



Bureau for Medical Services  
(BMS) Manual Chapter 512  
Traumatic Brain Injury Waiver  
Policy Revision  
2023

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July 13, 2023



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## Agenda

- Overview of Changes/Revisions/Additions to BMS Manual Chapter 512
- Overview of Program Forms (Removed, Remaining, Revised, and New)
- Questions and Answers



1

1

## General Changes



Member's Program documents created by Kepro, Providers and/or PPL are now being uploaded or located in the UMC Web Portal.

Throughout this manual, changes were made for Providers/PPL to either view or upload documents in the UMC Web Portal.

Not all items that are reflected on the Change Log are going to be covered today. Please make sure that you are aware of the changes. Please note that timelines for some program activities have changed.

Providers will be given time to develop any new policies/procedures and staff training curriculum after manual effective date of August 1, 2023.

2

2

## What's New



- Home and Community-Based (HCB) Settings Requirements
- Provider Agency Certification - New Policy/Procedures
- Office Criteria
- Record Requirements
- Case Manager Qualifications/Initial and Annual Training
- Personal Attendant Qualifications/Initial and Annual Training
- Training Documentation Requirements
- Incident Classification and Management
- Incident Reporting Requirements

3

3

## What's New (Cont.)



- Medicaid Fraud and Reporting
- Financial Eligibility - Coming off the MEL
- Medical Re-evaluation
- Environmental Accessibility Adaptation (EAA)
- Budget Development
- Self-Directed Service Delivery Model - Involuntary Transfers
- Transfers
- Person-Centered Service Plan Development

4

4

## 512.1 HCBS Setting Requirements



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

5

5

## 512.1 HCBS Setting Requirements (Cont.)



All members and settings for all the Waiver programs will be reviewed annually.

Individual private residences are defined as settings owned, leased, or rented by the member or one of their family members in which the member resides in a normative community with neighbors who do not all receive long-term care Medicaid services. These settings are presumed to follow the Home and Community-Based Settings Rule.

Regardless of this presumption, the State is required to assess all members annually to assure that they are integrated into their community and have full access to the benefits of community living.

6

6

## 512.1 HCBS Setting Requirements (Cont.)



If the member is living in a setting that is owned or leased by an unrelated live-in paid caregiver, then that setting is a provider-controlled setting. Inform BMS and Kepro.


If the member is living in a setting that is owned, leased, or operated by the agency and is providing services for much of the day, then that setting is a provider-controlled setting. Inform BMS and Kepro.

### Program Forms:

- West Virginia Home & Community-Based Services (HCBS)
- Member Controlled Setting Assessment (April 28, 2023, V4)
- West Virginia Home & Community-Based Services (HCBS)
- Provider Controlled Setting Assessment

7


7



# Implementation of WV Statewide Transition Plan

8

8




## Workflow – Case Management

Activity	Timeframe	Documentation
TBIW CM completes/passes the required BMS LMS training: WV Statewide Transition Plan Training	Training for existing CM must have been completed by <b>April 30, 2023</b> .  This is an <i>initial</i> training for all newly hired Case Managers (BMS Directive Memo dated 1/25/2023)	Maintain a copy of the Certificate of Training generated from BMS LMS in the personnel file at your agency. Evidence will be requested during the 2024 Quality Provider Reviews.

Page  
9

9

Workflow – Case Management




  

Activity	Timeframe	Documentation
Complete Member Education (training at member's <i>next</i> scheduled Service Planning event (Annual/6 Month))	* <b>May 1, 2023</b> (Start Date for implementation)	<b>Member Education:</b> Document the following on the Service Plan signature page : <i>CM provided a copy of the WV Statewide Transition Plan brochure and reviewed the contents with the Member/Legal Guardian.</i>

Page  
10

10

Workflow – Case Management




  

Activity	Timeframe	Documentation
Complete the MCS Assessment at the member's <i>next</i> scheduled Service Planning event (annual/6 month)	* <b>May 1, 2023</b> (Start date for implementation)	<b>Completed MCS Assessment</b> (Save in member's file at agency) Include as an upload with the Annual SP in ANG 6-month upload to the current UM cases with current authorization

Page  
11

11

Workflow – Case Management




Activity	Timeframe	Documentation
MCS Assessment	<b>Yearly</b> at Annual Service Planning (SP) Meeting	<b>Completed MCS Assessment</b> (Save in member’s file at agency) Include as an upload with the Annual SP in ANG

Page  
12

12

Workflow – Personal Attendant Agency



Activity	Timeframe	Documentation
Personal Attendant Staff completes/passes required training on WV Statewide Transition Plan	Existing Personal Attendant Staff trained by January 31, 2024 New staff (initial) upon hire	BMS LMS Training Certificate <i>OR</i> <i>Document on the Training log and maintain copies of competency.</i>  Evidence will be requested during the 2024 Quality Provider Reviews

Page  
13

13

## 512.3 Provider Agency Certification



### Changes/Additions/Edits

- Removal of the escrow requirement
- Providers are to develop two new policies/procedures:
  - Policy and Procedure for reporting Medicaid Fraud to the BMS (Office of Program Integrity and Program Manager)
  - Policy and Procedure for documentation training for Case Managers and Personal Attendants that must include current program forms and proper documentation correction procedures

14

14

## 512.6.5 Office Criteria



Removed: The requirement that required the agency location/office to serve eight contiguous counties

Added: TBIW providers cannot obtain certification for the sole purpose of serving individuals from another program, such as the Veteran Administration (VA).

15

15



## 512.14 Record Requirements



Added: Documentation must be member-specific, legible, and errors in documentation cannot be completely covered over but should be indicated with a line through the error and noted/initialed by the person making the correction.

Added: Uploading Service Planning Documents into the UMC Web portal. Including the completed Member Controlled Setting Assessment.

16

16

## 512.16.1 Case Manager Qualifications



Additional information provided regarding the four-year Human Services degree and steps to request a review of a potential Case Manager employee's transcripts.

17

17

## 512.16.2 Case Manager Initial and Annual Training



### New Initial Training Topics:

- Recognizing Medicaid Fraud and how to report
- Statewide Transition Plan Rules and Member Controlled Assessment training found on the BMS Learning Management System (LMS)
- Training regarding proper documentation correction requirements and forms

### New Annual Training Topic:

- Recognizing Medicaid Fraud and how to report

18

18

## 512.16.3 Personal Attendant Qualifications



Personal Attendants that have current Certified Nursing Assistant (CNA) certification meet the qualifications for Personal Attendant once they have completed First Aid/CPR training, member specific needs, Member Handbook, required TBI training, and specific agency policy trainings.

19

19

CNA Cont. Initial Training		
TBI Waiver Personal Attendant Initial Training Topic	Nurse Aide Training and Competency Evaluation Program- Curriculum Components	Additional Waiver Requirement
Personal Attendant Professional Ethics Delivering Person-Centered Care Training	Communication and Social Interaction	
Universal Precautions Training Health and Welfare Training	Basic Nursing Skills	Member specific needs to be addressed by Agency trainer
Personal Attendant Skills	Personal Care Skills	Member specific needs to be addressed by Agency trainer
Personal Attendant Skills	Basic Restorative Services	Member specific needs to be addressed by Agency trainer
Member Rights and Responsibilities Training	Rights of Residents	Must include a review of the TBI Waiver Member's Rights and Responsibilities handbook and/or other relevant provider specific policies

20

CNA Cont.: Annual Training		
TBI Waiver Personal Attendant Annual Training Topic	Nurse Aide Training and Competency Evaluation Program- Curriculum Components	Additional Waiver Requirement
Universal Precautions Training	Basic Nursing Skills	Member specific needs to be addressed by Agency trainer
Two (2) Hours of training focused on enhancing personal Attendant service delivery knowledge and skills	Personal Care Skills	

21

## 512.16.4-5 Personal Attendant Initial and Annual Training



### New Initial Training Topics:

- Personal Attendant Professional Ethics now includes information on Medicaid Fraud, Waste, and Abuse
- Statewide Transition Plan Rules and Member Controlled Assessment training is available on the BMS Learning Management System (LMS) or providers can create their own training
- Training regarding proper documentation correction requirements and forms.

### New Annual Training Topic:

- Medicaid Fraud, Waste and Abuse

22

22

## 512.16.6 Training Documentation



Documentation for training conducted by an agency RN, social worker/counselor, or a documented specialist in the content area must include the training topic, date of the training, and the signature of the instructor and the trainee or for *Personal Options*, the member/program representative's signature.

Documentation for the UMC approved internet-based training must include the employee's name, the name of the internet provider/trainer, and either a certificate or other documentation proving successful completion of the training. Providers may use the approved TBIW Form to document training, **or they may provide the certificates for all required trainings.**

### Program Forms:

Personal Attendant Initial/Annual Training Log  
Case Manager Initial/Annual Training Log

23

23

## 512.17 Incident Classification and Management



Abuse, Neglect, or Exploitation (A/N/E) narrative was expanded and provides more detail as to when incidents meet the threshold of suspected abuse, neglect and/or exploitation. Reporting requirements and timeframes for APS and CPS has been defined in more detail.

24

24

## 512.17.1 Incident - Reporting Requirements



Agencies are responsible to add new staff and remove staff no longer with the agency within the WV IMS in five business days of being hired/employment ending.

25

25

## 512.18 Medicaid Fraud and Reporting Requirements



Providers are required to report any and all suspected fraud to BMS. Suspected fraud includes any instance in which a provider of any Medicaid service knowingly provides false information to a payer or employer in order to enhance their reimbursement or to receive reimbursement for services never provided.

Fraudulent activities include, but are not limited to, falsifying documentation such as timesheets, certifications, or medical records; submitting duplicative claims; or knowingly billing for medically unnecessary services.

When a provider becomes aware of potentially fraudulent behavior, they must immediately complete the fraud referral form available on the OPI page of the [BMS website](#) and submit the completed form to OPI at [DHHRBMSMedicaidOPI@wv.gov](mailto:DHHRBMSMedicaidOPI@wv.gov) and to the TBIW Program Manager.

26

## 512.22 Financial Eligibility - Coming off MEL



No longer able to enroll an applicant with a valid/non-expired Yellow DHS-2. Must establish financial eligibility (White DHS-2) for eligible applicant coming off the MEL.

### New language in Manual:

When the applicant is released from the MEL, financial eligibility must be obtained.

### Process:

Kepro will send the selected Case Management Agency the White DHS-2 and the Enrollment Request form when a funded slot has been awarded to the eligible applicant.

27

27

### 512.23.2.3 Medical Re-evaluation



Annual re-evaluations for medical eligibility for each member utilizing the TBIW must be conducted. The process is as follows:

- The UMC will contact the member 90 days prior to the member's Anchor Date to schedule the reevaluation appointment.
- Once UMC contacts the member, a letter is sent to the member and Case Management agency noting the date, location, and time of the assessment.

28

28

### 512.23.2.3 Medical Re-evaluation (Cont.)



- If the UMC is unable to contact the member after three attempts, a potential closure letter will be sent to the member, the Case Management agency, the Personal Attendant agency or the F/EA (if applicable), and the TMH office (if applicable).
- If no contact is made by the member to the UMC within 10 business days of the date of the potential closure letter, the UMC will send the final closure letter to the member, Case Management agency and Personal Attendant agency or F/EA (if applicable). The UMC will then close the case.

29

29

## 512.35 Environmental Accessibility Adaptations (EAA)



### **Environmental Accessibility Adaptions (EAA) Home -Definition**

Physical adaptations to the private residence of the member who receives services or the family in which the member resides and receives services which maximize physical accessibility to the home and within the home. These adaptations enable the member who receives services to function with greater independence in the home. This service is used only after all other non-family funding sources have been exhausted.

### **Environmental Accessibility Adaptions (EAA) Vehicle - Definition**

Physical adaptations to the vehicle including paying for accessibility adaptations if the member who receives services has the capacity to drive, or the family member in which the member resides. The purpose of this service is to maximize accessibility to the vehicle only.

30

## Environmental Accessibility Adaptations (EAA) (Cont.)



The Case Manager (CM) must add the EAA service to the member's Service Plan. All EAA requests must be submitted to the UMC for approval. If approved, an authorization is issued for the Personal Attendant agency (PAA) or F/EA to begin the process of obtaining the EAA.

The PAA or F/EA is responsible for ensuring the adaptation to the home/vehicle is completed as specified in the plan.

Documentation including dated and itemized receipts of the completed adaptation must be maintained by the PAA or F/EA and a copy shared with the Case Manager.

The Case Manager will also verify that the EAA was provided as outlined in the members' Service Plan.

31

31



## Environmental Accessibility Adaptations (EAA) (Cont.)



### Traditional Model Procedure Codes:

Home: S5165 U2    Vehicle: T2039 U2

### Personal Options Model Procedure Codes:

Home: S5165 U3    Vehicle: T2039 U3

Service Unit: 1 unit = \$1.00

Service Limit: \$1,000 per Service Plan Year

Prior Authorization: All units of service must be prior authorized before service is provided.

### Program Forms:

Prior Authorization Cover Sheet, Budget Template, Assessment, and Service Plan documents have been revised to include the new service codes.

32

32

## Requesting EAA Home/Vehicle



If the request for EAA occurs ***before the member's scheduled assessment and planning event***, the Case Manager is responsible for obtaining prior authorization for EAA by completing the following steps:

- Create a new UM Case in ANG to request the new service.
- Attach the Service Plan Addendum that documents the requested EAA and confirmation that the member requested the service (Case Log/Monthly Contact Form).
- Kepro will review the documentation and inform the CMA and PAA or F/EA of the decision to authorize the service.

33

33

## Requesting EAA Home/Vehicle (Cont.)



If the request for EAA occurs **during the member's scheduled assessment and planning event**, please remember the following:

- Person Centered Assessment - mark "Yes" for EAA Home and/or Vehicle
- If you mark *Yes for EAA Vehicle*, confirm that member has the capacity to drive (verify driver's license) or needs regular transportation from a family member.
- On Person-Centered Service Plan Summary page mark "Yes" for EAA Home and/or Vehicle
- Include the Service Code on both the Prior Authorization Cover Sheet and Budget.

34

34


## EAA Authorization



- Member now has an authorization for the EAA service.
- The authorization is issued to the member's PAA or F/EA (if self directing).
- The Member's assigned Case Manager is responsible to work with the member and/or the court appointed legal guardian to secure the vendor to perform the work for EAA - Home/Vehicle.
- The PAA or F/EA must not pay EAA funds to the member who receives services, staff, or family/legal representative.
- Payment for cost of services must be issued to the vendor of the EAA service.
- The monetary equivalent of this service cannot be rolled over to increase any other self-directed services such as Personal Attendant services or Non-Medical Transportation.

35


**Once Adaptations Have Been Completed**



- The member’s assigned CM is responsible for ensuring the adaptation to the home and/or vehicle was completed as specified.
- Documentation including dated and itemized receipts of the completed adaptation must be sent to the CM and maintained by the PAA or F/EA.
- The member’s assigned CM will complete the West Virginia TBI Waiver EAA Home/Vehicle form, attach the required supporting documentation, and upload to the existing UM case in ANG.

36

**512.28 Budget Development**



Service	Maximum Budget
Personal Attendant + Transportation	\$35,000
Personal Attendant + Transportation + PERS	\$35,600
Personal Attendant + PERS	\$35,600
Personal Attendant + Transportation + EAA	\$36,000
Personal Attendant + EAA	\$36,000
Personal Attendant + PERS + EAA	\$36,600
Personal Attendant + Transportation + PERS + EAA	\$36,600

37

37

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## Funds for YOU! TBI Services

Funds for YOU is available for West Virginians who have a documented Traumatic Brain injury (TBI).

Awards may be up to \$2,300

Traumatic Brain Injury Program  
959 Hartman Run Road  
Morgantown, WV 26505  
Email: [TBI@hsc.wvu.edu](mailto:TBI@hsc.wvu.edu)  
Phone: 877-724-8244

**Handouts:**  
TBI Funds for YOU! Policy and Steps for Completing 2022-2023  
Funds For YOU! Application

38

38

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## Olmstead Transition and Diversion Program

**What is the purpose of the Olmstead Transition and Diversion Program?**

- To help people who are at imminent risk of placement into a facility to remain in their own home.

**What does it mean to be at “imminent risk of institutionalization?”**

- Individuals in the community whose mental or physical health has deteriorated resulting in a new need to support their self-care that cannot be met without the requested support from the Olmstead Transition/Diversion fund, and
- facility placement is likely within 3 months

**Handout:** West Virginia Olmstead Transition and Diversion Program, Policy and Application Instructions (effective January 13, 2022)

39

39

## 512.25.2 Self-Directed Service Delivery Model



Involuntary Transfers from the Self-Directed service delivery model (Personal Options) to the Traditional service delivery model

Reasons for Involuntary Transfers include:

- Non-compliance with the Self-Direction program requirements
- Non-compliance with TBIW program requirements
- Demonstrated inability to supervise self-directed employee(s)
- Demonstrated inability to complete and maintain employee paperwork
- Inability to hire an employee within 90 days of enrollment or to retain employees after being enrolled on Personal Options
- Refusal to have a Program Representative or inability to retain a Program Representative to assist with the responsibilities of self-direction

40

40

## 512.25.2 Self-Directed Service Delivery Model (Cont.)



It is possible for a member to transition back from the Traditional Service Model after an Involuntary Transfer has taken place. BMS will consider if the member's circumstances surrounding the reason for the Involuntary Transfer have changed.

Involuntary Transfers for the following reason would require a **six month wait** before being able to transfer back to self-direction:

- Non-compliance with the Self-direction program requirements;
- Non-compliance with TBIW program requirements; and
- Demonstrated inability to supervise employee(s)

41

41

## 512.50 Transfers to Another Agency or Personal Options



- Removed the limit to the number of transfers.
- Modified the requirement **from** a new Service Plan development **to** Review the current Service Plan, using the Service Plan Addendum to reflect the revisions to the plan based on the transfer.
- Added language about Transfers resulting from Conflict-Free Case Management.

42

42

# Person-Centered Service Plan Development



43

43

## 512.27 Person-Centered Service Plan Development



### Risk Assessment and Mitigation Planning

- A critical step in the assessment process is the comprehensive analysis of risk. A risk analysis is not a one-time exercise but rather a process by which the analysis of risk and the development of risk mitigation strategies are continually revisited.
- The Person-Centered Assessment requires the team to review areas of risk and or potential risk and include in the Service Plans methods to mitigate risks.

44

44

## 512.27 Person Centered Service Plan Development (Cont.)




### 24-Hour Emergency Back Up Planning

- The purpose of 24-hour emergency backup planning is to ensure that critical services and support are provided to safeguard members' health and safety whenever there is a breakdown in the delivery of planned services.
- The BMS approved Person-Centered Service Plan requires the team to address this during initial/annual and six month plan reviews.

45

45

**512.27 Person Centered Service Plan Development (Cont.)**




Type of Service Plan	Policy	Forms to be Completed and Submitted
Initial/ Annual Service Plan	512.27	<ul style="list-style-type: none"> <li>▪ Prior Authorization Cover Sheet</li> <li>▪ Copy of the signed Service Plan</li> <li>▪ Copy of signed Assessment</li> <li>▪ Completed budget</li> <li>▪ PC Discovery Tools</li> <li>▪ PT/OT/ST Home therapy plan (if applicable)</li> <li>▪ Member Controlled Assessment</li> <li>▪ COI Exception Form (if applicable)</li> </ul>

46

46

**512.27 Person-Centered Service Plan Development (Cont.)**



Type of Service Plan	Policy	Forms to be Completed and Submitted
6 Month	512.27.1	<ul style="list-style-type: none"> <li>▪ 6 month review of Assessment and Service Plan</li> </ul>
Service Plan Addendum	512.27.1	<ul style="list-style-type: none"> <li>▪ Service Plan Addendum-Change in Need</li> <li>▪ Service Plan Addendum-Transfer</li> </ul>
Interim	512.27.2	<ul style="list-style-type: none"> <li>▪ Interim Person-Centered Service Plan</li> </ul>

47

47



## 512.27 Six Month Service Planning



Participation in the six month Person-Centered Service Plan and Annual Person-Centered Service Plan development is mandatory for the member, the Case Manager, and the Personal Attendant provider agency.

The member may choose to have whomever else they wish to participate in the process such as Personal Attendant staff, family members, other service providers, informal supports, Personal Options Resource Consultant (if applicable), etc.

The Personal Attendant staff can bill up to one hour for participating in the six month and Annual Service Planning meetings.

48

48

## 512.27 Six Month Service Planning (Cont.)



The six month review meeting is held six months from the Initial/Annual Service Plan meeting month and includes a review of the Initial/Annual Assessment and Service Plan documents.


This review does not result in a new assessment and Service Plan but modifications to the existing Assessment and/or Service Plan would be documented on the six month review page.

Changes, modifications, revisions and new assessed needs to the Assessment and/or Service Plan are documented on **the six month review page and signatures are obtained from those in attendance.**

49

49

## Six Month Service Planning (Cont.)


  
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**Example:**


Member's Anchor Date	Annual Service Planning Meeting held	Annual Service Plan Date Range (one year aligns with Anchor Date and Authorizations)	Six Month Service Plan Review date is Six Months from the ANNUAL Meeting Month	Six Month Service Plan Review (to review the Annual Service Plan/make revisions as needed)
May 1	April 10	May 1, 2023- April 30, 2024	October 2023 (to be held during the month due)	

TBI Waiver Service Authorizations are generated for one year (aligned with member's anchor date).

50

50

## Anchor Date Definition - TBIW

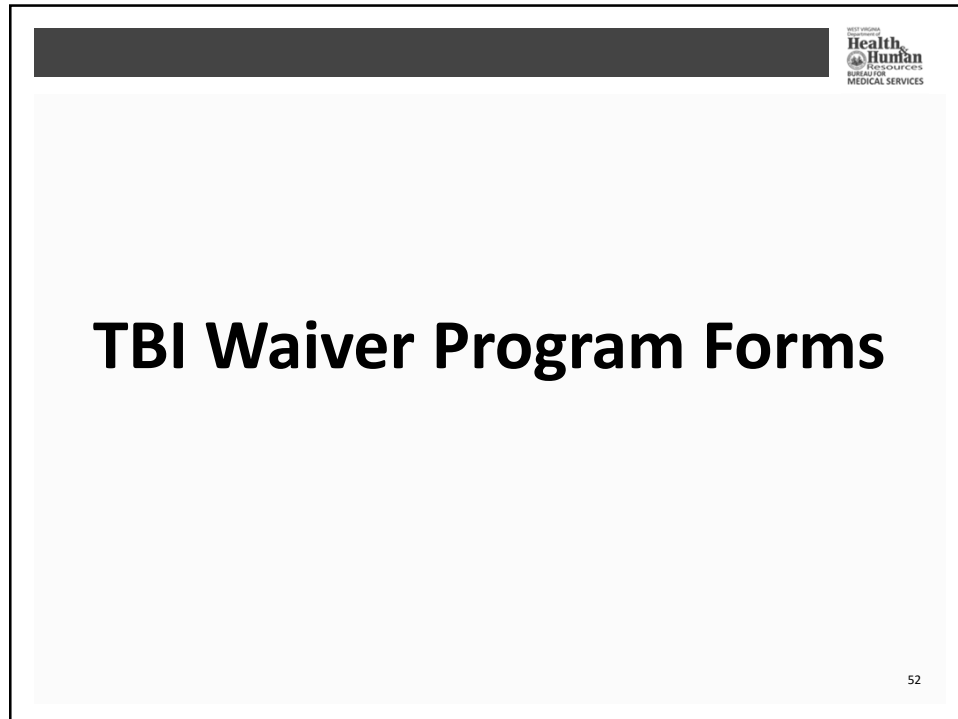

  
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Upon enrollment in the TBIW program, each member is assigned an "Anchor Date" which falls on the first day of the month following the date that the member's initial medical eligibility was determined by the UMC.

The anchor date is the date by which the member's annual medical eligibility must be redetermined. This fixed date serves as the due date for the Annual Person-Centered Assessment and Service Plan and the re-evaluation of the person's medical eligibility, as well as the start date for TBIW service authorizations (Chapter 512 TBIW Glossary).

51

51

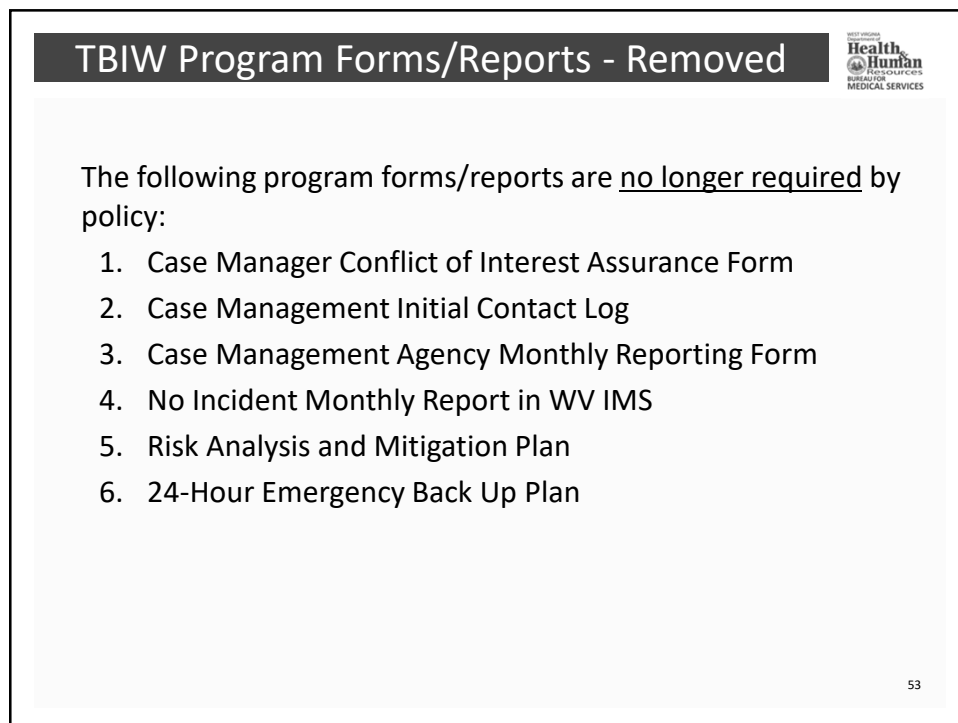


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# TBI Waiver Program Forms

52

52



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## TBIW Program Forms/Reports - Removed


The following program forms/reports are no longer required by policy:

1. Case Manager Conflict of Interest Assurance Form
2. Case Management Initial Contact Log
3. Case Management Agency Monthly Reporting Form
4. No Incident Monthly Report in WV IMS
5. Risk Analysis and Mitigation Plan
6. 24-Hour Emergency Back Up Plan

53

53

**TBIW Program Forms – Remain (No Changes)**




1. TBIW Case Management Log
2. Provider Agency Change Request
3. Personal Attendant Worksheet
4. HCBS Notice of Death Form
5. Interim Service Plan
6. Enrollment Request Form
7. Good Day/Bad Day
8. Morning Rituals
9. Grievance Form
10. Request for Discontinuance
11. Transfer Request
12. TBI Waiver Responsibility Agreement

54

54

**TBIW Program Forms - Revised**



Name of Form	Changes Made
Case Management Monthly Contact Form	Modify to reflect both Face-to-Face and Phone Calls
TBIW MNER	Remove MNER Re-Eval fields from the form
TBIW Prior Authorization Cover Sheet	New Service Codes Additional Doc Requested
Budget Template	New Service Codes/Rates/Budget Total Layout of template

55

55

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### TBIW Program Forms - Revised (Cont.)

Name of Form	Changes Made
Personal Attendant Initial/ Annual Training Log	Added new training topics revised the log to have date of training and required signatures
Case Manager Initial/ Annual Training Log	Added new training topics, revised the log to have date of training and required signatures

56

56

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### TBIW Program Forms - Revised (Cont.)

Name of Form	Changes Made
Person-Centered Assessment	Layout of form/removed some content integrative the Risk Mitigation and 24-hour emergency back up, created a Risk Assessment section, added a Summary Page, created a six month review page and PDF fillable document

57

57

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### TBIW Program Forms - Revised (Cont. )

Name of Form	Changes Made
Person-Centered Service Plan	<p>Removed: Personal Attendant Worksheet sections/information that was repetitive</p> <p>Added: New Service Codes, Six Month Service Plan Review Page, consolidated the Risk Mitigation and 24-Hour Emergency Back-Up into Service Plan, and created PDF fillable document</p>

58

58

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### TBIW Program Forms - New

Manual Section	Title of Form
512.1 Home and Community Based (HCB) Settings Requirements	West Virginia Home & Community-Based Services (HCBS) Member Controlled Setting Assessment (completed by the TBIW Case Manager) (April 28, 2023, V4)
512.3 Provider Agency Certification	TBIW Geographical and Cultural/Linguistic Conflict of Interest Exception Application for Home and Community-Based Waiver Services

59

59

## TBIW Program Forms – New (Cont.)




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Manual Section	Title of Form
512.35 Environmental Accessibility Adaptations (EAA)	West Virginia TBIW EAA Home/Vehicle forms

60

60

## Reminders



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Revised Program Forms will be on the BMS website on **8/1/2023**.

Agencies are required to have policies and procedures completed by **10/1/2023**.

Agencies are required to have the training outline developed and submitted to the UMC (Kepro) by **10/1/2023**.

Employees hired **before** August 1 must have the Medicaid Fraud Training completed by **12/1/2023** and annually thereafter.

Employees hired **after** August 1 must have the Medicaid Fraud Training completed by **12/1/2023** or during initial training and then annually thereafter.

61

61



# Questions?

62

62



## Contacts

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63

63



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64