



CHAPTER 517 PERSONAL CARE SERVICES

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DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.



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BACKGROUND

This chapter sets forth the West Virginia (WV) Department of Health and Human Resources (DHHR) Bureau for Medical Services (BMS) requirements for payment of Personal Care (PC) services provided to eligible West Virginia Medicaid members.

All forms for this program can be found on the [BMS Website](#).

PROGRAM DESCRIPTION

Personal Care (PC) services are available to assist an eligible member to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in the member's home, place of employment or community. To be medically eligible for PC services, Medicaid members must have three deficits according to the most current Pre-Admission Screening (PAS) which was initiated by a Personal Care Medical Necessity Evaluation Request (PC-MNER) signed by a physician, physician assistant, or nurse practitioner, and require hands-on assistance/supervision/cueing in ADLs/IADLs. Services must be provided by a qualified PC provider(s). Specialized Family Care Providers (SFCPs) must maintain a fully certified home in accordance with the Bureau of Children and Families Specialized Family Care Policy at all times. Members can receive a maximum of 210 hours of service per month based on assessed needs. Services may not solely involve ancillary tasks such as housekeeping or assistance with chores. PC services do not replace the age appropriate care that any child would need from a parent or legal guardian. ADLs provided for children must be for assistance beyond the age appropriate care that is typically provided by a parent or legal guardian and must be medically necessary.

All PC services covered in this chapter are subject to a determination of medical necessity. PC services are medically necessary activities or tasks which are implemented according to a Nursing Plan of Care (POC) developed and supervised by a Registered Nurse (RN). These services enable members to meet their physical needs and allow them to remain in their home and community.

Services must be:

- Determined to be medically necessary by BMS' Utilization Management Contractor (UMC);
- Necessary to the long-term maintenance of the member's health, safety, and long-term need for hands-on assistance with activities of daily living (ADL's);
- Provided pursuant to a Nursing POC developed and monitored by an RN;
- Rendered by an individual who has met the basic training requirements and credentials described in this manual; and
- Prior authorized by BMS' UMC.

PC services are 1:1 services. This means that no single Direct Care Worker can bill for more than one member during a single 15 minute period. Direct Care Workers, including SFCPs, are limited to billing no more than 16 hours per day regardless of the number of members they are caring for or are placed in their home.

The PC Services program cannot provide direct care personal care services on a 24 hour a day, seven day a week basis. It is not intended to be used as respite, nor can time be billed for waiting in the home to assist a PC member.

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PROVIDER PARTICIPATION REQUIREMENTS

517.1 BUREAU FOR MEDICAL SERVICES (BMS) CONTRACTUAL RELATIONSHIPS

BMS contracts with an Operating Agency (OA). The OA acts as an agent of BMS and administers the operation of the Personal Care program. The OA conducts education for PC providers, members receiving PC services, advocacy groups and others as requested.

The OA, in collaboration with BMS, will provide answers to policy questions which will serve as policy clarifications. These policy clarifications will be posted on the [BMS website](#).

BMS contracts with a Utilization Management Contractor (UMC) that completes the PAS to determine initial and continuing medical eligibility for Personal Care services. The UMC will also review service level change requests. The UMC provides a framework and a process for authorizing PC services. The UMC provides authorization for services that are based on the member's assessed needs and forwards authorization information to the claims payer.

BMS contracts with PC providers for the provision of services for members receiving PC services. All PC providers must be certified by the OA and enrolled as a Medicaid Provider.

Please refer to the [Personal Care Program website](#) for OA and UMC contact information.

517.2 PROVIDER AGENCY CERTIFICATION

In order to provide PC services under West Virginia Medicaid, a provider agency must have a Certificate of Need (CON) from the WV Health Care Authority. Agencies that were providing Personal Care services (SFCP's, Senior Centers, WV Lincensed Comprehensive Behavioral Health Care Centers, CCIL and All Aid) prior to the standards approved by the governor on November 28, 2016 are exempt from this provision.

After receiving a CON from the WV Health Care Authority (HCA), PC provider applicants (excluding SFCPs) must submit a Certification Application to the OA.

An agency may provide both PC services and Home and Community Based Waiver Services provided they maintain a separate certification from the OA and a National Provider Identifier (NPI) or Atypical Provider Identifier (API) number for billing purposes. Separate member and personnel files must be maintained for PC services and Waiver services. A copy of all Specialized Family Care Provider certifications must be sent to the OA when initially certified by the Bureau for Children and Families' contracted agency and annually thereafter.

In addition, the provider agency must submit to the OA and maintain the following:

- A. A valid Certificate of Need (CON);
- B. A business license issued by the State of West Virginia;
- C. A federal tax identification number (FEIN);



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- D. A competency based curriculum for required training areas for Direct Care Worker (See [Section 517.3.1.1 Direct Care Worker Initial Training Requirements](#) and [Section 517.3.1.2 Direct Care Worker Annual Training Requirements](#));
- E. An organizational chart;
- F. A list of the Board of Directors;
- G. A list of all provider staff, which includes their qualifications (See [Section 517.3 Staff Qualifications and Training Requirements](#), and [Section 517.2.2 Criminal Background Checks](#)) and all of their subparts);
- H. County or a list of counties served;
- I. A Quality Management Plan for the agency;
- J. A physical office located in WV that meets the criteria outlined in [Section 517.2.3 Office Criteria](#);
- K. Written policies and procedures for processing complaints and grievances, from staff or members receiving PC services, that:
 - a. Addresses the process for submitting a complaint;
 - b. Provides steps for remediation of the complaint including who will be involved in the process;
 - c. Provides steps which include the process for notifying the member/staff of the findings and recommendations;
 - d. Provides steps for advancing the complaint if the member/staff does not feel the complaint has been resolved; and
 - e. Ensures that a member receiving PC services or agency staff are not discharged, discriminated, or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process that involves a PC provider.
- L. Written policies and procedures for the use of personally and agency owned electronic devices which includes, but is not limited to:
 - a. Prohibits using personally identifiable information in texts and subject lines of emails;
 - b. Prohibits the use of personally identifiable information in the body of emails unless the email is sent securely through a HIPAA compliant connection;
 - c. Prohibits personally identifiable information from being posted on social media sites;
 - d. Prohibits using public Wi-Fi connections without use of a secure connection;
 - e. Informs agency employees that during the course of an investigation all information on their personal cell phone is legally discoverable; and
 - f. Requires all electronic devices be encrypted.
- M. Written policies and procedures for member transfers;
- N. Written policies and procedures for the discontinuation of member services;
- O. Office space that allows for member confidentiality;
- P. An Agency Emergency Plan (for members and for office operations).
 - a. Office Emergency Back-Up Plan ensuring office staffing and facilities are in place during emergencies such as floods, fires, etc. However, the new temporary facilities must meet all requirements. The Provider must notify the OA within 48 hours. Providers must inform members receiving PC services of their Emergency Back-Up Plan.
- Q. Written policies and procedures to avoid conflict of interest (if agency is providing both PC services and Waiver services) which must include at a minimum:
 - a. Education of all staff on general Conflict of Interest/Professional Ethics with verification;
 - b. Annual signed Conflict of Interest Statements for all staff and the agency director;
 - c. Process for investigating reports on conflict of interest complaints;
 - d. Process for reporting to BMS; and



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- e. Process for complaints to professional licensing boards for ethics violations.
- R. Policies and procedures for members with limited English proficiency and/or accessible format needs that are culturally and linguistically appropriate to ensure meaningful access to services.
- S. Computer(s) for staff to use HIPAA secure email accounts, UMC web portal access, internet access, and current (within last five years) software for spreadsheets.
- T. Qualified workforce that meets the criteria in the policy manual for training and credentials.
- U. Discharge policy that ensures a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services that the member needs to another provider(s) and is agreed upon by the member and the receiving provider(s).
- V. Documentation of services delivered meets regulatory and professional standards before the claim is submitted.
- W. Participation in all mandatory training sessions sponsored by the OA or UMC.

PC providers are prohibited from discriminating against potential or existing members based on member needs or personal characteristics. For example, providers must accommodate members who need evening or weekend PC staffing, Hoyer lift assistance, or other special needs. If the OA determines a provider has a pattern of refusing members under these circumstances, BMS may request their removal from the Provider Selection Lists so no new members may be accepted by the agency. This restriction will remain until it is determined by BMS that the agency can serve all members.

Provider Agencies will be reviewed by the OA within six months of initially providing services and annually thereafter. Please refer to [Section 517.2.5 Provider Reviews](#).

More information regarding provider participation requirements in Medicaid services can be found in [Chapter 300, Provider Participation Requirements](#). Please note, providers will be held accountable for information contained in all Medicaid Common Chapters.

Providers are encouraged to contact the OA for training needs and technical assistance at any time.

The hourly wage of agency staff employed by a PC provider is determined solely by the agency that employs the staff person. Agency providers must at all times comply with all local, state, and federal wage and hour employment laws and regulations, including, but not limited to, the West Virginia Wage and Hour Act, Fair Labor Standards Act (FLSA) and Internal Revenue Service (IRS) laws and regulations. PC providers are solely responsible for making their own determination as to whether an individual performing work for the agency is an employee or independent contractor under applicable state and federal laws and regulations. Provider agencies should not interpret this as an opportunity to misclassify workers as independent contractors. Provider agencies are solely responsible for any liability resulting from misclassification of workers. BMS reserves the right to dis-enroll any PC provider which is found to have misclassified employees by the U.S. Department of Labor, IRS, or any other applicable state or federal agency. All agency staff hired by a PC provider must meet the requirements listed in the applicable [Section 517.3 Staff Qualifications and Training Requirements and its subparts](#).

517.3 ELECTRONIC VISIT VERIFICATION

The Centers for Medicare & Medicaid Services (CMS), Section 12006 of the 21st Century Cures Act, requires providers to implement Electronic Visit Verification (EVV) by January 1, 2019. EVV systems must be able to track the type of service performed, the individual receiving the service, the date of service, the

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location of service delivery, the individual providing the service, and the time services begin and end for each Direct Care Worker with each member they serve.

CMS is scheduled to release a guidance document on EVV in January 2018. BMS is evaluating the possibility of a State system solution and will work with providers in the implementation of EVV. Additional guidance will be provided when it becomes available.

517.4 CONFLICTS OF INTEREST

Conflicts of interest are prohibited. A conflict of interest is when any staff has competing interests due to affiliation with a provider agency, combined with some other action. "Affiliated" refers to either an employment, contractual or other relationship with a provider agency such that the staff person receives financial gain or potential financial gain or job security when the provider agency receives business serving PC clients. This includes exerting pressure on or requiring that the member use one agency for both waiver and PC services.

If any agency staff pressures or tries to influence a member towards receiving services from the agency(s) with which the staff is affiliated, then a conflict of interest occurs. All staff must always ensure any affiliation with a provider agency does not influence their actions with regard to seeking services for members. Failure to abide by this Conflict of Interest policy will result in the loss of PC provider certification and removal from the selection lists for the provider involved for a period of one calendar year. All members being currently served by the suspended provider will be transferred to other PC agencies. Additionally, any RN who takes improper action as described above, will be referred to their professional licensing board for a potential violation of ethics. Billed RN services for the month this activity occurred will be disallowed. This is considered influencing a PC member's "Right to Choose (transfer)." 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 OA and the results of this investigation will be reported to BMS for review and possible action.

In the event a provider sells their business, the members do not automatically transfer with the sale. Members must be provided freedom to choose from available PC providers in their catchment area. Any effort to coerce a member to transfer to the purchasing PC provider will be considered a conflict of interest and will result in the purchasing PC provider being removed from the PC provider selection list for one calendar year. See [Section 517.31 Voluntary Agency Closure](#).

517.5 SPECIALIZED FAMILY CARE PROVIDERS (SFCPS)

Specialized Family Care Providers (SFCPs) are certified annually by the West Virginia Bureau for Children and Families (BCF) and must maintain their certification at all times in order to provide PC services. SFCPs must follow the policies in this manual unless otherwise noted in specific sections of the manual. SFCPs must document services as they are provided in 15 minute units on the day in which they occur. Services provided must meet the definition of PC and do not replace Specialized Family Care duties agreed upon with BCF.

PC services provided by informal supports in Specialized Family Care Settings are not billable. If the member receiving PC Services is out of the home for respite or any other reason, i.e. in the hospital, the SFCP with whom the individual/s lives may not bill during that time. If the SFCP cannot provide all

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services on the POC for individuals living in their home, they may get the additional services from a PC provider. If the SFCP travels out of state with the member, services cannot be billed. The only exception is for those who live in a West Virginia county bordering another state. In those instances, the provider may bill up to 30 miles beyond the state border for a medically necessary service.

When an SFCP has lost certification, the SFCP must immediately stop providing Personal Care services and the SFC program will meet to determine if the individual is going to remain in the SFCP's home. The activities covered under the Room and Board definition through SFCP such as laundry and housekeeping duties in private and common living space, cannot be placed on a PC member's Plan of Care and paid by the Personal Care Services Program. This would be considered a duplicate service.

517.6 CRIMINAL BACKGROUND CHECKS

517.6.1 Pre-Screening

All direct access personnel will be prescreened for negative findings by way of an internet search of registries and licensure databases through the WV DHHR designated website: [WV Clearance for Access: Registry & Employment Screening \(WV CARES\)](#).

"Direct access personnel" is defined as an individual who has direct access by virtue of ownership, employment, engagement, or agreement with a covered provider or covered contractor. Direct access personnel does not include volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations or similar services for the covered provider.

If the applicant has a negative finding on any required registry or licensure database, the applicant will be notified, in writing, of such finding. Any applicant with a negative finding on any required registry or licensure database is not eligible to be employed.

Negative findings that would disqualify an applicant in the WV CARES Rule include:

1. State or federal health and social services program-related crimes;
2. Patient abuse or neglect;
3. Health care fraud;
4. Felony drug crimes;
5. Crimes against care-dependent or vulnerable individuals;
6. Felony crimes against the person;
7. Felony crimes against property;
8. Sexual offenses;
9. Crimes against chastity, morality and decency; and
10. Crimes against public justice.

517.6.2 Fingerprinting

If the applicant does not have a negative finding in the prescreening process, and the entity or independent health contractor, if applicable, is considering the applicant for employment, the applicant must submit to fingerprinting for a state and federal criminal history record information check and may be employed as a provisional employee not to exceed 60 days subject to the provisions of this policy.

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Applicants considered for hire must be notified by the hiring entity that their fingerprints will be retained by the State Police Criminal Identification Bureau and the Federal Bureau of Investigation to allow for updates of criminal history record information according to applicable standards, rules, regulations, or laws.

Note: WV CARES can request a name based search when two federal or two state rejections have been received. Once the name based search results are received they will enter a fitness determination.

517.6.3 Employment Fitness Determination

After an applicant's fingerprints have been compared with the state and federal criminal history record information, the State Police shall notify WV CARES of the results for the purpose of making an employment fitness determination.

If the review of the criminal history record information reveals the applicant does not have a disqualifying offense, the applicant will receive a fitness determination of "eligible" and may be employed.

If the review of the criminal history record information reveals a conviction of a disqualifying offense, the applicant will receive a fitness determination of "not eligible" and may not be employed, unless a variance has been requested or granted.

The hiring entity will receive written notice of the employment fitness determination. Although fitness determination is provided, no criminal history record information will be disseminated to the applicant or hiring entity.

A copy of the applicant's fitness determination must be maintained in the applicant's personnel file.

517.6.4 Provisional Employees

Provisional basis employment for no more than 60 days may occur when:

1. An applicant does not have a negative finding on a required registry or licensure database and the employment fitness determination is pending the criminal history record information; or
2. An applicant has requested a variance of the employment fitness determination and a decision is pending.

All provisional employees shall receive direct on-site supervision by the hiring entity until an eligible fitness determination is received.

The provisional employee, pending the employment fitness determination, must affirm, in a signed statement, that he or she has not committed a disqualifying offense, and acknowledge that a disqualifying offense shall constitute good cause for termination. Provisional employees who have requested a variance shall not be required to sign such a statement.

517.6.5 Variance

The applicant, or the hiring entity on the applicant's behalf, may file a written request for a variance of the fitness determination with WV CARES within 30 days of notification of an ineligible fitness determination.

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A variance may be granted if mitigating circumstances surrounding the negative finding or disqualifying offense is provided, and it is determined that the individual will not pose a danger or threat to residents or their property.

Mitigating circumstances may include:

1. The passage of time;
2. Extenuating circumstances such as the applicant's age at the time of conviction, substance abuse, or mental health issues;
3. A demonstration of rehabilitation such as character references, employment history, education, and training; and
4. The relevancy of the particular disqualifying information with respect to the type of employment sought.

The applicant and the hiring entity will receive written notification of the variance decision within 60 days of receipt of the request.

517.6.6 Appeals

If the applicant believes that his or her criminal history record information within the State of West Virginia is incorrect or incomplete, he or she may challenge the accuracy of such information by writing to the State Police for a personal review.

If the applicant believes that his or her criminal history record information from outside the State of West Virginia is incorrect or incomplete, he or she may appeal the accuracy of such information by contacting the Federal Bureau of Investigation for instructions. If the purported discrepancies are at the charge or final disposition level, the applicant must address this with the court or arresting agency that submitted the record to the State Police.

The applicant shall not be employed during the appeal process.

517.6.7 Responsibility of the Hiring Entity

The WV CARES system will provide monthly rechecks of all current employees against the required registries. The hiring entity will receive notification of any potential negative findings. The hiring entity is required to research each finding to determine whether or not the potential match is a negative finding for the employee. The hiring entity must maintain documentation establishing no negative findings for current employees.

Note: The WV CARES Registry Recheck Report must be researched and maintained on site for each month.

517.6.8 Record Retention

Documents related to the background checks for all direct access personnel must be maintained by the hiring entity for the duration of their employment. These documents include:

1. Documents establishing that an applicant has no negative findings on registries and licensure databases.



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2. The employee's eligible employment fitness determination;
3. Any variance granted by the Secretary, if applicable; and
4. For provisional employees, the hiring entity shall maintain documentation that establishes the individual meets the qualifications for provisional employment.

Failure of the hiring entity to maintain state and federal background check documentation that all direct access personnel are eligible to work, or employing an applicant or engaging an independent contractor who is ineligible to work may subject the hiring entity to civil money penalties.

517.6.9 Change in Employment

If an individual applies for employment at another long term care provider, the applicant is not required to submit to fingerprinting and a criminal background check if:

1. The individual previously submitted to fingerprinting and a full state and federal criminal background check as required by this policy;
2. The prior criminal background check confirmed that the individual did not have a disqualifying offense;
3. The individual received prior approval from the DHHR Secretary to work for or with the health care facility or independent health contractor, if applicable; and
4. No new criminal activity that constitutes a disqualifying offense has been reported.

The WV CARES system retains all fitness determinations made for individuals.

517.7 OFFICE CRITERIA

PC providers must designate and staff at least one physical office location within West Virginia. The office cannot be in or part of a private residence. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

- 1) Be located in West Virginia and have designated counties approved by the OA.
- 2) PC providers requesting to expand services into an additional county or counties are required to obtain a new Certificate of Need (CON). PC providers who want to reduce the number of counties served must contact the HCA for instruction on submitting a Determination of Reviewability letter. After a determination from HCA, the provider must contact the OA to inform them of the changes so that PC selection forms and website can be updated.
- 3) Be readily identifiable to the public through signage that includes hours of operation.
- 4) Meet Americans with Disabilities Act (ADA) requirements for physical accessibility. (Refer to [28 CFR 36](#), as amended). These include but are not limited to:
 - a. Maintains an unobstructed pedestrian passage in the hallways, offices, lobbies, bathrooms, entrance, and exits;
 - b. The entrance and exit has accessible handicapped curbs, sidewalks and/or ramps;
 - c. The restrooms have grab bars;
 - d. A telephone is accessible; and
 - e. Drinking fountains and water are made available as needed.
- 5) Maintain a primary telephone that is listed under the name and local address of the business. (**Note:** Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone.).



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- 6) Maintain an agency secure Health Insurance Portability and Accountability Act (HIPAA) compliant e-mail address for communication with others inside your agency, (unless communicating through a secure agency network), BMS, and the OA for all staff.
- 7) Have access to a computer, fax and/or e-fax, scanner, and internet.
- 8) Utilize any database system, software, etc., compatible with/approved and/or mandated by BMS.
- 9) Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.
- 10) Ensure all personally identifiable information is secure if the agency provides electronic devices to their staff.
- 11) Contain space for securely maintaining program and personnel records. (Refer to [Chapter 100, General Administration and Information](#), and [Chapter 300, Provider Participation Requirements](#), for more information on maintenance of records).
- 12) Maintain a method to be contacted 24-hours per day/seven days a week. Urgent issues should be addressed within two hours. Other issues require a response the next business day.
- 13) Maintain qualified staff to provide services based on the member needs including evening and weekend hours for PC members that require those service hours.
- 14) Notify the OA within one business day of any agency relocation due to emergencies such as flood or fire. Any relocation lasting for over 30 days requires a site review by the OA.
- 15) All electronic and stamped signatures must meet the following basic authentication requirements:
 - a. Unique to the person using it;
 - b. Capable of verification;
 - c. Under the sole control of the person using it; and
 - d. Linked to the data in such a manner that if the data is changed, the signature is invalidated.

517.7.1 Initial/Continuing Certification of Provider Agencies

Following the receipt of the Certificate of Need from the HCA, the prospective PC provider must submit a completed Certification Application to the OA. The OA will contact the Applicant to provide technical assistance to ensure understanding of requirements. The OA will schedule an onsite review to verify that the potential provider meets the certification requirements outlined above in the [Section 517.2, Provider Agency Certification and its subparts](#). The OA will notify the BMS fiscal agent upon satisfactory completion of the initial onsite review. The BMS fiscal agent will provide the applicant with an enrollment packet which includes the BMS Provider Agreement. The applicant must return the Provider Agreement, signed by an authorized representative, to the BMS fiscal agent. A letter from the BMS fiscal agent informing the agency they may begin providing and billing for PC services will be sent to the agency. The Provider Agency must inform the OA when they have received their letter. PC services cannot be provided from an office location that has not been certified by the OA.

When a provider is physically going to move their agency to a new location or open a satellite office, they must notify the OA 45 days **prior** to the move. The OA will schedule an on-site review of the new location to verify the site meets certification requirements. The provider must submit a new Certification Application to the OA which includes information regarding the new location.

In addition, all providers of PC services are subject to and bound by WV Medicaid rules and regulations found in [Chapter 100, General Administration and Information](#) of the BMS Provider Manual.



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Once certified and enrolled as a WV Medicaid provider, PC providers must continue to meet the requirements listed in this chapter as well as the following:

- A. Employ adequate, qualified, and appropriately trained personnel who meet minimum standards for providers of the Personal Care program;
- B. Provide services based on each member's individual assessed needs, including their needs on evenings and weekends. Failure to provide services to a member can result in health and safety issues. Findings of consistent non-compliance of provision of evening and weekend services or provision of PC services to members who require dual services will result in a Corrective Action Plan (CAP) and/or a temporary removal of the provider from the selection list due to a lapse in continuing certification of Personal Care Services. Once the provider begins to meet the certification requirement, the provider will be added back to the selection list;
- C. Maintain records that fully document and support the services provided;
- D. Furnish information to BMS, or its designee, as requested. (Refer to [Chapter 100, General Administration and Information](#), and [Chapter 300, Provider Participation Requirements](#), for more information on maintenance of records);
- E. Maintain a current list of members receiving PC services;
- F. Comply with the West Virginia Incident Management System (WVIMS) (Refer to [Section 517.5, Incident Management and its subparts](#)) and maintain an administrative file of Incident Reports; and
- G. Adhere to the conflict of interest policy outlined in this manual. Failure to comply could result in loss of provider certification;

517.7.2 Provider Reviews

The primary means of monitoring the quality of PC services is through provider reviews conducted by the OA as determined by BMS on a defined cycle.

The OA performs annual on-site reviews and desk documentation reviews as requested by BMS to monitor program compliance. The OA also performs annual Continuing Certification reviews for agency and staff compliance. Targeted on-site PC reviews and/or desk reviews may be conducted in follow up to Incident Management Reports, complaint data, Plans of Corrections, etc.

Agency Continuing Certification Reviews

All providers including the Specialized Family Care Program are required to submit designated evidence to the OA every 12 months to document continuing compliance with all agency and staff certification requirements. This evidence must be attested to by an appropriate official of the provider agency (e.g., Executive Director or Board Chair). If appropriate documentation is not received by the OA either prior to or on the established date, a pay hold will be placed on the provider's claims and the provider will be prohibited from accepting new members until documentation is received. A provisional certification will be issued; however, an on-site visit will be waived if required documentation is received within 30 days. If after 60 days documentation is not received, steps will be taken to execute an emergency transfer of all members receiving PC services. If the provider wants to resume/continue service provision, they must submit all required documentation and an on-site continuing certification review will be conducted by the OA staff.

The OA will review all submitted certification documentation and provide a report to BMS. Services provided that do not meet policy requirements must be repaid. The provider must remove employees who

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do not meet requirements from provision of services until certification standards are met and required documentation is approved by the OA.

If the documentation is not received within 30 days of the request, BMS will:

- Place a payment hold on all future claims until the provider can prove they meet all certification requirements;
- Remove the provider from all selection forms; and
- Terminate the provider's participation as a PC provider if all issues are not resolved within 60 calendar days of the date of the report.

Note: Continuing Certification Review Reports are not subject to document/desk reviews. All information entered into the OA web portal is entered by the provider, attested to by the provider to be complete and accurate and becomes final once submitted.

A random ten percent sample of employee records, from each Continuing Certification Review Report will be generated annually for a validation review. The self-reported noncompliant employee records will also be represented in the sample. The OA will verify that the noncompliance was addressed within the time stated in the PC provider's Continuing Certification Review report. If the OA finds that the noncompliance was not fixed during that time, BMS will request reimbursement for paid claims that occurred where employee certification requirements were not met. If a lapse occurs for any checks within WV CARES, BMS will request reimbursement for paid claims, should any disqualifying offenses during the lapse be found. If during a validation review by the OA it is found that a provider did not procure a fitness for employment determination from WV CARES, the OA will report the finding to BMS. BMS will report the findings to WV CARES for any applicable penalties.

Program Reviews

Program reviews include a statewide representative sample of records of those receiving PC services. The OA will review program records using the BMS approved Monitoring Tools. (These tools are available on the [Personal Care program website](#). A proportionate random sample will also be implemented to ensure that at least two records from each provider site are reviewed.

Upon completion of the review, the OA conducts a face-to-face exit summation with the agency director or their designee. The agency has until 3:00 pm the following business day to provide any missing documentation the OA required for the review. Thirty days following the exit summation, the OA will make available to the provider a draft report and draft CAP, if applicable to be completed by the PC provider. If potential disallowances are identified, the PC provider will have 30 days from receipt of the draft report to send comments back to the OA. After the 30 day comment period has ended, BMS will review the draft report and any comments submitted by the PC provider and issue a final report to the PC provider's director. A cover letter to the PC provider's director will outline the following options to effectuate repayment:

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

If the PC provider disagrees with the final report, the PC provider may request a document/desk review within thirty days of receipt of the final report pursuant to the procedures in [Chapter 100, General](#)

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[Administration and Information](#) of the BMS Provider Manual. The PC provider must still complete the written repayment arrangement within thirty days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. BMS may place a lien on future payments if a written repayment form is not submitted within 30 days of receipt of the final report. The request for a document/desk review must be in writing, signed and set forth in detail to the items in contention. Please note, the items of contention must have been noted on the draft report and addressed by the provider before requesting a document/desk review of the contended items. Requesting a document/desk review means that the provider and the OA could not reach an agreement on the contested items on the draft report, therefore a third party is asked to intervene.

The letter must be addressed to:

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

Corrective Action Plan

In addition to the draft report sent to the PC providers, the OA will also send a draft Corrective Action Plan (CAP). The PC providers are required to complete the CAP and submit it to the OA for approval within thirty calendar days of receipt of the draft report from the OA. BMS may place a hold on claims if an approved POC is not received by the OA within the specified time frame, unless the provider requests and has been granted an extension. Requests for extensions must be in writing detailing the reason for the request. The CAP must include:

1. How the deficient practice cited in the review will be corrected. What system will be put into place to prevent recurrences of the deficient practice;
2. How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
3. The date the CAP will be completed; and
4. Any provider-specific training requests related to the deficiencies.

The OA will review the CAP, if applicable, submitted and either approve it or return it to the provider for a revision. Revisions must be returned within fourteen calendar days or BMS will place a hold on claims.

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

Note: It is common that certified PC providers contract the service provision to other entities (i.e. contracted providers). It should be noted that the certified PC provider is responsible for all criteria described in this policy as well as all applicable Medicaid policies. Also note that all BMS, OA, and UMC correspondence will be to the Certified PC agency. BMS, the OA, and the UMC are under no obligation to correspond with contracted PC entities.

517.7.3 Training and Technical Assistance

The OA develops and conducts training for PC providers and other interested parties as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available

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through both face-to-face and web-based venues. All PC agencies must send at least one representative to mandatory quarterly provider meetings. That representative is responsible for disseminating the information learned at the quarterly provider meeting to all other pertinent agency personnel. A representative from the designated agency assigned as the contracted Specialized Family Care Program must also attend the quarterly provider meetings and disseminate this information to pertinent agency personnel.

517.7.4 Self-Audit

PC providers have an ethical and legal duty to ensure the integrity of their partnership with the Medicaid program. This duty includes an obligation to examine and resolve instances of noncompliance with program requirements through self-assessment and voluntary disclosures of improper use of State and Federal resources. A self-audit must be conducted when:

- a. The provider becomes aware there was a noncompliance issue, and/or
- b. A self-audit is assigned by BMS.

PC providers must use the approved format for submitting [self-audits](#) to the Office of Program Integrity (OPI). Failure to submit self-audits may jeopardize the future status of the PC provider as a West Virginia Medicaid provider. PC providers are required to send all completed forms in an electronic format to the OPI along with the original Excel spreadsheet and repayment forms.

For more information on self-audits and sanctions refer to [Chapter 800, Program Integrity](#).

517.7.5 Record Requirements

Providers must fully complete all required Personal Care forms and follow the instructions for the published forms. Forms with corrective fluid, tape or removeable labels used on them will not be accepted. Any alteration or change in document after medical professional, member or Medicaid provider has signed it could result in a targeted review and disallowances. Forms and instructions can be found on the [Personal Care Program website](#). Certified PC providers must meet the following record requirements:

Program Records:

- A. The provider must keep a file on each member they serve;
- B. Files must contain all original and required documentation for services provided to the member by the provider responsible for development of the document including the POC, Pre-Admission Screening (PAS), the completed Nursing Assessment, Contact Notes, Direct Care Worker Worksheets, etc;
- C. All original required documentation must be maintained onsite by the provider for at least five years from the date of service or for an additional three years after audits, with any and all exceptions having been declared resolved by BMS, in the member's services file subject to review by authorized BMS personnel or contracted agents. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years whichever is greater;
- D. The provider must upload the following into the UMC web portal within twelve calendar days of completion:
 - a. POC;
 - b. RN Assessment; and

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- c. Any legal documents pertaining to power of attorney, legal guardianship, conservatorship, etc.

Personnel Records:

- A. Original or legible copies of personnel documentation including training records, licensure, confidentiality agreements, signed conflict of interest statements, etc. must be maintained on file by the certified provider;
- B. Minimum credentials for the RN must be verified upon hire and thereafter based upon applicable professional license requirements for each year of employment; and
- C. All documentation on each staff member must be kept by the Medicaid provider in the designated office that represents the county where services were provided.

Certified PC providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the Personal Care program. Providers must also agree to make themselves, Board Members (if applicable), their staff, and any and all records pertaining to services available for any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.

Providers must ensure that all required documentation is maintained at the agency as required by state and federal regulations and is accessible for state and federal audits.

SFCP personnel records for direct care staff must be kept in the office of the Family-based Care Specialist assigned to the SFCP. See Sections 517.8.2 Direct Care Worker Initial Training Requirements and 517.8.3 Direct Care Worker Annual Training Requirements for specific credentials.

517.8 STAFF QUALIFICATIONS AND TRAINING REQUIREMENTS

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

Prior to using an internet provider for training purposes, PC providers must submit the name, web address, and course name(s) to the OA for review. The OA will respond in writing whether this internet training meets the training criteria.

Staff must be trained to meet the needs for the age of the member they are serving.

517.8.1 Direct Care Worker Qualifications

A Direct Care Worker is an individual paid to provide the day-to-day care to members receiving PC services.

Medicaid prohibits persons legally responsible for members from providing PC services for purposes of reimbursement. Legally responsible persons include: a spouse or a parent of a minor child. Court appointed Legal Guardians and Conservators are also prohibited from providing PC services for purposes of reimbursement.

Legal Representatives such as a Medical Power of Attorney (MPOA), Power of Attorney (POA), Health Care Surrogate may provide services if employed by a PC agency.

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Note: For more information about legally responsible people and legal representatives, see [Section 517.12 Legal Representatives](#) and the [Glossary](#).

A Direct Care Worker must be at least 18 years of age and have the ability to perform the tasks required for the member receiving PC services. In addition, they must have completed the competency-based initial training as described in this policy before providing service and annually thereafter as required.

All documented evidence of Direct Care Worker qualifications such as licenses, transcripts, certificates, fingerprint-based background checks, signed confidentiality statements and references shall be maintained on file by the provider. SFCP training records will be maintained by BCF's contractor for that program. The provider must have an internal review process to ensure that the Direct Care Worker providing PC services meets the minimum qualifications as required by policy.

517.8.2 Direct Care Worker Initial Training Requirements

All direct care workers must have the following training:

- A. Cardiopulmonary Resuscitation (CPR) training – Provided only by certified trainers of [OA approved courses](#). Additional CPR courses may be approved by the OA. All CPR courses must include a skills based demonstration. Documentation that each trainee successfully completed the course and is certified must be maintained by the agency and made available upon demand. If training is conducted by agency staff, documentation that each trainer has successfully completed and been certified by the certified entity must be maintained by the agency and made available upon demand. On-line CPR courses are not allowed.
- B. First Aid – Provided only by certified trainers of [OA approved courses](#). Documentation that each trainee successfully completed the course and is certified must be maintained by the agency. If training is conducted by agency staff, documentation that each trainer has successfully completed and been certified by the certified entity must be maintained by the agency and made available upon demand. On-line First Aid courses are allowed, but it must be an OA approved course.
- C. Competency-based universal Precautions Training.
- D. Competency-based training on assisting members with ADLs/IADLs – must be provided by the provider agency RN.
- E. Competency-based Abuse/Neglect/Exploitation identification training*.
- F. Competency-based HIPAA training*
- G. Competency-based Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity that must be provided by the provider agency nurse or a documented specialist in this content area, or a qualified internet training provider.
- H. Competency-based Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to the member's special needs and must be provided by the provider agency nurse.

Competency-based training curriculum is defined as a training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum should have goals, objectives and an evaluation system to demonstrate competency in training areas. Competency is defined as passing a graded posttest at no less than 80%. If a staff fails to meet competency

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requirements, the PC agency must conduct additional training and retest the staff (must score at least 80%) before the staff can work with members.

SFCPs providing PC services must have a home that meets the definition of a certified Specialized Family Care Home as established by the Bureau for Children and Families (BCF) and must be certified by BCF, or its contractor, initially and annually thereafter. All training documentation necessary to be a certified Specialized Family Care Home must be up-to-date in accordance with the [Bureau for Children and Families' Specialized Family Care policy manual](#). BCF is responsible for ensuring that SFCPs are trained in all areas above. The SFC provider's file is kept in the DHHR office where the FBCS is based.

* Providers may use training modules provided by the OA for these mandatory trainings or develop their own with the same components that must be approved by the OA.

517.8.3 Direct Care Worker Annual Training Requirements

CPR; First Aid; OSHA; Abuse, Neglect, and Exploitation; and HIPAA trainings must be kept current.

- A. CPR is current as defined by the terms of the approved certifying agency (i.e. American Red Cross, American Heart Association. A list of approved agencies can be found on the OA's website.).
- B. First Aid is current as defined by the terms of the approved certifying agency (i.e. American Red Cross, American Heart Association. A list of approved agencies can be found on the OA's website.).
- C. Training will be considered current as defined by the time period on the card.
- D. Universal Precautions Training; Abuse, Neglect and Exploitation; and HIPAA training must be renewed every 12 months or less. Training will be determined current in the month it initially occurred.

In addition, four hours of training focused on enhancing direct care service delivery knowledge and skills must be provided annually. Member specific on-the-job training can be counted toward this requirement. It is recommended that the same trainings not be repeated from year to year. It is suggested that providers evaluate and identify trends at their agencies when identifying potential training topics.

The SFC provider's file is kept in the DHHR office where the FBCS is based.

517.8.4 Registered Nurse Qualifications

An RN must be employed by a certified PC provider and have a current West Virginia RN license. Licensure documentation must be maintained in the employee's file. Documentation that shows the RN was licensed for the employee's entire employment period must be present. (For example: If an employee has been with the provider for three years, documentation of licensure must be present for all three years.) The provider shall have an internal review process to ensure that employees providing PC services meet the minimum qualifications.

517.8.5 Registered Nurse Training Requirements

All Registered Nurses must maintain professional license requirements and have the following training:

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- Competency-based Abuse/Neglect/Exploitation* identification training initially and then annually;
- Competency-based Person-centered planning* training initially and then annually; and
- Current CPR/First Aid training (Certified trainers are exempt).

* Providers may use training modules provided by the OA for these mandatory trainings or develop their own with the same components that must be approved by the OA.

517.9 TRAINING DOCUMENTATION

Documentation of training conducted by the provider agency nurse must include the training topic, date, beginning time of the training, ending time of the training, location of the training and the signatures of the instructor and the trainee. Training documentation for internet based training must include the person's name, the name of the internet training provider, and either a certificate or other documentation proving successful completion of the training. A card from the American Heart Association, the American Red Cross or other OA approved training entity is acceptable documentation for CPR and First Aid training. All documented evidence of training for each direct care worker must be kept on file by the PC provider and be available, upon request, for review by BMS or the OA. Providers must use the approved [Personal Care](#) form to document training. The documented evidence of training requirements for SFCPs must be kept on file by the Bureau for Children and Families or its contractor and be available, upon request, for review by BMS or the OA.

517.10 INCIDENT MANAGEMENT

PC providers shall have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve.

Investigations must be conducted by an RN who is licensed and registered in the State of WV. All incident details must be objectively and factually documented (what, when, where, how). All inconsistencies must be explored. The PC provider must ensure the safety of all involved (the member receiving PC services and/or the staff) during the investigation. And, all required entities must be notified as applicable (Adult or Child Protective Services, law enforcement, Medicaid Fraud Control Unit, etc.)

The provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all members served. Anyone providing PC services who suspects an allegation of abuse, neglect, or exploitation concerning a PC member must report the incident to [West Virginia Centralized Intake for Abuse and Neglect](#) immediately by calling 1-800-352-6513, seven days a week, 24 hours a day. If this initial referral is for adult protective services, it must then be followed by a written report, submitted to the local Department of Health and Human Resources in the county where the alleged victim resides, within 48 hours following the verbal referral. At this time, a written report is not a requirement for child protective services. A Protective Services Worker may be assigned to investigate the alleged abuse, neglect and/or exploitation. Suspected sexual assault and/or sexual abuse, serious physical abuse, or exploitation must also be reported to the local law enforcement agency by calling 911. Any incident attributable to the failure of PC provider staff to perform his/her responsibilities that compromises the health or safety of the member receiving PC services is considered to be neglect and must be reported to Adult or Child Protective Services, as applicable.

Incidents shall be classified by the provider as one of the following:

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Critical Incidents

Critical incidents are occurrences with a high likelihood of producing real or potential harm to the health and welfare of the member receiving PC services or incidents which have caused harm or injury. It could also include any type of suspected criminal activity. For the purpose of this system, critical incidents do not result from abuse/neglect/exploitation. These incidents may include, but are not limited to, the following:

- A. Attempted suicide, or suicidal threats or gestures.
- B. Suspected and/or observed criminal activity by the member receiving PC services, member's families, health care providers, concerned citizens, and public agencies that compromise the health or safety of the member.
- C. An unusual event such as a fall or injury of unknown origin requiring medical intervention or first aid if abuse and neglect is not suspected.
- D. A significant interruption of a major utility, such as electricity or heat in the member's residence that compromises the health or safety of the member.
- E. Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that compromises the health or safety of the member.
- F. Fire in the home resulting in relocation or property loss that compromises the health or safety of the member.
- G. Unsafe physical environment in which the Direct Care Worker and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.
- H. Disruption of the delivery of PC services, due to involvement with law enforcement authorities by the member receiving PC services and/or others residing in the member's home that compromises the health or safety of the member.
- I. Medication errors by a member or his/her family caregiver that compromises the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
- J. Disruption of planned services for any reason that compromises the health or safety of the member receiving PC services, including failure of member's emergency backup plan.
- K. Any other incident judged to be significant and potentially having a serious negative impact on the member receiving PC services.
- L. Any incident attributable to the failure of PC provider staff to perform his/her responsibilities that compromises the member's health or safety is considered to be neglect and must be reported to Adult or Child Protective Services through the [West Virginia Centralized Intake for Abuse and Neglect](#) or by calling 1-800-352-6513.

Simple Incidents

Simple incidents are any unusual events occurring to a member receiving PC services that cannot be characterized as a critical incident and do not meet the level of abuse or neglect. Examples of simple incidents include, but are not limited to, the following:

- A. Fall or other incident that does not require minor first aid or medical intervention.
- B. Minor injuries of unknown origin with no detectable pattern.
- C. Dietary errors with minimal or no negative outcome.

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517.10.1 Incident Management Documentation and Investigation Procedures

Until such time that the [West Virginia Incident Management System \(WV IMS\)](#) is available to PC providers, the Incident Report form must be completed within incident reporting timeframes (See [Section 517.10 Incident Management](#)) for each member incident that occurs. Completed incident reports must be placed in an agency administrative file and must be available for review by the OA. The forms can be found on the [BMS website](#).

The Provider Agency Director or designated RN will immediately review each incident report. All Critical Incidents and incidents of abuse, neglect and/or exploitation must be investigated by a RN. All incidents involving abuse, neglect and/or exploitation must be reported to Adult or Child Protective Services through [West Virginia Centralized Intake for Abuse and Neglect](#), within mandated time frames. An Incident Report documenting the outcomes of the investigation must be completed and submitted to the OA within 14 calendar days of learning of the incident.

When the WV IMS is available for PC providers, the Incident Report must be entered into the WV IMS within one business day of learning of the incident and the follow up must be entered within 14 calendar days of learning of the incident. Each Incident Report must be printed, reviewed and signed by the Agency Director or designee and placed in an administrative file.

Providers are to report monthly if there are no incidents in the WV IMS. Until such time that the WV IMS is available, the provider must complete the No Monthly Incidents form and place in the certified PC agency administrative file.

The WV IMS does not supersede the reporting of incidents to Adult or Child Protective Services through the West Virginia Centralized Intake for Abuse and Neglect. At any time during the course of an investigation, should an allegation or concern of abuse, neglect and/or exploitation arise, the provider shall immediately notify Adult or Child Protective Services through [West Virginia Centralized Intake for Abuse and Neglect](#) or by calling 1-800-352-6513.

The provider is responsible for investigating all incidents, including those reported to Adult or Child Protective Services. If requested by Adult or Child Protective Services, a provider shall delay its own investigation and document such request and report to the OA or when available in the online WV IMS.

The criteria utilized for a thorough investigation include:

- Report was fully documented to include the date of the incident, date the agency learned of the incident, facts of the incident, type of incident, initial determination of the incident, and verification that an approved professional conducted the investigation.
- Documentation that all parties were interviewed and incident facts were evaluated, that member was interviewed, determination of cause of incident, identification of preventive measures.
- Documentation of any action taken as the result of the incident (worker training, personnel action, removal of staff, changes in the POC) and
- Change in needs were addressed on the POC.

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Unanticipated/unexplained deaths must be reported in the WV IMS (when available, until such time make incident reports to the OA) within one business day of learning of the incident. This would include deaths that occur in the member's home that are not anticipated, unexplained and not medically or age related. Example: Direct Care Worker arrives at the member's home and finds the member deceased with no known reason. For incident type, choose "critical" incident category, then choose "unanticipated deaths" in the WV IMS system.

517.10.2 Incident Management Tracking and Reporting

Providers must review and analyze incident reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the agency Quality Management Plan. The Quality Management Plan must be made available to the OA monitoring staff at the time of the provider monitoring review or upon request.

The PC provider holding the NPI number is responsible for IMS reporting. However, if the NPI number holder chooses to assign an agency they have contracted with to provide PC services a user ID number in the IMS system they may do so.

Contracted PC Agencies may not be set up in the IMS system as a PC agency. Individual users with the contracted agency must be established under the parent agency.

517.11 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

General Requirements for Certified PC Providers:

- PC provider agencies must comply with the documentation and maintenance of records requirements described in [Chapter 100, General Administration and Information](#), [Chapter 300, Provider Participation Requirements](#), and [Chapter 800, Program Integrity](#) of the BMS [Provider Manual](#).
- PC provider agencies must comply with all other documentation requirements of this chapter;
- All required documentation must be maintained onsite by the certified PC provider for at least five years from the date of service or an additional three years after audits, with any and all exceptions having been declared resolved by BMS, in the member's services file subject to review by authorized BMS personnel or contracted agents. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years whichever is greater;
- All required documentation and records must be available upon request by BMS or federal monitors, or contracted agents for auditing and/or medical review purposes;
- Failure to maintain all required documentation and in the manner required by BMS, may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.

Specific Requirements for Certified PC Providers

PC provider agencies must maintain a specific record for all services received for each PC member, but not limited to:

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- All Personal Care program forms as applicable to the policy requirement or service code requirement.
- Agencies may only use forms developed and published by BMS which can be found on the [BMS website](#). Refer to [Chapter 300, Provider Participation Requirements](#), for a description of general requirements for Medicaid record retention and documentation.
- All providers of PC services must maintain records to substantiate that services billed by the PC provider agency were provided on the dates listed and were for the actual amount of time and number of units claimed.
- All services provided must meet the criteria for documentation as indicated in the policy manual such as date, actual time of service and number of units claimed.
- Day to day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for services rendered. Monitoring and review of services as related to the POC or monthly summary (visit) are to be maintained in the provider record.
- Required on-site documentation may be maintained in an electronic format as long as the documentation is accessible to individuals who may need to access it.
- Electronic health record and electronic signature requirements described in [Chapter 100, General Administration and Information](#) of the BMS Provider Manual.

All direct care workers should begin to obtain an NPI, if they do not already have one.

PC providers should begin billing each day separately (not including more than one day per claim). Each provider should bill one claim per date of service, per worker. (i.e. If you have two workers for the same member, the provider would submit two separate claims.)

Additional information regarding the implementation of daily billing and direct care worker NPI's will be provided when available. BMS will not require the use of direct care worker NPI numbers or daily billing until the EVV systems are implemented. Providers will be given time to ensure all direct care workers have their own NPI.

517.12 LEGAL REPRESENTATIVES

When reference is made to "Member" in this manual, it also includes any person who may, under State law, act on the member's behalf when the member is unable to act for himself or herself. That person is referred to as the member's legal representative. There are various types of legal representatives, including but not limited to: guardians, conservators, power of attorney representatives, health care surrogates and representative payees. Each type of legal representative has a different scope of decision-making authority. For example, a court-appointed conservator might have the power to make financial decisions, but not health care decisions. The RN should verify that a representative has the necessary authority and obtain copies of supporting documentation, e.g., court orders or power of attorney documents, for the member's file.

Legal representatives must always be consulted for decisions within their scope of authority. However, contact with or input from the legal representative should not replace contact and communication with the member. If the member can understand the situation and express a preference, the member should be kept informed and his/her wishes respected to the degree practicable.

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517.13 PROGRAM ELIGIBILITY

Applicants for the Personal Care Services Program must meet all of the following criteria to be eligible for the program:

- A. Be a resident of West Virginia. The individual may be discharged or transferred from a nursing home or other institution in any county of the state, or in another state, as long as his/her residence is in West Virginia;
- B. Be approved as medically eligible as described in this section and its subparts;
- C. Meet Medicaid financial eligibility criteria for the program as determined by the county DHHR office.

517.13.1 Medical Eligibility Determination

The UMC is the entity responsible to conduct the medical necessity assessment to confirm a person's eligibility for Personal Care services. The UMC will use the Pre-Admission Screening (PAS) tool to certify an individual's medical eligibility for PC services and determine the level of service required. To be medically eligible, a member must demonstrate three deficits, based on the presence and level of severity of functional deficits, possibly accompanied by certain medical conditions. A service level will be assigned based on a member's functional deficit and specified medical conditions identified on the PAS.

The purpose of the medical eligibility review is to ensure the following:

- A. Applicants and existing members receiving Personal Care services are medically eligible based on current and accurate evaluations.
- B. Each applicant/member determined medically eligible for Personal Care services receives an appropriate service level that reflects current/actual medical conditions and short and long-term service needs.

517.13.2 Initial Request for Evaluation

A request for PC services begins with the PC-Medical Necessity Evaluation Request (PC-MNER). The UMC will verify Medicaid eligibility and any requirements for requesting dual services. If the review results in finding an applicant or member does not qualify for an evaluation (or an evaluation cannot be scheduled) the UMC will close the applicant or discharge the member. A person may re-apply for the PC program at any time. A request for PC evaluation will not be processed when:

- A. The PC-MNER provided is incomplete or incorrect
- B. The person is not a resident of West Virginia
- C. An applicant or member does not have PC coverage in their approved benefit plan or is not WV Medicaid eligible. The person receives notification and hearing rights from their local DHHR office if they are found not eligible for WV Medicaid.
- D. An applicant or member is already approved for Waiver services and does not meet the screening criteria for dual services. The UMC will notify the applicant when the dual service request cannot be processed. The PC agency will be notified through the UMC web portal for members.
- E. The UMC cannot reach the applicant/member to schedule or conduct the assessment after three attempts. The UMC will notify the applicant when the request cannot be processed. The PC agency will be notified through the UMC web portal for members.

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517.13.3 Initial Medical Evaluation

The following is an outline of the initial medical evaluation process:

1. An applicant for Personal Care services shall initially apply for the Personal Care Services program by having his/her treating physician (M.D. or D.O.), Advanced Practice Registered Nurse (APRN) Practitioner, or Physician Assistant (PA) (referent) complete and sign a Personal Care Medical Necessity Evaluation Request (PC-MNER) form including diagnosis. The referent, applicant, family member, advocate or other interested party may submit this form by fax, mail or electronically to the UMC. The UMC will not process a PC-MNER if either/both the referent's and applicant's signatures is greater than 60 days old.
2. Within two business days of a complete PC-MNER's receipt, the UMC will attempt to contact the applicant (or legal representative) to schedule the PAS assessment. If contact is made, the UMC will issue a notice to the individual and/or contact person detailing the scheduled home visit and time.
3. The UMC will make up to three attempts to contact the applicant. If unable to contact after three attempts, the UMC will issue a closure letter to the applicant. An applicant can apply at any time but must have a new PC-MNER if either/both the referent's and applicant's signatures on the PC-MNER is greater than 60 calendar days. If the time is less than three months since the anchor date the member can keep their services with no new assessment. If the time is greater than 90 days since the anchor date, the individual would need to submit a new PC-MNER to start the application process.
4. If the PC-MNER form indicates the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition and/or if he/she has a legal representative, the assessment will not be scheduled without the legal representative, or a contact person present to assist the applicant. A minor child must have a parent/legal guardian present at the assessment.
5. The UMC RN will complete the Pre-Admission Screening assessment within 30 days a complete and correct PC-MNER being submitted for PAS review. Assessments will take place in the applicant's home, nursing facility or hospital, as applicable. The RN will carry over any diagnoses from the PC-MNER to the PAS. During the assessment, the RN will review the abuse/neglect/exploitation brochure and will offer the applicant their choice of Personal Care Services providers in their catchment area.
 - a. If an applicant is currently out of state and cannot be transported in state for the medical eligibility assessment, the UMC will work with the referring facility to complete and submit the PAS for medical eligibility determination by the UMC.
 - b. If the applicant requires an emergent determination necessary for discharge from a medical facility, the UMC will conduct the PAS assessment within two business days of receiving a complete and correct PC-MNER.
6. The UMC RN will enter the PAS data into the web portal, which will determine medical eligibility and calculate a service level (if approved). The UMC RN will enter the chosen PC provider agency into the system. A PC provider agency will have five days to accept a referral through the UMC web portal. Emergency/discharges must be accepted within 24 hours or the next business day. If the provider cannot accept the referral, the Operating Agency will be notified so they can assist the applicant with choosing a different provider. If it is an emergency/discharge the OA will respond in 24 hours or the next business day.
7. The UMC will issue the approved applicant an Anchor Date, which will serve as the annual due date for redetermination of medical eligibility. No services can be provided prior to the date the applicant is determined eligible for Personal Care services. For those persons already enrolled

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with Intellectual/Developmental Disabilities Waiver (IDDW), Aged and Disabled Waiver (ADW), or Traumatic Brain Injury Waiver (TBIW), the PC Anchor Date will default to the Waiver Anchor Date.

8. If a discharged member wishes to resume PC services and their prior PC PAS is still current, the UMC can reopen the case in the UMC web portal. A new initial PC-MNER will be required to initiate this process.

517.13.4 Redetermination of Medical Eligibility

Personal Care Services program members must be reevaluated annually to determine if they continue to meet medical eligibility criteria. The redetermination process is as follows:

1. The assigned Personal Care agency must submit a PC-MNER to the UMC no sooner than 90 days prior the member's PC Anchor Date and no later than 45 days prior to the member's Anchor Date. The referent's and member's/legal representative's signatures on the PC-MNER must be no older than 60 days of the date the PC-MNER is submitted/received by the UMC. The form must be data-entered into the UMC's web-based system and the original (with signatures) scanned and attached into the system.
2. The UMC will attempt to contact the member within two business days of receiving a complete and correct PC-MNER which is submitted for PAS review. If contact is made, the UMC will issue a notice to the individual and/or contact person detailing the scheduled home visit and time.
3. The UMC will make up to three attempts, on separate days, to contact the member. If unable to contact after three attempts or if the PC member is not available or refuses the PAS assessment, as scheduled, the UMC will issue a Referral Closure letter to the member and the Personal Care provider will be notified electronically. If the PC member wishes to have PC services at a later time, he or she may reapply at any time by submitting a new PC-MNER.
4. If the PC-MNER form indicates the member has Alzheimer's, multi-infarct, senile dementia, or related condition and/or if he/she has a legal representative, the assessment will not be scheduled without the legal representative or a contact person present to assist the member. A minor child must have a parent/legal guardian present at the assessment.
5. The UMC RN will complete the Pre-Admission Screening assessment prior to the member's Anchor Date so long as the PC-MNER was submitted within timeline. Assessments will take place in the applicant's home, nursing facility, or hospital, as applicable. The RN will carry over any diagnoses from the PC-MNER to the PAS. During the assessment, the RN will review the abuse/neglect/exploitation brochure and will offer the applicant available Personal Care providers in their catchment area. If the member wishes to transfer Personal Care agencies, they will contact their existing PC agency or the OA to initiate a transfer.
6. The UMC RN will enter the PAS data into the web portal, which will determine medical eligibility and calculate a service level (if approved).
7. If, during a program member's service year, the PC agency suspects the PC member is no longer eligible for PC services, the PC agency must obtain or complete and submit a PC PAS to the UMC for determination of medical eligibility. If the member is found to be no longer eligible the UMC will send a termination letter with Fair Hearing Rights.



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517.13.5 Medical Criteria

An individual must have three deficits as described on the PAS Form to qualify medically for the Personal Care Program. These deficits are derived from a combination of the following assessment elements on the PAS. The UMC RN will use Center for Disease Control (CDC) guidelines for age appropriate developmental milestones as criteria when determining functional levels and abilities for children.

Section	Observed Level	
#26	Functional abilities of individual in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)
d.	Grooming	Level 2 or higher (physical assistance or more)
e.	Continence, Bowel	Level 3 or higher (must be incontinent)
f.	Continence, Bladder	
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transferring	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)

An individual may also qualify for PC services if he/she has two functional deficits identified as listed above (items refer to PAS) and any one or more of the following conditions indicated on the PAS:

Section	Observed Level
#24	Decubitus; Stage 3 or 4
#25	In the event of an emergency, the individual is Mentally unable or Physically unable to vacate a building. Independently or With Supervision are not considered deficits.
#27	Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.
#28	Individual is not capable of administering his/her own medications.

517.13.6 Service Level Criteria

There are two Service Levels for PC services. Points will be determined as follows based on the following sections of the PAS:

Section	Description of Points
#24	Decubitus - 1 point
#25	1 point for With Supervision, Mentally unable, or Physically unable.
#26	Functional Abilities: Level 1 - 0 points



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Section	Description of Points
	Level 2 - 1 point for each item a through i . Level 3 - 2 points for each item a through m , i (walking) must be at Level 3 or Level 4 in order to get points for j (wheeling) Level 4 – 1 point for a , 1 point for e , 1 point for f , 2 points for g through m
#27	Professional and Technical Care Needs - 1 point for continuous oxygen.
#28	Medication Administration - 1 point for b. or c.

Total number of possible points is 30.

517.13.7 Service Level Limits

The service limit for **T1019** Personal Care (Direct Care) Level 1 Services is up to 60 hours per calendar month. In the event that the PAS reflects 14 or more points as described in [Section 517.7.3 Service Level Criteria](#), and the member assessments fully document the need, the PC Agency may access/provide up to 210 hours at Service Level 2.

Service Level	Points Required	Range of Hours Per Month
1	Less than or equal to 13	Up to 60
2	14-30	61-210

The actual number of hours available for a member eligible for PC is determined by the current BMS approved [Personal Care Standards](#) and POC. The maximum number of hours in the range is not guaranteed. Though a member's PAS may indicate a Level 2 is approved, the PC provider is responsible to adhere to the current BMS approved Personal Care Standards. Only those services necessary and appropriate per assessments, the POC and per the current BMS approved Personal Care Standards may be provided/billed.

Current BMS approved Personal Care Standards can be found on the [BMS website](#).

If a member reports formal Direct Care Worker services to assist with ADLs are not needed, the report must be documented by the agency and the agency must submit a request for discharge within 7 business days. An eligible member has at least three long-standing deficits that were considered for medical eligibility for the PC program. If the member no longer needs assistance with the ADL's associated with these deficits, the member is no longer eligible for the PC program. An exception would be need for PC services for a short time after surgery or an illness.

Units of Personal Care services provided by the public school system are excluded from service limits authorized by the UMC for a member's Personal Care services in a home or community setting.

517.13.8 Results of PAS Evaluation

APPROVAL

If the applicant or member meets the criteria for medical eligibility, the UMC will electronically issue an authorization for the approved service level to the selected Personal Care provider of record. The UMC will forward the authorization information to the claims payer. Once authorization is received from the

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UMC, the PC provider must complete the member's PC Assessment and PC POC, based on identified needs and member preferences, and initiate direct care services within 10 calendar days. When the PC agency receives the approval from the UMC, the PC agency RN must start to document actions on the RN Initial Contact Form.

DENIAL

If the UMC determines the applicant/member does not meet medical eligibility criteria for PC services, the UMC will provide the applicant/member with a denial letter within five business days of the decision date. The letter will include: why he/she does not meet medical eligibility, a copy of the PAS Summary, the applicable Personal Care policy manual section(s), notice of free legal services, and a Request for Hearing Form to be completed if the applicant/member wishes to contest the decision, and specific timeframes for filing an appeal.

The applicant/member may request a pre-hearing conference at any time prior to the Medicaid Fair Hearing and the OA will schedule. The applicant/member, the OA, and BMS will review the information submitted for the medical eligibility determination and the basis for the denial or termination. If the applicant/member and BMS come to an agreement during the pre-hearing conference, the applicant/member may either contact the Board of Review (BOR) to withdraw the request for hearing or request the OA to do so on their behalf. All parties will be notified by the OA in writing that the issue(s) have been resolved and the hearing request has been withdrawn.

If the applicant's/member's medical eligibility is denied and the applicant/member is subsequently found medically eligible after the fair hearing process, services cannot start earlier than the date of the hearing decision.

517.13.9 Service Level Change Request

If during the course of the member's service year, the member experiences a change in need, the PC agency must document the deficits, diagnoses and conditions and must obtain documentation from the member's treating physician (M.D. or D.O.), Advanced Practice Registered Nurse Practitioner, or Physician Assistant (PA) to substantiate the request for a Service Level Change. The PC agency must submit all required information via the web portal to the UMC for consideration of a new service level.

POLICY

517.14 MEMBER ASSESSMENT

Assessment is the structured process of interviews which is used to identify the member's abilities, needs, preferences, risks and supports; determine needed services or resources; and provide a sound basis for developing the POC. A purpose of the assessment is to provide the member a good understanding of the program, services, and expectations.

Once the member has chosen a PC provider agency, the agency RN will schedule a home visit within seven business days to complete the Initial PC Member Assessment (T1001).

The PC Member Assessment must be completed at least every six months from the date of the initial Assessment and annually thereafter. The provider is to maintain a copy of the entire PC Member Assessment in the member's record.

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A new Assessment must be completed when a member's needs change. Changes in a member's needs are to be incorporated into the POC and uploaded into the web portal within seven business days.

A copy of all PC Member Assessments must be provided to the member within 14 calendar days.

Note: Caution is advised for situations in which the member lives with their direct care worker, or if their direct care worker is a relative, to ensure services are for the sole benefit of the eligible member to avoid disallowances.

517.15 PLAN OF CARE DEVELOPMENT

The Plan of Care (POC) is a person centered plan developed by the PC RN, in collaboration with the member, outlining the Direct Care Worker activities that will be provided to the member. Services that are person-centered, include choice, preference, individual need, cultural considerations, ensure health and welfare, reasonable, and identify a person's strengths and goals.

The PC RN is responsible for development of the Plan of Care every six months or as needed in collaboration with the member. It is the PC RN's responsibility to ensure that all assessments are reviewed with the member and considered in the development of the POC. The PC RN must use the BMS approved PC Standards of Care in the development of the POC. Once the Plan of Care is developed, the PC agency will begin providing DCW services within ten calendar days. For emergency/discharges Direct Care services will begin upon the latter of: the calendar day after facility discharge or the day medical eligibility is approved.

Personal Care activities that will be performed outside the routine of the day must have a rationale on the RN Assessment explaining the need for the personal care activity at that time of day. Example: A second bath in the evening for a person who is incontinent.

Participation in the development of the Initial Plan of Care is mandatory for the member and the PC RN. The member may choose to have whomever else they wish to participate in the process (other service providers, informal supports, etc.). The PC RN must provide the member with a copy of the Personal Care Member User Guide initially and can be found on the BMS PC website or the OA website.

It is the PC RN's responsibility to provide a copy of the POC to the member within 14 calendar days from the meeting.

A copy of all Plans of Care must be provided to the member. The PC Agency must have the original document in the member's file.

When the member has a change in need, the POC should be changed to document any permanent Plan changes. (i.e. change in service hours, types of assistance with the activity, frequency of the activity, destination for community activity or essential errands, etc.). Approved minor daily changes (i.e. direct care worker arrived at 8:00 A.M. to get the person ready for a doctor appt.) in a member's needs, such as hours of service, may be documented on the POC worksheet and does not constitute the need for a change. However, if a change becomes permanent, a new POC must be completed.

If the member receives dual services, any permanent PC schedule changes must be made with the IDDW, TBIW, or ADW Service Coordinator or Case Manager on a dual schedule and then uploaded into the web portal. See [Section 517.24 Request for Dual Services with Waiver](#) for more information.

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Personal Care services are not intended to replace supports/services that a child would receive from the school system during a school day or educational hours provided during home schooling. PC services do not replace the age appropriate care that any child would need from a parent or legal guardian.

Note: Where there is more than one PC recipient (or other Medicaid service recipient) in the same home, environmental tasks may not be duplicated or provided twice (once for each member). For example, a PC worker cannot provide house cleaning services during the same day an ADW worker provides those services for another person in the home.

517.16 COVERED SERVICES

The following information describes the PC services and activities which are reimbursable by Medicaid. These apply to all PC providers unless otherwise noted. For individuals who will receive PC services as well as a Medicaid Waiver service, please see [Section 517.15 Provision of Dual Services](#) and its subparts.

Personal Care Services, eligible for reimbursement by Medicaid, are to be provided exclusively for the person utilizing the program and only for necessary activities as listed in their Service Plan. They are not to be provided for the convenience of others living in the household or others whom the person utilizing the program has contact. Although informal supports are not mandatory in the PC Program, the program is designed to provide formal supports services to supplement, rather than replace, the person's existing informal support system.

517.16.1 Initial Member Assessment/Re-Evaluation

Procedure Code: T1001
Service Unit: Event
Limit: One per 300 days
Prior Authorization: N/A

Required Documentation: A PC Assessment, and a PC POC. All activities must be conducted by the provider agency RN.

- A. Conduct the initial and annual person-centered face-to-face PC Assessment.
- B. Develop the initial and annual PC POC using the BMS approved [PC Standards of Care](#). The POC must be developed with the member and must address the member's assessed needs and preferences using a person-centered approach.

517.16.2 Ongoing RN Assessment and Care Planning

Procedure Code: T1002
Service Unit: 15 minutes
Limit: Six units per month
Prior Authorization: N/A

Required Documentation: A six month PC Assessment (except members receiving dual services), a six month PC POC using the BMS approved [PC Standards of Care](#), and/or the [PC RN Member Contact Form](#).



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- A. A person-centered face-to-face PC Assessment must be conducted every six months. Additional PC Assessments may be conducted if the member's condition indicates a need. The PC Assessment must be signed and dated by the RN and the member .
- B. The POC must consider any informal supports (i.e. family, friends or community supports) that are available to address the member's needs identified on the PAS and the PC Assessment. The POC must be modified as necessary to address changes in the member's condition.
- C. Environmental maintenance (examples: housekeeping, washing dishes, laundry, etc.) may not exceed one-third of the time spent providing PC services.
- D. The RN must monitor and assess the quality and appropriateness of the direct care service and assure that it is provided according to the POC by signing and dating the logs.
- E. The RN must review, sign, and date the PC POC once it is completed by the member, and the Direct Care Worker, certifying all activities were performed as needed and met the member's preferences allowed by policy. This activity is limited to one unit per month per member.
- F. One-on-one training of the Direct Care Worker by the RN is reimbursable if the purpose of the one-on-one training is to instruct the Direct Care Worker in a specific care technique for the member. The RN must document the reason and the specific training provided in the member's home on the [PC RN Member Contact Form](#).
- G. The RN must attend and participate in the IDDW interdisciplinary team meeting if the member has dual service with PC/IDDW.
- H. The RN can pre-fill med boxes for a member with an order from the physician, physician assistant or nurse practitioner.

Note: The rounding of any Personal Care Service units billed can only be made once per calendar month until daily billing has been implemented. Once daily billing has been implemented, rounding of any Personal Care Service units billed is not allowed.

Although the goal is to provide services to a member who cannot perform activities of daily living, when assessing and doing care planning, the RN assures that this goal is balanced with the goal of promoting independence and encouraging the highest possible level of function for the individual.

517.16.3 Personal Care (PC) Services (Direct Care Services)

Procedure Code:	T1019
Service Unit:	15 Minutes
Service Limit:	210 hours per month or 840 units
Prior Authorization:	Yes
Ratio:	1:1

Required Documentation: There must be a Plan of Care log signed and dated by Direct Care Worker, provider agency RN and member with a schedule outlining the dates/times when the member will receive PC services.

The functions of the PC Direct Care Worker include providing direct care services as defined by the POC, recording services and time spent with the member, and communicating to the RN any member changes. The direct care worker must document any change on the POC log. This includes change in time of services, services not completed, change in arrival/departure times, etc.



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- A. Assist member with ADLs/IADLs in the home or community.
- B. Assist member with environmental tasks necessary to maintain the member in the home.
- C. Assist member with completion of errands that are essential for the member to remain in the home (IADLs). Examples: grocery shopping, medical appointments, laundromat, and trips to the pharmacy. The member may accompany the Direct Care Worker on these errands.
- D. If ADLs or IADLs tasks are provided in the community, the amount may not exceed 20 hours per month.
- E. Assist members in obtaining or retaining competitive employment of at least 40 hours a month by providing PC services in locations for obtaining employment such as employment agencies, human resource offices, accommodation preparation appointments, job interview sites, and work sites.
- F. Report significant changes in member's condition to the RN.
- G. Report any incidents to the RN. (Examples: member falls (whether a Direct Care Worker was present or not), bruises (whether Direct Care Worker knows origin or not), etc.).
- H. Report any environmental hazards to the RN. (Examples: no heat, no water, pest infestation or home structural damage).
- I. Prompt for self-administration of medications.
- J. Maintain records as instructed by the RN.
- K. Perform other duties as assigned by the RN within program guidelines.
- L. Accurately complete PC POC and other records as instructed by the RN.

Note: The rounding of any Personal Care Service units billed can only be made once per calendar month until daily billing has been implemented. Once daily billing has been implemented, rounding of any Personal Care Service units billed is not allowed.

Environmental tasks cannot be provided by the Direct Care Worker for all minor children (under the age 18) including children in a SFC home.

PC Direct Care Worker cannot perform any service that is considered to be a professional skilled service or any service that is not on the member's POC. Functions/tasks that cannot be performed include, but are not limited to, the following:

- A. Care or change of sterile dressings.
- B. Colostomy irrigation.
- C. Gastric lavage or gavage.
- D. Care of tracheostomy tube.
- E. Suctioning.
- F. Vaginal irrigation.
- G. Administer injections, including insulin.
- H. Administer any medications, prescribed or over-the-counter.
- I. Perform catheterizations, apply external (condom type) catheter.
- J. Tube feedings of any kind.
- K. Make medical judgments or give advice on medical or nursing questions.
- L. Application of heat.
- M. Nail trimming for members who are diabetic.

Note: There may be instances whereby a SFCP performs what would be considered skilled nursing tasks for the individuals living in their homes. **However, these tasks should not be placed on the Medicaid**



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PC POC, nor can they be billed to Medicaid. If these are provided by the SFCP then it is considered natural supports.

More than one Personal Care Agency can provide direct care services to a person receiving services on Personal Care. However, providers are to provide staffing in the evenings and weekends, based on the person's needs. Therefore, before a second Personal Care Agency is contacted to provide services, the Personal Care Agency must contact the OA to explain why a second agency is necessary. **The OA must approve the second Personal Care Agency before the process continues.** The initial agency the person selected is the primary agency and is responsible for coordinating services. The Plan of Care must indicate which agency is the primary agency. The primary agency must coordinate the billable nursing units. There cannot be a duplication of services.

In order to prevent duplication of services for those receiving dual services, the personal care activities must be provided during normal routines of the day. For exceptions, the RN must document in the assessment the rationale an activity is provided outside the routine for the day. Example: For dual services, the person may need a second bath at night due to incontinence.

A Personal Care Agency must not stop direct care services to a member for any reason, including lack of staff, lack of cooperation between waiver and Personal Care Agency, environmental issues that are not addressed in Section 517.28 about unsafe environment, etc. without first consulting with the OA for technical assistance. If after the technical assistance with the OA, the Personal Care Agency is still unable to serve the member within seven calendar days, the Personal Care Agency must counsel the member on the right to transfer to another Personal Care Agency. At no time is it acceptable for a PC provider to not provide PC services for 30 calendar days. If this occurs the PC provider must initiate a transfer to a provider who can meet the member's needs.

517.17 PRIOR AUTHORIZATIONS

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to [Chapter 300, Provider Participation Requirements](#) of the Provider Manual.

In order to receive payment from BMS, a provider must comply with all prior authorization requirements. BMS in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not guarantee payment.

517.18 BILLING PROCEDURES

Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement the amount of time documented in minutes must be totaled and divided by the minutes in a unit of service to arrive at the number of units billed. After arriving at the number of billable units, billing for T1002 can be rounded only once within a calendar month. Once BMS requires daily billing commence, services cannot be rounded up at any time.

Medicaid is the payer of last resort. Claims will not be honored for services (inclusive of service code definitions) provided outside of the scope of this policy manual or outside of the scope of federal regulations.

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Note: Once EVV systems are available, PC providers will be required to bill daily and include the direct care worker's individual NPI number. By billing daily, it is meant that each day will be billed separately, thereby eradicating span billing. This will enable program integrity and reduce opportunities for fraud.

517.19 PAYMENTS AND PAYMENT LIMITATIONS

PC providers must comply with the payment and billing procedures and requirements described in [Chapter 600, Reimbursement Methodologies](#) of the BMS Provider Manual.

PC services may not be charged while an individual is inpatient in any setting such as:

- a nursing home,
- hospital,
- rehabilitation facility,
- other inpatient medical facility,
- other type of facility, or
- incarcerated.

Direct Care services may be provided on the day of admission and day of discharge. PC services cannot be billed when a PC member is temporarily or semi-permanently staying out of state, i.e., vacation or visiting family.

517.20 SERVICE LIMITATIONS AND SERVICE EXCLUSIONS

Services governing the provision of all West Virginia Medicaid services apply pursuant to [Chapter 300, Provider Participation Requirements](#), of the BMS Provider Manual and applicable sections of this Chapter. Reimbursement for services is made pursuant to [Chapter 600, Reimbursement Methodologies](#); however, the following limitations also apply to the requirements for payment of services that are appropriate, and necessary for the PC services described in this chapter.

PC services are made available with the following limitations:

1. The member receiving PC services must be a resident of and live in West Virginia and be available for planned services;
2. All PC regulations and policies must be followed in the provision of the services. This includes the requirement that all PC providers be licensed in the State of West Virginia and enrolled in the West Virginia Medicaid Program;
3. The services provided must conform to the member's POC.
4. Personal Care activities that will be performed outside the routine of the day must have a rationale on the RN Assessment explaining the need for the personal care activity at that time of day. Example: A second bath in the evening for a person who is incontinent.

Reimbursement for PC services cannot be made for:

1. Services provided outside a valid POC;
2. Services provided when medical and/or financial eligibility has not been established;
3. Services provided when there is no POC;
4. Services provided without supporting documentation;
5. Services provided by unqualified staff;

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6. Services provided outside the scope of the service definition;
7. Services provided by another Medicaid/Medicare program or through the Veterans Administration (VA) (no duplication of services);
8. Services that exceed service limits;
9. Environmental tasks cannot be provided by the Direct Care Worker for minor children (under the age of 18). This includes SFC Providers.;
10. Personal Care services are not intended to replace supports/services that a child would receive from the school system during a school day or educational hours provided during home schooling; and
11. Personal Care is not to be used for respite or companion care.

517.21 LOCATION OF SERVICES

PC Services may be delivered in the member's home, place of employment or in the local, public community. PC hours provided in the community may not exceed 20 hours per month. Hours can be used to assist the member with completion of essential errands and medical appointments.

PC Services may be provided to assist eligible individuals to obtain and retain competitive employment of at least 40 hours per month. Services are designed to assist a member with a disability to perform daily activities on and off the job; these would include activities that the member would typically perform if he/she did not have a disability. Locations for obtaining employment may include employment agencies, human resource offices, accommodation preparation appointments, and job interview sites.

PC services **cannot** be provided in a hospital, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) site, Intellectual and Developmental Disabilities (IDD) Waiver group homes with four or more members, IDDW Intensively Supported Setting (ISS) homes, or any other settings in which personal assistance and/or nursing services are provided.

PC services cannot be billed when a PC member is temporarily or semi-permanently staying out of state, i.e., vacation or visiting family.

517.22 ASSISTED LIVING RESIDENCES AND BMS APPROVED GROUP RESIDENTIAL FACILITIES

Generally, PC services may not be provided in assisted living residences or in Non-BMS approved group residential facilities. However, there may be instances where the provision of PC services in these types of facilities would be allowed. Before providing services in assisted living residences and/or BMS approved group residential facilities the following criteria must be met:

- A. Medicaid PC services shall not duplicate or replace those services which a provider is required by law or regulation to provide. By definition, assisted living residences and group residential facilities must provide a certain level of PC services; therefore these services cannot be replaced or duplicated. This includes private pay facilities.
- B. If a Medicaid member who resides in an assisted living residence or a group residential facility requests PC services the following documentation must be submitted to the OA:
 - 1) A detailed itemization of all services the facility must provide according to state regulations or contract;



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- 2) A detailed itemization of all services the PC provider will be undertaking for the member and why the additional services are necessary.

517.23 SERVICES AND/OR COSTS NOT ELIGIBLE FOR REIMBURSEMENT

The following services and/or costs are not eligible for reimbursement:

- A. Room and Board Services including the provision of food, shelter, maintenance and supplies.
- B. PC services which have not been certified by a physician, physician assistant, or nurse practitioner on a PAS or are not in the approved POC.
- C. PC/Direct Care Worker service hours which have not received prior authorization.
- D. Supervision and other activities that are considered normal child care that is appropriate for a child of a similar age.
- E. Respite service
- F. Monitoring and supervision of the member (this includes both awake and asleep times and waiting to provide a personal care service).
- G. Skilled Nursing Services.
- H. Environmental tasks cannot be provided by the Direct Care Worker for minor children (under the age 18). This includes SFC Providers.
- I. Duplication of Services and activities with other programs the member receives.

517.24 REQUESTS FOR DUAL SERVICES WITH WAIVER

Individuals who are receiving Aged and Disabled Waiver (ADW) services, Intellectual/Developmental Disabilities Waiver (IDDW) services, or Traumatic Brain Injury Waiver (TBIW) services may also receive PC Services; if they have unmet direct support needs (above what can be provided through Waiver) and meet PC criteria.

The use of PC services as a dual service is not intended to provide direct care coverage 24 hours a day, seven days a week.

Personal Care services are not intended to replace supports/services that a child would receive from the school system during a school day or educational hours provided during home schooling.

Though a dual PC request will include a prior authorization starting with the waiver anchor date, PC services must not be provided until medical eligibility for PC services has been approved by the UMC.

For people who access their waiver services through Personal Options (self-directed model) the hours of daily service must be documented on the ADW Personal Attendant Log (PAL), TBIW Personal Attendant Worksheet (PAW), or combined PC/Waiver schedule (IDDW). There cannot be a duplication of services. While Waiver Personal Options (self-directed model) services offer flexibility in scheduling, the PC Plan of Care must still meet all program criteria.

Combined Waiver/PC schedule must:

- A. Specify days and times each program will be used during each week.
- B. Specify tasks during the time period they are to be completed.

Any changes to the dual services schedule requested by a member requires agreement to the changes indicated by the signatures of all waiver and PC parties on a revised dual services schedule and

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uploaded into the UMC web portal by the PC RN. The dual service schedule cannot be changed for the convenience of a provider agency. Please refer to the appropriate "sample dual service schedule" for the corresponding waiver program ([See the BMS Personal Care Website](#)). Any duplication/conflict of schedules will be subject to retro review monitoring.

517.24.1 Dual Service Requests for Participants Receiving ADW Services

People enrolled in ADW who wish to request additional services through Personal Care and who meet the ADW/PC Dual requirements may apply for PC as indicated below:

- A. For initial PC requests, the PC applicant, ADW Case Manager or referent will submit an Initial PC-MNER to the UMC via fax or mail. The UMC will verify the ADW member is authorized to receive Level D (140-155 hours per month) ADW services. If Waiver requirements are met, the UMC will key the ADW PAS previously completed (by the UMC) into the PC web portal and will reach out to the PC applicant to acquire their choice of PC agency in their catchment area. If approved for PC, the UMC will refer the new PC member to their chosen PC agency via the PC web portal. If Waiver requirements are not met, the UMC will close the request, and the person may reapply for PC if/when the person meets the Waiver requirements.
- B. For reevaluation requests of PC services, the PC agency will submit the Reevaluation PC-MNER and attach the PC-MNER and a copy of the ADW PAS Summary into the UMC's PC web-based PC system. The UMC will verify the ADW requirements are met. If Waiver requirements are met, the UMC will key the ADW PAS previously completed (by the UMC) into the PC web portal for determination of PC eligibility. If Waiver requirements are not met, the request will be closed.
- C. If an existing PC member becomes eligible for ADW and is offered a slot, but does not meet ADW requirements (Service Level D) for dual services, the member must choose between ADW or PC services.

Once Dual Services are approved for an ADW/PC member, the ADW Person-Centered Assessment and the ADW PAL must be used in order to determine the member's needs for PC services. For members who receive ADW services through Personal Options, the Personal Options Assessment and Service Plan must be used to determine a member's needs for PC services. A PC RN Assessment is not required for ADW recipients but can be done if necessary.

- A. For members who receive ADW services through an ADW provider agency, the ADW Case Manager is responsible to coordinate and attend the service plan meeting(s) which includes the ADW Personal Attendant RN, the PC RN and the member.
- B. For members who receive ADW services through Personal Options the PC RN is responsible to coordinate and attend the service plan meeting(s) with the member receiving ADW services, the Resource Consultant (when there is no ADW Case Manager), and the PC RN.
- C. A service plan meeting between the Resource Consultant, if applicable, the PC RN and the Case Manager, if applicable, must be held with the member in the member's residence. The PC RN is responsible to develop the PC Nursing POC. The ADW Service Plan must include the PC POC and a combined ADW/PC schedule as an attachment. The PC RN, ADW Case Manager, ADW RN, if applicable, and member must agree to and sign the ADW Service Plan and attached PC POC. The ADW Service Plan, PC POC and combined ADW/PC schedule must be attached to the UMC's web portal and disseminated to all meeting attendees within 14 calendar days of the meeting.

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- D. The combined schedule must outline when all direct support services (PC and Waiver) are expected to be delivered. The PC and ADW agencies are responsible to monitor and assure that the two programs are being administered according to the member's needs including evenings and weekends, as needed.

517.24.2 Dual Service Requests for Participants Receiving IDWW Services

People enrolled in IDW Waiver who wish to request additional services through Personal Care may apply for PC as indicated below.

- A. For initial PC requests, the PC applicant, IDWW Service Coordinator or referent will submit an Initial PC-MNER to the UMC via fax or mail. The UMC will verify the IDWW member meets the IDWW/PC Dual requirements: (1) Member is authorized to receive the maximum number of Direct Care Services hours, (2) Member does not live in a 24-hour staffed IDWW setting, and (3) Member has an Inventory for Client and Agency Planning (ICAP) Service Level of 1, 2, 3 or 4 in the IDWW program. If IDWW/PC requirements are met, the UMC will schedule and complete the PC PAS and will offer the PC applicant their choice of PC agencies (PCA) in their catchment area. If approved for PC, the UMC will refer the new PC member to their chosen PC agency via the PC web portal. If Waiver requirements are not met, the UMC will close the request, and the person may reapply for PC if/when the person meets the Waiver requirements.
- B. For reevaluation requests of PC services, the PC agency will submit the Reevaluation PC-MNER, a copy of the IDWW approved budget and a copy of the ICAP results (as obtained from the IDWW Service Coordinator), into the UMC's PC web portal. The UMC will verify the IDWW criteria. If Waiver requirements are met, the UMC will schedule and complete the PC PAS assessment. If Waiver requirements are not met, the request will be closed.
- C. If an existing PC member becomes eligible for IDWW and is offered a slot, but does not meet IDWW requirements for dual services, the member must choose between IDWW or PC services.

Once Dual Services are approved for an IDWW/PC member, the IDWW and PC RN Assessments must be used to determine the member's needs for PC services

- A. If PC medical eligibility is approved, there must be a PC Nursing POC and an IDWW Individual Program Plan (IPP) coordinated between the two agencies providing direct services (PC and IDWW) to ensure that services are not duplicated. PC and IDWW Direct Care services cannot be provided during the same hours on the same day. A service planning meeting between the Resource Consultant (for those self-directing their IDWW services), the PC RN and the IDWW Service Coordinator must be held with the member in the member's residence or agreed-upon location.
- B. The PC and IDWW providers must use all available assessments to determine appropriate PC services. (ICAP, Adaptive Behavior Assessment System (ABAS), Health and Safety Reports, nursing and habilitation assessments, etc.).
- C. The IDWW and the PC agencies are responsible for assuring that the two programs are being administered according to the member's needs and the respective plans of care. A combined IDWW and PC schedule must be included in the PC POC and the IDWW IPP. At no time can a duplication of services between the two programs occur.
- D. The IDWW Service Coordinator must provide a copy of the IDWW member's IDWW IPP and assessments to the PC RN. The PC Agency must provide copies of the PC assessments and Plan of Care to the IDWW Service Coordinator.



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- E. Personal Care services must meet the definition of the service and may not be used as a substitute for Respite Care, nor can they be used for monitoring and supervision during the day or during the night.
- F. Personal Care activities that will be performed outside the routine of the day must have a rationale on the RN Assessment explaining the need for the personal care activity at that time of day. Example: A second bath in the evening for a person who is incontinent.

517.24.3 Dual Service Requests for Participants Receiving TBIW Services

People enrolled in TBIW who wish to request additional services through Personal Care and who meet the TBIW/PC Dual requirements may apply for PC as indicated below.

- A. For initial PC requests, the PC applicant, TBIW Case Manager or referent will submit an Initial PC-MNER to the UMC via fax or mail. The UMC will verify the TBIW member has maximized their TBIW budget. If Waiver requirements are met, the UMC will key the TBIW PAS previously completed into the PC web portal and reach out to the PC applicant to acquire their choice of PC agency within their catchment area. If approved for PC, the UMC will refer the new PC member to their chosen PC agency via the PC web portal. If Waiver requirements are not met, the UMC will close the request, and the person may reapply for PC if/when the person meets the Waiver requirements.
- B. For reevaluation requests of PC services, the PC agency will submit the Reevaluation PC-MNER and will attach a copy of the signed PC-MNER and a copy of the TBIW approved budget into the UMC's PC web-based PC system. The UMC will verify the TBIW member has maximized their TBIW budget. If Waiver requirements are met, the UMC will key the TBIW PAS previously completed (by the UMC) into the PC web portal for determination of PC eligibility. If Waiver requirements are not met, the request will be closed.
- C. If an existing PC member becomes eligible for TBIW and is offered a slot, but does not meet TBIW requirements for dual services, the member must choose between TBIW or PC services.

Once Dual Services are approved for a TBIW/PC member, the TBIW Person-Centered Assessment and the TBIW Personal Attendant Worksheet (PAW) must be used in order to determine the participant's needs for PC services.

- A. For participants who are receiving TBIW service through a TBI provider agency or Personal Options, the coordination of the dual service planning meeting is the responsibility of the Case Manager. The dual service planning meeting includes the PC RN, the Case Manager, Resource Consultant (if applicable) and the participant. The dual service planning meeting between the Resource Consultant (if applicable), the PC RN and participant must be held in the participant's residence.
- B. The PC RN is responsible for the development of the PC Nursing POC. The TBI Service Plan must include the PC POC in a combined TBIW/PC schedule as an attachment. The PC RN, TBIW Case Manager, member, must agree to and sign both documents. Plans must be coordinated between the agencies providing direct services to ensure that services are not duplicated. PC and TBIW Personal Attendant services cannot be provided during the same hours on the same day.
- C. The PC RN is responsible to submit the TBIW Service Plan, POC and the combined TBIW/PC schedule in the UMC's Personal Care web portal.

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- D. Dual services must meet the criteria for Personal Care services, must not duplicate activities/services in another service/program and is not for respite, monitoring/supervision or companion care. Personal Care activities that will be performed outside the routine of the day must have a rationale on the RN Assessment explaining the need for the personal care activity at that time of day. Example: A second bath in the evening for a person who is incontinent.

517.25 MEMBER RIGHTS AND RESPONSIBILITIES

At a minimum, PC agencies must communicate in writing to members their right to:

- A. Transfer to a different provider agency.
- B. Address dissatisfaction with services through the provider agency's grievance procedure.
- C. Access the West Virginia DHHR Fair Hearing process.
- D. Freedom from retribution when expressing dissatisfaction with services or appealing service decisions.
- E. Considerate and respectful care from their provider(s).
- F. Freedom from abuse, neglect and exploitation.
- G. Take part in decisions about their services.
- H. Confidentiality regarding PC services.
- I. Access to all of their files maintained by providers.

And their responsibility to:

- A. Notify the PC provider within 24 hours prior to the day services are to be provided if services are not needed.
- B. Notify providers promptly of changes in Medicaid coverage.
- C. Comply with the POC.
- D. Cooperate with all scheduled in-home visits.
- E. Notify the PC provider of a change in residence or an admission to a hospital, nursing home or other facility.
- F. Notify the PC provider of any change in medical status or direct care need.
- G. Maintain a safe home environment for the PC provider to provide services.
- H. Verify services were provided by initialing and signing the POC.
- I. Communicate any problems with services to the PC provider.
- J. Report any suspected fraud to the provider agency or the Medicaid Fraud Unit at (304)558-1858.
- K. Report any incidents of abuse, neglect and/or exploitation to the PC provider and the [West Virginia Centralized Intake for Abuse and Neglect](#) at 1-800-352-6513.
- L. Report any suspected illegal activity to the local police department or appropriate authority.
- M. Notify the provider of any changes in their legal representation and/or guardianship/conservatorship and provide copies of the appropriate documentation.
- N. Not ask Direct Care Worker to provide services that are excluded by policy or not on their POC.
- O. Inform the PC provider if they receive any other in home care services such as but not limited to Waiver services, Veterans services, Hospice, etc. If so, member must make available the schedule of other in-home services to the PC provider.

517.26 TRANSFER TO A DIFFERENT AGENCY

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A PC member may request a transfer to another provider agency at any time unless the member is currently being closed due to persistent noncompliance or unsafe environment. The OA will assist with transfers if needed.

If the person transfers before the Anchor Date with a valid PAS, a new authorization is not needed from the UMC.

Transferring Provider Agency Responsibilities:

- Ensure the current Member Assessment (PC or ADW, or TBIW), PC POC, Individual Program Plan, ICAP (when applicable) and Service Plan (when applicable) is uploaded in the UMC's web portal. In addition, the transferring provider agency should share other documents as needed such as any legal documents regarding POA, legal guardianship, conservatorship, etc.
- Maintain all original documents for monitoring purposes. Continue to provide services to the member until the transfer process is completed.

Note: The existing PC POC from the transferring agency must continue to be implemented until such time that the receiving agency can develop and implement a new PC POC to prevent a gap in services.

Receiving Provider Agency Responsibilities:

- Complete Member Assessment and develop the PC POC within seven business days and upload into the UMC web portal.

517.27 EMERGENCY TRANSFER OPTIONS

A request to transfer that is considered an emergency, such as when a member receiving PC services suffers abuse, neglect, or harm, or a health and safety risk, including inability to provide services, will be reviewed by the OA, and the OA will take appropriate action. The PC agency that the member is transferring from must submit supporting documentation and submit the transfer request via the UMC's web portal notifying the OA that it has been uploaded, that explains why the member is in emergency status. The OA will expedite the request as necessary, coordinating with the member and agencies involved.

517.28 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services Form be submitted and approved by the OA:

- A. Unsafe Environment – an unsafe environment is one in which the Direct Care Worker and/or other agency staff are threatened or abused and the staff's welfare is in jeopardy. The provider must follow the steps in the [PC Procedural Guidelines](#) for non-compliance and unsafe closures. This may include, but is not limited to, the following circumstances:
 - 1) The member or other household members repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a Direct Care Worker or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals.
 - 2) The member or other household members display an abusive use of alcohol and/or drugs or engages in the manufacture, buying and/or selling of illegal substances.

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- 3) The physical environment is either hazardous or unsafe.
- B. The member is persistently non-compliant with the PC Nursing POC creating a risk to their health and safety.
- C. Member no longer desires services (must include a signed statement from the member (when possible) indicating he or she no longer desires services; if unable to obtain signed statement, provide documentation of contact with member about desire to discontinue PC services). If the member is receiving dual services and the PC member no longer desires PC services.
- D. Member has not accessed PC services for 30 days unless the member is in a facility.
- E. Member no longer medically eligible for PC services (must include latest Member Assessment and/or PAS reflecting that the member does not have three deficits).

If the closure is due to an unsafe environment, the PC provider will contact the OA for assistance. The provider must notify Adult or Child Protective Services if an unsafe situation warrants such notification by calling the [West Virginia Centralized Intake for Abuse and Neglect](#) at 1-800-352-6513.

The Request for Discontinuation of Services Form must be uploaded into the UMC web portal within seven days of determination of need to close. Discharge must also be requested in the UMC web portal by changing the member's eligibility status.

The OA will review all requests for a discontinuation of services. If it is an appropriate request, and the OA approves the discontinuation, the OA will send notification of discontinuation of services to the member. The effective date for the discontinuation of services is 13 calendar days after the date of the OA notification letter, if the member does not request a hearing. If it is an unsafe environment, services may be discontinued immediately and a report must be made by the PC RN to Adult or Child Protective Services through the [West Virginia Centralized Intake for Abuse and Neglect](#) by calling 1-800-352-6513. Due to the nature of unsafe environment closure, the member is not eligible for the option to continue existing PC services during the fair hearing process.

A PC provider agency must not stop services to a member for any reason, including lack of staff, lack of cooperation between waiver and PC agency, environmental issues that are not addressed in the above section about unsafe environment, etc. without first consulting with the OA for technical assistance. If after the technical assistance with the OA, the PC provider agency is still unable to serve the member within 7 calendar days, the PC agency must counsel the member on the right to transfer to another PC agency. At no time is it acceptable for any PC member to go without direct care services for 30 calendar days.

517.29 MEMBER GRIEVANCE PROCESS

Members who are dissatisfied with the services they receive from a provider agency have a right to file a grievance about the provision of services. All PC providers will have a written member grievance procedure. Providers will provide members grievance procedure information and grievance forms at the time of application and annual medical eligibility re-evaluation. These forms will also be provided upon request by the member in addition to the time of application and the annual re-evaluation.

There are two levels of grievance review:

- A. Level One: Personal Care Provider:** A Personal Care Provider has 10 business days from the date it receives a Member Grievance Form to hold a meeting, in person or by telephone with the



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member. The meeting will be conducted by the provider agency director or designee. The provider has five days from the date of the meeting to respond in writing to the grievance.

If the member is dissatisfied with the agency decision, he/she may request that the grievance be submitted to the OA for a Level Two review and decision.

- B. Level Two: Operating Agency:** If a Personal Care provider is not able to address the grievance in a manner satisfactory to the member, the member may request a Level Two review. The OA will, within 10 business days of the receipt of the Member Grievance Form, contact the member and the Personal Care provider to review the Level One decision, and issue a Level Two decision. Level Two decisions are based on Medicaid policy and/or health and safety issues.

517.30 MEDICAL ELIGIBILITY APPEALS

If a person is determined not to be medically eligible, a written Notice of Final Decision, a Request for Hearing form and the results of the PAS assessment are sent by mail by the UMC to the person. A notice is also sent to the person's Case Manager via the UMC's web portal. The termination may be appealed through the Fair Hearing process if the Request for Hearing form is submitted to the Board of Review within 90 days of receipt of the Notice of Final Decision.

Note: If the person wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted to the Board of Review within 13 days of the person's receipt of the Notice of Final Decision. This does not apply to cases closed due to unsafe environment. PC services will cease to those members upon submission of a Request to Discontinue services to the OA.

If the Request for Hearing form is not submitted to the Board of Review within 13 days of the person's receipt of the Notice of Final Decision, reimbursement for all PC services will cease.

A pre-hearing conference may be requested by the person once a Fair Hearing has been requested at any time prior to the Fair Hearing and the OA will schedule the meeting. At the pre-hearing conference, the person, the OA, and BMS will review the information submitted for the medical eligibility determination and the basis for the termination. If the person and BMS come to an agreement during the pre-hearing conference, the OA, upon request of the member, will withdraw the person's hearing request from the Board of Review. All parties will be notified by the OA in writing that the issue(s) have been resolved and the hearing request has been withdrawn.

If the denial of medical eligibility is upheld by the hearing officer, services that were continued during the appeal process must cease on the date of the hearing decision. If the termination based on medical eligibility is reversed by the Hearing Officer, the person's services will continue with no interruption.

517.31 VOLUNTARY AGENCY CLOSURE

A provider may terminate participation in the Personal Care Program with 30 calendar day's written notification of voluntary termination. The written termination notification must be submitted to the BMS claims agent and to the OA. The provider must provide the OA with a complete list of all members currently receiving PC services that will need to be transferred.

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The OA will provide selection forms to everyone being served by the agency along with a cover letter explaining the reason a new selection must be made.

If at all possible, a joint visit with the member will be made by both the agency ceasing participation and the new one selected in order to explain the transfer process. Services must continue to be provided until all transfers are completed by the OA. If a joint visit is not possible, both providers must document how contact was made with the member to explain the transfer process.

The agency terminating participation must ensure that the transfer of the member is accomplished as safely, orderly and expeditiously as possible. All program records must be made available to BMS upon closing.

The agency must submit their final continuing certification for any part of the year they provided services prior to closing.

517.32 INVOLUNTARY AGENCY CLOSURE

In the event a provider sells their business the members do not automatically transfer with the sale. Members must be provided freedom to choose from available PC providers in their catchment area. Any effort to coerce a member to transfer to the purchasing PC provider will be considered a conflict of interest and will result in the purchasing PC provider being removed from the PC provider selection list for one calendar year. See [Section 517.4 Conflicts of Interest](#).

BMS may terminate a provider from participation in the Personal Care Program for violation of the rules, regulations, or for the conviction of any crime related to health care delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the Personal Care Program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review. Refer to [Chapter 100, General Administration and Information](#) and [Chapter 800, Program Integrity](#) for more information on this procedure.

Prior to closure, the provider will be required to provide the OA with a complete list of all members currently receiving PC services that will need to be transferred. The OA will provide selection forms to each of the members on the agency's list, along with a cover letter explaining the reason a new selection must be made. The OA will ensure that the transfer of all members is accomplished as safely, orderly and expeditiously as possible.

The agency must submit their final continuing certification for any part of the year they provided services prior to closing.

All program records must be made available to BMS upon closing.

517.33 ADDITIONAL SANCTIONS

If BMS or the OA receives information that indicates a provider is unable to serve new members due to staffing issues, member health and safety risk, etc. or has a demonstrated inability to meet recertification requirements, BMS may remove the agency from the provider information list on the OA website until the

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issues are addressed to the satisfaction of BMS. Health and safety deficiencies deemed critical may include other sanctions including involuntary agency closure.

517.34 HOW TO OBTAIN INFORMATION

Please refer to the [WV BMS Personal Care Program](#) website and all [forms and the policy manual](#) for this program.

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

1:1: Means the ratio for billing purposes of one Direct Care Worker to one member.

Abuse: The infliction or threat to inflict bodily injury on or the imprisonment of any child or incapacitated adult.

Activities of Daily Living (ADLs): Activities that a person ordinarily performs during the course of a day, such as mobility, personal hygiene, bathing, dressing, eating, and skills required for community living.

Advanced Practice Registered Nurse (APRN): As defined in [West Virginia Code §30-7-1](#): A registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advanced practice registered nurse that shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner.

Anchor Date: The annual date by which the member's eligibility for continuing Personal Care services must be recertified. The Anchor Date will be the first of the month in which the member was determined eligible for Personal Care services.

Assisted Living Residence: Any living facility, residence or place of accommodation, however named, available for four or more residents which is advertised, offered, maintained or operated by the ownership or management, whether for payment or not, for the express or implied purpose of having personal assistance or supervision, or both, provided to any residents therein who are dependent upon the services of others by reason of physical or mental impairment and who may also require nursing care at a level that is not greater than limited and intermittent nursing care as defined in the [State Code §16-5D-1](#).

Behavioral Health Center: Any inpatient, residential or outpatient facility for the care and treatment of persons with mental illness, intellectual/developmental disabilities or addiction which is operated, or licensed to operate, by the Department of Health and Human Resources.

Certificate of Need (CON): A regulatory program originally enacted in 1977 under which reviews are conducted to determine the need for certain medical services, the financial feasibility, and whether the service(s) is consistent with the WV State Health Plan. For more information on the CON process please see the [West Virginia Healthcare Authority](#) web page.

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Community Integration: The full participation of all people in community life.

Competency Based Curriculum: A training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum should have goals, objectives and an evaluation system to demonstrate competency in training areas. Competency is defined as passing a graded post-test at no less than 80%. If a staff fails to meet competency requirements, the PC Agency must conduct additional training and retest the staff (must score at least 80%) before the staff is allowed to work with members.

Conservator: A person appointed by the court who is responsible for the estate and financial affairs of a protected person. WV Code §44A-1-4.

Corrective Action Plan (CAP): A plan submitted by the provider describing how identified deficiencies found during a provider review will be corrected. A CAP must include:

1. How the deficient practice for the person is cited in the deficiency will be corrected. What system will be put into place to prevent recurrences of the deficient practice;
2. How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
3. The date each item on the CAP will be completed; and
4. Any provider-specific training requests related to the deficiencies.

Cueing: Giving a signal or reminder to do something.

Days: Calendar days unless otherwise specified.

Direct Access: Physical contact with a resident or beneficiary or access to the resident or member's property, personally identifiable information, or financial information.

Direct Care Worker: The individuals who provide the day-to-day care to Personal Care members.

Dual Services: When a Medicaid member is approved for and receiving both Medicaid Waiver services and Personal Care services.

Duplication of Services: PC services are 1:1 staff to member ratio services. No single Direct Care Worker can bill for more than one member during a single 15 minute period. A Direct Care Worker/workers cannot bill for the same tasks for the same member (or for environmental tasks shared across multiple Medicaid recipients or funding sources).

Emergency Plan: A written plan which details who is responsible for what activities in the event of an emergency, whether it is a natural, medical or man-made emergency.

Environmental Maintenance: Activities such as light house cleaning, making and changing the member's bed, dishwashing, and member's laundry.

Financial Exploitation: Illegal or improper use of a member's financial resources. Obvious examples of financial exploitation include cashing a person's checks without authorization; forging a person's

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signature; or misusing or stealing a person's money or possessions. Another example is deceiving a person into signing any contract, will, or other document.

Group Residential Facility: A facility which is owned, leased, or operated by a behavioral health service provider and in which residential services and supervision for members who are developmentally or behaviorally disabled are provided.

Home and Community Based Services (HCBS): Services which enable Medicaid members to remain in the community setting rather than being admitted to a Long Term Care Facility (LTCF).

Informal Supports: Family, friends, neighbors or anyone who provides a service to a Medicaid member but is not reimbursed.

Instrumental Activities of Daily Living (IADLs): Skills necessary to live independently, such as the ability to shop for groceries, handle finances, perform housekeeping tasks, prepare meals, and take medications.

Legal Guardian/Guardian: A person appointed by the court who is responsible for the personal affairs of a protected person. [[WV Code §44A-1-4\(5\)](#)]

Legal Representative: One who stands in the place of and represents the interest of another, i.e. Power of Attorney, Medical Power of Attorney, Medical Surrogate.

Legally Responsible Person: A spouse or a parent of a minor child (under the age of 18) that is legally responsible to provide supports that they are ordinarily obligated to provide.

When reference is made to "Member" in this manual, it also includes any person who may, under State law, act on the member's behalf when the member is unable to act for himself or herself. That person is referred to as the member's legal representative. There are various types of legal representatives, including but not limited to, guardians, conservators, power of attorney representatives, health care surrogates and representative payees. Each type of legal representative has a different scope of decision-making authority. For example, a court appointed conservator might have the power to make financial decisions, but not health care decisions. The RN should verify that a representative has the necessary authority and obtain copies of supporting documentation, e.g., court orders or power of attorney documents, for the member's file.

Legal representatives must always be consulted for decisions within their scope of authority. However, contact with or input from the legal representative should not replace contact and communication with the member. If the member can understand the situation and express a preference, the member should be kept informed and his/her wishes respected to the degree practicable.

Minor Child: A child under the age of 18.

Neglect: "The failure to provide the necessities of life to an incapacitated adult or child" or "the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or child" ([WV State Code §9-6-1](#)). Neglect would include the lack of or inadequate medical care by the service provider and inadequate supervision resulting in injury or harm to the incapacitated member. Neglect also includes, but is not limited to: a pattern of failure to establish or carry

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out a member's individualized program plan or treatment plan that results in negative outcome or places the member in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the member.

Operating Agency (OA): The agency contracted by the Bureau for Medical Services, to manage the Personal Care Program. The Operating Agency is responsible for approving providers who have a valid Certificate of Need, assisting with member transfers when requested, monitoring and reviewing Personal Care agencies and conducting member case reviews.

Person-Centered Planning: A process-oriented approach which focuses on the person and his/her needs by putting him/her in charge of defining the direction for his/her life, not on the systems that may or may not be available. Services that are person-centered, include choice, preference, individual need, cultural considerations, ensure health and welfare, reasonable, and identify a person's strengths and goals.

Plan of Care (POC): A person centered plan developed by the PC RN, in collaboration with the member, outlining the Direct Care Worker activities that will be provided to the member.

Quality Management Plan: A written document which defines the acceptable level of quality, and describes how the provider will ensure this level of quality in its deliverables and work processes.

Remediation: Act of correcting an error or a fault.

Representative Sample: A small quantity of a targeted group such as customers, data, people, products, whose characteristics represent (as accurately as possible) the entire batch, lot, population, or universe.

Residential Care Community: Any group of 17 or more residential apartments, however named, which are part of a larger independent living community and which are advertised, offered, maintained or operated by an owner or manager, regardless of payment for the expressed or implied purpose of providing residential accommodations, personal assistance and supervision on a monthly basis to 17 or more persons who are or may be dependent upon the services of others by reason of physical or mental impairment or who may require limited and intermittent nursing care who are capable of self-preservation and are not bedfast.

Room and Board: (BCF-SFCP Policy definition 8/26/2015) Room and Board Services are defined as the provision of food and shelter including private and common living space; linen, bedding, laundering and laundry supplies; housekeeping duties and common lavatory supplies (i.e. Hand soap, towels, toilet paper); maintenance and operation of home and grounds, including all utility costs.

Scope of Services: The range of services deemed appropriate and necessary for an individual member. Such services may include but are not limited to prevention, intervention, outreach, information and referral, detoxification, inpatient or outpatient services, extended care, transitional living facilities, etc.

Self-Preservation: Protection of oneself from harm or destruction.

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Sexual Abuse: Any act towards an incapacitated adult or child which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the incapacitated individual may have suffered no apparent physical injury as a result of such conduct:

1. Sexual intercourse/intrusion/contact; and
2. Any conduct whereby an individual displays his/her sex organs to an incapacitated adult or child for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult, or child, or for the purpose of affronting or alarming the incapacitated adult or child.

Additionally, any act which constitutes an act of sexual abuse pursuant to the criminal code of West Virginia.

Sexual Exploitation: When an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult or child to display his/her sex organs for the sexual gratification of that individual or third person, or to display his/her sex organs under circumstances in which that individual knows such display is likely to be observed by others who would be affronted or alarmed.

Specialized Family Care Provider (SFCP): An individual who operates a foster care home which has received certification through the WVDHHR [Specialized Family Care Program](#). Both the home and the individual providing services must be certified by a Specialized Family Care Family Based Care Specialist.

Standards of Care: A methodology describing approved amounts of time that may be included for specific personal care tasks on a member's Plan of Care. Standards of Care are used to determine overall amount of time of service per month.

Utilization Management Contractor (UMC): The UMC is authorized to grant prior authorization for services provided to members enrolled in the West Virginia Medicaid Personal Care program. The UMC utilizes nationally recognized medical appropriateness criteria established and approved by BMS for medical necessity reviews.

REFERENCES

West Virginia State Plan references Personal Care services at sections [3.1-A\(24\)\(f\)](#), [3.1-B\(24\)\(f\)](#), [supplement 2 to appendices 3.1-A and 3.1-B\(24\)\(f\)](#), and reimbursement at [4.19-B\(24\)\(f\)](#).

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Personal Care Services	10/01/2016
Entire Chapter	Personal Care Services	01/01/2018
Section 517.2	The addition of "without use of a secure connection"	01/01/2018
Section 517.3	The addition of the requirement for Electronic Visit Verification (EVV)	01/01/2018



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Section 517.5	Specialized Family Care providers cannot bill for environmental tasks	01/01/2018
Section 517.7	The addition of use of e-fax and when urgent issues had to be addressed after office hours	01/01/2018
Section 517.7.2	Changed the name of the Plan of Correction to Corrective Action Plan	01/01/2018
Section 517.8.2	DCW Training, added certification information and where SFC provider records are kept	01/01/2018
Section 517.8.4	Removed RN evidence of staff qualification	01/01/2018
Section 517.11	The addition of NPI number requirement for Direct Care Workers	01/01/2018
Section 517.13.2	Initial and annual eligibility evaluation by the UMC, Use of a Personal Care- Medical Necessity Evaluation Request (PC-MNER)	01/01/2018
Section 517.13.3	When a new PC-MNER is required, timelines a provider responds to a referral in the web portal and accepting an emergency/discharge	01/01/2018
Section 517.13.5	#25 removed the letters used for sequencing	01/01/2018
Section 517.13.6	#25 removed the letters used for sequencing	01/01/2018
Section 517.13.7	The addition of need of long standing deficits of ADLs to remain on program.	01/01/2018
Section 517.15	The addition of Person Centered Plan of Care language, how long a POC is valid and when DCW services begin	01/01/2018
Section 517.16.2	Removed the PC Monthly Report	01/01/2018
Section 517.16.3	Disallowed the rounding of units billed once daily billing is required	01/01/2018
Section 517.18	The addition of the requirement for individual National Provider Identifier (NPI) numbers for direct care workers and daily billing	01/01/2018
Glossary	The addition of Person Centered Planning and Plan of Care.	01/01/2018