West Virginia Department of Health and Human Resources' Bureau for Medical Services Intellectual/Developmental Disabilities Waiver (IDDW)

Quarterly Provider Meeting

November 28, 2018




WEST VIRGINIA
Department of
Health & Human Resources
BUREAU FOR
MEDICAL SERVICES

Agenda

- Welcome
- Bureau for Medical Services (BMS) Update
- Public Partnerships Limited (PPL) Update
- Quality Improvement Advisory Counsel (QIA) Update
- WVU Center for Excellence in Disabilities (CED)
- WVABLE Accounts
- Completing DD9s
- DSSLAs
- Exceptions
- Questions and Wrap-Up

Noted Change

- PLEASE NOTE THE FOLLOWING CHANGE:
  - Based upon provider feedback, effective January 1, 2019 there is a **new order** for requesting services.
  - Authorizations MUST be requested in the following order: Service Coordination, Direct-Care, then all other services. This will allow providers to receive an authorization for Service Coordination in order to facilitate exceptions requests, if needed.
  - The average use for Service Coordination is 240 units. Those requesting an Exception may request 240 SC units within budget and then request more via the Exceptions Process.

BMS Update

--Stacy Broce, BMS

Announcements

- The October status report concerning the Statewide Transition Plan may be found at: https://dhhr.wv.gov/bms/Programs/WaiverPrograms/WVSWTP/Settings/Pages/SettingStatusUpdates.aspx

Announcements

- Please welcome the new I/DD Waiver Program Manager, Alanna Cushing.
  - Alanna has a background in Long Term Care Medicaid Eligibility. She has experience as an Eligibility Caseworker, Long Term Care Medicaid Supervisor, and most recently, a Medicaid Eligibility Policy Specialist.

Alanna Cushing
Program Manager
Intellectual/Developmental Disabilities (I/DD) Waiver
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
(304)356-4853
Alanna.b.cushing@wv.gov

Announcements

- The Bureau for Medical Services would also like to extend thanks and appreciation to Stacy Broce for filling the role as Acting IDD Waiver Program Manager for the last several months. Stacy has done an excellent job and is now helping the Home and Community Based Unit by functioning as the Acting Program Manager for the Substance Use Waiver. Thank you, Stacy!

Announcements

- The Home and Community Based Services Unit also welcomes a face familiar to many of you – Jennifer Eva.
  - Jen joins us as the Acting Program Manager for the newest 1915 C waiver for Children with Serious Emotional Disturbance. Jen is out in the field this week with Pat as they travel the state conducting focus groups on this new waiver. Look for Jen to join you at the next provider meeting to tell you more about this exciting new opportunity for the WV children. Welcome, Jen!

Public Partnerships Limited Update

--Sara Martin, PPL

Quality Improvement Advisory Council (QIA) Update

--Amber Hinkle, Open Doors

WVU Center for Excellence in Disabilities (CED) Update

--Lashanna Brunson (WVU CED)

WVABLE Accounts

-- Kristi Pritt (WV State Treasurer's Office)

What is WVABLE?

- The Federal Government passed the Achieving a Better Life Experience “ABLE” Act in 2014.
  - This act allows qualified individuals access to investment accounts without jeopardizing needs-based benefits such as Medicaid or SSI.
- WVABLE accounts launched February 9, 2018.
  - The account is similar to a 529 college savings account and can work alongside Special Needs Trusts.
  - The account may also function like a regular checking account.

What are the benefits of WVABLE?

- Financial Independence and Empowerment
  - Qualified individuals are able to save and invest money for Qualified Disability Expenses.
- Needs-based benefits are not affected by savings
  - Assets are capped at $2,000 for those without a WVABLE account accessing services like Medicaid or SSI.
  - WVABLE accounts allow qualified individuals to invest up to $15,000 annually without affecting Medicaid or SSI eligibility
  - Individuals who are employed are able to save an additional $12,060 per year; or $27,060 annually when combined with the $15,000 limit.

What are the benefits of WVABLE?

- Money may be withdrawn for use on Qualified Disability Expenses.
  - Qualified expenses include, but may not be limited to: education, housing, transportation, healthcare, assistive technology, and basic living expenses.
- Funds used for Qualified Disability Expenses are not subject to federal income taxes.
- All account holders may access a STABLE Card.
  - The STABLE card is a loadable, prepaid debit card which does not pull money directly from your account; and are accepted anywhere VISA is used.

What are the benefits of WVABLE?

- WVABLE offers diverse choices.
  - Account holders may invest money in up to five different options including mutual funds and FDIC-insured savings.
- Accounts can be accessed without a trip to the bank.
  - Individuals are able to enroll online at **wvable.com** with as little as $50.
  - Account holders can monitor investments, make contributions, and request withdrawals online.

Who is eligible for a WVABLE Account?

- "Eligible individuals" must have developed a disability before the age of 26, have lived with a disability for over a year, or expect their disability to last more than one year.
- One of the following criteria must also be met:
  - Eligible to receive SSI or SSDI
  - Have a condition listed on the Social Security Administration's "List of Compassionate Allowances Conditions"
  - Can Self-certify their diagnosis

Who is eligible for a WVABLE Account?

- Individuals can learn more about eligibility by visiting **wvable.com/eligibility/**
- If you need assistance, or have any questions, you may also contact Kristi Pritt at the West Virginia State Treasurer's Office (**304-340-5050**).

Completing DD9s

-- Kara Young (KEPRO)

- The DD9 – Request for Nursing Services – is required documentation any time an initial request for LPN services is made.
  - An updated DD9 is also required any time a request is made to increase LPN services.
- It is imperative the form be filled out accurately, with meaningful and member-specific information, to ensure the justification of services is clear.
- Incomplete or unclear documentation can slow down processing and/or result in services being closed.

- The DD9 consists of the following sections:
  - General Information
  - Units Requested
  - Medications
  - Hospitalizations/Surgeries
  - Medical Conditions
  - Medically Necessary Specialized Treatments
  - Why skilled nursing services are required
  - Supporting Documentation
  - Additional Information
  - RN Acknowledgement

General Information

- This section provides basic demographic information.
- Each field should have up-to-date information included, and no space should be left blank.

General Information			
Date Submitted:	Click here to enter a date.	Record ID:	Click here to enter text.
Name of Person Who Receives Services:	Click here to enter text.		
Age of Person Who Receives Services: Click here to enter text. (Unless the individual aged 18-20 attends day service or lives in an Unlicensed Residential Home/GH, LPN services are available to those aged 21 and over ONLY)			
Anchor Date:	Click here to enter a date.		
Current Living Arrangement	☐ Unlicensed Residential/GH ☐ NF/SFCH		
Service Coordination Provider Agency:	Click here to enter text.	Agency Location (if applicable):	Click here to enter text.
Residential Services Provider Agency:	Click here to enter text.		
Name of person submitting request:	Click here to enter text.		
Phone #/Extension:	Click here to enter text.	Email Address:	Click here to enter text.

Units Requested

- The units requested section needs to indicate the number of direct-care LPN, indirect-care LPN, and RN services being requested.
  - If more than one service agency is requesting units, information from both providers may be included.
- If the team is seeking an Exception, under and over-budget requests should be outlined.

Units Requested (specify units of LPN and/or RN the team has or will request.)			
LPN:	**Under-budget: 100 (direct); 20 (indirect)** **Over-budget: 250 (direct); 240 (indirect)**	**RN:**	**Under-budget: 50** **Over-budget: 125**

Medications

- Medication lists must be kept current. Medications may be documented on an attached MAR or outlined on the form.
  - All medications listed should match those outlined in the member's IPP.
- If the member does not take any medications, put N/A in the table.

Medications				
MAR Attached to CareConnection©? (not required if medications are listed below) ☐Yes X No—below, list all medications as indicated on the current MAR—add rows as needed				
Name of Medication	**Dose/ Frequency**	**Route**	**Special Instructions**	**Purpose/Diagnosis for Which Medication is Prescribed**
N/A				

Hospitalizations/Surgeries

- This section outlines any hospitalizations/surgeries **within the past year**, which could impact the medical services the member receives.
  - It is important to outline any complications or issues to help reviewers get a clear picture of the member's medical needs.
- If no hospitalizations/surgeries occurred within the past year, put N/A.

Hospitalizations/Surgeries (list all hospitalizations/surgeries in the past year. Include any issues/complications that may have occurred that could impact services needed—add rows as needed.)			
Type of Hospital Stay/Surgery	**Date(s)**	**Hospital Course/Significant Findings**	**Discharge Instructions**
N/A			

Medical Conditions

- This section outlines those diagnoses which result in the need for LPN care. Be sure to list any current medical conditions or diagnosis which may require care by a healthcare professional.
- Indicating appropriate conditions assists reviewers with estimating the level of care a member requires.

Medical Conditions (list diagnosed medical conditions that require the individual to receive LPN services—add rows as needed.)		
Medical Condition/Diagnosis and Brief Description	**Approx. Date of Diagnosis**	**Duration of Condition**
Diabetes	2/8/2010	Lifetime
Depression/Anxiety	8/1/1998	Lifetime
Seizure Disorder	10/10/1990	Lifetime

Treatments

- Treatments are often (but, not always) a direct response to a condition or diagnosis listed in the previous section.
- Only those treatments which require an LPN or RN are considered to be specialized medically-necessary treatments.
  - Examples include: wound care, evaluating lung sounds, g-tube/trach care, and sliding scale injections

Treatments

- If the treatment is able to be completed by an AMAP, it should not be included in this section. While the treatment may be necessary for the member, it is not justifiable for nursing services (see 513.20.1).
  - Examples include: vitals, ADLs, med administration, and blood sugar levels

Medically Necessary Specialized Treatments (list frequent and time-consuming treatments that are required—add rows as needed.)			
Name/Description of Required Treatments	**Reason Treatment is Required**	**Frequency/Duration of Required Treatment** (include approximate time per treatment and how long it is anticipated treatment will be needed)	**Identify Available Natural Supports Who Can Administer Treatment**
Sliding scale injections	Diabetes	15 mins BID	None available
Wound care	Ex. Pressure ulcer/venous stasis ulcer, wound related to injury related to behaviors	15 – 20 mins PRN	None available
VNS management	Seizures	5 – 20 mins PRN	None available

Identified Reasons for Skilled Nursing

- This section is often the most challenging. The purpose is to outline services the member requires, but are not considered treatment.
  - Remember, any task outlined in this section **must** require completion by a medical professional.
    - This includes direct and indirect nursing care.
- This section also should not list those tasks completed by an AMAP, or describe why AMAPs are being used. The form is a justification for *nursing* services.

Identified Reasons for Skilled Nursing

- Needs Improvement Example

Describe reasons the team has identified that skilled nursing services are required and Approved Medication Assisted Personnel (AMAP) cannot be used to meet identified needs.
Joey's health causes many limitations to his daily activities. He requires total assistance with checking his blood sugar and using his VNS. He receives medication for health maintenance, health problems, and mood/behavior. AMAP staff is used on a PRN basis to pass medications under supervision of an RN. LPN units will be used to check vitals, pass medications, monitor for side effects, and provide emergency care. RN units will be used for staff training, assessments, and IPPs.

Identified Reasons for Skilled Nursing

- Detailed Example

Describe reasons the team has identified that skilled nursing services are required and Approved Medication Assisted Personnel (AMAP) cannot be used to meet identified needs.
Joey requires RN services for assessments (annually and PRN) related to his health and diagnoses, training staff on health and safety, preparation of MARs for use, supervision of LPNs/AMAPs, reviewing test results and consultations with Joey's physicians, and IPP prep/participation. Joey requires direct-care LPN for his sliding scale injections, monitoring for signs of low or high blood sugar, emergency care of blood sugar fluctuations, wound care, VNS management and use, evaluating skin conditions and completing nail clippings related to his diabetes, evaluating Joey on a PRN basis related to prolonged seizure activity, monitoring for medication side effects, and training Joey on how to properly manage his diabetes. Joey requires indirect-care LPN for monitoring seizure logs, blood sugar documentation, and vital sign logs, and scheduling medical appointments.

Supporting Documentation

- The IPP must always be available for comparison and processing of authorization requests.
- If a member requires more than two hours per day of direct-care nursing, a 15 minute schedule of LPN services and one week of LPN notes must be provided.
- Hospitalization records, treatment records, or any other documentation supporting the request may be submitted for review.

Additional Information

- This section is meant to give information on the member's typical response to medical treatment.
  - If the member requires sedation, special positioning for treatment, or special staffing be sure to describe the circumstances.

Additional Information
Usual response to medical treatment ☐Cooperative X Partially cooperative ☐Resistant ☐Fearful ☐Requires sedation (explain) N/A ☐Requires special positioning for treatment (explain) N/A ☐Requires special staffing for treatment (explain) N/A

RN Acknowledgement

- In order to be considered a valid DD9, the RN must sign the document.
  - Any unsigned documents will be DOC requested and result in delayed authorizations.

RN Acknowledgement	
Printed Name of RN Completing Form:	
Signature of RN Completing Form:	

DSSLAs

-- Ashley Quinn, KEPRO

What is a DSSLA?

- A DSSLA (Direct Support Services – Living Arrangement Assessment) is a form detailing circumstances surrounding a planned change in living arrangement.
- The form **must** be completed and a decision obtained prior to moving members who are wanting to transition to a costlier environment.
  - Examples: Natural Family to any ISS setting; ISSx3 to ISSx2/ISSx1

When should the DSSLA be submitted?

- The request should be submitted *at least* 14 business days prior to the tentative move date.
  - Keep in mind, processing can only occur when the submission is complete. This includes correct information and all required supporting documentation.
  - Incorrect/incomplete assessments and/or not submitting the required documentation will slow down processing time.
- Effective immediately, all requests for change in living must be submitted on the new form labeled DSS-LA 20181114 in the footer.

Completing DSSLAs

- Section 1 – General Information must be completed for <u>all requests</u>.
  - New information includes Date of IPP/Addendum where Team Agreed to Services Requested. Team agreement must be uploaded to CareConnection© for review.

Section 1. General Information (complete this section for all requests)			
Date Submitted:	Click here to enter a date.		
Name of Person Who Receives Services:	Click here to enter text.	Record ID:	Click here to enter text.
Anchor Date:	Click here to enter a date.		
Date of IPP/Addendum where Team Agreed to Services Requested (must be uploaded to CareConnection©):			Click here to enter a date.
Anticipated Start Date of Service Request:	Click here to enter a date.		
Service Coordination Provider Agency:	Click here to enter text.		
Residential Services Provider Agency:	Click here to enter text.		
Name of person submitting request:	Click here to enter text.		
Phone #/Extension:	Click here to enter text.	Email Address:	Click here to enter text.

Completing DSSLAs

- Section 2 – Reason for Request must be filled out for all requests.
  - There is now a space to provide a brief summarization of the circumstances leading to the change.
  - For each reason selected, the corresponding section must be filled out and required supporting documentation included.
  - Do not fill out sections of the assessment which are not selected as reason for request (e.g. – if Medical Conditions is not selected, do not fill out section 9).

Completing DSSLAs

Section 2. Reason(s) for Request: (complete this section for all requests and select all that apply)

Please include a brief description of the circumstances related to the requested change in services.

Click here to enter text.

☐ A. Residence Ownership: Individual owns his/her own residence

Complete section 7: Residence Ownership

☐ B. Residence Rental/Lease: Individual is currently in a lease/rental agreement

Complete section 8: Residence Rental/Lease

☐ C. Maladaptive Behaviors: Individual has a history of extremely serious maladaptive behaviors documented as placing the member or others in imminent danger

Complete section 9: Maladaptive Behaviors

☐ D. Medical Conditions: Individual has a medical condition requiring limited exposure to others

Complete section 10: Medical Conditions

☐ E. Other Click here to enter text.

Complete section 11: Other

Completing DSSLAs

- Section 3 – Roommate Review must be completed for all requests.
  - Make sure to list record IDs for all current roommates and the record IDs of any tentative roommates.
  - Put N/A if there is no current roommate(s) and/or if there is no planned roommate(s).

Section 3. Roommate Review (complete this section for all requests—indicate the individual's current and planned roommates, as applicable)	
Record ID for Current Roommate(s)	Record ID for Planned Roommate(s)

Completing DSSLAs

- Section 4 – Requested Services, Ratios, and Units must be completed for all requests.
  - This section now includes an “Authorized Units” and “Requested Units” column.
  - The “Requested Units” column must outline services requested for the *entire service year*. This includes pro-rating service which will no longer be used (e.g. PCS-F if moving to an ISS), and pro-rating new services based upon how many days are remaining in the service year.
- Section 4 **must** match units outlined the IPP/Addendum.

Completing DSSLAs

- Any request for new or increased LPN services requires a DD9 to be uploaded to CareConnection©.

Section 4. Requested Services, Ratios, and Units (complete this section for all requests—indicate ALL services requested for the entire service year so a total cost can be determined)			
Service Description and Code	Ratio	**Authorized Units** (how many units are currently authorized in CareConnection© for each service? For services not authorized put N/A)	**Requested Units** (how many units of each service does the team project the individual will need during the service year?)
Example: Unlicensed PCS (S5125HI)	1:1	5,000	11,680

Completing DSSLAs

- Section 5 – History of Living with Others must be completed for all requests.
  - Pay special attention to item C, as it is new. Explain why the least restrictive ratios (1:2/1:3) are a concern for the member's health and safety.

Section 5. History of Living with Others: (complete this section for all requests)

A. Does the individual currently live with others?
Click here to enter text.

B. How many others receiving I/DD Waiver live with the individual?
Click here to enter text.

C. Explain why the individual cannot access 1:3 or 1:2 services. Why are those less restrictive ratios a concern for the individuals health and/or safety?
Click here to enter text.

D. Any additional information relevant to the individual living with others?
Click here to enter text.

Completing DSSLAs

- Section 6 – Explanation of Professional Services to be completed for all requests.
  - If any professional services are requested to be increased, please provide an explanation for each service.

Section 6. Explanation of Professional Services: (complete this section for any request to increase professional services)
Indicate why an increase is being requested for each professional service, as applicable. Click here to enter text. *Example: Behavior Support Professional – Sally requires more BSP services because she has never lived with anyone other than her family. Services will address the change in environment and allow for revisions to her current goals and training of staff to meet her needs in her new home.*

Completing DSSLAs

- Section 7 – Residence Ownership is only completed if residence is selected as a reason for request in Section 2. If residence is not selected, do not complete this section.
  - There are no changes to this section. Be sure to answer each question A – F.
  - Note required documentation for processing: Proof of Ownership.

Completing DSSLAs

- Section 8 – Residence Rental/Lease is completed only if rental/lease is chosen as a reason for request in Section 2. If rental/lease is not selected, leave this section blank.
  - No alterations have been made to this section.
  - Note the required documentation: Current rental/lease agreement.

Completing DSSLAs

- Section 9 – Maladaptive Behaviors will only be completed if behaviors are chosen in Section 2. Do not complete this section if behaviors are not selected.
  - Pay particular attention to “Describe measures the team has implemented to address issues preventing him/her from access 1:2 and/or 1:3 services”.
  - Note required documentation: Current PBSP, FBA, and six months of behavioral data – and/or – Protocol and six months of behavioral data – and/or – Guideline. **If no formal behavioral interventions are implemented** be sure to indicate why.

Completing DSSLAs

Section 9. Maladaptive Behaviors (complete ONLY if this item is selected in section 2 above)

Current ICAP General Maladaptive Behavior Index score:

- ☐ 10 to -10 *Normal*
- ☐ -11 to -20 *Marginally Serious*
- ☐ -21 to -30 *Moderately Serious*
- ☐ -31 to -40 *Serious*
- ☐ -41 and below *Very Serious*

Describe the problem behaviors preventing the individual from using the least restrictive services (i.e. 1:2 and/or 1:3): (Provide detailed information **including specific incidents with dates**. Include how long the individual has experienced the issue that prevents him/her from sharing a residence.)

Click here to enter text.

Describe measures the team has implemented to address issues preventing him/her from accessing 1:2 and/or 1:3 services:

Click here to enter text.

Has the individual ever shared a residence with others, excluding parents/family? (If yes, describe, including when and for how long, and events preventing the individual from continuing in the current setting.)

Click here to enter text.

Behavior Documentation is required. Indicate which type of data is included. If no behavioral documentation is available, please indicate why the team has not taken steps to formally address problem behaviors:

- ☐ Current Positive Behavior Support Plan, Functional Behavioral Assessment, and 6-months of behavioral tracking (if PBSP is less than 6-months old, provide all tracking data from date of implementation)
- ☐ Behavior Protocol and 6-months of behavioral tracking (if Protocol is less than 6-months old, provide all tracking data from date of implementation)
- ☐ Behavior Guideline
- ☐ No formal implementation of behavioral interventions (explain below):
  Click here to enter text.
- ☐ Additional documentation that supports the request (list):
  Click here to enter text.

Completing DSSLAs

- Section 10 – Medical Conditions will be completed only if medical is indicated as a reason in Section 2. If medical is not a reason, do not complete this section.
  - No changes have been made to the body of this section.
  - Note the required documentation: DD9 is required for all requests including LPN services. Physicians orders are required, where applicable. Examples may include frequent and time-consuming treatments or conditions preventing the member from sharing a residence.

Completing DSSLAs

- Section 11 – Other is completed only if selected as a reason for request in Section 2.
  - Note changes to the first box, “Describe the situation including why the individual is seeking a change in living and why they are unable to access the least restrictive services (1:2 and/or 1:3).

Section 11. Other (complete ONLY if this item is selected in section 2 above)
Describe the situation including why the individual is seeking a change in living and why they are unable to access the least restrictive services (1:2 and/or 1:3). Click here to enter text.
For consideration, provide supporting documentation, if applicable (list): Click here to enter text.

Exception Process

--Josh Ruppert, KEPRO

What is an Exception?

- An Exception is the new process for requesting services in excess of the member's annual budget.
  - This process has replaced 2nd level for any individual who has an anchor date of July 1, 2018 and later.
  - Any request to exceed the budget for members with anchor dates from January 1st through June 30th will continue to be handled by the 2nd level process until their next anchor date.
- Each request is reviewed to determine whether services in excess of the budget are required to prevent risk of institutionalization.

When to submit an Exception

- The team has 14 business days from the anchor date or submit a request for Exception.
- Throughout the service year, if the member experiences a change in need documented via Critical Juncture (see 513.8.1.4), then the team has 14 business days from *the date of the meeting* to submit a request for Exception.
  - If the member is requesting a change in living at/around their anchor date – the team would wait until receiving the DSSLA decision before deciding whether or not an Exception is required.

What is required to submit an Exception?

- Before an Exception request can be reviewed by a panel comprised of BMS and KEPRO staff, the following must be completed:
  - IPP and required attachments uploaded to CareConnection©
  - Initial authorizations obtained in CareConnection© (see section 513.8 for purchasing order).
  - Exception form filled out completely and accurately, with service requests matching the IPP, and submitted to IDDWExceptions@kepro.com.
  - Supporting documentation submitted with Exception form.

What is required to submit an Exception?

- If an Exception is completed with ratios not in accordance with the member's assessed demographics (i.e. Member is assessed at ISSx3 and ratios requested are URPCS 1:1 and 1:2), please make note of the following:
  - If the team is requesting a permanent transition from one living setting to another, **do not** submit the Exception and first complete a DSSLA.
  - If the team is only requesting units, and not a change in living status, **make sure that is clear** on the form (example include 3rd roommate moved out, but the team is currently attempting to locate another).
  - Exceptions submitted without clarification may be withdrawn and the team advised to submit a DSSLA.

Completing an Exception

- The member's name and record ID will be indicated at the top of the form.
- The next section to complete is basic demographical information. Put N/A if no legal representative.

Service Coordinator Name	
Service Coordinator Agency	
Service Coordinator Phone Number	
Service Coordinator Email	
Legal Representative Name (if applicable)	
IPP year (e.g., 2/12/2015 to 2/11/2016)	

Completing an Exception

- Requested Services Section (NF Example)
  - Example of services for entire year with a $35,000 budget:
    - SC: 250
    - FPCS: 11,680
    - In-Home Respite: 2,000
    - BSP: 300
    - BSP IPP: 2
    - Transportation Miles: 4,200
    - Total cost: $49,946.68

Completing an Exception

Service	Per Unit Cost	Total Units Requested Within Your Budget	Annual Cost of Within-Budget Services	Additional Units Request Above Budget	Annual Cost of Units Requested Above Budget
FPCS 1:1 (S5215US)	$2.74	11,680	$32,003.20	0	$0.00
In-Home Respite (T1005UB)	$5.01	133	$666.03	1,867	$9,353.67
Service Coordination (T1016HI)	$9.70	240	$2,328.00	10	$97.00
BSP I (T2021HN)	$10.41	0	$0.00	300	$3,123.00
BSP IPP (T2024HI)	$53.74	0	$0.00	2	$107.48
Transportation Miles (A0160U1)	$0.54	0	$0.00	4,200	$2,268.00

Completing an Exception

- Purchase requests for ISS may look different. In order to obtain authorizations, 24 hours of care must be requested. However, it may not always be possible to purchase 24 hours of care in the desired ratios.
  - This may mean initial requests are made for 1:2 or 1:3 services, regardless of whether the member lives in a 1:2 or 1:3 setting.
  - Requesting ratios the member cannot receive (i.e. – 1:3 when the person lives in ISSx2) does not mean members are locked in to these services. They are just required for initial authorizations to move forward with the Exception process.

Completing an Exception

- Requested Services (ISS Example)
  Example of services for entire year with a $110,000 budget, assessed at ISSx2:
  - URPCS 1:1 – 11,680
  - URPCS 1:2 – 23,360
  - LPN 1:1 - 240
  - SC: 250
  - BSP: 300
  - BSP IPP: 4
  - RN: 200
  - RN IPP: 4
  - Transportation Miles: 6,000
  - Total cost: $132,375.52

Completing an Exception

Service	Per Unit Cost	Total Units Requested Within Your Budget	Annual Cost of Within-Budget Services	Additional Units Request Above Budget	Annual Cost of Units Requested Above Budget
URPCS 1:1 (S5125HI)	$5.01	11,680	$58,516.80	0	$0.00
URPCS 1:2 (S5125UN)	$2.51	11.680	$29,316.80	11,680	$29,316.80
URPCS 1:3 (S5125UP)	$1.67	11,680	$19,505.60	(-11,680) for a total of 0	(-$19,505.60)
LPN 1:1 (T1003U4)	$11.02	30	$330.60	210	$2,314.20
Service Coordination (T1016HI)	$9.70	240	$2,328.00	10	$97.00
Transportation Miles (A0160U1)	$0.54	0	$0.00	6,000	$3,240.00
BSP I (T2021HN)	$10.41	0	$0.00	300	$3,123.00
BSP IPP (T2024HI)	$53.74	0	$0.00	4	$214.96
RN IPP (T2024TD)	$80.34	0	$0.00	4	$321.36
RN (T1002HI)	$16.28	0	$0.00	200	$3,256.00

Completing an Exception

- Question 1 – General Questions will be completed in it's entirety for all requests.
  - Items A and B are questions about insurance, and an answer of yes will require an explanation in the space provided. By law, BMS cannot pay for services covered by private insurance.
  - Pay particular attention to item C, "Can you decrease or substitute other services to try to purchase the requested units within your budget?" An answer of no will require an explanation.
    - The team should be discussing whether or not a less expensive service can meet the member's needs (example – respite through PPL rather than through the provider). If a substitution is not possible – explain why (example – respite provider receives health insurance through provider).

Completing an Exception

1. General Questions

A. Medicaid pays for many services outside of the I/DD Waiver. For example, Medicaid pays for personal care services, physical therapy, and speech therapy, outside of the I/DD Waiver. A list of Medicaid services is available through your service coordinator.

Are any of the services you are requesting available through Medicaid outside of the Waiver? YES ☐ NO ☐

If yes, please describe why these Medicaid services provided outside of the I/DD Waiver are not sufficient to meet your needs (attach separate sheet if more space is needed):

_____
_____
_____

B. Do you have private insurance? YES ☐ NO ☐ If yes, what is the name of your private insurance company and what policy do you have?

_____

If you have private insurance, are any of the services you are requesting through the I/DD Waiver covered by private insurance? YES ☐ NO ☐

Please list the services requested that are covered by your private insurance:

_____

By law, BMS can only pay for services not covered by private insurance. In order to approve a request for professional services (e.g. physical therapy, RN services) above your budget, BMS will need confirmation that none of your Waiver services (both those paid within your budget and the request for additional services) are not available through your private insurance. Please submit any evidence that the requested professional services are not covered by your private insurance. Otherwise, BMS will contact your insurance company, which may delay a decision on your request.

C. Can you decrease or substitute other services to try to purchase the requested units within your budget? (e.g. substitute Approved Medication Administration Personnel services for LPN services; substitute LPN services for RN services; substitute 1:2 or 1:3 person-centered support for 1:1 person-centered support) YES ☐NO ☐

If decrease or substitution is not possible, please explain why:

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- Question 2 is only completed if the team is requesting additional Person-Centered Supports and/or Respite.
  - Item A is completed for all requests requesting an increase in PCS and/or respite, and should be a detailed description of why the member requires more services. Be sure to include any documentation which supports the request (behavior, medical, etc.).
  - Item B will be completed for those members living in a Natural Family setting who are requesting an increase to PCS/Respite.

Completing an Exception

1. **Are you requesting additional units of <u>Person-Centered Support (PCS) or Respite</u>? This includes Home-Based PCS, Family PCS, PCS-Personal Options, and In-Home or Out-of-Home Respite.**

YES ☐ NO ☐ (If no, please skip to Question 3)

A. Please provide a detailed explanation supporting the request. Please attach an additional sheet if more space is needed.

_____

_____

_____

Please attach any documentation that supports your request.

B. If you live with your family or in a certified Specialized Family Care Home, please answer the following questions: (If not, please skip to Section C).

i. Why are the adult family members with whom you live not able to provide these additional services (Check all boxes that apply)

a. ☐ All the adults with whom I live are elderly (age 65 or older) or disabled**

b. ☐ Other _____

Please attach any documentation that supports your answer. For example:

- An official government document, such as a driver's license that establishes the age of an elderly adult.
- Documentation establishing that an adult receives, or is eligible to receive, disability payments or workers compensation.

ii. Please fill out the following chart about the adults that live in your family home:

Name of Adult	At least age 65? (Circle one)	Disabled? (Circle one)	Other reason why the adult cannot provide support for the Waiver member
	Y / N	Y / N	
	Y / N	Y / N	
	Y / N	Y / N	

**Please Note: Family members who are unable to provide natural support due to disability or age will not be eligible to be paid for other services provided to the Waiver Member.

Completing an Exception

- Item C is completed for individuals who live in ISS or LGH settings.
  - If the team is requesting more 1:1 services and/or more than 28 hours of 1:1 per week (i and ii), the proof of burden is on the provider to show why an increase in 1:1 is necessary.
  - If the team is requesting more 1:2 services, there needs to be an explanation of why 1:3 services cannot be used.
  - Attachments are acceptable as proof; however, relevant sections should be clearly indicated. Highlighting and labeling sections of documentation will assist the panel in locating the correct supporting documentation for each item.

Completing an Exception

Do you live in an ISS or a Group Home?

YES ☐ NO ☐ (If no, please skip to Question 3)

i. Are you requesting additional 1:1 services? YES ☐ NO ☐

If yes, why do you require additional 1:1 services, instead of 1:2 or 1:3 services? (check all that apply).

a. ☐ I have obtained employment that requires additional 1:1 services

b. ☐ Other (please describe)

_____

_____

ii. Are you requesting more than 4 hours per day (28 hours per week) in 1:1 services? YES ☐ NO ☐

If yes, please explain why you cannot substitute 1:2 or 1:3 services for some or all of the 1:1 that you are requesting. Please attach an additional sheet if more space is needed.

_____

_____

_____

iii. Are you requesting additional 1:2 services? YES ☐ NO ☐

If yes, why do you require additional 1:2 services, instead of 1:3 services? (Check all that apply)

a. ☐ I have obtained employment that requires additional 1:2 services.

b. ☐ Other (please describe)

_____

_____

If you are requesting additional 1:1 or 1:2 services, please provide documentation to support your request that 1:1 or 1:2 services are necessary. For example, you may attach medical records that show the need for additional 1:1 or 1:2 services.

Completing an Exception

- Question 3 is completed for requests to increase any of the following: FBDH, Pre-Voc, Supported Employment, Job Development, RN, LPN, SC, BSP, Therapies (ST, OT, PT, DT), and Transportation.
  - There should be a detailed explanation for each service requested.
  - It is imperative to keep specific and meaningful documentation to provide as evidence.
    - As an example, it is difficult for the panel to decide a member requires more BSP services if no behavioral data has been submitted, ABC data does not indicate antecedents, or there is no documented BSP follow-up.

Completing an Exception

If you are requesting additional units of Day Habilitation, Supported Employment, Pre-Vocational Training, Job Development, LPN, RN, Service Coordination, Behavior Support Professional, Dietary Therapy, Physical Therapy, Occupational Therapy, Speech Therapy or Transportation, please provide a detailed explanation supporting the request, including the reason that your Interdisciplinary Team requested additional professional services. Please attach an additional sheet if more space is needed.

_____

_____

_____

_____

_____

_____

Please attach any documentation that supports your request. For example:

- Documentation of diagnoses and/or prescriptions that make frequent, professional medical monitoring and assessment necessary.
- Documentation of the frequency of maladaptive behaviors.
- Documentation as to how the therapy plan for which units are requested in excess of the budget would improve functionality and/or prevent deterioration.

Completing an Exception

- Question 4 is completed only if the team is requesting additional Environmental Home or Vehicle Adaptation (EAA) or Goods and Services.
  - As with most other sections, if the answer is yes, the team must indicate why the request is being made.
  - All requests should relate to member need, so pay particular attention to item B “What need listed on the IPP does this address?”
    - The team should be discussing member need and plans to address those needs in IPPs.

Completing an Exception

Are you requesting additional units of Environmental Home or Vehicle Adaptations or Goods and Services? YES ☐ NO ☐ (If no, please skip to Question 5).

A. What type of environmental adaptation, goods, or services are you requesting? (check all that apply)
   i. Ramps for the home
   ii. Hoyer Lift
   iii. Therapy table
   iv. ☐ Other adaptations for the home (please specify)_____
   v. ☐ Other adaptations for transportation (please specify)_____

B. Why is this adaptation needed? What need listed on the IPP does this address?

_____

_____

_____

_____

Please provide any documentation that supports your request for an environmental adaptation.

Completing an Exception

- Question 5 may be completed for all requests and is for additional information.
  - If any of the above questions did not address or adequately capture the member's need for services, the team may provide a narrative here. Keep in mind, BMS may – but is not required to – review documentation not attached to the request.

Is there anything else you would like BMS to know about your request for services above the budget? Please attach an additional sheet if more space is needed.

Completing an Exception

- Question 6 address whether or not the team felt there was a calculation error for the member's budget.
  - If the answer is yes, provide a detailed description of why you think a calculation error was made (example – Structured interview states the member is ambulatory, but the member uses a wheelchair for all mobility).
  - Indicating the budget is not enough to cover requested services ***does not*** constitute an error in calculation.

Completing an Exception

Do you believe an error was made in your budget calculation? YES ☐ NO ☐

Please describe what error you believe was made in your budget calculation.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please provide any documentation that supports your belief that an error was made in your budget calculation.

Completing an Exception

- Make sure the bottom of the form is completed in it's entirety – both the SC and the member/guardian must sign and date the request.

Service Coordinator Signature: _____

Printed Name: _____

Date: _____

Member and/or Legal Representative Signature:

_____

Printed Name(s): _____

Date: _____

Questions and Wrap Up