CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

TBIW services are to be provided exclusively to the person eligible for services and only for necessary activities as listed in the Service Plan. Enrollment on the TBIW is contingent on a person requiring two or more of the services offered in the TBIW in order to avoid institutionalization, one of which must be Personal Attendant services on a monthly basis either through a Traditional provider or Personal Options. The other service required is Case Management. Individuals may not be enrolled in the TBIW for the sole purpose of obtaining Medicaid eligibility.

Within the TBIW program, members may choose from either the Traditional (Agency) Model or the Participant-Directed Model known as Personal Options for service delivery. In the Traditional Model, people receive their services from employees of a certified provider agency. In Personal Options, members are able to hire, supervise, and terminate their own employees.

The person receiving TBIW services must receive Personal Attendant services on a monthly basis unless in a nursing home, hospital, or other inpatient medical facility

TAKE ME HOME, WEST VIRGINIA (TMH) OVERVIEW

Individuals wishing to transition from long-term care facilities to the community often face numerous obstacles including lack of basic household items and furniture, limited community supports, and no one to help develop comprehensive plans to transition home. Transition Services help address many of these barriers by providing a variety of services and supports to program participants to promote a successful and safe transition to the community.

Transition Coordination is the essential part of Transition Services. Transition Coordinators, provided via a contract, work one-on-one with residents and their Transition Teams to:

- Accept and follow up with referrals from the Aging and Disability Resource Network (ADRN);
- Conduct interviews to share information about options for returning to the community, including the availability of Waiver transition services;
- Assess residents' transition support needs, including risk factors that may jeopardize a safe and successful transition to the community;
- Assess and verify residents' readiness to begin transition assessment and planning;
- Facilitate the development of a Transition Team consisting of the resident, the Transition Coordinator, the Waiver Case Manager, the facility social worker and other appropriate staff, and anyone else the resident chooses to include in the transition process;
- Work with resident and his/her Transition Team to develop a written Transition Plan which incorporates specific services and supports to meet identified transition needs;
- Conduct a Risk Analysis and develop a written Risk Mitigation Plan to address and monitor all identified risks that may jeopardize the resident's successful transition, and;
- Arrange and facilitate the procurement and delivery of needed transition services and supports including Waiver transition services prior to transition.

Transition Services Available
There are two services available to assist individuals in transitioning back to the community beginning in January 1, 2019:

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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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1. Pre-Transition Case Management (Section 512.19.1): To develop a Waiver Participant Service Plan and ensure that the needed community services and supports are in place on the first day of the participants return to the community; and
2. Community Transition Services (Section 512.20.2) – One-time expenses that address identified barriers to a safe and successful transition from facility-based living to the community.

PROVIDER PARTICIPATION REQUIREMENTS

512.1 BUREAU FOR MEDICAL SERVICES CONTRACTUAL RELATIONSHIPS

BMS contracts with a Utilization Management Contractor (UMC). The UMC is responsible for day-to-day operations and oversight of the TBIW Program including conducting medical eligibility evaluations, determining medical eligibility for applicants and people enrolled in the program, initial and ongoing certification of provider agencies and providing prior authorization for services provided to people enrolled in the TBIW, conducts education for TBIW Providers, advocacy groups, and people receiving TBIW services.

The UMC, in collaboration with BMS, will provide answers to policy questions which will serve as policy clarifications. These policy clarifications will be posted on the BMS TBIW website located at: http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/TBIW/Pages/Member-and-Provider-info.aspx.

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

BMS contracts with TBIW providers for the provision of services for people receiving TBIW services. All TBIW providers must be certified by the UMC and enrolled as a Medicaid Provider.

Please refer to the TBIW Website for UMC and Personal Options contact information at: http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/TBIW/Pages/default.aspx

512.2 PROVIDER AGENCY CERTIFICATION

TBIW provider agencies must be certified by the UMC. A Certification Application must be completed and submitted to the UMC. Please refer to the TBIW Program website for Program contact information.

An agency may provide case management and/or Personal Attendant Service, provided they maintain:

A. A separate certification and WV Medicaid provider number for each service;
B. Separate staffing; and,

Conflicts of interest and self-referral are prohibited. Conflict of interest is when the Case Manager, who represents the TBIW person, has competing interests (the same provider agency), takes action on behalf
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financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for the provision.

**Traditional Model Procedure Code:** A0160 UB  
**Personal Options Model Procedure Code:** A0160 U2

**Service Unit:** 1 unit - 1 mile  
**Service Limit:** 300 units per Calendar Month

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

**Documentation Requirements:** All transportation with, or on behalf of, the person receiving TBIW services must be included in the Service Plan and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity). The Service Plan must document the purpose of the travel and the destination. The Personal Attendant must document on the Personal Attendant Worksheet accurate miles traveled, exact location of the beginning and ending destination and reason for the travel.

### 512.19 PRIOR AUTHORIZATIONS

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to [Chapter 300, Provider Participation Requirements](#) of the BMS 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. All services provided within the TBIW program must be authorized with the UMC. The Case Manager is responsible for ensuring that all prior authorization requests are forwarded to the UMC.

### 512.19.1 PRE-TRANSITION CASE MANAGEMENT

**Procedure Code:** T1016 U2  
**Service Unit:** 15 minutes  
**Service Limit:** 24 units  
**Prior Authorization Required:** Yes

**Service Definition:** This service is not available until January 1, 2019.

The purpose of the pre-transition case management service is to ensure that waiver services are in place the first day of the participant’s transition to the community. Prior to the participant’s transition from the facility, pre-transition case managers will:

- Participate in the transition assessment and planning process to help ensure that home and community-based services and support needs are thoroughly considered in transition planning;
- Conduct the person-centered assessment as required by waiver policy;
- Complete the required waiver service plan;

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**Effective TBD**

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- Facilitate the development of the assessment for those eligible for and planning to enroll in the TBIW program when returning to the community;
- Facilitate the development of the service plan by the selected waiver personal attendant agency;
- Coordinate with the personal attendant agency to ensure that Personal Attendant services are in place the first day the resident returns home;
- Enroll the participant in the waiver program immediately prior to their transition home. Individuals who have been determined eligible are not "enrolled" in the program until they are ready to receive services. Residents of nursing homes may apply and be determined eligible but are not enrolled into the waiver until they have been discharged from the facility (transitioned) and begin waiver services.

Limits

Individuals eligible to receive this service:

1. Live in a nursing facility, hospital, IMD, or a combination of any of the three for at least 90 consecutive days; and
2. Have been determined medically and financially eligible for the TBIW program; and
3. Wish to transition from facility-based living to their own homes or apartments in the community consistent with the Centers for Medicare and Medicaid Services (CMS) Settings Rule (1915(l)); and
4. Have a home or apartment in the community to return to upon leaving the facility that is consistent with the CMS Settings Rule (1915(l)); and
5. Require waiver transition services to safely and successfully transition to community living; and
6. Can reasonably be expected to transition safely to the community within 180 days of initial date of transition service.

The pre-transition case management service may be billed up to 24 units (a unit is 15 minutes) only one-time following transition to the community. This service is not available once the resident transitions to the community and enrolls in the waiver.

NOTE: Pre-transition case management qualifications are the same as case manager qualifications listed in Section 512.3.1 with the exception that the case manager must be fully licensed as a social worker, therapist or registered nurse.

512.19.2 COMMUNITY TRANSITION SERVICES

Procedure Code: T2028 U2
Service Unit: Unit = $1.00
Service Limit: 4000 units
Prior Authorization Required: Yes

Service Definition: This service is not available until January 1, 2019.

Community transition services are the primary waiver service available to support qualifying individuals' safe and successful transition from facility-based living to the community. Community transition services are one-time expenses necessary to support individuals wishing to transition from a nursing facility,
hospital or IMD to their own home or apartment in the community. Allowable expenses are those necessary to address barriers to a safe and successful transition identified through a comprehensive transition needs assessment and included in an approved individualized transition plan. Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other services. Community transition services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

The components of the community transition service include:

a. Home Accessibility Adaptation Modification: Assistance to individuals requiring physical adaptations to a qualified residence. This service covers basic modifications such as ramps, widening of doorways, purchase and installation of grab-bars and bathroom modifications needed to ensure health, welfare and safety and/or to improve independence.

b. Home Furnishings and Essential Household Items: Assistance to individuals requiring basic household furnishings to help them transition back into the community. This service is intended to help with the initial set-up of a qualifying residence.

c. Moving Expenses: Includes rental of a moving van/ truck or the use of a moving or delivery service to move an individual’s goods to a qualified residence. Although this service is intended as a one-time set-up service to help establish a qualified residence, under certain circumstances it may be used throughout the transition period to relocate a member.

d. Security Deposit: Used to cover rental security deposit.

e. Utility Deposits: Used to assist participants with required utility deposits for a qualifying residence.

f. Transition Support: Provides assistance to help individuals with unique needs based on assessed needs and necessary for a successful transition.

g. Personal Emergency Response System (PERS): One-time payment that includes initial installation upon transition to the community and service for the initial transition period (one year).

h. Equipment: Items and services and necessary to enable individuals to interact more independently and/or reduce dependence on physical supports and enhance quality of life (e.g. lift chairs, bathing aids such as handheld showers, shower chairs, transfer boards and portable showers). These items or services must be justified in the transition plan.

i. Transportation: Assists participants with transportation service prior to transition in order to gain access to community activities, services and resources (i.e. food pantry). This service is used when other forms of transportation are not otherwise available. This service does not replace the Medicaid non-emergency transportation (for medical appointments) or emergency ambulance services.

j. Specialized Medical Supplies: Includes purchases of various specialized medical supplies that enable individuals to maintain or improve independence, health, welfare and safety and reduce dependence on the physical support needed from others. The service includes one-time purchases of incontinence items and food supplements needed as a bridge until Medicaid covers once the participant transitions home.

Services or supports that address an identified need in the transition plan, and decreases the need for other Medicaid services, or increase the person’s safety in the home, or improves and maintains the individual’s opportunities for full membership in the community may be considered.
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Limits

The total expenditure for community transition services cannot exceed $4000 per transition period. Community transition services cannot be used to cover the following items. Please Note: This is not intended to be an all-inclusive list of exclusions:

- Daily living expenses such as rent, mortgage payments, appliances, and food;
- Home improvements or repairs that are considered regular maintenance or upkeep;
- Recreational or illegal drugs; Alcohol;
- Medications or prescriptions;
- Past due credit card or medical bills;
- Payments to someone to serve as a representative;
- Gifts for staff, family, or friends;
- Electronic entertainment equipment including payment for diversional/recreational purposes;
- Regular utility payments;
- Swimming pools, hot tubs, spas or any accessories, repairs or supplies for these items;
- Travel;
- Vehicle expense including routine maintenance and repairs, insurance and fuel/gasoline;
- Internet service;
- Pet/Service/Support Care, including food and veterinary care;
- Experimental or prohibited treatments;
- Education;
- Personal hygiene services (manicures, pedicures, haircuts, etc.);
- Discretionary cash; or
- Assistive technology

Any service or support that does not address an identified need in the transitional plan, or decrease the need for other Medicaid services, or increase the person's safety in the home, or improve and maintain the person's opportunities for full membership in the community is excluded.

The Fiscal Management Services (FMS) vendor is responsible for validating vendor qualifications prior to processing invoices and verifies that the item is on an approved transition plan. The Take Me Home transition manager verifies the item is not on the exclusions list and a receipt is present for the purchase.

512.20 BILLING PROCEDURES

Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement the amount of time documented in minutes must be totaled and divided by the minutes in a unit of service to arrive at the number of units billed. After arriving at the number of billable units, billing must take place on the last date in the service range. Billing cannot be rounded more than once within a calendar month. The billing period cannot overlap calendar months.

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