A66: [4/7/16] The Service Coordinator is responsible for ensuring that incidents are entered into the IMS, as well as for maintaining a written copy of the report in the member file. While PPL Resource Consultants have capability to enter incidents into the IMS and follow-up with families on a monthly basis regarding reportable incidents, they will verify with the SC prior to entering an incident in order to avoid duplication.

[Update 11/2/23] If an incident is reported to PPL, PPL will enter the incident into the IMS and will also follow up with the CM to ensure that this information is being communicated accordingly as documented in the member's IPP. The CM will also have access to those incidents in the system, which can be linked, as necessary, in order to avoid duplication.

Please be reminded that all members of the IDT must work together to ensure that all documentation, as it relates to the accurate recordkeeping of incident reporting, is made available to all applicable IDT members.

Q91: When an incident occurs involving an individual who receives Service Coordination services from one agency and residential and/or day services from another, which agency is responsible to enter the incident into WV IMS?

A91: [9/1/16] The agency whose staff observe or are involved in the incident should report the agency in WV IMS. In the event the individual receives Service Coordination from another agency, the residential/day service agency is responsible for notifying the SC of the incident, as well as for completing follow-up in the IMS. That agency must also provide the SC with copies of all related documentation. If the incident occurs in a residential or day setting where the individual also receives SC services, the observer can notify the SC who can then enter the incident.

[Update 6/22/22] All members of the IDT must work together to ensure that all documentation, as it relates to the accurate recordkeeping of incident reporting, is made available to all applicable IDT members.

Q213: If there is an outage with the WV Incident Management System (IMS) that prevents users from accessing and entering member information what should agencies do in order to remain compliant with policies related to incident management requirements?

A213: [3/3/22] Providers are encouraged to reach out to the DHHR IMS Help Desk for technical assistance by emailing dhhrrapidshelpdesk@wv.gov. Please include a description of the issue or question. For error messages, please include a screen shot of the error and a description of what the user was doing or clicked on just before getting the error. If the request is participant specific, supply only the participant's name, the waiver program, and no other identifiable information.

If a system-wide issue is confirmed, Kepro will assist BMS with identifying the timeframe that the system was inaccessible and notify all providers accordingly. Providers for whom members experienced an incident during the identified timeframe should be certain to maintain documentation in the member file indicating that the incident could not be entered due to issues with the system. It will not be necessary to reach out to the agency's assigned Provider Educator in order to demonstrate compliance.

[Updated 3/9/23] Once Kepro/BMS/DHHR become aware of an outage with IMS, Kepro will assist BMS with identifying the timeframe that the system was inaccessible and notify all providers accordingly. Providers for whom members experienced an incident during the identified timeframe should be certain to maintain documentation in the member file indicating that the incident could not be entered due to issues with the system. It will not be necessary to reach out to the agency's assigned Provider Educator or the help desk in order to demonstrate compliance.

Q214: According to the reporting and investigation guidelines for incidents released by OHFLAC in December 2021, medication errors are now considered critical incidents. Previously, medication errors would be reported in the IMS as a simple incident if it did not result in an adverse effect that necessitated medical treatment or intervention. How should providers report incidents of this nature in the IMS moving forward?

A214: [3/3/22] The guidelines indicate that medication errors ***might*** be included as a critical incident. As in the past, not all medication errors will need to be entered into the IMS as critical incidents. Providers will need to use their professional/clinical judgement when entering incidents of this nature in the IMS. For members that utilize AMAP services, it is the responsibility of the RN who supervises the AMAP to provide that professional/clinical judgement to the person entering the incident.

- **If the medication error did result in an adverse effect that necessitated medical treatment or intervention,** the IMS user should enter this as a Critical Incident and select the "Treatment Error with Negative Outcomes" or "Other" option and an investigation/reporting consistent with these guidelines must occur.
- **If the medication error did not result in an adverse effect that necessitated medical treatment or intervention,** the IMS user can enter this as a Simple (Non-Critical) Incident, and the agency should use this to track and follow-up upon any pattern(s) of refusal behavior. Providers must ensure that this is addressed in the member's treatment plan.

Q221: When do providers need to begin entering incidents into the new WellSky Incident Management System? Will leniency be granted by BMS while providers are transitioning between the two incident management systems?

A221: [11/2/23] Providers should enter incidents in the new WellSky IMS beginning on August 1, 2023 moving forward. As of August 1, 2023, providers should no longer enter incidents into the old IMS. Providers will be granted a grace period to come into compliance with the use of the new WellSky IMS. Incidents that are either not entered into the new WellSky IMS or are deficient from 8.1.2023 - 10.31.2023 will only be subject to technical assistance during this transition from one system to the other in order to accommodate the learning curve.

[Update 6/6/24] Providers should enter incidents in the new Atrezzo IMS beginning on June 1, 2024 moving forward. Providers will need to complete any required incident

follow in Wellsky's system before June 14, 2024. As of May 31, 2024, providers should no longer enter incidents into the Wellsky IMS. Providers will be granted a grace period to come into compliance with the use of the new Atrezzo IMS. Incidents that are either not entered into the new Atrezzo IMS or are deficient from 6.1.2024 - 6.30.2024 will only be subject to technical assistance during this transition from one system to the other in order to accommodate the learning curve.

Q227: In the Wellsky IMS, an incident that occurred in the home and required first aid was considered a simple incident. In the Atrezzo IMS, an incident with the same circumstances is considered a critical incident. For IDDW purposes, which incident category is accurate, and should this be marked differently if the incident occurs in the member's day setting?

A227: [7/11/24] For IDDW purposes, BMS has determined that if an incident requiring first aid care is necessary in the member's home or day setting, then it should be entered as a simple incident. If first aid is sought outside the member's home or day setting, then it should be entered as a critical incident. To complete this in the Atrezzo IMS, the user must:

- Select Simple/Accident/Injury not requiring first aid/medical intervention.
- Describe the incident in the text box.
- Enter the location where first aid care was provided in the text box.

[Updated 8/1/24] An incident resulting in a minor injury (shallow cut, scratch, scrape, bruise, minor burn) that requires no first aid or only simple first aid (antiseptic, topical cream/ointment, bandage) should be reported as a simple incident. This applies to all settings (member's home, community, and day setting). To enter minor injury incidents in the Atrezzo IMS, the user must:

- Select Simple/Accident/Injury not requiring first aid/medical intervention.
- Describe the incident in the text box.
- Enter the location where first aid care was provided in the text box.

More serious injuries that require first aid/medical treatment outside of the member's home or day setting (emergency room, urgent care) are to be reported as critical incidents.

Sudden illnesses that require medical treatment outside of the member's home or day setting are also to be reported as critical incidents. Visits to urgent care settings in lieu of a scheduled doctor's appointment for non-emergency treatment of minor illnesses (common cold, seasonal allergies) may be reported as simple incidents.

Individual Program Plan (IPP)

Q25: What sections of the I/DD-5 are required to be uploaded to CareConnection©?

A25: [1/7/16] The entire IPP (I/DD-5) must be uploaded to CareConnection© before requesting prior authorization for services. APS and BMS must have access to the entire document in order to review when considering requests.

Q30: The ISP section of the new I/DD-5 requires that the name of the staff person be indicated in the section for provider. Is it permissible to indicate the agency in this space instead of the staff person's name for those who live in ISS and for those who attend agency day services? Frequent turnover in these particular settings would require very frequent updates to the IPP document.

A30: [1/7/16] For Licensed Group Home PCS, Unlicensed Residential PCS, Facility-Based Day Habilitation, Pre-vocational Training, Job Development, and Supported Employment, it is acceptable to indicate the name of the agency that will supply the staff. For all other services, the name of the staff person must be indicated.

Q52: Can video-conferencing such as Omnijoin or Go To Meeting be used for BSPs and RNs to attend IDT meetings?

A52: [2/4/16] These professionals can attend IDT meetings using such services; however RN IPP Planning and/or BSP IPP Planning can only be billed by the professional when he/she is physically present.

Q54: As many agencies and families are using technology more, is it permissible to send an IPP to the family by email instead of printing and mailing a hard copy? If so, how is this best documented?

A54: [2/4/16] If any IDT members prefer to receive the IPP via email, then this is permissible. All email communication that includes Protected Health Information (PHI) must be sent securely. In order to document that the email with the attachment was forwarded, a service note can done and a copy of the email attached to that service note, which would then go into the record of the person who receives services.

Q63: When a member transitions to new services at a juncture other than the annual, can an addendum be uploaded to CareConnection© or must the entire IPP be provided?

A63: [4/7/16] If the annual IPP is not already in CareConnection©, it must be uploaded before any authorizations will be provided. In the event that the transition occurs at a critical juncture or quarterly, an addendum showing the changes to the annual IPP is sufficient. If the transition occurs at the 6 month juncture, the 6 month IPP showing the changes must be provided.

Q78: Under what circumstances may an IDT member write in "attended" on a signature page instead of agree or disagree? What is billable for the SC when trying to obtain those signatures after the meeting?

A78: [6/2/16] The SC can bill for documenting the IPP. Signatures and attendance, and if possible, agreement and/or disagreement should be obtained during the IDT meeting. In the event that a team member chooses not to provide agreement/disagreement at the meeting, the SC should send a copy of the signature sheet with the completed IPP for the team member to indicate agreement/disagreement and return. The IPP is not valid until all required signatures and indication of agreement/disagreement are obtained.

Q88: Policy Clarification #30 (under the Individual Program Plan section) mentions that all services other than the direct care services listed in the answer must indicate a name of the staff person who provides the service. For those living in an ISS or group home setting, Transportation Trip and/or Mileage could be provided by a number of staff members who work in the ISS or group home. Could these two transportation services also be indicated as being provided by the name of the agency as opposed to a roster of staff members who work with the individual?

A88: [9/1/16] Yes, this is permissible.

Q104: In situations when the Waiver recipient refuses or is unable to sign the IPP, how should providers proceed?

A104: [11/03/16] In such cases, it should be documented in the meeting minutes and on the signature sheet that the individual cannot or will not sign the IPP. Note that members do have the right to refuse to sign and/or disagree, so it is important that the reason for the refusal be documented.

Q109: Agencies are experiencing a frequent need for addendums regarding ratios of 1:1, 1:2, and 1:3 services. In conducting addendums, I am finding that IDTs are not concerned with the number of units of each ratio provided; rather they are concerned that 24 hours of service overall be provided. As such, is it acceptable for the team to identify in the annual meeting that 24 hours of service will be provided across ratios throughout the year, and then update the ISP as needed, without the requirement to hold an addendum again when simply changing ratios, as long as the budget is not exceeded?

A109: [11/03/16] An addendum is required, but a face-to-face meeting is not. The IPP must specify ratios as agreed upon by the team and be updated when they change.

Q117: Are Medical Powers of Attorney/Healthcare Surrogates required to attend members' IDT meetings?

A117: [2/2/17] A person designated as a Medical Power of Attorney (MPOA) is someone chosen (via advanced directives) in the event the member is not able to make decisions on his or her own behalf. When a member is determined unable to make health care decisions, the MPOA is a required team member. Medical providers identify a healthcare Surrogate in the event the member is unable to make decisions. If a program member has an identified Healthcare Surrogate, that Healthcare Surrogate would be required to attend all IDT meetings. For additional information regarding advance directives requirements, see WV State Code 16 Article 30 § 6, which can found here: http://www.legis.state.wv.us/wvcode/Code.cfm?chap=16&art=30

Q126: Is it necessary for the specific DHHR guardian listed in CareConnection© to sign the I/DD-5 or can any DHHR guardian sign the document in order to obtain prior authorization for services?

A126: [6/1/17] Any DHHR guardian can sign in place of the one listed in CareConnection©; however the circumstances surrounding the alternate attendee should be noted in the meeting minutes for the sake of clarity.

Q128: Section 513.8.1.3 of the IDDW Manual states, "when a person 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 person needs to successfully access the new setting and services. A thirty day IDT must occur to finalize these services." Is a seven day and/or a thirty day meeting(s) required if a person chooses to access the traditional and person options service delivery model?

A128: [8/3/17] No. In this instance, a seven day meeting would only be required if there was a change to the person providing the primary caregiver residential services.

Q129: The ISP section of the DD-5 has the SC specify the amounts and frequencies of each service by completing the following: "Services should average ___ units per month & should not exceed ___ units per year." Can this statement be manipulated to better describe services that are not necessarily used on a monthly basis and/or if the billing increments are actually miles, trips, or events?

A129: [8/3/17] Yes. The SC can do this, but should still specify an average amount over the course of the service year, as well as the amount of services that will not be exceeded during the service year.

Q130: Is it necessary for the person's IPP to address all maladaptive behaviors listed on the ICAP in order for service requests to be approved by KEPRO?

A130: [8/3/17] Registration Coordinators at KEPRO will review the necessary documentation to ensure that health and safety needs are sufficiently addressed in a person's IPP. If it is unclear in the documentation submitted, then the Registration

Coordinators will request additional information in order to make a clinical determination.

Q131: Is it necessary for all IDT members to be present for the entire duration of a team meeting in order for the IPP to be considered valid?

A131: [9/7/17] Policy does not dictate all members must be present for the entire duration of a team meeting in order for an IPP to be considered valid. Per Chapter 513.8, "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 person receiving services or their legal representative must agree with the plan for it to be considered a valid IPP."

Make note that the validity of the IPP has different requirements than those for providers billing for attending/participating in an IDT meeting. See each service description for IDT attendance and documentation requirements.

[6/27/18] Section 513.25.2 of the manual states that the person and/or their legal representative (if applicable) have the responsibility of being present during IDT meeting. In extremely extenuating circumstances, the legal representative or other team persons may participate by teleconferencing if they do not bill for the time spent in the IDT. The person **must** be present and stay for the entire meeting if they do not have a legal representative.

Q145: When a person chooses to transfer services to a different Service Coordination agency should this be documented on an I/DD-4 or on an I/DD-5?

A145: [6/7/18] This should be documented on an I/DD-5. The I/DD-4 is only appropriate to use for new slot releases. Documenting this on an I/DD-5 allows the Registration Coordinators to see the ISP boxes that they will need to have access to in order to make a determination in regards to modifications and/or purchase requests.

Q150: The new budget letters indicate, "If you request an exception, your IDT must fill out two sections of the IPP; one for the services you want, including services in excess of the budget, and one in which services requested are within the budget." Will the I/DD-5 template be updated to include samples of these required sections in the event the IDT chooses to pursue the Exceptions Process?

A150: [7/5/18] The I/DD-5 will be updated and made available soon. In the meanwhile, if the IDT plans to pursue the Exceptions Process, the SC should ensure that these details are included in the meeting minutes.

Q168: OHFLAC requires that the IPP be reviewed by the IDT no later than 180 days after the date of the annual meeting. IDDW requires that the meeting be held within six

months of the anchor date. On occasion, these two requirements conflict with one another. Is there a solution?

A168: [3/7/19] If this occurs, a DD12 can be submitted to hold the meeting outside timelines and it will be approved to allow agencies to remain in compliance with OHFLAC requirements. Simply explain the issue on the DD12 and be sure to maintain it in the member's record.

Q176: Are providers required to attach a signature page in CareConnection© that is signed by all IDT members for an addendum in order to gain approval?

A176: [8/1/19] In general, a signed signature page is not required for authorizations through CareConnection©. A signature page indicating verbal agreement from all IDT members would suffice until the physical signatures are obtained and included in the member's file. However, there are circumstances in which the physical signatures will be required that include, but are not limited to, when multiple agencies are involved, any circumstance(s) having an impact on the integrity of the documentation, and/or if the IDT decides not to pursue a Medicaid Fair Hearing (MFH), but chooses to make modifications during the timeframe in which a MFH could be requested.

Q180: Is a 7-day and/or 30-day IPP required when transferring SC (Case Management) services only?

A180: [6/4/20] No. When transferring SC (Case Management) services only the original transfer IPP and DD10 are the only requirements. A 7-day and/or 30-day meeting should not be held. If modifications to SC services are required after transferring, an addendum may be completed. If the necessary modifications would cause the budget to be exceeded – complete a regular CJ IPP and request an Exception for the additional services in excess of the budget.

Q181: If services can be finalized when transferring residential and/or day services at the 7-day IPP, is a 30-day IPP required?

A181: [6/4/20] While policy says that both meetings are required, BMS has opted to amend this requirement as follows: a 30-day meeting is only required in this circumstance if services cannot be finalized at the 7-day meeting. The 30-day meeting, if necessary, should be conducted after the transfer occurs.

[Updated 6/3/21] Initial IPPs for new slots are required to take place within 7 days of intake. Intake is defined as the date of enrollment with the agency that will provide services. In the event that services are finalized at the 7-day meeting, a 30-day meeting is not required. If services are finalized at the 7-day meeting OR if the 30-day meeting is required, and these meetings fall during the 30 day period before the anchor date, this meeting will also serve as the annual meeting of the IDT.

[Updated 7/1/21] In the event that services are able to be finalized at the 7-day meeting for a new slot, the CM should complete a I/DD-5 rather than a I/DD-4.

[Updated 7/22/21] Please refer to the 5.27.20 QPM for details and examples of IDT Meeting requirements for Initial and Transfer IPPs.

Q183: When a member receives direct care services from an agency and there is no professional, such as an RN or BSP on the IDT, is it acceptable for the parent provider to serve as the agency representative?

A183: [9/3/20] An agency representative may attend or the selected agency can provide written agreement to be included in the IPP. Accurate utilization must be provided to the SC prior to the meeting if an agency representative other than the parent will not be in attendance.

Q186: Is a formal meeting with team agreement required to begin the development of a Functional Behavioral Assessment (FBA)?

A186: [11/18/20] Yes. The FBA is a part of the Positive Behavior Support Plan process and team agreement is required after discussing the implementation of all areas of the Positive Behavior Support Plan process.

Q191: Are physical and/or acceptable electronic signatures required for Addendums?

A191: [1/7/21] Yes. While physical and/or acceptable electronic signatures are not required to obtain prior authorization, it is required that signatures confirming IDT agreement are obtained prior to or at the next meeting juncture.

[Update 1/21/21] Addendums will not require signatures during the time that Appendix K is approved. Signatures for all other documents related to the IPP will continue to be required.

Q204: Section 513.19.1 and the Change Log both indicate that Case Managers must 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. Is this an intentional change?

A204: [7/22/21] No. BMS will continue to require that Case Managers make purchase requests and upload documentation to member's file in CareConnection© within 14 calendar days following the date of the IDT meeting or team's approval of a service plan addendum.

Q216: What is BMS' expectation as far as the HCBS requirement to identify on the IPP that all staff who work with the member are properly trained and certified?

A216: [11/3/22] A statement to the effect that all direct care staff meet all requirements is sufficient. It is not necessary to list each staff person's name on the IPP or attach DD6s or other supporting documentation. This must be reviewed at each juncture to ensure it is accurate and current. BMS will update the IPP document to include this requirement.

Q228: What are the expectations and responsibilities of the IDT for pursuing Human Rights Committee (HRC) input/approval while identifying any potential rights restrictions and/or rationale for continuation of psychotropic medications in the new IPP template? Is there a distinction in the member's setting or services that might render the need for HRC input/approval non-applicable?

A228: [9/5/24] Regardless of the member's setting (natural family home, specialized family care home, ISS, group home, or day program), all restrictive measures or aversive procedures, including psychotropic medications to control inappropriate behaviors must be based upon the member's assessed needs, identified on the IPP, and reviewed/approved by the IDT. Restrictive measures/aversive procedures that are implemented by agencies with behavioral health licenses (including administration of psychotropic medications) must also be reviewed, approved, and monitored by the licensed agency's Human Rights Committee (HRC) as required by OHFLAC regulations. Providers are also encouraged to reach out to OHFLAC with questions regarding HRC requirements, as necessary.

Intellectual/Developmental Disabilities (I/DD) Waiver Forms

Q42: The transportation log portion of the I/DD-7 lists the starting address under the travel column and the ending address under the travel to column. This is different from the previous I/DD-7, so it appears that the actual street address is required on the form. Is this correct? If so, how should it be documented?

A42: [1/21/16] Yes, the street address is required, and should be documented as follows:

Date	Travel From (Starting Location)	Travel To (End Location)	Reason For Travel (Must Correspond To An Objective On The Member's IPP)	Total Miles Or Trips	Provider/ Staff Initials
12/30/15	1234 Main St Dunbar	100 Nitro Marketplace Cross Lanes	Small Purchase	10	CM

Q62: On the I/DD-5, in the medications section, there is space for both "reason rx/dx" and "rationale for continuation," which seems repetitive. What is the expectation for these items?

A62: [3/3/16] The "reason rx/dx" item should include the reason the medication is prescribed; to also include a "rationale for continuation" is an OHFLAC Behavioral Health regulation, and should include the reason the medication must continue to be taken at the time of the IPP. The reason the medication may be the member's diagnosis "dx."

Q99: If a member passes away, are both the DD-10 and DD-11 required?

A99: [10/6/16] As long as the SC submits the discharge in CareConnection© and attaches the DD-11 with all necessary information, the DD-10 is not required.

[Updated 11/7/24] Effective immediately, DD-11s (Notification of Death) will be discontinued. Providers will no longer be required to complete DD-11s or attach completed forms in CareConnection©. The DD-11 will be replaced by the Notification of Death in the Atrezzo IMS. When a member passes away, providers must complete an incident report, the Notification of Death in the Atrezzo IMS, and initiate the discharge process in CareConnection©.

Q120: On the I/DD-09, is it necessary to identify the number of units for each ratio if the IDT is requesting to utilize the LPN 1:2 and/or 1:3 code(s) or would the total number of LPN units needed suffice?

A120: [4/6/17] If the IDT plans to utilize the LPN 1:2 and/or 1:3 codes, then it will be necessary to identify the total number of units needed for each ratio of this service.

Q124: On the updated DD-3 that was sent out with the 3/2/17 policy clarification call information, a new section was added for the SC to verify that the individual received a Direct Care Service during the month. Does the SC have to submit a DD-12 if the individual did not receive a DCS during the month or should providers contact KEPRO in order to determine if a DD-12 is necessary?

A124: [5/4/17] According to the memo sent to all I/DD Waiver providers on 3/22/16, effective 4/1/16 if an individual goes longer than 30 days without accessing a DCS, the SC must submit a DD-12 to KEPRO if the person has gone 30 days without services or if it is anticipated that this may occur.

[Updated 4/7/17] It is the expectation that the SC records on the I/DD-3 whether or not the person received a DCS during the previous ***calendar month***, as well as if it is anticipated that the person will not receive a DCS during the current and subsequent months. If the person did not or will not receive a DCS in a calendar month, then the SC

should submit an I/DD-12 as soon as they become aware that this requirement has not or will not be met.

Q127: What is the process for requesting and receiving approval for Participant-Directed Goods and Services (PDGS)?

A127: [7/6/17] The SC requests authorization for PDGS in CareConnection©, being certain to attach a completed DD-8, applicable estimates, and the portion of the IPP that details the specific item/service and why it is needed, as well as a signature page showing team agreement. If the request is within budget and all necessary supporting documentation has been submitted, KEPRO will provide authorization in CareConnection©.

[UPDATE 6/2/22] Once the request is approved in CareConnection© and PDGS has been authorized, the member's PPL Resource Consultant will notify the member/representative and assist as needed with the completion of the PDGS packet. Upon receipt of the completed PDGS packet, PPL will confirm that the requested item/service complies with requirements in Section 513.16 Goods and Services of the IDD Waiver policy manual. The PPL Resource Consultant will notify the member/representative of the determination.

In order to obtain a PDGS Application/PRF packet or if there are any questions related to PDGS decisions, please contact your assigned Resource Consultant or email WV-PDGS@pcgus.com PPL requests that, in order to expedite processing of requests, instructions on the PDGS application be read and followed carefully.

Q134: Is it permissible to modify I/DD forms for specific agency purposes and, if so, would faxed/electronic signatures be considered compliant during an on-site review? Are original documents required to be maintained in files?

A134: Yes. The integrity of the form and all required information must be maintained; however the forms may be modified to meet specific member or provider needs. Faxed and/or electronic signatures are also acceptable.

[Updated 1/29/18] Original documents are to be maintained in the file.

Q141: In regards to the completing the I/DD-2 at the time of the Annual Functional Assessments the revised manual states, "If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days." The manual also states that, "If the person 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 Service Coordinator to obtain the signature of the legal representative prior to or at the Annual IPP." Considering that the Annual Functional Assessment is completed approximately 90 days prior to the person's

Anchor Date, how can both requirements be met if the legal representative does not attend the Annual Functional Assessment?

A141: [5/3/18] The expectation is that the I/DD-2 is to be completed with the legal representative within 10 days of the date that the Annual Functional Assessment was held. If, however, it is not possible to do so it should be completed at or before the person's Annual IPP meeting and the SC should document the circumstance that prohibited completion within 10 days.

Q142: If a Service Coordinator is required to complete the I/DD-2 with the legal representative as a result of the legal representative not attending the Annual Functional Assessment, then how can the Service Coordinator answer questions that the KEPRO Service Support Facilitator would otherwise field while still ensuring that conflict of interest policies are also being followed?

A142: [5/3/18] Service Coordinators are responsible to be familiar with policy and to answer questions regarding services and service options. In the event that a legal representative has questions the SC is unable to answer, they can contact their assigned Provider Educator or refer the legal representative to KEPRO's member/family Liaison for additional assistance.

Q145: When a person chooses to transfer services to a different Service Coordination agency should this be documented on an I/DD-4 or on an I/DD-5?

A145: [6/7/18] This should be documented on an I/DD-5. The I/DD-4 is only appropriate to use for new slot releases. Documenting this on an I/DD-5 allows the Registration Coordinators to see the ISP boxes that they will need to have access to in order to make a determination in regards to modifications and/or purchase requests.

Q208: All sections of the manual describing I/DD-07 documentation requirements indicate that the case management agency is to be included as part of the progress note. The I/DD-07 has a section for the provider agency to be completed. Is the expectation that the case management agency is noted here or should the DCS provider, if separate from CM, note their own agency in this section?

A208: [10/14/21] This is an oversight in the manual. The expectation is that the direct care provider agency is noted in this section of the I/DD-07, rather than the case management agency.

Q225: What documentation will require physical and/or acceptable electronic signatures upon the implementation of new policy?

A225: [2/1/24] Upon the start date of new policy, any and all forms that identify a place for signatures will require physical and/or acceptable electronic signatures. The only exception to this will be I/DD-3s that are completed via electronic means per policy.

Intensively Supported Settings (ISS)

Q21: Will there be any over-budget approval for individuals whose lease obligations or inability to find someone to share a home with prevent agencies from being able to provide direct support services in ratios other than 1:1?

A21: [12/17/15] These will be considered on a case-by-case basis. Service Coordinators should submit the Direct Support Living Arrangement assessment, attached, in advance of the annual IDT meeting in preparation. Agencies are encouraged to assist individuals with ensuring their living arrangement needs are met in the most cost-effective manner possible, as, unless clinical/medical necessity is demonstrated, 24-hour per day 1:1 ratios will not be approved. This may require that IDTs proactively identify alternatives to 1:1 ratios PRIOR to the annual IDT meeting.

Q22: What is the final decision on the requirement for requests for more than 12 hours, average, per day of 1:1 direct support? The Policy Manual states "all requests for more than an average of 12 hours per day of 1:1 services require BMS approval," however, we have been directed that the Direct Support Services Living Arrangement assessment is not required if the request is under budget?

A22: [Updated 3/3/16] The Direct Support Services Living Arrangement assessment (DSS LA) must be submitted under the following circumstances:

- The individual wishes to change the current living arrangement to a setting that will result in an increase over the current cost of annual services
- A change in living arrangement will result in the **current** budget being exceeded (note, approval of a DSS LA is required prior to changing living arrangement in the demographics section in CareConnection©)
- The current living arrangement is ISS, the individual does not wish to change living arrangement, however, the request for services agreed upon will cause the budget to be exceeded
- The individual lives in a setting other than ISS and wishes to receive greater than an average of 12 hours per day of direct support services

[Updated 5/5/16] Note that, as announced at the Quarterly Provider Meeting in March 2015, prior approval is required for individuals to receive a higher level of direct support services than he/she is currently receiving. While BMS does not approve or deny a person's choice of living setting, medical, behavioral, and/or circumstantial necessity must be demonstrated in order for a higher level of services to be approved and/or for the current assigned budget to be exceeded. **Agencies are**

advised against providing services prior to receiving authorization as reimbursement cannot be guaranteed.
[Updated 7/21/16] Per BMS: those who live in an ISS and are requesting a 2nd Level Negotiation decision from BMS about services not authorized are required to submit as well.

Q64: On the Direct Support Services Living Arrangement (DSS LA) assessment, what is the difference between "conditionally approved" and "approved as requested?" Specifically, what criteria must be met in order for BMS to "approve as requested?"

A64: [4/7/16] A DSS LA may be conditionally approved, rather than denied, if the request for new or continued requests for 24-hour per day direct support services can be approved, but not exactly as requested. For example, it may be possible for the individual to receive 24 hours of direct support service per day without exceeding the budget by utilizing different ratios than what is initially proposed. Conditionally approved means the request is approved so long as certain conditions are met. Approved as requested means the request is approved, and no additional conditions are necessary. In order for a request to be approved, medical, behavioral, or circumstantial necessity (such as owning a 1-bedroom home BEFORE March 2015 when this policy went into effect), must be demonstrated.

Q65: If an agency is temporarily unable to staff an ISS, can the individuals who live in that setting be placed in a crisis site?

A65: [4/7/16] This is not allowed. Agencies are expected to staff ISS. The purpose of crisis sites is to assist members who are experiencing behavioral crises or to assist those who live in natural family/SFCH and have lost their natural supports.

[Update 2/2/17] This also applies to individuals who live in an ISS and receive services via the Traditional with Personal Options Service Delivery Model. Individuals cannot be placed into a crisis site due to being unable to staff the home. **Exception: if the individual will transition to the Traditional Service Delivery Model upon discharge from the crisis site, this is allowed.**

Q67: Is a modified diploma required for someone to receive 24 hour residential services as an adult?

A67: [4/7/16] No; individuals over the age of 18 are not required to have any sort of diploma in order to receive residential services.

Q94: Please provide some clarification to [old] PC #133 that states "someone who lives in an ISS cannot receive PCS-Agency or PCS-Family on weekends in a Specialized Family Care Home." With new policy, ISS have been replaced by Licensed Group Home and Unlicensed Residential settings. Can someone who resides in a Licensed Group Home or

Unlicensed Residential setting be eligible to receive Home-Based Person Centered Supports as it seems to fit within the description of the service and the site of service outlined in the manual?

A94: [9/1/16] Individuals who live in ISS or GH are not eligible to receive Home-Based Person Centered Support services.

Q106: Can authorizations for individuals who live in ISS or group homes be modified according to the needs of all individuals who live in the home? For example, an unexpected staff shortage resulted in more 1:2 services being provided than originally planned, requiring adjustment of ratios for all who live in the home.

A106: [11/03/16] This is a staffing issue that the agency is expected to resolve and authorizations will only be considered based on member need.

Q110: If someone who receives I/DD Waiver services lives with a roommate who does not participate in the program but requires care, what ratios of direct care services should be billed?

A110: [11/03/16] If one staff person is working with more than one individual all must be considered when determining which service code to bill. For example, if a staff person works with one person who receives I/DD Waiver services and one who does not, the appropriate ratio to bill is 1:2.

Q136: (*Originally submitted 10/6/17)* What is the minimum age for an I/DD Waiver member to access an Individualized Support Setting (ISS)?

A136: While OHFLAC does generally adhere to this policy, there are exceptions in which they will consider allowing someone who is under 18 years old to be placed in an ISS. These exceptions are considered on a case by case basis. If such an exception is to be considered, then OHFLAC will require information related to where the person will be admitted, information about the other person(s) in the home, and information about the potential placement including:

- The ISS or group home being considered
- The ages and genders of the current residents
- The IPPs for the current residents
- The Behavior Support Plans for the current residents, if applicable
- The staffing ratios identified by the IPP and BSP for all current residents
- The identified maladaptive behaviors of the potential admission

[Updated 12/18/17] If a member who is under 18 years of age is granted an exception by OHFLAC and placed in an ISS setting the provider will not be reimbursed by the I/DD Waiver program.

Miscellaneous

Q4: The new policy manual says that if a home visit was not conducted, services cannot be billed during that month. If there is an approved DD-12, can services be billed?

A4: [12/3/15] Yes.

Q16: I understand that the Policy Manual will not be revised at this time. Will discussions and agreements during Policy Clarification calls be considered policy? Will Policy Clarifications be applied during Provider Reviews?

A16: [12/17/15] Yes, Policy Clarifications will be considered policy. It will be the expectation that agencies apply policy as clarified during conference calls. For Provider Reviews, clarifications will also be applied as approved policy.

Q47: The policy manual says "all required documentation must be maintained by the IDDW provider for at least five years in the person's file subject to review by authorized BMS personnel or contracted agents" and "the provider must retain the member's medical records for at least five years after the date of service. Any record that is disputed or under investigation must be maintained until the issue is resolved." What records, exactly, must remain on site for five years?

A47: [1/21/16] All records pertaining to I/DD Waiver eligibility, service provision, and treatment must be maintained per the instructions in the policy manual.

Q59: Are there plans to look at rate increases for services?

A59: [3/3/16] Not at this time, unless there is an increase in legislative appropriations for this program. BMS will conduct their annual rates review in the near future.

Q96: What is the SC's responsibility for making sure the "Motion for Authorization for Compensation" gets done? How does the absence of getting this done affect PPL?

A96: [12/1/16] WV Legislature House Bill 2885 is a bill to amend and reenact §44A-1-8 of the Code of West Virginia, relating to the eligibility of guardians or conservators to be hired to provide care to a protected person through employment with a behavioral health provider in certain circumstances. Section (g) of this bill allows for guardians/conservators of protected persons to be paid for the provision of services under certain circumstances. (Additional information can be found here: http://www.legis.state.wv.us/bill_status/bills_text.cfm?billdoc=hb2885%20intr.htm&yr=2011&sesstype=RS&i=2885).

[Updated 2/2/17] Guardians/conservators who wish to be paid for providing services are responsible for ensuring that they are in compliance with this rule, and must provide documentation showing such to the Service Coordination agency. This requirement applies to those who receive services via the Traditional service delivery model as well as those who receive services via the Traditional with Personal Options service delivery model.

If the guardian/conservator is employed by an agency via the Traditional service delivery model, the agency is responsible to maintain proof of the following: "the arrangement is disclosed in writing to the court making the appointment of the guardian or conservator and only if the court finds that this is in the best interest of the protected person that such an arrangement occur." Thus, the agency should have proof that the court has been notified and proof that the court finds it is in the best interest of the protected person that such an arrangement occur. If the guardian/conservator is employed by the member via the Traditional with Personal Options service delivery model, PPL is responsible for maintaining the same documentation.

[Updated 3/2/17] It is the expectation that the proof provided by court be attached to the person's file in CareConnection© under the file name, "Legal Forms". For all the existing court documents that haven't been attached in CareConnection©, the appropriate provider should attach them at the time of the person's next Annual or Six Month IDT meeting.

[Updated 11/13/17] This requirement only applies to individuals that are 18 years of age or older, who live in their natural family home, and have a direct care staff that bills Family-PCS. This requirement **DOES NOT** apply if the individual is under the age of 18 or to those that are their own legal guardian.

Q105: That day and residential services for individuals can be modified after the end of the service year has been helpful, particularly since the elimination of group auths. Is this something that can be done for other services, such as professional services or direct care services for those who live in settings other than ISS or group homes?

A105: [11/03/16] Modifications to services requested after the end of the service year are considered on an individual basis for those who live in ISS or group homes only. This practice is only allowed for day and residential services.

Q107: Can providers maintain pictures of documentation on staff cell phones? For example, can Service Coordinators take pictures of DD7s on home visits?

A107: [11/03/16] This is not allowed, as it poses a risk of protected health information being inadvertently disclosed.

Q125: Can Waiver services be provided to persons who are incarcerated?

A125: [6/1/17] No. I/DD Waiver services cannot be provided while someone is incarcerated. In the event that a member is jailed or imprisoned, the SC should submit an I/DD-12 to KEPRO and request an eligibility extension.

[Updated 5/31/17] If a person has gone or will go a calendar month without accessing a direct care service, the SC **must** submit an I/DD-12 to KEPRO as soon as they become aware of the person's circumstances.

Q133: Pertaining to I/DDW Discharges due to death – If the SC enters an Effective Discharge Date into CareConnection© *after* an actual date of death, can the provider still bill for services until the Effective Discharge Date? For example, a SC may need to acquire the death certificate.

A133: Services cannot be billed after a date of death. Molina will reject any claims submitted for services provided after the date of death.

Q136: (*Originally submitted 10/6/17)* What is the minimum age for an I/DD Waiver member to access an Individualized Support Setting (ISS)?

A136: While OHFLAC does generally adhere to this policy, there are exceptions in which they will consider allowing someone who is under 18 years old to be placed in an ISS. These exceptions are considered on a case by case basis. If such an exception is to be considered, then OHFLAC will require information related to where the person will be admitted, information about the other person(s) in the home, and information about the potential placement including:

- The ISS or group home being considered
- The ages and genders of the current residents
- The IPPs for the current residents
- The Behavior Support Plans for the current residents, if applicable
- The staffing ratios identified by the IPP and BSP for all current residents
- The identified maladaptive behaviors of the potential admission

[Updated 12/18/17] If a member who is under 18 years of age is granted an exception by OHFLAC and placed in an ISS setting the provider will not be reimbursed by the I/DD Waiver program.

Q136: How does BMS define a CRP (Community Rehabilitation Program) for the IDD Waiver program/Integrated Services Rule?

A136: [3/1/18] A Community Rehabilitation Program (CRP) with a behavioral health license is considered a specialized facility setting when individuals with disabilities (HCBS recipients/Title XIX Waiver funded) are working and/or receiving training there. This is

true for any facility/setting owned or leased by the CRP, even if it is regarded by some as a general workplace. As such, these programs cannot bill for Supported Employment which occurs at the facility/setting.

Q137: How does BMS define a Specialized Facility for the IDD Waiver program/Integrated Services Rule?

A137: [3/1/18] CMS has notified BMS that "…a specialized facility is a setting with characteristics that segregate or separate individuals with disabilities from a general workplace environment. Examples may include enclaves, sheltered workshop type environments, center-based or facility-based employment."

Q144: Is the time to document that a voicemail message was left billable?

A144: [6/7/18] No, this is not a billable activity. If the agency needs to maintain documentation that messages were left, the service notes are non-billable as is the service.

Q148: On the new budget letters it indicates that requests to pursue the Exceptions Process must be submitted to KEPRO within 30 days of the receipt of the letter. The date of the letter is often not the same as when the person or their legal representative actually receives the letter, so how can the IDT accurately determine the due date for this type of a request?

A148: [7/5/18] The language in the letter has been changed to reflect that requests for exception must be submitted no later than 14 days after the annual IPP meeting and initial purchases have been made in CareConnection©. Those who have already received budget letters with the 30-day language will be notified of the new timelines.

[7/17/18] The timeline for submitting such requests has been updated to include 14 **business days** rather than calendar days. For new slot releases, this will mean 14 business days after the date of the Initial IPP meeting. Future budget letters will be updated to include this clarification.

[8/2/18] The timeline for submitting such requests has been further clarified to reflect **14 business days from the person's Anchor Date.** For new slot releases, this continues to mean 14 business days after the date of the Initial IPP meeting.

Q149: Since there is a new Exceptions Process, is the DSS-LA still a required document and when should it be used?

A149: [7/5/18] Yes. It is still a required document and providers should continue to submit them as previously instructed.

Q153: The manual indicates that direct care services must be purchased first and then, "Professional Services may be purchased next in the following order if the IDT wishes to purchase any of these services: Service Coordination, RN, BSP, any of the specialty therapies (ST, PT, OT and DT), Transportation." Since service coordination is a required service, what options would an IDT have if the assigned budget only covers the cost of direct care services and there is no room in the budget for requesting professional services including SC?

A153: [9/6/18] Service Coordination is a required service for participation in the IDDW program and it cannot be declined if the person wishes to continue to receive services. IDTs are responsible to ensure that the person's assigned budget is utilized responsibly so that the person's needs are and program requirements are being met. Exceptions can be requested as needed.

Q154: Is it necessary to pro-rate all IDDW services including SC, BSP, RN, and miles/trips if services are requested at any time during a person's service year?

A154: [9/6/18] Dependent upon assessed need, there may be a requirement to prorate these services to an average daily number of units.

Q155: Upon implementation of the 2020 policy, and required Independent Service Coordination at that time, can an agency provide both Service Coordination and Direct Care services?

A155: [9/6/18] Yes, when the Independent Service Coordination requirement is implemented with 2020 policy, agencies can provide all available services offered via the I/DD Waiver program. It is important to note, however, that the agency that provides SC services to an individual cannot provide any other services TO THAT PERSON.

Q156: Can an agency keep an electronic copy of the ICAP booklet that is given to the SC at a person's Annual Functional Assessment? If so, is there a need to keep the original ICAP booklet on-site?

A156: [9/6/18] Yes, agencies can maintain electronic copies if they have an electronic records-keeping system (only for record keeping purposes). However, the original ICAP booklet must be maintained onsite as well. If the member/legal representative requests to review the ICAP booklet, the agency is required to allow review of either the electronic file or the original hard copy. The ICAP booklet is not to be copied or reproduced in any format. Agencies are reminded that the ICAP is protected by copyright and therefore cannot be uploaded to CareConnection©, emailed, copied or disseminated in any way.

[9/7/18] In an abundance of caution, the ICAP is a form protected by copyright and, as the IDDW procedures provide, the form is not be altered, copied or distributed in any manner. While the form may be stored electronically, it is advised that it be stored

separately from the medical record. In the event a copy of a medical record is requested, inclusion of the ICAP form would be considered distribution of the form.

Q159: Can a person's guardian attend and participate in the Annual Functional Assessment by phone?

A159: [12/6/18] Yes, but only if there are two other respondents that are physically present at the assessment location. In this scenario, the guardian would still need to sign the form to decline their physical attendance, but would also indicate that they attended and participated via phone.

Q161: Section 513.2.2 of manual indicates, "Referencing people receiving IDDW Services on social media is strictly prohibited." Does this mean that agencies cannot use social media at all or does this simply imply that names/IDDW status not be posted?

Q161: [12/6/18] It is acceptable to utilize social media, however agencies must ensure that all those involved sign a HIPAA compliant release. It is also the expectation that providers exercise good judgement with the information shared via social media by not including names and/or IDDW status.

Q167: It was previously indicated that "Requests for authorization for January anchor dates that are submitted after 1/1/19 and go over budget will be closed." Does this mean that the rate changes only affect those with 1/1/19 anchor dates and forward or do the changes apply to any request submitted after 1/1/19?

A167: [3/7/19] The rates changes apply to any services provided 1/1/19 and later. Requests for authorization that exceed budget due to the rates change will be closed and the provider will be advised to resubmit, taking the rates changes into consideration when determining the overall cost of services for the year.

Q168: OHFLAC requires that the IPP be reviewed by the IDT no later than 180 days after the date of the annual meeting. IDDW requires that the meeting be held within six months of the anchor date. On occasion, these two requirements conflict with one another. Is there a solution?

A168: [3/7/19] If this occurs, a DD12 can be submitted to hold the meeting outside timelines and it will be approved to allow agencies to remain in compliance with OHFLAC requirements. Simply explain the issue on the DD12 and be sure to maintain it in the member's record.

Q169: What is required to submit an exception?

A169: [3/7/19] Before an exception request can be reviewed by a panel comprised of BMS and KEPRO staff, the following must be completed:

- IPP and required attachments uploaded to CareConection©
- Initial authorizations within assigned budget obtained in CareConnection©
- Exception form filled out completely and accurately with service requested matching the IPP, and submitted to IDDWExceptions@kepro.com

Q171: If a member transfers SC agencies, does that agency maintain the completed ICAP booklet or does it go to the new agency as part of the member record?

A171: [4/2/19] The agency who provided services to the member at the time of the assessment retains the ICAP booklet.

Q173: Recent slot allocation letters indicate a specific slot release date for the person, but also specify that services can begin to be provided as soon as financial eligibility has been established and medical eligibility has been re-determined. If a person has completed these requirements prior to their slot release date, can services be provided prior to a person's slot release date or does the IDT need to wait until the identified slot release date for services to commence?

A173: [6/6/19] A person can access services as soon as both requirements are met, however, this does not happen often. There are several channels this information must pass through in order for these requirements to be met entirely, including the necessary coordination from DHHR, KEPRO, PC&A, and DXC Technology (formerly Molina Medicaid Solutions). Any provider that believes an individual has met all of these requirements prior to their slot release date is encouraged to contact the Lead Service Support Facilitator with KEPRO in order to confirm that the individual is active in all systems, prior to providing and billing for services provided. It should also be noted that any person with a July slot release date is prohibited from accessing services prior to their slot release date, due to the rollover of the new fiscal year.

Q178: Can an agency bill URPCS/LGHPCS in a ratio other than what was provided? For example, if a member does not have a roommate but has an authorization for 1:2 services, can the 1:2 ratio be billed when 1:1 services are actually provided?

A178: Billing for a ratio other than that which was provided is not allowed; however, members may pursue authorizations of services identified by the IDT via the exceptions process.

[Updated 4/9/20] BMS reversed their decision and providers can bill lesser ratios than what were actually provided. Ex. Can bill 1:2 if 1:1 services were actually provided, but cannot bill 1:1 if 1:2 services were actually provided.

Q179: Can claims cited for disallowance during provider review be reversed (voided/adjusted) rather than paid back as part of a repayment agreement?

A179: This is not allowed. Once a provider has received their review, no claims associated with the members or staff reviewed should be changed.

[Updated 5/8/20] This is not allowed. Once a provider has received their member sample for their review, no claims associated with those members or staff whose files are reviewed should be changed.

Q185: If a member has two residences, such as in a shared custody situation, does the agency conduct two home visits each month, one at each home?

A185: [11/5/20] No. Under these circumstances, the SC should alternate the location of the home visit so that only one is conducted each month. However, depending on the circumstances of the health and welfare of the member, the Case Manager may determine it necessary to complete visits at both homes in one month. If this is the case, documentation must clearly outline the rationale for both visits taking place.

Q188: What is the procedure for transferring new slots who live in an ICF to IDDW ISS? Who is responsible for completing Case Management activities during the transition period?

A188: [12/17/20] When a new member who lives in an ICF initially gets a slot, he/she receives a budget for Group Homex4. In most cases, these members plan to transition to IDDW ISSx1, ISSx2, or ISSx3. Under these circumstances, the short form DSSLA should be completed by the IDDW Case Manager as soon as the IDT identifies the IDDW living arrangement, being certain to request the most appropriate setting to meet the member's needs. Because the individual is most likely **not** receiving IDDW services during this time, this service is non-billable. It may also be necessary to conduct some meetings that are also non-billable, but these can be limited by the DSSLA short from being prior to the 7-day meeting and submitting it for approval with the initial submission for IDDW units.

Until the time that the member starts to receive IDDW services, the ICF is responsible for ensuring needs are met and facilitating the transition, with the exception of the activities that are unique to IDDW services. The ICF should ensure that all information regarding medications, medical status, and financial status are up-to-date and provided to the receiving IDDW agency.

Q190: Are the nieces and nephews of an IDDW member required to seek home certification through the Specialized Family Care Provider program in order to provide IDDW services in their home?

A190: [12/17/20] Yes. According to IDDW policy, family members that may provide services in their home only includes:

- Biological/adoptive parents or step-parents

- Biological/adoptive adult siblings or step-siblings
- Biological/adoptive grandparents or step-grandparents
- Biological/adoptive aunts/uncles or step-aunts/-uncles

Any other family members wishing to provide IDDW services in their home must seek certification through the WV Specialized Family Care Program.

Q192: If an agency provides behavioral health services such as psychiatric or counseling services to a member, do CFCM policies prohibit that agency from providing behavioral health services and case management services to the same member?

A192: [3/4/21] A member may receive case management and behavioral health services from the same agency. This would not be considered a conflict of interest.

[Updated 3/18/21] This also includes ABA therapy and other outpatient therapies that are not available through the IDDW program.

Q193: Would it be considered a conflict of interest if a member receives services from the same agency that employs a relative of the member?

A193: [3/18/21] If a member receives services from a provider that also employs a relative of the member, then it would not be considered a conflict of interest as long as the relative does not provide or is not involved in the provision of the actual service(s) provided to the member. It would be considered a conflict of interest if the member receives services directly from their relative or if the relative was involved in the provision of the actual service(s) provided to the member. The only services that can be provided by family members are Respite, Family PCS, and/or transportation.

[Updated 5/2/24] Services that can be provided by family members also includes Home-Based PCS. As outlined in section 513.17.2, services are not reimbursable if the DCS lives in the home with the member and/or if services are provided while the member is in the DCS's home.

Q194: Upon implementation of updated policy, would it be considered a conflict of interest if a case management agency also provides payee services to a member?

A194: [3/18/21] It is considered a conflict of interest for payee services to be provided by a member's case management agency, however exceptions may be granted on a case by case basis if no other payee services are available.

Q198: Is a transfer meeting required for a new slot who is Active in CareConnection© but does not have authorizations for services?

A198: [6/17/21] This should not be a common occurrence, but if it does take place, no meeting is needed to transfer to another agency. The transfer-from Case Manager should obtain agreement from the transfer-to agency and the IDT, complete a DD-2 and DD-10, and complete the transfer in CareConnection©.

Q202: Can EAA/PDGS dollars be combined from one year to the next so that $2,000 can be used ($1,000 from each service year) toward one item?

A202: [7/22/21] No, since authorizations are for services provided during a particular service year and cannot be extended into another service year, this is not allowed.

Q203: Section 513.2.2 (Office Criteria) states that an agency office site can serve no more than eight contiguous counties in WV. Since many IDDW providers serve more than eight contiguous counties in WV, is this an oversight?

A203: [7/22/21] This is an oversight. IDDW providers may serve more than eight contiguous counties in WV.

Q212: The IDDW policy manual states that agencies may round units only once per month but HHAeXchange's system rounds per visit/daily. Will this cause provider agencies to be cited for not following policy and/or be subject to disallowance?

A212: [1/6/22] The policy regarding the rounding of units will be updated to correspond with HHAeXchange's system. In the meantime, agencies will not be cited or subject to disallowances for rounding performed by HHAeXchange's system.

Q218: How often does the HCBS Integrated Settings Rule Questionnaire need to be completed for each member?

A218: [3/9/23] The HCBS Integrated Settings Rule Questionnaire should be completed at the Annual IPP.

[Updated 4/6/23] Setting Assessments are completed once a year at the Annual IPP. An additional Setting Assessment may be required if the member moves to a new home or if significant changes are made to the existing home.

Q220: What exactly will Medicaid pay for as it pertains to EAA and/or PDGS authorizations?

A220: [6/1/23] Medicaid will cover the cost of the item/service, labor costs, shipping, cost of permits, and taxes up to $1,000 per service year.

Q225: What documentation will require physical and/or acceptable electronic signatures upon the implementation of new policy?

A225: [2/1/24] Upon the start date of new policy, any and all forms that identify a place for signatures will require physical and/or acceptable electronic signatures. The only exception to this will be I/DD-3s that are completed via electronic means per policy.

Q226: During the January 4, 2024, Policy Clarification meeting changes to the Provider Self-Review process were introduced. Can you summarize the new requirements for the Provider Self-Review moving forward?

A226: [3/7/24] The Provider Self-Review process was updated in January of 2024. The IDDW Self Review (SR) Tool and Attestation documents were updated based on feedback received and disseminated during the February 1, 2024, Quarterly Provider Meeting. Changes to the Provider Self-Review process are as follows:

- The SR will now be completed as part of the provider's annual review beginning with reviews that will take place in April 2024 and moving forward.
    - Providers that have reviews scheduled in January, February, and March of 2024 will not be required to complete the 2023 SR, rather the previous years' SR will be utilized for review purposes.
- Providers will be given anywhere from 30-45 days notice prior to the start of their annual review to complete their SR and Attestation.
- Details related to successful completion of the SR will be communicated to the agency's leadership by the assigned Acentra Health Provider Educator.
    - Until these details have been communicated, there will not be a need for providers to begin completing their 2023 SR and Attestation.
- Starting with annual reviews scheduled to take place in April 2024, providers will complete the SR and Attestation using the included forms and updated instructions that better describe the parameters of the reporting requirements.
    - The Assigned Review Period for the SR will be reduced from all employees providing IDDW services for one year to all employees providing IDDW services for a period of 3 months.
    - As in the past, providers may utilize their own agency-specific tool that captures the same information.

Q228: What are the expectations and responsibilities of the IDT for pursuing Human Rights Committee (HRC) input/approval while identifying any potential rights restrictions and/or rationale for continuation of psychotropic medications in the new IPP template? Is there a distinction in the member's setting or services that might render the need for HRC input/approval non-applicable?

A228: [9/5/24] Regardless of the member's setting (natural family home, specialized family care home, ISS, group home, or day program), all restrictive measures or aversive procedures, including psychotropic medications to control inappropriate behaviors must be based upon the member's assessed needs, identified on the IPP, and

reviewed/approved by the IDT. Restrictive measures/aversive procedures that are implemented by agencies with behavioral health licenses (including administration of psychotropic medications) must also be reviewed, approved, and monitored by the licensed agency's Human Rights Committee (HRC) as required by OHFLAC regulations. Providers are also encouraged to reach out to OHFLAC with questions regarding HRC requirements, as necessary.

Qualified Providers/Training

Q13: The document responding to manual public comments indicates that BMS requires the facilitated APBS Overview of PBS or the WVUCED PBS Direct Care Overview initially, with the hopes that agencies will offer annual refreshers. However, the manual indicates that an Overview is required annually. Please clarify.

A13: [12/17/15] Either the facilitated APBS Overview of PBS or the WVUCED PBS Direct Care Overview is required upon hire. It is not required to be completed annually; however, to ensure that staff are apprised of the latest developments, BMS encourages agencies to offer annual refreshers.

Q18: Is a statement, signed by staff, acceptable verification that state/local laws are adhered to by the staff for auto insurance, inspection, and registration?

A18: [12/17/16] Auto insurance can be verified by requesting a copy of the insurance card required to be maintained in all vehicles and inspection can be verified by checking the inspection sticker on the vehicle.

Q29: For newly hired staff, does the PBS Direct Care Overview have to be completed prior to staff working the person who receives services?

A29: [1/7/16] Before providing any I/DD Waiver service, all staff must meet qualification requirements, with the exception of new policy that was effective 12/1/15. Agencies have until 5/31/16 to ensure that all staff hired before that date meet new requirements. This does apply to the new requirement of either completion of the facilitated WV APBS Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview.

Q31: Section 513.3.7 Person-Centered Support Agency Staff Qualifications, reads: "In addition to meeting all requirements for IDDW Staff in *Sections 513.2-513.2.1.* This gives the impression that there is additional information, though none is provided in this section. Is this a typo?

A31: [1/7/16] Yes, the statement should read: "Must meet all requirements for IDDW Staff in *Sections 513.2-513.2.1.*

Q37: The manual indicates that all agency staff, except extended professional staff, having direct contact with persons who receives services must meet all of the qualifications in that section. Does this apply to janitorial, clerical, and other staff who do not provide Medicaid services to individuals?

A37: [1/7/16] No. The requirements in Section 513.2 Provider Enrollment and Responsibilities, must be met by those who provide Medicaid services to persons who receive services. WV CARES will further clarify whether staff who do not provide Medicaid services are required to receive a Criminal Background Check.

[Updated 4/7/16] Only those who provide Medicaid services are required to receive the Criminal Background Check.

[Updated 6/2/16] WV CARES has clarified that direct access means physical contact with a resident, member, beneficiary, or client of a covered provider or covered contractor, or access to their property, personally identifiable information, protected health information, or financial information. As the requirement is for all direct access personnel to undergo a background check, agencies must maintain such on all employees who fit the definition. Any employee who has received a fingerprint-based background check within the last 3 years are covered until the expiration date of those 3 years. Those who have not received a background check in the past 3 years are required to submit an application in the WV CARES system and be fingerprinted.

Q39: The manual indicates that Service Coordinators are required to comply with training requirements in sections 513.2 and 513.2.1. Does this include the training in Direct Care Ethics and completion of the facilitated WV APBS Overview or WVUCED PBS Direct Care Overview?

A39: [1/7/16] SCs are required to receive the WV APBS Overview or WVUCED PBS Direct Care Overview; however they are not required to complete the Direct Care Ethics.

Q40: Are professional staff (TCs, RNs, SCs, and BSPs) required to receive person-specific training?

A40: [1/7/16] No. These professionals can familiarize themselves by reviewing clinical documentation for the individual as appropriate.

Q56: Section 513.3 of the policy manual states: "all staff must be trained to provide IDDW services in a culturally and linguistically appropriate manner." Since this section is separate from the training requirements in Section 513.2, please clarify who is required to receive this training.

A56: [1/7/16] All staff who provide Medicaid services to persons who receive I/DD Waiver services must receive this training.

Q58: Can I/DD Waiver trainings be completed using live interactive video feeds where the presenter and trainee(s) can see each other, interact with each other, and documents can be presented?

A58: [3/3/16] Yes, this is permissible, as long as the training is interactive as described in the question. This does not apply to CPR or First Aid training, which must be conducted face-to-face.

[6/6/19] First Aid and the non-demonstration portion(s) of CPR trainings may be completed using live interactive video feeds. This does not apply to the demonstration portion(s) of CPR, which must be completed face-to-face.

[Updated 5/14/20] It is permissible for required, non-member specific trainings including Confidentiality, Member Rights, Infectious Disease Control, Recognition and Reporting of Abuse/Neglect/Exploitation, Direct Care Ethics, Conflict Free Service Coordination, and the Overview of PBS to be conducted using pre-recorded materials.

Q70: For purposes of the definition of Human Services degree in the policy manual, what constitutes a Liberal Arts degree?

A70: [4/7/16] At least 15 credit hours in Human Services classes are required for a degree to be considered Liberal Arts.

Q75: Please clarify the difference between the WVUCED Positive Behavior Support Direct Care Overview and the WVAPBS Overview of PBS.

A75: [5/5/16] The WVUCED Positive Behavior Support Direct Care Overview provides a basic yet thorough review of the principles and implementation of PBS and can be obtained by contacting WVUCED at cedcontact@hsc.wvu.edu. CED also offers "Train the Trainer", which is required in order to conduct this overview. The WVAPBS Overview of PBS is a facilitated workshop that provides an introduction to Positive Behavior Support. Providers will be notified when this is offered.

[Update 6/2/16] The WVUCED Positive Behavior Support Direct Care Overview provides a basic yet thorough review of the principles and implementation of PBS and can be obtained by contacting WVUCED at cedcontact@hsc.wvu.edu. CED also offers "Train the Trainer", which is required in order to conduct this overview. The WVAPBS Overview of PBS is a facilitated workshop that provides an introduction to Positive Behavior Support. Providers will be notified when this is offered, however, any individual who has already received this training is qualified to train others. The training and workbooks are available to be downloaded on the WVAPBS website and Liz Bragg is the contact person

for behavioral health agencies. Please contact Liz at Lbragg@shsinc.org if you have trouble downloading the material or cannot locate it on the site.

[Update 7/23/19] The contact information for behavioral health agencies has changed. Please contact WVAPBS@gmail.com if you experience difficulties accessing the materials on the site.

Q77: Several trainings identified in the policy manual are required to be "competency-based." How is competency expected to be demonstrated?

A77: [6/2/16] A score of 85% or higher is required on a post-test in order to demonstrate competency.

[Updated 7/7/16] Person-specific (i.e. DD-6) training is not required to be competency-based.

[Updated 7/25/16] A score of 80% or higher is required on a post-test in order to demonstrate competency.

Q80: Can DD-6 training be conducted via telephone, as long as no billing occurs for the training?

A80: [8/4/16] It is not appropriate for DD-6 training to occur via telephone, even if it is not billed. Face-to-face training on goals/objectives and member health/safety and behavioral issues is required to ensure that the staff person is adequately prepared to provide services. In emergency circumstances, training may be provided via telephone to ensure health and safety of the person who receives services.

Q97: Can RNs provide health/safety training for I/DD Waiver staff via MDTV? If so, is this billable?

A97: [10/6/16] This training can be done via MDTV; however, is not billable. For additional information regarding Tele-health service provision, see WV Medicaid Chapter 503, Behavioral Health Rehabilitation Services, here: http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Behavorial%20Health%20Rehab%20Services/Chapter_503_Behavioral_Health_Rehabilitation_Services.pdf

Q118: For natural families, does the IDT decide if health and safety training is needed and what those health and safety needs are? Or will that still be required for all traditional service providers?

A118: [3/2/17] Policy requires that all staff working with I/DD Waiver members be trained on "person specific needs (including health, behavioral health, and other needs)," with

one exception: parents providing Family Person-Centered Support services or Family Person-Centered Support Personal Options services may waive only this training. All other staff must meet the requirement. The team is responsible to identify the most appropriate person to conduct the person-specific training. Most often this is a Behavior Support Professional, in the case of habilitation and/or behavioral needs, or a nurse in the case of medical needs. In the absence of one of these professionals on the team, parents may conduct the training. In the absence of a BSP to conduct the training, such as when someone uses the Traditional with Personal Options Service Delivery Model, the SC can conduct the training. The IPP must clearly identify who the team has selected to conduct the training, as well as any trainings that have been waived by parent providers. Please note: training on the crisis plan cannot be waived.

[Update 7/10/19] Training on the crisis plan cannot be waived by any staff member who bills a Medicaid service, regardless of Service Delivery Model. In the event that there is not a BSP on the team, the IDT must identify who will be responsible for conducting training on the crisis plan as well and clearly document agreement on the IPP.

[Update 9/1/22] It is the responsibility of the Case Manager to identify in the member's IPP who specifically is responsible to complete the health and safety training, as well as training on the member's crisis plan. If, upon review, either training is not clearly identified in the member's IPP the Case Management agency will be cited.

[Update 12/1/22] Because the dynamics of each IDT varies, BMS extends the liberty for each IDT to determine who is best suited to complete the health and safety training (as applicable), as well as training on the member's crisis plan with all applicable direct care staff. It is also highly recommended that the IDT identify a back-up trainer in the event the agreed upon IDT member becomes unavailable. Input on the contents and development of the member's crisis plan is also a shared responsibility of IDT and must be developed through means of collaboration in order to be meaningful. Training could occur and be documented during this collaboration, which will allow for the CM to identify the IDT's determination in the member's IPP. Future versions of the IPP template will be updated to include a section that prompts the CM to note the details of this discussion.

[Update 1/5/23] Each agency is responsible for maintaining documentation of training completion for their own staff on the member's crisis plan, as required, and for the health and safety training as applicable. The individual(s) identified on the IDT as the person(s) best suited to complete the training must make these records available to the staff person's employer. If an agency is unable to obtain this documentation, then it is recommended that the provider maintains a record of attempts to obtain the training records in the event it is questioned.

Q140: The manual states that an LPN can, "train persons on individualized medical and health needs, such as wound-care, medically necessary diets, ect." Does this mean that

an LPN can bill for training direct care staff or does this apply to training the individual receiving services?

A140: [4/5/18] This applies to training the individual who receives services and not the direct care staff.

Q143: The policy updates effective 2/1/18 include additional requirements for Direct Care Ethics training for Direct Support Professionals. By when are providers required to implement the new requirement?

A143: [5/3/18] Providers should include all required components immediately for anyone hired 4/1/18 or later. For existing staff, providers should ensure that all are trained with the new requirements no later than 8/31/18.

Q162: Are agencies required to maintain proof of WV CARES checks for contracted PT, OT, Speech, and Dietary therapists?

A162: [1/3/19] No, according to WV CARES, IDDW agencies are not required to maintain this documentation for those contractors.

Q187: With the implementation of Conflict-Free Case Management, can the transfer-to agency use the training certification documents (Respite, PCS, transportation, etc.) from the transfer-from agency as proof of certification?

A187: [11/18/20] Yes, this is acceptable.

Q190: Are the nieces and nephews of an IDDW member required to seek home certification through the Specialized Family Care Provider program in order to provide IDDW services in their home?

A190: [12/17/20] Yes. According to IDDW policy, family members that may provide services in their home only includes:

- Biological/adoptive parents or step-parents
- Biological/adoptive adult siblings or step-siblings
- Biological/adoptive grandparents or step-grandparents
- Biological/adoptive aunts/uncles or step-aunts/-uncles

Any other family members wishing to provide IDDW services in their home must seek certification through the WV Specialized Family Care Program.

Q206: New policy, section 513.2.4 Provider Agency Certification-Case Management-Only, says that Case Managers are required to receive education on Conflict of Interest/Professional Ethics, however, this requirement is not mentioned in any other

section of policy. Are Case Managers with full service agencies required to receive this education as well?

A206: [9/16/21] This requirement was omitted by mistake. All Case Managers are required to receive education on Conflict of Interest/Professional Ethics. It is also required, annually, for all Case Managers and the agency director to sign Conflict of Interest Statements.

Q210: Will providers be cited for missing or lapsed training for the WV APBS and/or WVUCED Direct Care Overview of Positive Behavior support since updated training materials were not available?

A210: [12/2/21] No, providers will not be cited for any missing or lapsed training from 3/1/2020 to 8/31/2021. Providers were instructed to bring all required staff into compliance by 9/1/2021.

Q215: The BMS Memo dated January 25, 2021 describes Mandated Conflict Free Case Management Training effective April 1, 2021. It is not clear if the expectation is that all new hires as of April 1, 2021 are allowed the same 3 month grace period or if the expectation is that all new hires as of April 1, 2021 have the required training prior to providing services. Which is accurate?

A215: [9/1/22] The expectation is that all existing Case Managers who are not Licensed Social Workers, Licensed Professional Counselors, or Licensed Registered Nurses will need to complete the CFCM training and certification in the State of West Virginia's Public Learning Center by January 1, 2023. New hires, as of October 1, 2022, will be given a three-month grace period to come into compliance with this requirement. Case Managers providing services without the required CFCM certification must do so under the clinical supervision of a certified Case Manager in order to bill for services.

[Update 5/4/23] The CFCM certification in the State of West Virginia's Public Learning Center has been updated and previous versions have been removed from the system. While it continues to be the expectation that CMs receive this certification upon hire, it will not be necessary for those that have completed their certification using the old course to re-take the training using the updated course. Either version of the certification will suffice as evidence of compliance and CMs will not be required to re-take the certification due to a change in employment. Additionally, the three-month grace period for CMs hired after October 1, 2022 described in the original answer continues to be acceptable.

Moving forward, it will not be necessary to complete any other training related to CFCM, rather the CFCM certification through the Public Learning Center will serve as the only training requirement necessary to demonstrate compliance. It continues to be the expectation that anyone providing CM services be familiar with the COI requirements outlined in section 513.2 "Provider Enrollment and Responsibilities" of the policy manual.

Q219: Which IDT member is responsible to complete training on the member's medical needs?

A219: [5/4/23] The RN is the IDT member that is responsible for completing any necessary medical training(s), however in the absence of an RN on the team the IDT will need to discuss and specifically document who is responsible.

[Update 6/6/24] The RN is the IDT member that is responsible for completing all necessary medical training(s) except in extenuating circumstances such as emergency staff coverage or the short-term unavailability of RN services. However, in the absence of an RN on the team or if RN services are not purchased, the IDT will still need to discuss and specifically document who is responsible to perform this training in the member's IPP. Providers must also continue to follow all regulations of the Approved Medication Assistive Personnel (AMAP) Program related to nursing oversight and staff training.

Q226: During the January 4, 2024, Policy Clarification meeting changes to the Provider Self-Review process were introduced. Can you summarize the new requirements for the Provider Self-Review moving forward?

A226: [3/7/24] The Provider Self-Review process was updated in January of 2024. The IDDW Self Review (SR) Tool and Attestation documents were updated based on feedback received and disseminated during the February 1, 2024, Quarterly Provider Meeting. Changes to the Provider Self-Review process are as follows:

- The SR will now be completed as part of the provider's annual review beginning with reviews that will take place in April 2024 and moving forward.
    - Providers that have reviews scheduled in January, February, and March of 2024 will not be required to complete the 2023 SR, rather the previous years' SR will be utilized for review purposes.
- Providers will be given anywhere from 30-45 days notice prior to the start of their annual review to complete their SR and Attestation.
- Details related to successful completion of the SR will be communicated to the agency's leadership by the assigned Acentra Health Provider Educator.
    - Until these details have been communicated, there will not be a need for providers to begin completing their 2023 SR and Attestation.
- Starting with annual reviews scheduled to take place in April 2024, providers will complete the SR and Attestation using the included forms and updated instructions that better describe the parameters of the reporting requirements.
    - The Assigned Review Period for the SR will be reduced from all employees providing IDDW services for one year to all employees providing IDDW services for a period of 3 months.
    - As in the past, providers may utilize their own agency-specific tool that captures the same information.

Q229: Section 513.3.13 Skilled Nursing Agency Staff Qualifications states, "The nursing license must include a CPR/First Aid component, or the nurse must have a separate and current CPR/First Aid card." Does this mean that a current/valid nursing license will demonstrate compliance for CPR/First Aid training requirements?

A229: [3/6/25] A valid/current nursing license or proof of advanced medical training would suffice as evidence of compliance for the First Aid training requirements; however, this license/certification alone would not necessarily meet the requirements necessary to demonstrate compliance for the CPR training requirements.

Regardless of the medical staff's license or certification, providers must be able to demonstrate that all nursing staff, or those with advanced medical training, have documentation to support current/valid CPR training requirements as outlined in policy. Any questions related to these requirements should be directed to your agency's assigned Provider Educator, as necessary, for further review.

Respite

Q55: Please clarify the difference between In-Home and Out-of-Home Respite.

A55: [2/4/16] In-Home Respite services are respite services that are provided in the home/community of the person who receives services or in a Specialized Family Care Home (SFCH) where the person who receives services **resides**. Out-of-Home Respite services are respite services that are provided in SFCHs where the person who receives services **DOES NOT reside**, in licensed facility-based day habilitation/pre-vocational sites, and/or public community locations.

Q73: If a child receives home-based school services due to being medically fragile, can I/DD Waiver respite be billed during the time that the teacher or school speech therapist is in the home?

A73: [5/5/16] This is not permissible, as I/DD Waiver services and school services being provided at the same time would be considered duplicative.

Q122: If an individual attends school or is otherwise away from home for one or more weeks at a time, is it acceptable for the person to receive more than the daily average of PCS and/or Respite units while the person is home in order to utilize units that were not able to be billed due to the member being away from home?

A122: [4/6/17] No, if a person is receiving services in any facility away from home, his/her needs are met during that time by the facility. Only the daily average of PCS and/or Respite units may be billed during the time the member is at home.

Q151: Can both Home-Based Person Centered Support and Respite services be billed by a Specialized Family Care Provider (SFCP) while a person is under the routine care and supervision of the SFCP? For example, would it be appropriate for the SFCP to bill Home-Based Person Centered Support while taking the person(s) out into the local, public community rather than billing Respite services?

A151: [7/5/18] Home-Based PCS may only be provided by staff providing services in the person's home. SFC Providers who are providing services in their own homes may only bill Out of Home Respite for the person who is there for respite.

Second Level Negotiation/Exceptions Process

Q92: Are there timeframes in place for how long it should take Kepro and/or BMS to process Direct Support Services Living Arrangement (DSS-LA) assessments and 2nd Level Negotiations?

A92: [9/1/16] Upon receipt, DSS-LAs and 2nd Level requests are assigned for clinical review. When KEPRO completes the clinical review, recommendations are forwarded to BMS for a final decision. It is difficult to provide a general timeframe, as each DSS-LA and 2nd Level is unique, and may require additional follow-up with the team. Clinical reviewers maintain contact with the submitting SC to ensure timely submission and receipt of any corrections/additional documentation needed. The volume of DSS-LAs and 2nd Level Negotiation requests is extremely high, however, so providers should feel free to follow-up with KEPRO for a status update at any time.

Q95: How is it possible that when BMS denies a 2nd Level or an Exception Request, KEPRO automatically makes modifications to service units in CareConnection© without team approval and no treatment plan that matches the recommendations of BMS?

A95: [9/1/16] When BMS issues a Notice of Denial, KEPRO modifies the units in CareConnection© to reflect BMS' decision. The SC is notified when this occurs. Per the "Requesting Prior Authorization for IDDW Services" document (attached) provided in March 2016, teams can either choose to have services provided according to the authorization, or discuss Medicaid Fair Hearing with the team. If the individual who receives services chooses to pursue Medicaid Fair Hearing, he/she may do so by submitting a Hearing Request form to the Board of Review.

[10/31/18] The question was modified to include "or an Exception Request" as the Exception Process did not exist in August 2016 when the original question was posed.

Q154: Is it necessary to pro-rate all IDDW services including SC, BSP, RN, and miles/trips if services are requested at any time during a person's service year?

A154: [9/6/18] Dependent upon assessed need, there may be a requirement to prorate these services to an average daily number of units.

Q169: What is required to submit an exception?

A169: [3/7/19] Before an exception request can be reviewed by a panel comprised of BMS and KEPRO staff, the following must be completed:

- IPP and required attachments uploaded to CareConection©
- Initial authorizations within assigned budget obtained in CareConnection©
- Exception form filled out completely and accurately with service requested matching the IPP, and submitted to IDDWExceptions@kepro.com

Q172: Can an exception only be requested within 14 business days of the person's anchor date or can this occur at any time during a person's service year?

A172: [5/2/19] If the IDT feels there is a need to submit an exceptions request during a person's service year then they may do so. Any time an exceptions request is submitted outside of the person's anchor date timeframe, a face-to-face Critical Juncture meeting must be held outlining the specific details of the need for the request. The exceptions request must be submitted within 14 business days of that meeting along with all other necessary supporting documentation in order to be considered.

[Update 11/7/19] Incorrect/incomplete exceptions requests will be returned to the SC. If this occurs, an addendum can be completed to facilitate the corrections. Corrected exceptions requests must be submitted within 14 business days of the addendum. This is the only circumstance in which a face-to-face meeting would not be required in order to pursue an exception request.

Self-Direction of Services

Q66: If an individual self-directs their services, who is responsible for entering incidents into the IMS?

A66: [4/7/16] The Service Coordinator is responsible for ensuring that incidents are entered into the IMS, as well as for maintaining a written copy of the report in the member file. While PPL Resource Consultants have capability to enter incidents into the IMS and follow-up with families on a monthly basis regarding reportable incidents, they will verify with the SC prior to entering an incident in order to avoid duplication.

[Update 11/2/23] If an incident is reported to PPL, PPL will enter the incident into the IMS and will also follow up with the CM to ensure that this information is being communicated accordingly as documented in the member's IPP. The CM will also have access to those incidents in the system, which can be linked, as necessary, in order to avoid duplication.

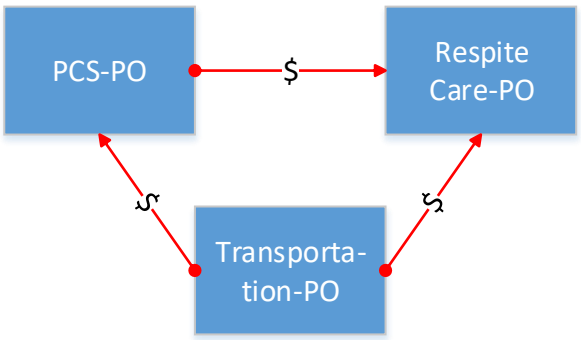
Please be reminded that all members of the IDT must work together to ensure that all documentation, as it relates to the accurate recordkeeping of incident reporting, is made available to all applicable IDT members.

Q86: Are individuals that self-direct through the Personal Options service delivery model allowed to use authorized Transportation funds in order to receive more respite and/or PCS?

A86: [9/1/16] Yes, this is permissible.

[Updated 10/5/17] The diagram below indicates the allowable exchanges of personal options funds across PCS-PO, Respite-PO, and Transportation-PO:

I/DDW Allowable Financial Authority Exchanges



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

Q108: When Transportation Personal Options services are requested and approved, then added into another service as opposed to being used for actual transportation, how should this be documented on the IPP?

A108: [11/03/16] This should be indicated in the meeting minute's section of the IPP; in the ISP section, the provider should also put "see participant-directed spending plan."

Q202: Can EAA/PDGS dollars be combined from one year to the next so that $2,000 can be used ($1,000 from each service year) toward one item?

A202: [7/22/21] No, since authorizations are for services provided during a particular service year and cannot be extended into another service year, this is not allowed.

Q220: What exactly will Medicaid pay for as it pertains to EAA and/or PDGS authorizations?

A220: [6/1/23] Medicaid will cover the cost of the item/service, labor costs, shipping, cost of permits, and taxes up to $1,000 per service year.

Service Coordination (SC) / Case Management (CM)

Q5: Can the Service Coordinator bill to complete the DD-9?

A5: [12/3/15] No, this should be completed by a Registered Nurse.

Q7: In Section 513.2 *Conflict of Interest,* the policy reads as though an agency that provides both Service Coordination and Residential Services can never refer an individual to their own company. Is this correct?

A7: [12/3/15] The intent of BMS is for the paragraph on conflict of interest at the end of Section 513.2 to be interpreted as in the paragraph below. The policy manual will be modified at the first opportunity to read:

Conflicts of Interest
Conflicts of interest and are prohibited. A conflict of interest is when the Service Coordinator who represents the person who receives services ("person") 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 Service Coordinator receives financial gain or potential financial gain or job security when the provider agency receives business serving IDDW clients. A Service Coordinator representing the person and being affiliated with a provider agency is not by itself a conflict. However, if a Service Coordinator affiliated with a provider agency: (1) takes action on behalf of the person they represent to obtain services for the person from the provider agency with which the Service Coordinator is affiliated while knowing of a non-affiliated, reasonable available provider agency clearly being more qualified to provide the services (regardless of whether any preference is expressed by the person or their guardian); or (2) influences the Freedom of Choice of the person by taking action on behalf of the person they represent to obtain services for the person from the company with which the Service Coordinator is affiliated with when the person or their guardian has expressed preferences to the Service Coordinator to use a different provider agency for service, then a conflict of interest occurs. Service Coordinators must always ensure any affiliation with a provider agency does not influence their actions with regard to seeking services for the person 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 Service Coordination agencies. Additionally, any Service Coordinator 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.

Q11: A new Service Coordination requirement is to "check with the BMS fiscal agent monthly to verify financial eligibility." Who is the BMS fiscal agent?

A11: [12/17/15] West Virginia Medicaid Provider Services is the fiscal agent who should be contacted. Eligibility can be verified by calling 888-483-0793. This number is included on form WV-BMS-I/DD-3 Monthly/Bi-Monthly SC Visit.

Q26: The home visit form states the SC should contact the MMIS on a monthly basis to verify financial eligibility. The new manual (page 36) states: Persons who are found financially eligible will receive documentation from the DHHR (ESNL-A) which the person needs to present to their Service Coordination provider. If the SC is verifying financial eligibility monthly, are we also expected to keep the ESNL-A on file?

A26: [1/7/16] Yes.

Q27: Page 101 of the policy manual indicates that SCs cannot bill to conduct training; however page 9 says: "Health and Safety training must be conducted by RN, BSP, or Service Coordinator. When an individual does not access TC services, is it acceptable for the SC to bill to train staff on the crisis plan?

A27: [1/7/16] Yes. In the absence of other team members who can provide training on the crisis plan, the SC may bill to do so. SCs may document on the I/DD-6 and bill Service Coordination for the task.

Q39: The manual indicates that Service Coordinators are required to comply with training requirements in sections 513.2 and 513.2.1. Does this include the training in Direct Care Ethics and completion of the facilitated WV APBS Overview or WVUCED PBS Direct Care Overview?

A39: [1/21/16] SCs are required to receive the WV APBS Overview or WVUCED PBS Direct Care Overview; however they are not required to complete the Direct Care Ethics.

Q40: Are professional staff (TCs, RNs, SCs, and BSPs) required to receive person-specific training?

A40: [1/7/16] No. These professionals can familiarize themselves by reviewing clinical documentation for the individual as appropriate.

Q56: Section 513.3 of the policy manual states: "all staff must be trained to provide IDDW services in a culturally and linguistically appropriate manner." Since this section is separate from the training requirements in Section 513.2, please clarify who is required to receive this training.

A56: [1/7/16] All staff who provide Medicaid services to persons who receive I/DD Waiver services must receive this training.

Q70: For purposes of the definition of Human Services degree in the policy manual, what constitutes a Liberal Arts degree?

A70: [4/7/16] At least 15 credit hours in Human Services classes are required for a degree to be considered Liberal Arts.

Q79: For individuals who do not have an approved extension or hold and are in out-of-state placement or attend school away from home, are monthly home visits required?

A79: [7/7/16] Yes. A requirement of the program is that the SC verifies health and safety monthly by conducting a home visit. Without an approved hold or extension, or an approved DD12 for an exception to the monthly home visit, the visit must take place.

Q84: Can Service Coordination and/or Behavior Support Professional be billed while an individual is in the hospital, for purposes of discharge planning?

A84: [8/4/16] These services cannot be billed while a person is in the hospital, or at any time when services are on hold. When a member is hospitalized, it is the responsibility of the hospital social worker to arrange for discharge planning. Note, this does not apply to when a person is in a Crisis PCS site and their status is Member Hold-Extension in CareConnection©.

Q96: What is the SC's responsibility for making sure the "Motion for Authorization for Compensation" gets done? How does the absence of getting this done affect PPL?

A96: [12/1/16] WV Legislature House Bill 2885 is a bill to amend and reenact §44A-1-8 of the Code of West Virginia, relating to the eligibility of guardians or conservators to be hired to provide care to a protected person through employment with a behavioral health provider in certain circumstances. Section (g) of this bill allows for guardians/conservators of protected persons to be paid for the provision of services under certain circumstances. (Additional information can be found here: http://www.legis.state.wv.us/bill_status/bills_text.cfm?billdoc=hb2885%20intr.htm&yr=2011&sesstype=RS&i=2885).

[Updated 2/2/17] Guardians/conservators who wish to be paid for providing services are responsible for ensuring that they are in compliance with this rule, and must provide documentation showing such to the Service Coordination agency. This requirement applies to those who receive services via the Traditional service delivery model as well as those who receive services via the Traditional with Personal Options service delivery model.

If the guardian/conservator is employed by an agency via the Traditional service delivery model, the agency is responsible to maintain proof of the following: "the arrangement is disclosed in writing to the court making the appointment of the guardian or conservator

and only if the court finds that this is in the best interest of the protected person that such an arrangement occur." Thus, the agency should have proof that the court has been notified and proof that the court finds it is in the best interest of the protected person that such an arrangement occur. If the guardian/conservator is employed by the member via the Traditional with Personal Options service delivery model, PPL is responsible for maintaining the same documentation.

[Updated 3/2/17] It is the expectation that the proof provided by court be attached to the person's file in CareConnection© under the file name, "Legal Forms". For all the existing court documents that haven't been attached in CareConnection©, the appropriate provider should attach them at the time of the person's next Annual or Six Month IDT meeting.

[Updated 11/13/17] This requirement only applies to individuals that are 18 years of age or older, who live in their natural family home, and have a direct care staff that bills Family-PCS. This requirement **DOES NOT** apply if the individual is under the age of 18 or to those that are their own legal guardian.

Q98: If a person who receives services passes away, does the SC need to submit a DD-12 if the home visit/day visit was not completed?

A98: [10/6/16] No, this is not required.

Q99: If a member passes away, are both the DD-10 and DD-11 required?

A99: [10/6/16] As long as the SC submits the discharge in CareConnection© and attaches the DD-11 with all necessary information, the DD-10 is not required.

[Updated 11/7/24] Effective immediately, DD-11s (Notification of Death) will be discontinued. Providers will no longer be required to complete DD-11s or attach completed forms in CareConnection©. The DD-11 will be replaced by the Notification of Death in the Atrezzo IMS. When a member passes away, providers must complete an incident report, the Notification of Death in the Atrezzo IMS, and initiate the discharge process in CareConnection©.

Q100: If an agency wishes to complete a Social History, which is no longer required for I/DD Waiver, can the SC bill for it?

A100: [10/6/16] Completion of a Social History is not a billable I/DD Waiver service. If the agency wishes to complete one and is a clinic/rehab provider, they can request approval for the code through the Behavioral Health authorization process or refer the needed service to a clinic/rehab provider.

Q112: Is it necessary for the SC to include the exact number of units of Personal Options services (i.e., those provided to individuals who self-direct) that a person plans to utilize in the IPP/meeting minutes or to monitor this on a monthly?

A112: [12/1/16] No. The person develops a spending plan with the assistance of their Resource Consultant with PPL in order to determine what is most appropriate to meet the needs of the person. PPL will provide the spending plan to the SC following its completion and will attach to CareConnection©.

Q124: On the updated DD-3 that was sent out with the 3/2/17 policy clarification call information, a new section was added for the SC to verify that the individual received a Direct Care Service during the month. Does the SC have to submit a DD-12 if the individual did not receive a DCS during the month or should providers contact KEPRO in order to determine if a DD-12 is necessary?

A124: According to the memo sent to all I/DD Waiver providers on 3/22/16, effective 4/1/16 if an individual goes longer than 30 days without accessing a DCS, the SC must submit a DD-12 to KEPRO if the person has gone 30 days without services or if it is anticipated that this may occur.

[Updated 4/7/17] It is the expectation that the SC records on the I/DD-3 whether or not the person received a DCS during the previous ***calendar month***, as well as if it is anticipated that the person will not receive a DCS during the current and subsequent months. If the person did not or will not receive a DCS in a calendar month, then the SC should submit an I/DD-12 as soon as they become aware that this requirement has not or will not be met.

Q127: What is the process for requesting and receiving approval for Participant-Directed Goods and Services (PDGS)?

A127: [7/6/17] The SC requests authorization for PDGS in CareConnection©, being certain to attach a completed DD-8, applicable estimates, and the portion of the IPP that details the specific item/service and why it is needed, as well as a signature page showing team agreement. If the request is within budget and all necessary supporting documentation has been submitted, KEPRO will provide authorization in CareConnection©.

[UPDATE 6/2/22] Once the request is approved in CareConnection© and PDGS has been authorized, the member's PPL Resource Consultant will notify the member/representative and assist as needed with the completion of the PDGS packet. Upon receipt of the completed PDGS packet, PPL will confirm that the requested item/service complies with requirements in Section 513.16 Goods and Services of the IDD Waiver policy manual. The PPL Resource Consultant will notify the member/representative of the determination.

In order to obtain a PDGS Application/PRF packet or if there are any questions related to PDGS decisions, please contact your assigned Resource Consultant or email WV-PDGS@pcgus.com PPL requests that, in order to expedite processing of requests, instructions on the PDGS application be read and followed carefully.

Q131: Is it necessary for all IDT members to be present for the entire duration of a team meeting in order for the IPP to be considered valid?

A131: [9/7/17] Policy does not dictate all members must be present for the entire duration of a team meeting in order for an IPP to be considered valid. Per Chapter 513.8, "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 person receiving services or their legal representative must agree with the plan for it to be considered a valid IPP."

Make note that the validity of the IPP has different requirements than those for providers billing for attending/participating in an IDT meeting. See each service description for IDT attendance and documentation requirements.

[6/27/18] Section 513.25.2 of the manual states that the person and/or their legal representative (if applicable) have the responsibility of being present during IDT meeting. In extremely extenuating circumstances, the legal representative or other team persons may participate by teleconferencing if they do not bill for the time spent in the IDT. The person **must** be present and stay for the entire meeting if they do not have a legal representative.

Q141: In regards to the completing the I/DD-2 at the time of the Annual Functional Assessments the revised manual states, "If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days." The manual also states that, "If the person 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 Service Coordinator to obtain the signature of the legal representative prior to or at the Annual IPP." Considering that the Annual Functional Assessment is completed approximately 90 days prior to the person's Anchor Date, how can both requirements be met if the legal representative does not attend the Annual Functional Assessment?

A141: [5/3/18] The expectation is that the I/DD-2 is to be completed with the legal representative within 10 days of the date that the Annual Functional Assessment was held. If, however, it is not possible to do so it should be completed at or before the person's Annual IPP meeting and the SC should document the circumstance that prohibited completion within 10 days.

Q142: If a Service Coordinator is required to complete the I/DD-2 with the legal representative as a result of the legal representative not attending the Annual Functional Assessment, then how can the Service Coordinator answer questions that the KEPRO Service Support Facilitator would otherwise field while still ensuring that conflict of interest policies are also being followed?

A142: [5/3/18] Service Coordinators are responsible to be familiar with policy and to answer questions regarding services and service options. In the event that a legal representative has questions the SC is unable to answer, they can contact their assigned Provider Educator or refer the legal representative to KEPRO's member/family Liaison for additional assistance.

Q145: When a person chooses to transfer services to a different Service Coordination agency should this be documented on an I/DD-4 or on an I/DD-5?

A145: [6/7/18] This should be documented on an I/DD-5. The I/DD-4 is only appropriate to use for new slot releases. Documenting this on an I/DD-5 allows the Registration Coordinators to see the ISP boxes that they will need to have access to in order to make a determination in regards to modifications and/or purchase requests.

Q149: Since there is a new Exceptions Process, is the DSS-LA still a required document and when should it be used?

A149: [7/5/18] Yes. It is still a required document and providers should continue to submit them as previously instructed.

Q150: The new budget letters indicate, "If you request an exception, your IDT must fill out two sections of the IPP; one for the services you want, including services in excess of the budget, and one in which services requested are within the budget." Will the I/DD-5 template be updated to include samples of these required sections in the event the IDT chooses to pursue the Exceptions Process?

A150: [7/5/18] The I/DD-5 will be updated and made available soon. In the meanwhile, if the IDT plans to pursue the Exceptions Process, the SC should ensure that these details are included in the meeting minutes.

Q152: Can a professional serve as a person's SC and BSP simultaneously?

A152: [8/2/18] No, this is not allowed at any time.

Q153: The manual indicates that direct care services must be purchased first and then, "Professional Services may be purchased next in the following order if the IDT wishes to purchase any of these services: Service Coordination, RN, BSP, any of the specialty therapies (ST, PT, OT and DT), Transportation." Since service coordination is a required

service, what options would an IDT have if the assigned budget only covers the cost of direct care services and there is no room in the budget for requesting professional services including SC?

A153: [9/6/18] Service Coordination is a required service for participation in the IDDW program and it cannot be declined if the person wishes to continue to receive services. IDTs are responsible to ensure that the person's assigned budget is utilized responsibly so that the person's needs are and program requirements are being met. Exceptions can be requested as needed.

Q155: Upon implementation of the 2020 policy, and required Independent Service Coordination at that time, can an agency provide both Service Coordination and Direct Care services?

A155: [9/6/18] Yes, when the Independent Service Coordination requirement is implemented with 2020 policy, agencies can provide all available services offered via the I/DD Waiver program. It is important to note, however, that the agency that provides SC services to an individual cannot provide any other services TO THAT PERSON.

Q157: If an SC provides services to someone who is not enrolled in the IDDW program, does that person(s) count towards the SC caseload limit of serving no more than 30 persons?

A157: [10/4/18] Yes, the limit to the caseload is 30 people regardless of what service the SC provides. Exceptions to this policy can be requested and processed via I/DD-12.

[Updated 2/3/22] As of 4/1/2021, there are no policies limiting the number of individuals a CM (formerly SC) may serve. Each agency is responsible for assigning manageable caseloads based upon the needs of the individuals served and/or the professional experience of the CM.

Q180: Is a 7-day and/or 30-day IPP required when transferring SC (Case Management) services only?

A180: [6/4/20] No. When transferring SC (Case Management) services only the original transfer IPP and DD10 are the only requirements. A 7-day and/or 30-day meeting should not be held. If modifications to SC services are required after transferring, an addendum may be completed. If the necessary modifications would cause the budget to be exceeded – complete a regular CJ IPP and request an Exception for the additional services in excess of the budget.

Q181: If services can be finalized when transferring residential and/or day services at the 7-day IPP, is a 30-day IPP required?

A181: [6/4/20] While policy says that both meetings are required, BMS has opted to amend this requirement as follows: a 30-day meeting is only required in this circumstance if services cannot be finalized at the 7-day meeting. The 30-day meeting, if necessary, should be conducted after the transfer occurs.

[Updated 6/3/21] Initial IPPs for new slots are required to take place within 7 days of intake. Intake is defined as the date of enrollment with the agency that will provide services. In the event that services are finalized at the 7-day meeting, a 30-day meeting is not required. If services are finalized at the 7-day meeting OR if the 30-day meeting is required, and these meetings fall during the 30 day period before the anchor date, this meeting will also serve as the annual meeting of the IDT.

[Updated 7/1/21] In the event that services are able to be finalized at the 7-day meeting for a new slot, the CM should complete a I/DD-5 rather than a I/DD-4.

[Updated 7/22/21] Please refer to the 5.27.20 QPM for details and examples of IDT Meeting requirements for Initial and Transfer IPPs.

Q185: If a member has two residences, such as in a shared custody situation, does the agency conduct two home visits each month, one at each home?

A185: [11/5/20] No. Under these circumstances, the SC should alternate the location of the home visit so that only one is conducted each month. However, depending on the circumstances of the health and welfare of the member, the Case Manager may determine it necessary to complete visits at both homes in one month. If this is the case, documentation must clearly outline the rationale for both visits taking place.

Q187: With the implementation of Conflict-Free Case Management, can the transfer-to agency use the training certification documents (Respite, PCS, transportation, etc.) from the transfer-from agency as proof of certification?

A187: [11/18/20] Yes, this is acceptable.

Q188: What is the procedure for transferring new slots who live in an ICF to IDDW ISS? Who is responsible for completing Case Management activities during the transition period?

A188: [12/17/20] When a new member who lives in an ICF initially gets a slot, he/she receives a budget for Group Homex4. In most cases, these members plan to transition to IDDW ISSx1, ISSx2, or ISSx3. Under these circumstances, the short form DSSLA should be completed by the IDDW Case Manager as soon as the IDT identifies the IDDW living arrangement, being certain to request the most appropriate setting to meet the member's needs. Because the individual is most likely **not** receiving IDDW services during this time, this service is non-billable. It may also be necessary to conduct some meetings

that are also non-billable, but these can be limited by the DSSLA short from being prior to the 7-day meeting and submitting it for approval with the initial submission for IDDW units.

Until the time that the member starts to receive IDDW services, the ICF is responsible for ensuring needs are met and facilitating the transition, with the exception of the activities that are unique to IDDW services. The ICF should ensure that all information regarding medications, medical status, and financial status are up-to-date and provided to the receiving IDDW agency.

Q189: In regards to EVV usage, how would a DCS clock-in if services do not begin in the member's home? An example could be picking up a school-aged member from the school or at the bus stop.

A189: [12/17/20] DCS can clock-in in the community through EVV using the app on their cell phone. The system will flag that the worker was not at the member's home and the agency will have the opportunity to review this prior to claims being submitted. Please note that waiver services are not to duplicate services from an entitlement program including school transportation.

Q192: If an agency provides behavioral health services such as psychiatric or counseling services to a member, do CFCM policies prohibit that agency from providing behavioral health services and case management services to the same member?

A192: [3/4/21] A member may receive case management and behavioral health services from the same agency. This would not be considered a conflict of interest.

[Updated 3/18/21] This also includes ABA therapy and other outpatient therapies that are not available through the IDDW program.

Q194: Upon implementation of updated policy, would it be considered a conflict of interest if a case management agency also provides payee services to a member?

A194: [3/18/21] It is considered a conflict of interest for payee services to be provided by a member's case management agency, however exceptions may be granted on a case by case basis if no other payee services are available.

Q195: Will the Per-Member Per-Month (PMPM) rate be reimbursable if the Case Manager is unable to complete the monthly home visit/contact? If not, would an approved exception via a DD-12 allow the Case Management agency to be reimbursed for services provided that month?

A195: [3/18/21] The PMPM is tied to the monthly home visit/contact and is reimbursable with an approved DD-12.

[Updated 10/3/24] It is unacceptable to perform a required, electronic home visit via text message, email, or any other format that does not include the ability to receive verbalized responses in real time from the participants. Electronic visits must be completed via phone or other electronic methods (Zoom, Skype, Teams for example) that allow for real time verbal interaction between the participants.

Q196: What are the procedures for accessing end of the service year modifications?

A196: [4/15/21] The details of the policies and procedures for accessing end of the service year modifications can be found in the IDDW UM Training document dated 2.18.21 that was sent to the IDDW Distribution List on 2.17.21.

Q197: If a member receives day services and requires day visits as outlined in policy, is the CM required to complete this day visit in order to bill for the PMPM event.

A197: [4/29/21] No. The PMPM event is solely based upon completion of the monthly home visit and not the day visit.

Q199: Upon implementation of updated policy, would it be considered a conflict of interest if a case management agency also provides Personal Care services to a member?

A199: [6/17/21] It is considered a conflict of interest for Personal Care services to be provided by a member's case management agency, however exceptions may be granted on a case by case basis if no other Personal Care service providers are available in the participant's catchment area.

Q200: Can Case Management services be purchased for an individual who is in hold status and whose treatment plan is out of date due to the individual being hospitalized/committed when due for an IDT meeting?

A200: [7/1/21] Yes.

[Updated 7/22/21] Requests for Case Management services can be approved under these circumstances with an approved I/DD-12 that includes details of the service(s) provided or to be provided while the member is in hold status.

[Updated 8/5/21] While Case Management services can be approved and billed while a member is in hold status, it may not be done for members who reside in an ICF. It is the responsibility of the ICF social worker to complete all Case Management activities, including securing housing and associated tasks.

Providers are advised that, if the member does not have a budget and service plan, Case Management services can be authorized with an approved I/DD-12 describing what

activities will be performed. It will also be necessary to maintain Case Management Logs while the member is on hold. Note that payment is not guaranteed in the event that the member is not determined to be medically eligible and that no billing can occur when the member is out of state. Further, billing Case Management services while the member is on hold is an option, but is not a requirement and should only be provided if the member needs the service. If the IPP cannot be developed while on the member is on hold, Case Management services can only be billed with an approved I/DD-12.

[Updated 8/19/21] This is allowable in any living arrangement except for members residing in an ICF. For individuals who are already on hold, if the IDT determines that CM units need to be requested, a new DD-12 must first be submitted and approved. Do not resubmit if there is no intention to bill CM while the member is on hold. Note that a brief summary of what services the CM intends to provide is all that is necessary.

Q201: Can Case Management services be billed for an individual who is hospitalized or receiving inpatient services if Case Management services were provided?

A201: [7/1/21] Effective 4/1/21, Case Management services can be billed while a member's status in CareConnection© reflects "Member Hold - Extension" if the member's needs warrant. Proper documentation, either the DD-3 and/or the Case Manager Log as applicable, must be maintained.

Q204: Section 513.19.1 and the Change Log both indicate that Case Managers must 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. Is this an intentional change?

A204: [7/22/21] No. BMS will continue to require that Case Managers make purchase requests and upload documentation to member's file in CareConnection© within 14 calendar days following the date of the IDT meeting or team's approval of a service plan addendum.

Q205: Section 513.19.1 indicates that Case Managers must "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)". This is also not mentioned in the change log, so is this an intentional change?

A205: Yes. BMS will require that Case Managers personally meet each quarter with the member and their support staff at the member's facility-based day program or pre-vocational center as applicable.

[Updated 8/19/21] The expectation is that there will be one visit each quarter for a total of four visits per service year. For the time-being, it is expected that the CM performs a day service contact/visit for any member that has returned to day services.

Q206: New policy, section 513.2.4 Provider Agency Certification-Case Management-Only, says that Case Managers are required to receive education on Conflict of Interest/Professional Ethics, however, this requirement is not mentioned in any other section of policy. Are Case Managers with full service agencies required to receive this education as well?

A206: [9/16/21] This requirement was omitted by mistake. All Case Managers are required to receive education on Conflict of Interest/Professional Ethics. It is also required, annually, for all Case Managers and the agency director to sign Conflict of Interest Statements.

Q207: Section 513.26 Discharge indicates that 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. What exactly does a case management agency do to demonstrate compliance with this requirement and what should the case manager do if a member they serve is determined to be financially ineligible?

A207: [9/30/21] In the event a member is determined to be financially ineligible by DHHR, the Case Manager would assist the member/legal representative as needed and notify all IDDW agencies that provide services to the member. The amount of assistance a case manager is responsible for will vary from member to member. The CM can verify eligibility monthly by calling 888-482-0793. Recent assets/income could also be discussed during the WV ABLE account discussion that takes places during the monthly contact. Also, the I/DD Waiver Financial Eligibility Helpful Hints document that was presented during the August 2019 Quarterly Provider Meeting contains additional details for demonstrating compliance.

Q209: Do routine CM activities such as IPPs and home visits have to be documented on the monthly CM log?

A209: [10/28/21] Any activity that results in the production of supporting documentation, like an I/DD-3 or I/DD-5, is not required to be noted on the monthly CM log. Any activity that does not result in the production of supporting documentation should be noted on the monthly CM log. It is optional to include the start/stop times.

Q211: Can service providers request an exception to modify services after the member's service year has concluded if the Case Manager did not request the modification in CareConnection©?

A211: [1/6/22] Yes. Authorizations can be provided up to 15 days after the anchor date without an I/DD-12, if the budget, or previously approved overage, is not exceeded. Authorizations via the I/DD-12 may be provided for days 16-30 after the anchor date

based on individual circumstances. I/DD-12s submitted for this purpose can only be submitted when the member receives other services from an agency that does not also provide Case Management or from a same or sister agency. Any request submitted beyond 30 days of the member's previous service year cannot be considered for review.

Further, the affected agency must submit documentation supporting their efforts to request the CM agency make modifications on their behalf. Documentation should show due diligence by the service provider and should demonstrate that requested modifications were made in a timely manner, that the service provider made attempts to follow-up with the CM agency, and that the request was necessary to the meet the unexpected changes in member's needs. This may include emails, progress notes, etc. that support the provider's request. Under these circumstances, a budget worksheet must also be provided to ensure budget/service limits are not exceeded. Requests to exceed the budget will not be considered and requests that lack clarity and/or that do not demonstrate sound utilization management practices will not be approved.

[Updated 12/1/22] Rather than waiting until the end of the member's service year, an I/DD-12 may be submitted at any time beyond the first 30 days of member's service year utilizing the same methods described in the original response. Interagency agreements must also be utilized per OHFLAC policy, and these agreements should clearly outline expectations for both parties involved.

Q215: The BMS Memo dated January 25, 2021 describes Mandated Conflict Free Case Management Training effective April 1, 2021. It is not clear if the expectation is that all new hires as of April 1, 2021 are allowed the same 3 month grace period or if the expectation is that all new hires as of April 1, 2021 have the required training prior to providing services. Which is accurate?

A215: [9/1/22] The expectation is that all existing Case Managers who are not Licensed Social Workers, Licensed Professional Counselors, or Licensed Registered Nurses will need to complete the CFCM training and certification in the State of West Virginia's Public Learning Center by January 1, 2023. New hires, as of October 1, 2022, will be given a three-month grace period to come into compliance with this requirement. Case Managers providing services without the required CFCM certification must do so under the clinical supervision of a certified Case Manager in order to bill for services.

[Update 5/4/23] The CFCM certification in the State of West Virginia's Public Learning Center has been updated and previous versions have been removed from the system. While it continues to be the expectation that CMs receive this certification upon hire, it will not be necessary for those that have completed their certification using the old course to re-take the training using the updated course. Either version of the certification will suffice as evidence of compliance and CMs will not be required to re-take the certification due to a change in employment. Additionally, the three-month grace period for CMs hired after October 1, 2022 described in the original answer continues to be acceptable.

Moving forward, it will not be necessary to complete any other training related to CFCM, rather the CFCM certification through the Public Learning Center will serve as the only training requirement necessary to demonstrate compliance. It continues to be the expectation that anyone providing CM services be familiar with the COI requirements outlined in section 513.2 "Provider Enrollment and Responsibilities" of the policy manual.

Q216: What is BMS' expectation as far as the HCBS requirement to identify on the IPP that all staff who work with the member are properly trained and certified?

A216: [11/3/22] A statement to the effect that all direct care staff meet all requirements is sufficient. It is not necessary to list each staff person's name on the IPP or attach DD6s or other supporting documentation. This must be reviewed at each juncture to ensure it is accurate and current. BMS will update the IPP document to include this requirement.

Q217: When a member transfers CM services in CareConnection©, can the transfer-from CM still access the member's record once the identified transfer date has passed? If not, how can the transfer-from CM attach the necessary documentation as required?

A217: [1/5/23] No. Once the transfer date that has been identified in CareConnection© has past, the transfer-from CM will no longer be able to access the member's record in the system. The I/DD-5 and I/DD-10 must be attached to the member's record within 14 calendar days of the meeting date. However, it is also the responsibility of the transfer-from CM to prioritize uploading all documentation to the member's record in CareConnection© prior to the identified transfer date.

Q218: How often does the HCBS Integrated Settings Rule Questionnaire need to be completed for each member?

A218: [3/9/23] The HCBS Integrated Settings Rule Questionnaire should be completed at the Annual IPP.

[Updated 4/6/23] Setting Assessments are completed once a year at the Annual IPP. An additional Setting Assessment may be required if the member moves to a new home or if significant changes are made to the existing home.

Q222: When can CM services be billed while a member's status in CareConnection© is listed as Member-Hold Extension?

A222: [11/15/23] Providers are able to bill Case Management services while on hold with an approved I/DD-12 under the following scenarios:

- **CM services ***WILL NOT* **be billed:** The CM will only need to submit an I/DD-12 for the Eligibility extension. This will also cover any missed visits/meetings.

Additional requests for other exceptions while the member is on hold will not be required.

- **CM services, including HVs, *WILL* be provided:** The CM will submit an I/DD-12 for the Eligibility extension, as well as request permission to bill CM services while on hold. Under these circumstances, CM services can only be requested and approved for 3 months at a time.
- **CM *WILL* be provided (holding meetings, transition planning, etc.), but *NOT* HVs:** The CM will submit an I/DD-12 for the Eligibility extension and HV exceptions. This can be completed on a single I/DD-12 and can only be requested and approved for 3 months at a time.

Q224: Section 513.16 of the policy manual indicates, "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." Does this logic also apply to accessing Environmental Accessibility Adaptions (EAA) and therapy services via the participant directed option?

A224: [2/1/24] Yes. In order to access EAA and/or any therapy service through the participant-directed option, the member must also access a PCS and/or Respite service through the participant-directed option.

Skilled Nursing Services

Q5: Can the Service Coordinator bill to complete the DD-9?

A5: [12/3/16] No, this should be completed by a Registered Nurse.

Q9: Can the RN code be billed for supervision and training of AMAP staff?

A9: [12/3/15] AMAPs have been used for many years by many agencies. The RN code has not been allowed to be billed for supervision or training of AMAP staff. I/DD Waiver reimburses for specific services to be provided to an individual recipient. Supervision of AMAP/LPN staff is not a member-specific service, rather it is an agency responsibility to ensure that personnel providing services are properly monitored.

Q34: BMS has indicated that up to 240 units per year of LPN can be provided for "indirect" LPN duties and thus be billed concurrently with other direct care services. What tasks are considered "indirect?"

A34: [1/7/16] "Indirect" LPN services are those that are conducted that do not require direct contact with the person who receives services. These include, but are not limited to, scheduling doctor appointments, documenting physicians' orders, and completing Medication Administration Records (MARs.)

Q35: BMS has indicated that the annual service limit for direct care services has been changed to 35,280 to accommodate "indirect" LPN activities. Should this number be changed to 35,376 due to leap year?

A35: [Updated 2/4/16] Yes, this limit has been changed to 35,376.

[Updated 2/6/19] This also applies to the 2020 leap year.

[Updated 3/1/19] The annual service limit accommodation due to the leap year only applies to those living in ISS/GH settings.

Q36: When are agencies required to stop billing for LPN travel time?

A36: [1/7/16] LPN travel may be billed for each individual until they transition to new services. Once the transition occurs, travel for LPN services can no longer be billed.

Q40: Are professional staff (TCs, RNs, SCs, and BSPs) required to receive person-specific training?

A40: [1/7/16] No. These professionals can familiarize themselves by reviewing clinical documentation for the individual as appropriate.

Q51: Is the I/DD-9 required to be submitted only at the Annual IPP, or must it be submitted if the team requests an increase in LPN units during the service year?

A51: [2/4/16] The I/DD-9 must be submitted each time a change in LPN need results in a request to modify for additional units of the service.

Q52: Can video-conferencing such as Omnijoin or Go To Meeting be used for BSPs and RNs to attend IDT meetings?

A52: [2/4/16] These professionals can attend IDT meetings using such services; however RN IPP Planning and/or BSP IPP Planning can only be billed by the professional when he/she is physically present.

Q56: Section 513.3 of the policy manual states: "all staff must be trained to provide IDDW services in a culturally and linguistically appropriate manner." Since this section is separate from the training requirements in Section 513.2, please clarify who is required to receive this training.

A56: [1/7/16] All staff who provide Medicaid services to persons who receive I/DD Waiver services must receive this training.

Q82: If more than one agency is requesting RN and/or LPN services for a member, does each agency need to have an RN fill out a DD-9 or is one sufficient to cover requests for both agencies?

A82: [8/4/16] One DD-9 can be submitted, however, how each facility will use the requested units must be specified.

Q90: The manual states that both the LPN and RN may attend and participate in the annual functional assessment conducted by the UMC. What code do they bill?

A90: [9/1/16] The LPN code must be billed by both the LPN and the RN who attend the annual functional assessment.

Q97: Can RNs provide health/safety training for I/DD Waiver staff via MDTV? If so, is this billable?

A97: [10/6/16] This training can be done via MDTV; however, is not billable. For additional information regarding Tele-health service provision, see WV Medicaid Chapter 503, Behavioral Health Rehabilitation Services, here: http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Behavorial%20Health%20Rehab%20Services/Chapter_503_Behavioral_Health_Rehabilitation_Services.pdf

Q120: On the I/DD-09, is it necessary to identify the number of units for each ratio if the IDT is requesting to utilize the LPN 1:2 and/or 1:3 code(s) or would the total number of LPN units needed suffice?

A120: [4/6/17] If the IDT plans to utilize the LPN 1:2 and/or 1:3 codes, then it will be necessary to identify the total number of units needed for each ratio of this service.

Q121: May RNs attend and bill for IPP attendance when they attend via telehealth mode?

A121: [4/6/17] Yes, if all the standards listed in Section 503.12 of the BMS Rehabilitation Services policy manual are met. This manual can be found at: http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Behavorial%20Health%20Rehab%20Services/Chapter_503_Behavioral_Health_Rehabilitation_Services.pdf

[Updated 4/1/19] Updated link: http://dhhr.wv.gov/bms/Provider/Documents/Manuals%20Archive/bms_manuals-chapter%20503_BHRS.pdf

Q140: The manual states that an LPN can, "train persons on individualized medical and health needs, such as wound-care, medically necessary diets, ect." Does this mean that

an LPN can bill for training direct care staff or does this apply to training the individual receiving services?

A140: [4/5/18] This applies to training the individual who receives services and not the direct care staff.

Q146: Can an RN bill to provide person-specific training to an LPN?

A146: [6/7/18] No. RNs may bill to conduct training on person-specific medical issues with non-licensed direct care staff only.

Q219: Which IDT member is responsible to complete training on the member's medical needs?

A219: [5/4/23] The RN is the IDT member that is responsible for completing any necessary medical training(s), however in the absence of an RN on the team the IDT will need to discuss and specifically document who is responsible.

[Update 6/6/24] The RN is the IDT member that is responsible for completing all necessary medical training(s) except in extenuating circumstances such as emergency staff coverage or the short-term unavailability of RN services. However, in the absence of an RN on the team or if RN services are not purchased, the IDT will still need to discuss and specifically document who is responsible to perform this training in the member's IPP. Providers must also continue to follow all regulations of the Approved Medication Assistive Personnel (AMAP) Program related to nursing oversight and staff training.

Q223: The manual indicates that LPN services are "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." Would this also apply to members that access Crisis Site PCS or would private duty nursing services be more appropriate due to the member's age?

A223: [1/4/24] The site of service definition includes crisis sites so this is allowable and will be included in future policy.

Q229: Section 513.3.13 Skilled Nursing Agency Staff Qualifications states, "The nursing license must include a CPR/First Aid component, or the nurse must have a separate and current CPR/First Aid card." Does this mean that a current/valid nursing license will demonstrate compliance for CPR/First Aid training requirements?

A229: [3/6/25] A valid/current nursing license or proof of advanced medical training would suffice as evidence of compliance for the First Aid training requirements; however, this license/certification alone would not necessarily meet the requirements necessary to demonstrate compliance for the CPR training requirements.

Regardless of the medical staff's license or certification, providers must be able to demonstrate that all nursing staff, or those with advanced medical training, have documentation to support current/valid CPR training requirements as outlined in policy. Any questions related to these requirements should be directed to your agency's assigned Provider Educator, as necessary, for further review.

Transportation

Q14: During transport in an agency-owned vehicle, if an agency is billing Person-Centered Support for one member and providing natural support for another, how should the agency document the natural support? Will BMS hold the agency accountable for having to attend to the person to whom natural support is being provided?

A14: [12/17/15] If an agency is transporting an individual in an agency-owned vehicle, "natural support" is not being provided, as the agency is being reimbursed. IDTs are responsible for identifying the level of support that an individual needs, including the level needed when transported in an agency vehicle. If the IDT determines that the individual does not require Person-Centered Support during transport, documentation on the transportation log of form WV-BMS-I/DD-7 would be completed.

Q15: Section 513.21 Transportation, of the Policy Manual, says "persons who receive IDDW services are required to access Non-Emergency Medical Transportation (NEMT) for non-IDDW Medicaid services, including doctor appointments." Does this mean that someone absolutely cannot bill I/DD Waiver for mileage to doctor appointments, or is it just a suggestion that NEMT is available since some people say they don't have enough miles?

A15: [12/17/15] CMS has indicated that I/DD Waiver services, including mileage, cannot duplicate state plan services. As such, NEMT must be utilized when I/DD Waiver services are not being provided and for non-emergency visits that result in Medicaid transportation being utilized.

Q17: Do the Transportation Services Agency Staff requirements apply to staff who bill mileage only?

A17: [12/17/15] These requirements apply to staff who bill mileage as well as those who bill trips.

Q18: Is a statement, signed by staff, acceptable verification that state/local laws are adhered to by the staff for auto insurance, inspection, and registration?

A18: [12/17/15] Auto insurance can be verified by requesting a copy of the insurance card required to be maintained in all vehicles and inspection can be verified by checking the inspection sticker on the vehicle and recording the date of inspection. In addition, the agency may choose to have staff sign a statement indicating that he/she agrees to comply with all state/local laws associated with operating a motor vehicle. If the vehicle is licensed/inspected in a state other than WV, the owner is required to comply with all of the licensing state's associated laws. For vehicles that are not licensed in WV, the agency can document so in the personnel file, specify the licensing state's inspection/other requirements, and document the date compliance was verified by the agency. The frequency agencies verify requirements will depend on the specific state requirements, which should also be documented.

Q19: Concerning the Transportation Trips service, if a person is transported from a day program setting to eat and go bowling, then is transported back to the day program, is this considered one trip?

A19: [Updated 2/18/16] A trip is defined as one outing. From the previous policy manual (applicable to current policy): Member starts from his/her home, goes to the post office, travels to a store, and travels to a restaurant and returns home is one (1) trip. Facility Based Programming: Member starts from his/her home, goes to the facility based day program and stays for six (6) hours. This is one (1) trip. Member leaves the day program facility at the end of the day and returns home. This is one (1) trip.

Q32: Who must access NEMT?

A32: [Updated 3/3/16] Once a person transitions to new services, he/she must access NEMT for all non-I/DD Waiver Medicaid services.

Q33: Can I/DD Waiver mileage be billed for transport to/from I/DD Waiver physical, occupational, dietary, and/or speech therapy?

A33: [1/7/16] Yes.

Q36: When are agencies required to stop billing for LPN travel time?

A36: [1/7/16] LPN travel may be billed for each individual until they transition to new services. Once the transition occurs, travel for LPN services can no longer be billed.

Q41: In Section 513.21.3 Transportation Trips, the third bullet indicates that the service limit is 520 trips annually; however in the WV I/DD Waiver Services, Units, Rates and Limitations sheet, the limit is 730. Which one is correct?

A41: [Updated 2/4/16] The policy manual is correct; the units on the Services, Units, Rates and Limitations sheet is an error and has been corrected. **Please note, however,**

that, though the policy manual indicates that there is a 2 trips per day limit, this will not apply—only the annual limit of 520 will apply.

Q43: Can parent providers enroll as NEMT providers?

A43: [1/21/16] Yes, they can receive gas mileage reimbursement (GMR) for transporting their child, family member, or friends. To do so, the individual must call MTM prior to a scheduled appointment at 1-844-549-8353. During this call, MTM will request information required to verify that the person being transported is Medicaid eligible. Upon eligibility verification, the caller is provided with a trip number and access information to obtain required forms. The individual providing transportation must take the required documents to the appointment for the medical provider to sign, verifying that the appointment was attended; the transporter then sends the completed form to MTM for processing. On the first trip, and annually thereafter, MTM requires the transporter to provide verification of current driver's license, and vehicle insurance and registration prior to receiving reimbursement. Trips must be arranged at least 5 business days before the appointment.

Q44: Families have reported that there is a 6-8 week delay in receiving GMR. Why is there such a delay, and is it anticipated that this delay will be reduced in the future?

A44: [1/21/16] MTM usually processes complete trip forms within 11 business days or receipt. Delays may be caused by incomplete forms or driver credentials not having been received.

Q45: Can MTM vehicles accommodate wheelchairs? If not, can I/DD Waiver mileage be billed for transport?

A45: [1/21/16] Yes, MTM has contracted transportation providers that can accommodate wheelchair transports. The individual must indicate that they need wheelchair transport when scheduling the trip. MTM is required to verify the wheelchair transport Level of Need (LON) with the requesting individual's physician.

Q46: Who should bill to schedule transportation with MTM?

A46: [1/21/16] The LPN or the SC can bill to schedule transport with MTM. For natural family settings, the parent may wish to schedule the transportation.

Q48: Can I/DD Waiver mileage/trips be billed for transportation to the Emergency Room or urgent care facilities, or must NEMT be utilized?

A48: [1/21/16] NEMT **cannot** be utilized for trips to the Emergency Room, as ER trips are considered emergent in nature. If necessary, an ambulance may be called or I/DD Waiver

mileage can be used. For transport to urgent care facilities, MTM may be able to arrange transport via their urgent request protocol, or I/DD Waiver mileage may be used.

Q49: Can I/DD Waiver mileage/trips be used for transport to Facility-Based Day Habilitation facilities and/or Supported Employment sites, or must NEMT be used?

A49: [1/21/16] I/DD Waiver mileage/trips can be used for this type of transport. Individuals can access NEMT for transportation to these types of facilities if the I/DD Waiver mileage/trips authorizations are exhausted.

Q74: The DD7s that were distributed (transportation log) says "starting address" and "end address" but the manual says "Transportation Log including beginning location (from) and end location (to). Is either acceptable?

A74: [5/5/16] When completing the transportation log "from" and "to" portions, staff should be as specific as possible. In most cases, indicating the address would be best practice; however on occasion the exact physical address would be acceptable. For example, for transportation from the individual's home to the local library, the individual's street address should be provided as the "from" address, but the exact address of the local library may not be available. In that case, it would be acceptable to indicate "Marmet Public Library on Rt 60 in Marmet."

Q115: Can agencies bill Transportation: Miles when providing transport in an agency-owned or - leased vehicle that is equipped to transport 7-16 passengers?

A115: [2/2/17] No. Provider should bill Transportation: Trips under the circumstance described.

Q123: According to section 513.2 of the policy manual, "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." If the provider has verified that the staff person has a valid license, registration, and proof of insurance both initially and annually thereafter, but during review KEPRO finds that this documentation has expired will recommendations for disallowance be made?

A123: [5/4/17] Allowing a staff person who provides this service to transport those receiving services without the valid documentation puts them at serious risk. As such, it is the expectation that the provider maintains current/valid documentation for any staff person that provides transportation services. If upon review it is discovered that a staff person providing this service does not have the required current/valid documentation in their file, then KEPRO will bring this to the attention of the provider and allow for the opportunity to obtain this documentation. If the provider is able to obtain current/valid

documentation that does not contain a lapse, then disallowance will not be recommended. If the provider is unable to obtain current/valid documentation or if documentation results in a lapse, then disallowance of all transportation services will be recommended for potential disallowance.

Q132: If an agency were to provide evidence of liability insurance coverage to include employment related accidents, would this be suffice and counted as compliant during an on-site review?

A132: [10/5/17] No. The agency must verify that all staff providing transportation services have current and valid proof of insurance prior to providing this service. The agency's policy may not provide adequate coverage to ensure legal protection in the event of an accident.

[Updated 11/2/17] If an employee uses a company vehicle to transport a member, and not their own personal vehicle, then the agency must maintain a current/valid driver's license for all staff providing this service. The agency must also be able to show evidence that supports that the company vehicle has current/valid registration and proof of insurance.

If a staff uses his/her own vehicle to provide transportation, proof of license, registration, and insurance must be maintained at the agency for the duration of time the employee transported I/DD Waiver members.

Q135: What service should be utilized while transporting a member to/from the person'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?

A135: [3/1/18] Transportation Miles, Transportation Miles-PO, and Transportation Trips can be utilized. Transportation Miles (Traditional Options) services may be billed concurrently with Person-Centered Support Services, Respite, LPN, RN, Supported Employment and all Day Services. Transportation Miles (PO) may be billed concurrently with Person-Centered Support Services: Personal Options or Respite Personal Options. Transportation Trips (Traditional Option) may be billed concurrently with Person-Centered Support Services, Respite and any Day Services. While it is true that transportation services (including non-emergency medical transportation) can be billed concurrently with direct support services, the IDT must agree upon a safe and responsible plan that takes the person's medical and/or behavioral needs into consideration.

Q163: Can NEMT be billed for more than one appointment per day?

A163: [1/3/19] Policy allows for one trip per household per day, so if a member requires transportation to more than one appointment per day, those must be done during one round trip in order for NEMT to be utilized.

Q164: Are members who live in ISS/Group Home subject to the NEMT "one trip per household per day" rule? Sometimes more than one person in the home has appointments on the same day.

A164: [1/3/19] The agency provider should notify Logisticare that the address is that of an ISS or Group Home. Logisticare will classify the address as "group home" in their system, which will allow more than one trip per day for those residents.

Q165: Can transportation services be billed to visit relatives, either in-state of out-of-state, or to locations outside of the person's local public community?

A165: The transportation sections 513.21.1 and 513.21.2 state under Site of Service that "This service may be billed to and from any activity or **service outlined on the person's IPP** and based on assessed need." The purpose of paying transportation is to transport individuals **to and from Medicaid-approved services**, which allows the individual to become more independent in **their local community.**

Visiting relatives is a family activity that is covered under natural support for individuals living with their families—the entire family benefits from visits to grandparents, etc. As such, it is only allowable for transportation services to be billed for a member to visit with relatives if the visit occurs in the member's local public community, they are going to and from a Medicaid-approved service, and it is documented in the person's IPP.

[1/2/19] An exception would be if the member lives in an ISS/GH or SFCP. If the member will be transported to visit his/her family, it is billable to do so as long as all other requirements for the service are followed. Keep in mind that transportation services cannot be billed outside the state except for those who live in border counties and for services provided within 30 miles.

WV CARES

Q1: When will providers be required to utilize the WV CARES system for conducting CIBs and monthly OIG checks?

A1: [12/3/15] WV CARES is an independent program operated by BMS. The manager of this program has indicated that trainings will be offered in January or February 2016. Until that time, providers should continue to conduct CIBs and OIG checks utilizing the current procedure. Providers will be notified of the training dates and locations when they are received.

Q37: The manual indicates that all agency staff, except extended professional staff, having direct contact with persons who receives services must meet all of the qualifications in that section. Does this apply to janitorial, clerical, and other staff who do not provide Medicaid services to individuals?

A37: [1/7/16] No. The requirements in Section 513.2 Provider Enrollment and Responsibilities, must be met by those who provide Medicaid services to persons who receive services. WV CARES will further clarify whether staff who do not provide Medicaid services are required to receive a Criminal Background Check.

Q71: If an agency does not have capability to provide supervision while someone is provisionally employed and awaiting results from WV CARES, can an Intellicorp check be used instead?

A71: [4/7/16] Yes, this is permissible.

Q76: What date is used to determine when the next background check through WVCARES is due?

A76: [5/5/16] As an existing CIB expires, the employee should be entered into the WVCARES. All CIBs expire within 3 years of completion, so an individual's entry into WVCARES will be required within 3 years of their original CIB. Once an employee is entered and determined fit for employment, the next WVCARES check will be due within 5 years.

Q81: What is the process for securing a background check via WV CARES when fingerprints are rejected due to lack of clarity?

A81: [8/4/16] The process for rejections is as follows:

- If fingerprints have been rejected twice for a state background check, both "hard cards" must be provided to WV CARES, who will then initiate a name-based search and will submit the "hard cards" for manual processing to the FBI.
- If fingerprints have been rejected twice for a federal background check, WV CARES will initiate a name search with the FBI. No additional information is needed from the agency.

Q101: Are agencies required to submit fingerprints via WV CARES for providers of extended professional services?

A101: [10/6/16] If the extended professional service is provided in the I/DD provider's office or in the home of the person who receives services, this is required. If the

occupational, physical, speech, and/or dietary therapies are provided at the extended professional's office, submission of prints to WV CARES is not required.

Q162: Are agencies required to maintain proof of WV CARES checks for contracted PT, OT, Speech, and Dietary therapists?

A162: [1/3/19] No, according to WV CARES, IDDW agencies are not required to maintain this documentation for those contractors.