CHAPTER 501–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES
CHANGE LOG

Replace	Title	Change Date	Effective Date
Entire Chapter	Entire Chapter	September 1, 2011	September 1, 2011
Section 501.3	Provider Certification	April 25, 2012	July 1, 2012
Section 501.3.3	Record Requirements – Member Records	April 25, 2012	July 1, 2012
Section 501.3.4	Provider Certification Reviews	April 25, 2012	September 1, 2011
Section 501.3.5	Staff requirements	April 25, 2012	September 1, 2011
Section 501.3.7	Criminal and Investigation Background Checks	April 25, 2012	July 1, 2011
Section 501.4.1	Incident Management Documentation & Investigation Procedures	April 25, 2012	July 1, 2012
Section 501.5.1.2	Initial Medical Evaluation	April 25, 2012	July 1, 2012
Section 501.5.1.3	Medical Reevaluation	April 25, 2012	July 1, 2012
Section 501.9	Plan of Care Development	April 25, 2012	September 1, 2011
Section 501.12.1	Personal Assistance/Homemaker (Direct Care Staff) Code, Unit, Limit and Documentation Requirements	April 25, 2012	September 1, 2012
Section 501.12.3	Nursing Services Code, Unit, Limit and Documentation Requirements	April 25, 2012	July 1, 2012
Section 501.12.3.1	Nursing Responsibilities	April 25, 2012	September 1, 2011
Section 501.12.4.1	Transportation Code, Unit, Limit and Documentation Requirements	April 25, 2012	September 1, 2011
Section 501.14	Member Rights and Responsibilities	April 25, 2012	September 1, 2011
Section 501.5.1.2(a)	Results of Initial Medical Evaluation	May 3, 2014	June 1, 2014
Section 501.5.2	Financial Eligibility	May 3, 2014	June 1, 2014

June 1, 2014

Old Policy

501.5.1.2(a) Results of Initial Medical Evaluation

A. Approval

If the applicant is determined medically eligible and a slot is available, then a notice of approved medical eligibility, which includes the maximum number of personal assistance/homemaker hours the person may receive and a copy of the PAS, is sent to the applicant (or legal representative) and the referring physician.

Additionally, APS Healthcare/IRG sends a Service Delivery Model Selection Form advising the applicant to choose either Traditional or Personal Options. A Freedom of Choice Case Management Selection Form and a Freedom of Choice Personal Assistance/Homemaker Selection Form are also provided to the applicant (or legal representative), advising him/her to choose a Case Management Agency and a Personal Assistance/Homemaker Agency if he/she choose the Traditional Model. The forms are to be returned to APS Healthcare/IRG once selections are made.

APS Healthcare/IRG will notify both of the agencies selected, and provide them with a copy of the applicant's PAS. The Case Manager must use the Initial Contact Log at this point. It provides the Case Manager with the ability to document their initial contact to assist with financial eligibility (Refer to *Chapter 501.5.2*), Member Enrollment (Refer to Section 501.6) and the required 7 day contact (Refer to *Chapter 501.7*). If Personal Options has been selected APS Healthcare/IRG will notify BoSS and provide them with a copy of the PAS.

If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant (or legal representative) and the referring entity informing them a slot is not currently available and they will be contacted when one becomes available.

New Policy

501.5.1.2(a) Results of Initial Medical Evaluation

A. Approval

If the applicant is determined medically eligible and a slot is available, a notice of approved medical eligibility, including the maximum number of personal assistance/homemaker hours the person may receive and a copy of the PAS, is sent to the applicant and/or legal representative/designated contact and the referring physician. The notice will be sent by certified mail.

Additionally, APS Healthcare/IRG sends a Service Delivery Model Selection form advising the applicant to choose either Traditional or Personal Options. A Freedom of Choice Case Management Selection form and a Freedom of Choice Personal Assistance/Homemaker Selection form are also provided to the applicant (or legal representative), advising him/her to choose a Case Management Agency and a Personal Assistance/Homemaker Agency if he/she chooses the Traditional Model. The forms must be returned within 15 calendar days of the receipt of the certified letter to APS Healthcare/IRG. APS Healthcare/IRG will start the 15 day clock upon receipt of the signed Return Receipt (PS Form 3811). If the form is not returned within 15 days, APS Healthcare will make three attempts to contact the applicant by telephone. If contact is not made in 3 business days, the slot will be surrendered to the next person on the Managed Enrollment List. If the applicant surrendering the slot still wants ADW services, a new Medical Request for Evaluation is required and the application process begins all over again.

APS Healthcare/IRG will notify the Case Management and Personal Assistance/Homemaker agencies selected, and provide them with a copy of the applicant's PAS. The Case Manager must use the Initial Contact Log at this point. It provides the Case Manager with the ability to document their initial contact to assist with financial eligibility (Refer to *Chapter 501.5.2*). Member Enrollment (Refer to Section 501.6) and the required 7 day contact (Refer to *Chapter 501.7*). If Personal Options has been selected APS Healthcare/IRG will notify BoSS and provide them with a copy of the PAS.

If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant (or legal representative) and the referring entity informing them a slot is not currently available and they will be contacted when one becomes available. When a slot becomes available, the applicant and/or the legal representative/designated contact will be sent a certified letter.

Old Policy

501.5.2 Financial Eligibility

The financial eligibility process starts once an applicant is determined to be medically eligible for ADW services and has returned the Service Delivery Model Selection Form to APS Healthcare/IRG. If the applicant selects the Traditional Model they must also return the Freedom of Choice Case Management Selection Form and the Personal Assistance/Homemaker Selection Form to APS Healthcare/IRG.

If the applicant has chosen Traditional Model, the Case Management Agency that has been selected by the applicant will be notified, and a copy of the PAS will be provided. Within 3 business days of receipt of this notification, the Case Manager must make an initial contact by telephone or face-to-face with the applicant. The applicant and/or Case Manager must submit a DHS-2 form to the county DHHR office to determine financial eligibility based on ADW criteria. A copy of the Eligibility Determination page of the PAS

must be attached to the DHS-2 form. Financial eligibility cannot be initiated without both documents.

If the applicant has chosen Personal Options, BoSS will mail the applicant a financial packet that includes instructions on how to contact his/her local DHHR office and schedule a financial determination appointment, a copy of page 6 of the PAS, and a Personal Options DHS-2 form.

Factors such as income and assets are taken into consideration when determining eligibility. An applicant/member's gross monthly income may not exceed 300% of the current maximum SSI payment per month for participation in the ADW Program. Some assets of a couple are protected for the spouse who does not need nursing home or home and community based care and these assets are not counted to determine eligibility for the individual who needs care in the home.

The financial eligibility process must be initiated within 60 calendar days from the date the case management agency or the applicant receives the notification of selection letter. Case Managers, or in the case of Personal Options the applicant, must notify BoSS when the financial eligibility process has been initiated. If the financial eligibility process is not initiated within the 60 calendar days, BoSS will close the referral. If the applicant wants ADW services after the closure, a new Medical Request for Evaluation to APS Healthcare/IRG is required.

ADW services cannot be paid until an applicant's financial eligibility is established and the enrollment process has been completed with BoSS. (Refer to *Chapter 501.6*). If the member has been a member of another waiver program, no services may be charged prior to an applicant's discharge from the other waiver program. The only exception is Case Management which may bill 30 days prior to discharge.

Termination of the Medicaid benefit itself (e.g., the medical card) always requires a 13 calendar day advance notice prior to the first of the month Medicaid stops. Coverage always ends the last day of a month unless otherwise dictated by policy. Examples: 1) Advance notice for termination is dated January 27, Medicaid would end February 28. 2) Advance notice is dated January 16, Medicaid ends January 31. This is true regardless of when ADW services end.

New Policy

501.5.2 Financial Eligibility

The financial eligibility process starts once an applicant receives notification that a slot is available and returns the Service Delivery Model Selection Form to APS Healthcare/IRG. If the applicant selects the Traditional Model they must also return the Freedom of Choice Case Management Selection form and the Personal Assistance/Homemaker Selection form to APS Healthcare/IRG.

If the applicant selects the Traditional Model, the Case Management Agency chosen by the applicant will be notified, and a copy of the PAS will be provided. Within 5 business days of receipt of this notification, the Case Manager must make an initial contact by telephone or face-to-face with the applicant and sign the DHS-2 form. The applicant and/or Case Manager must submit a DHS-2 form to the county DHHR office to determine financial eligibility based on ADW criteria. A copy of the Eligibility Determination page of the PAS must be attached to the DHS-2 form. Financial eligibility cannot be initiated without both documents. The Case Manager or BoSS, if Personal Options is selected, must enter an expiration date on the DHS-2 form. The expiration date will be 60 calendar days from the date it is signed.

If the applicant selects Personal Options, BoSS will mail the applicant a financial packet within 3 business days. The packet includes instructions on how to contact his/her local DHHR office to schedule a financial determination appointment, (or may also go as a walk-in) a copy of page 6 of the PAS, and a Personal Options DHS-2 form, which must be presented to the local DHHR office.

Factors such as income and assets are taken into consideration when determining eligibility. An applicant's gross monthly income may not exceed 300% of the current maximum SSI payment per month for participation in the ADW Program. Some assets of a couple are protected for the spouse who does not need nursing home or home and community based care and these assets are not counted to determine eligibility for the individual who needs care in the home.

The applicant has a total of 60 calendar days from the date the DHS-2 form is signed by the Case Manager or BoSS if Personal Options is selected to establish financial eligibility and enroll with BoSS. Applicants must establish financial eligibility at a local DHHR office. This is evidenced by the signed DHS-2 form by the staff at the local DHHR office verifying the applicant is either financially eligible or ineligible. This process can take up to 30 days for a final determination. Therefore, it is imperative the process begin immediately. If the applicant presents the DHS-2 form after the expiration date, financial eligibility for the ADW program will be denied.

Case Managers, or in the case of Personal Options, the applicant, must notify BoSS when the financial eligibility process has been initiated. If the financial eligibility process and enrollment are not completed within 60 calendar days, BoSS will close the referral and notify the applicant. The letter will include the reason for closure, the applicable ADW policy manual section(s), notice of free legal services, and a Request for Hearing form to be completed if the applicant wishes to contest the decision. The letter will outline specific timeframes for filing an appeal.

If the applicant wants ADW services after the closure, a new Medical Request for Evaluation to APS Healthcare/IRG is required and the application process started again. BMS will ensure that all closed referrals will be reviewed within 30 calendar days before releasing the slot to the next applicant on the Managed Enrollment List.

ADW services cannot be paid until an applicant's financial eligibility is established and the enrollment process has been completed with BoSS. (Refer to *Chapter 501.6*). If the member has been a member of another waiver program, no services may be charged prior to an applicant's discharge from the other waiver program. The only exception is Case Management which may bill 30 days prior to discharge.

Termination of the Medicaid benefit itself (e.g., the medical card) always requires a 13 calendar day advance notice prior to the first of the month Medicaid stops. Coverage always ends the last day of a month unless otherwise dictated by policy. Examples: 1) Advance notice for termination is dated January 27, Medicaid would end February 28. 2) Advance notice is dated January 16, Medicaid ends January 31. This is true regardless of when ADW services end.

July 1, 2012

Introduction: Section 501.3, Provider Certification

Old Policy: Only a provider agency certified by BoSS can serve as an ADW provider. A Certification Application must be completed and submitted to:

The Bureau of Senior Services
1900 Kanawha Blvd East
Charleston, WV 25305

An agency may provide both Case Management and Personal Assistance/Homemaker Services provided they maintain:

A. A separate certification and provider number for each service;
B. Separate staffing, for example, an agency Registered Nurse may not provide both Personal Assistance/Homemaker RN and Case Management Services for the same member; and,
C. Separate member files must be maintained for Case Management and Personal Assistance/Homemaker Services.

Conflicts of interest and self-referral are prohibited.

To be certified as an ADW provider, applicants must meet and maintain the following requirements:

A. A business license issued by the State of West Virginia.
B. A federal tax identification number (FEIN).
C. A competency based curriculum for required training areas for Personal Assistance/Homemaker direct care staff. (Refer to *Chapter 501.3.5* and its subparts)
D. An organizational chart
E. A list of the Board of Directors (if applicable)

F. A list of all agency staff, which includes their qualifications. (Refer to *Chapter 501.3.6* and its subparts)
G. A Quality Management Plan that is consistent with the Centers for Medicare & Medicaid's (CMS) quality framework and assurances. (Refer to http://www.hcbs.org/files/28/1377/QFramework.pdf).
H. A physical office that meets the criteria outlined in *Chapter 501.3.1*.
I. Written policies and procedures for processing member grievances.
J. Written policies and procedures for processing member and staff complaints.
K. Written policies and procedures for member transfers.
L. Written policies and procedures for the discontinuation of member services.
M. Written policies and procedures to avoid conflict of interest (if agency is providing both Case Management and Personal Assistance/Homemaker Services).
N. Office space that allows for member confidentiality.
O. An Agency Emergency Plan (for members and office operations).

Agencies will be reviewed by BoSS within six months of initial agency certification, and annually thereafter. (Refer to *Chapter 501.3.4*).

More information regarding provider participation requirements in Medicaid services can be found in *Common Chapter 300, Provider Participation Requirements*.

New Policy: Only a provider agency certified by BoSS can serve as an ADW provider. A Certification Application must be completed and submitted to:

The Bureau of Senior Services
1900 Kanawha Blvd East
Charleston, WV 25305

An agency may provide both Case Management and Personal Assistance/Homemaker Services provided they maintain:

A. A separate certification and provider number for each service;
B. Separate staffing, for example, an agency Registered Nurse may not provide both Personal Assistance/Homemaker RN and Case Management Services for the same member; and,
C. Separate member files must be maintained for Case Management and Personal Assistance/Homemaker Services.

Conflicts of interest and self-referral are prohibited.

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A. A business license issued by the State of West Virginia.
B. A federal tax identification number (FEIN).
   A competency based curriculum for required training areas for Personal Assistance/Homemaker direct care staff. (Refer to *Chapter 501.3.5* and its subparts)
C. An organizational chart
D. A list of the Board of Directors (if applicable)
E. A list of all agency staff, which includes their qualifications. (Refer to *Chapter 501.3.6* and its subparts)
F. A Quality Management Plan that is consistent with the Centers for Medicare & Medicaid's (CMS) quality framework and assurances. (Refer to http://www.hcbs.org/files/28/1377/QFramework.pdf).
G. A physical office that meets the criteria outlined in *Chapter 501.3.1*.
H. Written policies and procedures for processing member grievances.
I. Written policies and procedures for processing member and staff complaints.
J. Written policies and procedures for member transfers.
K. Written policies and procedures for the discontinuation of member services.
L. Written policies and procedures to avoid conflict of interest (if agency is providing both Case Management and Personal Assistance/Homemaker Services).
M. Office space that allows for member confidentiality.
N. An Agency Emergency Plan (for members and office operations).

Agencies will be reviewed by BoSS within 6 months of providing services to an ADW member and annually thereafter. (Refer to Chapter 501.3.4).

More information regarding provider participation requirements in Medicaid services can be found in *Common Chapter 300, Provider Participation Requirements*.

Directions: Replace Section 501.3

Introduction: **Section 501.3.3, Record Requirements – Member Record**

Old Policy: **Member records**:

A. The provider must keep a file on each Medicaid member.
B. Member files must contain all original documentation for services provided to the member by the provider responsible for development of the document (for example the Case Management agency should have the original Service Plan and the Personal Assistance/Homemaker agency should have the original Plan of Care) including the Pre-Admission Screening (PAS), the complete Member Assessment, Contact

Notes, RN Plan of Care, Personal Assistance/Homemaker Worksheets, Member Enrollment Confirmation, etc.

C. Original documentation on each member must be kept by the Medicaid provider for five years or three years after audits, with any and all exceptions having been declared resolved by BMS, in the designated office that represents the county where services were provided.

New Policy: **Member records**:

A. The provider must keep a file on each Medicaid member.

B. Member files must contain all original/required documentation for services provided to the member by the provider responsible for development of the document including the Service Plan, Pre-Admission Screening (PAS), the complete Member Assessment, Contact Notes, RN Plan of Care, Personal Assistance/Homemaker Worksheets, Member Enrollment Confirmation, etc.

C. Original documentation on each member must be kept by the Medicaid provider for 5 years or 3 years after audits, with any and all exceptions having been declared resolved by BMS, in the designated office that represents the county where services were provided.

Directions: Replace Section 501.3.3

Introduction: **Section 501.3.4, Provider Certification Reviews**

Old Policy: Providers are required to submit designated evidence to BoSS every 12 months to document continuing compliance with all Certification requirements as specified under *Chapter 501.3* and all of its subparts. 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 provided within 30 days, a Provisional Certification will apply. Providers who receive a Provisional Certification will be required to have an onsite review by BoSS prior to full re-certification. If deficiencies are found by BoSS during document review, the provider must submit a corrective action plan within 30 days. If an approved corrective action plan and required documentation is not submitted within the required time frame BMS may hold provider claims until an approved corrective action plan is in place. A percentage of providers will be randomly selected annually for an onsite review to validate certification documentation.

Certification reviews will also include a statewide representative sample of member records. BoSS will review member records using the Personal Assistance/Homemaker Monitoring Tool and the Case Management Monitoring Tool. (These tools are available on BoSS' Web site at www.wvseniorservices.gov). The West Virginia Participant Experience Survey (PES) will also be conducted with those members whose charts are selected

for review. A proportionate random sample will also be implemented to ensure that at least one member record from each provider site is reviewed.

Targeted onsite certification reviews may also be conducted based on Incident Management Reports and complaint data. In some instances, when member's health and safety are in question, a full review of all records will be conducted.

Completed reports will be made available to the provider agency or PPL within 30 calendar days of the Certification review. Providers must respond to any corrective action within 30 calendar days after receipt of the completed report. Sanctions will be imposed as findings dictate.

New Policy: Providers are required to submit designated evidence to BoSS every 12 months to document continuing compliance with all Certification requirements as specified under *Chapter 501.3* and all of its subparts. 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 BoSS either prior to or on the established date, a pay hold may be placed on the provider's claims until documentation is received and the provider may be removed from all selection forms. 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 may be taken to execute an emergency transfer of ADW members. 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 BoSS staff.*

BoSS will review all submitted certification documentation and provide a report to BMS. BMS may request payback for certification requirements not met. The provider must remove employees who do not meet requirements from provision of services until certification standards are met and required documentation is approved by BoSS. If the documentation is not received within 30 days of the request, BMS may:

- *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 an ADW provider if all issues are not resolved within 60 calendar days.*

A provider who is terminated from the ADW program for any of the reasons listed above may apply for recertification by contacting BoSS. Recertification includes a mandatory site visit by a BoSS monitor and a 6 month review.

A percentage of providers will be randomly selected annually for an onsite review to validate certification documentation.

Certification reviews will also include a statewide representative sample of member records. BoSS will review member records using the Personal Assistance/Homemaker Monitoring Tool and the Case Management Monitoring Tool. (These tools are available on BoSS' Web site at www.wvseniorservices.gov). The West Virginia Participant Experience Survey (PES) will also be conducted with those members whose charts are selected for review. A proportionate random sample will also be implemented to ensure that at least one member record from each provider site is reviewed.

Targeted onsite certification reviews may also be conducted based on Incident Management Reports and complaint data. In some instances, when member's health and safety are in question, a full review of all records will be conducted.

Completed reports will be made available to the provider agency or PPL within 30 calendar days of the Certification review. Providers have 30 days to respond to draft review findings or to submit a corrective action plan if requested. Sanctions will be imposed as findings dictate.

Directions: Replace Section 501.3.4

Introduction: Section 501.3.5, Staff Requirements

Old Policy: Medicaid prohibits the spouse of an ADW member from providing ADW services for purposes of reimbursement.

Personal Assistance/Homemaker direct care staff and Personal Options direct care staff must be at least 18 years of age and must have the following competency based training before providing services:

A. Cardiopulmonary Resuscitation (CPR) – must be provided by the agency nurse, or a certified trainer from the American Heart Association or American Red Cross.
B. First Aid – may be provided by the agency nurse, a certified trainer or an approved internet provider.
C. Occupational Safety and Health Administration (OSHA) training – must use the current training material provided by OSHA.
D. Personal Assistance/Homemaker Skills – training on assisting members with ADL's – must be provided by the agency RN.
E. Abuse, Neglect and Exploitation - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.

F. HIPAA – training must include agency staff responsibilities regarding securing Protected Health Information - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
G. Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
H. Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to any member special needs - must be provided by the agency nurse.

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

Personal Options members and their direct care employees may access a Resource Consultant for training materials and assistance.

New Policy: Medicaid prohibits the spouse of an ADW member from providing ADW services for purposes of reimbursement.

Personal Assistance/Homemaker direct care staff and Personal Options direct care staff must be at least 18 years of age and must have the following competency based training before providing services:

A. *Cardiopulmonary Resuscitation (CPR) – must be provided by the agency nurse, or a certified trainer from the American Heart Association, American Red Cross, American Health and Safety Institute, or American CPR. Additional CPR courses may be approved by BoSS and can be found at http://www.wvseniorservices.gov/.*
B. First Aid – may be provided by the agency nurse, a certified trainer *or a qualified internet provider.*
C. Occupational Safety and Health Administration (OSHA) training – must use the current training material provided by OSHA.
D. Personal Assistance/Homemaker Skills – training on assisting members with ADL's – must be provided by the agency RN.
E. Abuse, Neglect and Exploitation - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, *or a qualified internet training provider.*
F. HIPAA – training must include agency staff responsibilities regarding securing Protected Health Information - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area *or a qualified internet training provider.*

G. Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, *or a qualified internet training provider.*
H. Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to any member special needs - must be provided by the agency nurse.

Personal Options members and their direct care employees may access a Resource Consultant for training materials and assistance.

Directions: Replace Section 501.3.5

Introduction: **Section 501.3.7, Criminal and Investigation Background Checks**

Old Policy: **Criminal Investigation Background Checks and Restrictions and Medicaid Exclusion List**

At a minimum, a state level criminal investigation background check which includes fingerprints must be conducted by the West Virginia State Police initially and again every three years for all ADW staff including direct-care personnel, case managers, RN's and anyone who has direct access to member(s). If the prospective employee has lived out of state within the last five years, the agency must also conduct a federal background check utilizing fingerprints through the National Crime Information Database (NCID).

Prior to providing any ADW services, the prospective employee or the employee must have initiated the fingerprint check process with the WV State Police. ADW providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

A. Abduction
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
C. Any type of felony battery
D. Child/adult abuse or neglect
E. Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation
F. Felony arson
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm

H. Felony drug related offenses within the last 10 years
I. Felony DUI within the last 10 years
J. Hate crimes
K. Kidnapping
L. Murder/ homicide
M. Neglect or abuse by a caregiver
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct
O. Purchase or sale of a child
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
Q. Healthcare fraud
R. Felony forgery

If aware of a recent conviction or change in status, appropriate action must be taken and BMS notified about the change.

The OIG Medicaid Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Medicaid Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All payments for services provided by excluded providers will be recovered by BMS.

New Policy: ***501.3.7 Criminal and Investigation Background Checks***

For the ADW Program the Criminal Investigation Background Check consists of three things:

1. *A fingerprint based criminal history check conducted by the WV State Police contracted entity and, in certain situations, an FBI fingerprint check through the National Crime Information Database (NCID);*
2. *A check of the U.S. Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE); and*
3. *A check of the WV DHHR Protective Services Record Check.*

At a minimum, a state level criminal investigation background check which includes fingerprints must be initially conducted by the West Virginia State Police contracted entity and again every three years for all ADW staff including direct-care personnel, case managers, RN's and anyone who has direct access

to member(s). If the prospective employee has lived out of state within the last 5 years, the agency must also conduct an FBI I background check utilizing fingerprints through the NCID.

Prior to providing any ADW services, the prospective employee or the employer must have initiated the fingerprint check process with the WV State Police contracted entity. "Initiated" means the prospective employee has had a live fingerprint scan taken at an approved location, or, if submitting hard copies of fingerprints, the day the copies are mailed for processing. ADW providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

A. Abduction
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
C. Any type of felony battery
D. Child/adult abuse or neglect
E. Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation
F. Felony arson
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm
H. Felony drug related offenses within the last 10 years
I. Felony DUI within the last 10 years
J. Hate crimes
K. Kidnapping
L. Murder/ homicide
M. Neglect or abuse by a caregiver
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct
O. Purchase or sale of a child
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
Q. Healthcare fraud
R. Felony forgery

Results which include a history of Medicaid fraud or abuse or which may place members at risk of personal health and safety should be taken into consideration prior to employment.

If aware of a recent conviction or change in status, appropriate action must be taken and BMS notified about the change.

The OIG Medicaid Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment and monthly thereafter.

Persons on the OIG Medicaid Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All ADW provider agency staff hired after the implementation date of this manual having direct contact with members must have a WVDHHR Protective Services Record Check. These must be initiated (sent to WVDHHR) on each individual upon hire. The Authorization and Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the DHHR Bureau for Children and Families (BCF), Division of Children and Adult Services or at www.wvdhhr.org/bcf. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of the date that the form is submitted to BCF for processing must be in the Agency Staff's personnel file.

All payments for services provided by excluded providers will be recovered by BMS.

Directions: Replace Section 501.3.7

Introduction: **Section 501.4.1, Incident Management Documentation and Investigation Procedures**

Old Policy: Any incidents involving an ADW member must be entered into the West Virginia Incident Management System (WVIMS) within 24 hours of learning of the incident. The Agency Director, designated RN, or Case Manager will immediately review each incident report. All Critical Incidents must be investigated. As noted in Section *501.4*, all incidents involving abuse, neglect and/or exploitation must be reported to APS but also must be noted in WVIMS.

An Incident Report documenting the outcomes of the investigation must be completed and entered into the WVIMS within 14 calendar days of the incident. Each Incident Report must be printed, reviewed and signed by the Director and placed in an administrative file.

Personal Assistance/Homemaker provider agencies must report to WVIMS monthly the number of hospitalizations which occurred during the month. In addition, providers are to report if there were no incidents.

For Personal Options, PPL must report any incidents in the WVIMS within one business day of learning of the incident. BoSS reviews each incident, investigates and enters outcomes of the investigation within 14 calendar days of the incident.

The WVIMS does not supersede the reporting of incidents to APS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS (W.Va. Code §9-6-9a).

An agency is responsible to investigate all incidents, including those reported to APS. If requested by APS, a provider shall delay its own investigation and document such request in the online WVIMS.

New Policy: Any incidents involving an ADW member must be entered into the West Virginia Incident Management System (WVIMS) within 24 hours of learning of the incident. The Agency Director, designated RN, or Case Manager will immediately review each incident report. All Critical Incidents must be investigated. As noted in Section *501.4*, all incidents involving abuse, neglect and/or exploitation must be reported to APS but also must be noted in WVIMS.

An Incident Report documenting the outcomes of the investigation must be completed and entered into the WVIMS within 14 calendar days of the incident. Each Incident Report must be printed, reviewed and signed by the Director and placed in an administrative file. *Providers are to report monthly if there were no incidents.*

For Personal Options, PPL must report any incidents in the WVIMS within one business day of learning of the incident. BoSS reviews each incident, investigates and enters outcomes of the investigation within 14 calendar days of the incident.

The WVIMS does not supersede the reporting of incidents to APS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS (W.Va. Code §9-6-9a).

An agency is responsible to investigate all incidents, including those reported to APS. If requested by APS, a provider shall delay its own investigation and document such request in the online WVIMS.

Directions: Replace Section 501.3.7

Introduction: Section 501.5.1.2, Initial Medical Evaluation

Old Policy: Following is an outline of the initial medical evaluation process (as directed in 2005 Cyrus decree):

A. An applicant shall initially apply for the ADW program by having his/her treating physician (M.D. or D.O. only) complete and sign a Medical Necessity Evaluation Request Form. The referring physician, applicant, family member, advocate or other interested party, may submit this form by fax, mail or electronically to APS Healthcare/IRG. APS Healthcare/IRG will not process any Medical Necessity Evaluation Request Form if the physician's signature is more than 60 days old. If the Medical Necessity Evaluation Request form is incomplete, it will be returned to the physician for completion and resubmission, and the applicant will be notified.
B. APS Healthcare/IRG will attempt to contact the applicant (or legal representative) to schedule the assessment, allowing at least two weeks notification. If contact, is made, a notice shall be sent to the individual and/or contact person so noting scheduled home visit date and time.
C. APS Healthcare/IRG will make up to three attempts to contact the applicant. If unable to contact after three attempts, APS Healthcare/IRG will issue a potential referral closure letter to the applicant (or legal representative) and the referring entity. If no contact is made with APS Healthcare/IRG within five business days the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral is required.
D. If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian or legal representative, the assessment will not be scheduled without the guardian, or legal representative present to assist the applicant.
E. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.

New Policy: Following is an outline of the initial medical evaluation process (as directed in 2005 Cyrus decree):

A. An applicant shall initially apply for the ADW program by having his/her treating physician (M.D. or D.O. only) complete and sign a Medical Necessity Evaluation Request Form. The referring physician, applicant, family member, advocate or other interested party, may submit this form by fax, mail or electronically to APS Healthcare/IRG. APS Healthcare/IRG will not process any Medical Necessity Evaluation Request Form if the physician's signature is more than 60 days old. If the Medical Necessity Evaluation Request form is incomplete, it will be returned to the physician for completion and resubmission, and the applicant will be notified.

B. APS Healthcare/IRG will attempt to contact the applicant (or legal representative) to schedule the assessment, allowing at least two weeks notification. If contact, is made, a notice shall be sent to the individual and/or contact person so noting scheduled home visit date and time.
C. APS Healthcare/IRG will make up to three attempts to contact the applicant. If unable to contact after 3 attempts, APS Healthcare/IRG will issue a potential referral closure letter to the applicant (or legal representative) and the referring entity. If no contact is made with APS Healthcare/IRG within 5 business days, the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral is required.
D. *If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.*
E. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.

Directions: Replace Sections 501.5.1.2

Introduction: Section 501.5.1.3, Medical Reevaluation

Old Policy: Annual reevaluations for medical eligibility for each ADW member must be conducted. The process is as follows (as directed in 2005 Cyrus decree):

A. A Medical Necessity Evaluation Request Form must be submitted to APS Healthcare/IRG dated and signed by the member (or legal representative). The forms may be faxed to APS Healthcare/IRG but a copy of the original form with the signatures must be maintained in the member's file. The Case Manager, or the member (or legal representative) must check the reevaluation line at the top of the form. A physicians signature is required only if there is a change in, or an additional, diagnosis.
B. The request can be submitted up to 90 calendar days prior to the expiration of the current PAS, and no later than 45 calendar days prior to the expiration of the current PAS. A member's medical eligibility is at risk if the PAS request is submitted less than 45 calendar days before it expires. The expiration of a PAS does not constitute a reason for member appeal.
C. After receiving the reevaluation request, APS Healthcare/IRG will attempt to contact the member (or legal representative) to schedule an assessment, allowing at least two weeks notification.

D. If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian, or legal representative, the assessment will not be scheduled without the guardian, or legal representative present to assist the applicant.
E. If APS Healthcare/IRG makes the contact, a letter is sent to the member (or legal representative), Case Management Agency or PPL, noting the date and time of the assessment.
F. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.
G. If APS Healthcare/IRG is unable to contact the member (or legal representative) within three attempts, a potential closure letter will be sent to the member (or legal representative), the Case Management Agency, or PPL.

H. If no contact is made with APS Healthcare/IRG within five business days of the date of the potential closure letter, APS Healthcare/IRG will send the final denial letter to the member and copy BoSS and the Case Management Agency or PPL. BoSS will close the case.

New Policy: Annual reevaluations for medical eligibility for each ADW member must be conducted. The process is as follows (as directed in 2005 Cyrus decree):

A. A Medical Necessity Evaluation Request Form must be submitted to APS Healthcare/IRG dated and signed by the member (or legal representative). The forms may be faxed to APS Healthcare/IRG but a copy of the original form with the signatures must be maintained in the member's file. The Case Manager, or the member (or legal representative) must check the reevaluation line at the top of the form. A physicians signature is required only if there is a change in, or an additional, diagnosis.
B. The request can be submitted up to 90 calendar days prior to the expiration of the current PAS, and no later than 45 calendar days prior to the expiration of the current PAS. A member's medical eligibility is at risk if the PAS request is submitted less than 45 calendar days before it expires. The expiration of a PAS does not constitute a reason for member appeal.
C. After receiving the reevaluation request, APS Healthcare/IRG will attempt to contact the member (or legal representative) to schedule an assessment, allowing at least 2 weeks notification.
D. If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian, contact person or legal representative, the assessment will not be scheduled without the

guardian, contact person or legal representative present to assist the applicant.

E. If APS Healthcare/IRG makes the contact, a letter is sent to the member (or legal representative), Case Management Agency or PPL, noting the date and time of the assessment.
F. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.
G. If APS Healthcare/IRG is unable to contact the member (or legal representative) within three attempts, a potential closure letter will be sent to the member (or legal representative), the Case Management Agency, or PPL.
H. If no contact is made with APS Healthcare/IRG within 5 business days of the date of the potential closure letter, APS Healthcare/IRG will send the final denial letter to the member and copy BoSS and the Case Management Agency or PPL. BoSS will close the case.

Directions: Replace Section 501.5.1.3

Introduction: Section 501.9, Plan of Care Development

Old Policy: The Personal Assistance/Homemaker RN Assessment is used in conjunction with the PAS and the Member Case Management Assessment to develop the member's Plan of Care. The Plan of Care details how Personal Assistance/Homemaker services will be used to meet the direct care needs of the member.

Once the Personal Assistance/Homemaker RN has completed the Initial or Annual Personal Assistance/Homemaker RN Assessment AND has received the Service Plan from the Case Manager, he/she must develop the member's Plan of Care based on identified needs and member preferences within seven (7) calendar days and THEN initiate direct care services within three (3) calendar days.

A copy of all Personal Assistance/Homemaker RN Assessments and member Plans of Care must be provided to the member (or legal representative) and the Case Management Agency. The Personal Assistance/Homemaker Agency must have the original document in the member's file.

New Policy: The Personal Assistance/Homemaker RN Assessment is used in conjunction with the PAS, the Member Case Management Assessment, and the Service Plan to develop the member's Plan of Care. The Plan of Care details how Personal Assistance/Homemaker services will be used to meet the direct care needs of the member.

Once the Personal Assistance/Homemaker RN has completed the Initial or Annual Personal Assistance/Homemaker RN assessment AND has received the Service Plan from the Case Manager, he/she must develop the member's Plan of Care based on identified needs and member preferences and initiate direct care services within 10 calendar days.

A copy of all Personal Assistance/Homemaker RN Assessments and member Plans of Care must be provided to the member (or legal representative) and the Case Management Agency. The Personal Assistance/Homemaker Agency must have the original document in the member's file.

Directions: Replace Section 501.9

Introduction: **Section 501.12.1 Personal Assistance/Homemaker (Direct Care Staff) Code, Unit, Limit and Documentation Requirements**

Old Policy: **Procedure Code:** S5130

Service Unit: 15 minutes

Service Limits: Determined by Service Level Criteria and Service Level Limits (Refer to *Sections 501.5.1.1(a and b)*

Prior Authorization Required: Yes

Documentation Requirements: All services provided to a member must be documented on the Personal Assistance/Homemaker Worksheet and maintained within the member's record.

New Policy: **Procedure Code:** S5130

Service Unit: 15 minutes

Service Limits: Determined by Service Level Criteria and Service Level Limits (Refer to *Sections 501.5.1.1(a and b)*

Prior Authorization Required: Yes

Documentation Requirements*: All services provided to a member must be documented on the Plan of Care and maintained within the member's record.*

Directions: Replace Section 501.12.1

Introduction: Section 501.12.3, Nursing Services Code, Unit, Limit and Documentation Requirements

Old Policy:

Procedure Code: T1002

Modifier: UD

Service Unit: 15 minutes

Service Level: 6 units per month

Prior Authorization Required: No

Documentation Requirements: All contacts with, or on behalf of, a member must be documented using the Personal Assistance/Homemaker RN Member Contact Form and maintained within the member's record. The RN Assessment and Plan of Care must be complete.

New Policy:

Procedure Code: T1002

Modifier: UD

Service Unit: 15 minutes

Service Level: 6 units per month

Prior Authorization Required: No

Documentation Requirements: *All contacts (except for the 6 month and annual visits) with, or on behalf of, a member must be documented using the Personal Assistance/Homemaker RN Member Contact Form and maintained within the member's record. The RN Assessment and Plan of Care must be complete.*

Directions: Replace Section 501.12.3

Introduction: Section 501.12.3.1, Nursing Responsibilities.

Old Policy: The RN responsibilities are:

A. If requested by the member (or legal representative) attends the Initial Service Plan meeting.
B. Attend the six (6) month and Annual Service Plan meeting.
C. If requested by the member (or legal representative) attends the member's ADW medical eligibility appointments with APS Healthcare/IRG.

D. If the Case Management Agency develops an Interim Service Plan, the Personal Assistance/Homemaker RN must develop an Interim Plan of Care and initiate homemaker services within three business days. (The Interim Plan of Care can only be used for a maximum of 21 days.)
E. Make a home visit with the member and Personal Assistance/Homemaker within 30 calendar days after Personal Assistance/Homemaker services begin.
F. Complete a Personal Assistance/Homemaker RN Assessment within six (6) months from the date of the Initial or annual Personal Assistance/Homemaker RN Assessment.
G. Based on clinical judgment, complete a Personal Assistance/Homemaker RN Assessment to determine the need for changes in the Plan of Care such as following discharge from an acute care hospital, nursing facility or other residential setting. The RN must notify the Case Manager if additional services or changes in services are needed.
H. Review the Personal Assistance/Homemaker Worksheets to assure services were provided as described in the Plan of Care before submitting billing under code S5130.
I. Review the Personal Assistance/Homemaker Worksheets to assure it has been completed per policy before submitting billing under code S5130.
J. Sign and date all accurately completed Personal Assistance/Homemaker Worksheets.
K. Provide member specific training to Personal Assistance/Homemakers.
L. Complete a home visit with the member to assess any change in needs. Documentation must substantiate the need for the visit using the Personal Assistance/Homemaker RN Member Contact Form.
M. Attend any member Dual Service planning meetings. (Refer to *Section 501.18*)
N. Compile, prepare, and submit material that can be used to assess an ADW member's need for an increase in their Service Level. Service level changes can only be requested for members at Service Level A, B, or C, and only when there is a substantial change in the member's medical condition. In order to determine whether additional hours are warranted, a completed Request for Service Level Change must be submitted to APS Healthcare/IRG. Clinical documentation sufficient to support the request must be submitted, which may include applicable test results from a member's physician or hospital discharge summary. These documents must be on the letterhead of the physician and/or hospital and dated no later than one month prior to, or one month following, the request for an increased Service Level. Information that will not be considered includes any verbal or telephonic statements; or letters from family, neighbors, friends, or Case Management and Personal Assistance/Homemaker staff without attached physician's documentation or discharge summary. The request must be signed by both the Personal Assistance/Homemaker RN and the member (or legal representative). Original signatures are required; i.e., "signature of member on file" is not acceptable. This

request may or may not result in a change in the Service Level. Notice of the determination will be sent to the member (or legal representative) and the Personal Assistance/Homemaker Agency, or if a Personal Option member, to PPL. The Personal Assistance/Homemaker Agency must notify the appropriate Case Management Agency of the Service Level determination.

Members who are appealing a denial of medical eligibility will remain at their current Service Level pending a Fair Hearing decision. APS Healthcare/IRG will not review a request for an increased Service Level for such members.

Administrative duties are not billable. These include but are not limited to:

A. Sending copies of any Personal Assistance/Homemaker RN Assessments or Plans of Care to the member (or legal representative) or the Case Management Agency.
B. Notifying the Case Management Agency if a member has been admitted to or discharged from an acute care hospital, nursing home, or other residential facility.
C. Being available to the Personal Assistance/Homemaker (direct care staff) for consultation and assistance at any time when the Personal Assistance/Homemaker (direct care staff) is providing services.
D. Completing and submitting required program reports to BMS, BoSS or APS Healthcare/IRG.
E. Telephone calls.

New Policy: The RN responsibilities are:

A. If requested by the member (or legal representative) attends the Initial Service Plan meeting.
B. Attend the 6 month and Annual Service Plan meeting.
C. If requested by the member (or legal representative) attends the member's ADW medical eligibility appointments with APS Healthcare/IRG.
D. *If the Case Management Agency develops an Interim Service Plan, the Personal Assistance/Homemaker RN must develop an Interim Plan of Care and initiate homemaker services within three business days.*
E. Make a home visit with the member and Personal Assistance/Homemaker within 30 calendar days after Personal Assistance/Homemaker services begin.
F. *Complete a Personal Assistance/Homemaker RN Assessment within 6 months from the date of the Initial or annual Personal Assistance/Homemaker RN Assessment.*
G. Based on clinical judgment, complete a Personal Assistance/Homemaker RN Assessment to determine the need for changes in the Plan of Care such as following discharge from an acute care hospital, nursing facility or

other residential setting. The RN must notify the Case Manager if additional services or changes in services are needed.

H. *Review the Plan of Care to assure services were provided as described in the Service Plan before submitting billing under code S5130.*
I. *Review the Plan of Care to assure it has been completed per policy before submitting billing under code S5130.*
J. *Sign and date all accurately completed Plans of Care.*
K. Provide member-specific training to Personal Assistance/Homemakers.
L. Complete a home visit with the member to assess any change in needs. Documentation must substantiate the need for the visit using the Personal Assistance/Homemaker RN Member Contact Form.
M. Attend any member Dual Service planning meetings. (Refer to *Section 501.18*)
N. Compile, prepare, and submit material that can be used to assess an ADW member's need for an increase in their Service Level. Service level changes can only be requested for members at Service Level A, B, or C, and only when there is a substantial change in the member's medical condition. In order to determine whether additional hours are warranted, a completed Request for Service Level Change must be submitted to APS Healthcare/IRG. Clinical documentation sufficient to support the request must be submitted, which may include applicable test results from a member's physician or hospital discharge summary. These documents must be on the letterhead of the physician and/or hospital and dated no later than 1 month prior to, or 1 month following, the request for an increased Service Level. Information that will not be considered includes any verbal or telephonic statements; or letters from family, neighbors, friends, or Case Management and Personal Assistance/Homemaker staff without attached physician's documentation or discharge summary. The request must be signed by both the Personal Assistance/Homemaker RN and the member (or legal representative). Original signatures are required; i.e., "signature of member on file" is not acceptable. This request may or may not result in a change in the Service Level. Notice of the determination will be sent to the member (or legal representative) and the Personal Assistance/Homemaker Agency, or if a Personal Option member, to PPL. The Personal Assistance/Homemaker Agency must notify the appropriate Case Management Agency of the Service Level determination.

Members who are appealing a denial of medical eligibility will remain at their current Service Level pending a Fair Hearing decision. APS Healthcare/IRG will not review a request for an increased Service Level for such members.

Administrative duties are not billable. These include but are not limited to:

A. Sending copies of any Personal Assistance/Homemaker RN Assessments or Plans of Care to the member (or legal representative) or the Case Management Agency.

B. Notifying the Case Management Agency if a member has been admitted to or discharged from an acute care hospital, nursing home, or other residential facility.
C. Being available to the Personal Assistance/Homemaker (direct care staff) for consultation and assistance at any time when the Personal Assistance/Homemaker (direct care staff) is providing services.
D. Completing and submitting required program reports to BMS, BoSS or APS Healthcare/IRG.
E. Telephone calls.

Directions: Replace Section 501.12.3.1

Introduction: **Section 501.12.4.1, Transportation Code, Unit, Limit and Documentation Requirements**

Old Policy:

Procedure Code: A0160

Service Unit: 1 unit - 1 mile

Service Limit: N/A

Prior Authorization: No

Documentation Requirements: All transportation with, or on behalf of, a member must be included in the Personal Assistance/Homemaker RN Plan of Care and documented on the Homemaker Worksheet and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity).

New Policy:

Procedure Code: A0160

Service Unit: 1 unit - 1 mile

Service Limit: N/A

Prior Authorization: No

Documentation Requirements: *All transportation with, or on behalf of, a member must be included in the Plan of Care and documented on the Plan of Care and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity).*

Directions: Replace Section 501.12.4.1

Introduction: Section 501.14, Member Rights and Responsibilities.

Old Policy: At a minimum, Case Management Agencies or for Personal Options PPL must communicate in writing to each member (or legal representative)

Their right to:

A. Transfer to a different provider agency or to Personal Options.
B. Address dissatisfaction with services through the provider agency's or PPL's grievance procedure.
C. Access the West Virginia DHHR Fair Hearing process.
D. Considerate and respectful care from their provider(s).
E. Take part in decisions about their services.
F. Confidentiality regarding ADW services.
G. Access to all of their files maintained by agency providers.

And their responsibility to:

H. Notify the ADW Personal Assistance/Homemaker Agency or PPL within 24 hours prior to the day services are to be provided if services are not needed.
I. To notify providers or PPL promptly of changes in Medicaid coverage.
J. Comply with the Personal Assistance/Homemaker RN Plan of Care or for Personal Options Members the Participant Directed Service Plan.
K. Cooperate with all scheduled in-home visits
L. Notify the ADW agencies or PPL of a change in residence or an admission to a hospital, nursing home or other facility.
M. Notify the ADW agencies or PPL of any change of medical status or direct care need.
N. Maintain a safe home environment for the agency or PPL to provide services.
O. Verify services were provided by initialing and signing the Personal Assistance/Homemaker Worksheet.
P. Communicate any problems with services to the provider agency or PPL.
Q. Report any suspected fraud to the provider agency or the Medicaid Fraud Unit at (304)558-1858.
R. Report any incidents of abuse, neglect or exploitation to the provider agency, PPL or the APS hotline at 1-800-352-6513.
S. Report any suspected illegal activity to their local police department or appropriate authority.

New Policy: At a minimum, Case Management Agencies or for Personal Options PPL must communicate in writing to each member (or legal representative):

Their right to:

A. Transfer to a different provider agency or to Personal Options.
B. Address dissatisfaction with services through the provider agency's or PPL's grievance procedure.
C. Access the West Virginia DHHR Fair Hearing process.
D. Considerate and respectful care from their provider(s).
E. Take part in decisions about their services.
F. Confidentiality regarding ADW services.
G. Access to all of their files maintained by agency providers.

And their responsibility to:

H. Notify the ADW Personal Assistance/Homemaker Agency or PPL within 24 hours prior to the day services are to be provided if services are not needed.
I. To notify providers or PPL promptly of changes in Medicaid coverage.
J. Comply with the Plan of Care or for Personal Options Members, comply with the Participant Directed Service Plan.
K. Cooperate with all scheduled in-home visits
L. Notify the ADW agencies or PPL of a change in residence or an admission to a hospital, nursing home or other facility.
M. Notify the ADW agencies or PPL of any change of medical status or direct care need.
N. Maintain a safe home environment for the agency or PPL to provide services.
O. Verify services were provided by initialing and signing the Plan of Care.
P. Communicate any problems with services to the provider agency or PPL.
Q. Report any suspected fraud to the provider agency or the Medicaid Fraud Unit at (304)558-1858.
R. Report any incidents of abuse, neglect or exploitation to the provider agency, PPL or the APS hotline at 1-800-352-6513.
S. Report any suspected illegal activity to their local police department or appropriate authority.

Directions: Replace Section 501.14

CHAPTER 501–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES
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CHAPTER 501–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR AGED AND DISABLED WAIVER SERVICES

INTRODUCTION

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This Program, therefore, must also function within federally defined parameters. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered.

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all State and Federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible and completed documentation to justify medical necessity of services provided to each Medicaid member and made available to BMS or its designee upon request.

This chapter sets forth the BMS requirements for the Aged and Disabled Waiver (ADW) Program provided to eligible West Virginia Medicaid members. Requirements for other West Virginia Medicaid services can be found in subsequent chapters of the provider manual.

The policies and procedures set forth herein are promulgated as regulations governing the provision of ADW services by ADW providers in the Medicaid Program administered by the West Virginia DHHR under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia.

All forms for this program can be found at http://www.dhhr.wv.gov/bms/hcbs/ADW/Pages/ADW.aspx.

501.1 DEFINITIONS

Definitions governing the provision of all West Virginia Medicaid services will apply pursuant to *Common Chapter 200, Acronyms and Definitions*, of the Provider Manual. In addition, the following definitions apply to the requirements for payment of services in the ADW Program described in this chapter.

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

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

APS Healthcare/Innovative Resources Group (IRG) – serves as the Administrative Services Organization for the Aged and Disabled Waiver program which includes conducting the medical evaluations and determining medical eligibility for the program

Bureau of Senior Services (BoSS) – is the state agency which serves as the operating agency for the Aged and Disabled Waiver Program.

Community Integration: the provision of services which allows a person to live and participate in his/her community and the activities it offers to all citizens.

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.

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

Environmental Maintenance: activities such as light housecleaning, making and changing the client's bed, dishwashing, and client's laundry.

Felony: a serious criminal offense punishable by imprisonment in the penitentiary.

Financial Exploitation: illegal or improper use of an elder's or incapacitated adult's resources. Obvious examples of financial exploitation include cashing a person's checks without authorization; forging a person's 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.

Fiscal Employer/ Agent (FE/A): under Personal Options which receives, disburses, and tracks funds based on participants' approved service plans and budgets; assists participants with completing participant enrollment and worker employment forms; conducts criminal background checks of prospective workers; and verifies workers' information (i.e., social security numbers, citizenship or legal alien verification documentation). The FE/A also prepares and distributes payroll including the withholding, filing, and depositing of federal and state income tax withholding and employment taxes and locality taxes; processes and pays vendor invoices for approved goods and services, as applicable; generates reports for state program agencies, and participants; and may arrange and process payment for workers' compensation and health insurance, when appropriate.

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

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

Instrumental Activities of Daily Living (IADL): skills necessary to live independently, such as abilities used to shop for groceries, handle finances, perform housekeeping tasks, prepare meals, and take medications.

Legal Representative: a personal representative with legal standing (as by power of attorney, medical power of attorney, guardian, etc.).

Misdemeanor: a less serious criminal offense than a felony which is punishable by a fine or imprisonment in jail.

Molina Medicaid Solutions: the claims processing agent for the West Virginia BMS.

Neglect: "failure to provide the necessities of life to an incapacitated adult" 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" (§9-6-1). Neglect would include the lack of or inadequate medical care by the service provider and inadequate supervision resulting injury or harm to the incapacitated member. Neglect also includes, but is not limited to: a pattern of failure to establish or carry 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.

Participant-Direction: the member, or his/her representative, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. Participant-Direction promotes personal choice and control over the delivery of waiver and state plan services, including who provides the services and how services are provided.

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 lives, not on the systems that may or may not be available.

Public Partnerships, LLC (PPL): serves as the FE/A for participants who choose Personal Options. PPL also provides resource consultants to assist members.

Quality Management Plan: a written document which defines the acceptable level of quality, and describes how the project 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.

Resource Consultant: assists ADW members who chose Personal Options with the responsibilities of self-direction; developing a plan and budget to meet their needs; providing information and resources to help hire, train and manage employees; developing and maintaining a directory of eligible employees; providing information and resources to help purchase goods and services; connecting with a network of peer supports; helping to complete required paperwork for Personal Options; and helping the member select a representative to assist them, as needed.

Scope of Services: the range of services deemed appropriate and necessary for an individual client. 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.

Sexual Abuse: any following act toward an incapacitated adult in 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 for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult, or for the purpose of affronting or alarming the incapacitated adult.

Sexual Exploitation: when an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult 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.

501.2 PROGRAM DESCRIPTION

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who would otherwise be eligible for placement in a long-term care facility.

The ADW Program is defined as a long-term care alternative which provides services that enable an individual to remain at or return home rather than receive nursing home care. The program provides home and community-based services to West Virginia residents who are eligible to participate in the program. Members must also be at least 18 years of age and choose home and community-based services rather than nursing home placement. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, participant-direction, respect, and dignity and community integration. All members are offered and have a right to freedom of choice of providers for services. BMS contracts with the Bureau of Senior Services (BoSS) to operate the program.

ADW services (reimbursable by Medicaid) are to be provided exclusively to the member, for necessary activities as listed in the Service Plan, the Plan of Care, or Personal Options Participant-Directed Service Plan. They are not to be provided for the convenience of the household or others. Although informal supports are not mandatory in the ADW Program, the program is designed to provide formal support services to supplement, rather than replace, the member's existing informal support system.

ADW services include Case Management, Personal Assistance/Homemaker Services and Participant-Directed Goods and Services.

Within the ADW 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, members receive their services from employees of a certified provider agency. Members have individualized service hours based on their assessed level of need. In Personal Options, members are able to hire, supervise and terminate their own employees. Members are allocated a monthly budget based on their assessed level of need.

501.3 PROVIDER CERTIFICATION

Only a provider agency certified by BoSS can serve as an ADW provider. A Certification Application must be completed and submitted to:

The Bureau of Senior Services
1900 Kanawha Blvd East
Charleston, WV 25305

An agency may provide both Case Management and Personal Assistance/Homemaker Services provided they maintain:

A. A separate certification and provider number for each service;
B. Separate staffing, for example, an agency Registered Nurse may not provide both Personal Assistance/Homemaker RN and Case Management Services for the same member; and,
C. Separate member files must be maintained for Case Management and Personal Assistance/Homemaker Services.

Conflicts of interest and self-referral are prohibited.

To be certified as an ADW provider, applicants must meet and maintain the following requirements:

A. A business license issued by the State of West Virginia.
B. A federal tax identification number (FEIN).
C. A competency based curriculum for required training areas for Personal Assistance/Homemaker direct care staff. (Refer to *Chapter 501.3.5* and its subparts)
D. An organizational chart.
E. A list of the Board of Directors (if applicable).

F. A list of all agency staff, which includes their qualifications. (Refer to *Chapter 501.3.6* and its subparts)
G. A Quality Management Plan that is consistent with the Centers for Medicare & Medicaid's (CMS) quality framework and assurances. (Refer to http://www.hcbs.org/files/28/1377/QFramework.pdf)
H. A physical office that meets the criteria outlined in *Chapter 501.3.1*.
I. Written policies and procedures for processing member grievances.
J. Written policies and procedures for processing member and staff complaints.
K. Written policies and procedures for member transfers.
L. Written policies and procedures for the discontinuation of member services.
M. Written policies and procedures to avoid conflict of interest (if agency is providing both Case Management and Personal Assistance/Homemaker Services).
N. Office space that allows for member confidentiality.
O. An Agency Emergency Plan (for members and office operations).

Agencies will be reviewed by BoSS within 6 months of providing services to an ADW member and annually thereafter. (Refer to *Chapter 501.3.4*).

More information regarding provider participation requirements in Medicaid services can be found in *Common Chapter 300, Provider Participation Requirements*.

501.3.1 Office Criteria

ADW providers must designate and staff at least one physical office location. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

A. Be located in West Virginia.
B. An agency office site can serve no more than eight contiguous counties. (ADW providers wishing to make changes in the approved counties they serve **must** make the request in writing to BoSS. BoSS will make a determination on the request and inform the provider in writing. No changes in counties served can be made unless approved by BoSS).
C. Meet ADA requirements for physical accessibility. (Refer to 28CFR36, as amended)
D. Be readily identifiable to the public.
E. 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.)
F. Maintain an agency secure (HIPAA compliant) e-mail address for communication with BMS and BoSS.
G. Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.
H. Contain space for securely maintaining member and personnel records. (Refer to *Common Chapter 800*, *General Administration*, and *Common Chapter 300*, *Provider Participation Requirements*, for more information on maintenance of records).
I. Maintain a 24-hour contact method (Personal Assistance/Homemaker Agencies only).

Following the receipt of a completed Certification Application, BoSS will schedule an onsite review to verify that the applicant meets the certification requirements outlined in *Chapter 501.3*. BoSS will notify Molina, BMS claims agent, upon satisfactory completion of the onsite review. Molina will provide the applicant with an enrollment packet which includes the Provider Agreement. The applicant must return the Provider Agreement, signed by an authorized representative, to BMS. Once this process has been completed, Molina will assign a provider number. A letter informing the agency that it may begin providing and billing for ADW services will be sent to the agency and to BoSS.

Personal Options member employees enter into a simplified provider agreement facilitated and signed by Public Partnerships, LLC (PPL) which acts as the Fiscal Employer/Agent-Resource Consultant, a subagent to the BMS.

When a provider is physically going to move their agency to a new location or open a satellite office, they must notify BoSS **prior** to the move. BoSS will schedule an on-site review of the new location to verify the site meets certification requirements. Medicaid services cannot be provided from an office location that has not been certified by BoSS.

501.3.2 Continuing Certification

Once certified and enrolled as a Medicaid provider, ADW providers must continue to meet the requirements listed in *Chapter 501.3* and its subparts as well as the following:

A. Employ adequate, qualified, and appropriately trained personnel who meet minimum standards for providers of the ADW Program.
B. Provide services based on each member's individual assessed needs, including evenings and weekends.
C. Maintain records that fully document and support the services provided.
D. Furnish information to BMS, or its designee, as requested. (Refer to *Common Chapter 800, General Administration*, and *Common Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
E. Maintain a current list of members receiving ADW services.
F. Comply with the Incident Management System (Refer to *Chapter 501.4* and its subparts) and maintain an administrative file of Incident Reports.

501.3.3 Record Requirements

Providers must meet the following record requirements:

Member records:

A. The provider must keep a file on each Medicaid member.
B. Member files must contain all original/required documentation for services provided to the member by the provider responsible for development of the document including the Service Plan, Pre-Admission Screening (PAS), the complete Member Assessment, Contact Notes, RN Plan of Care, Personal Assistance/Homemaker Worksheets, Member Enrollment Confirmation, etc.

C. Original documentation on each member must be kept by the Medicaid provider for 5 years or 3 years after audits, with any and all exceptions having been declared resolved by BMS, in the designated office that represents the county where services were provided.

Personnel Records:

A. Original or legible copies of personnel documentation including training records, licensure, confidentiality agreements, criminal investigation background checks (CIB) (Refer to *Chapter 501.3.7*), etc. must be maintained on file by the certified provider.
B. Minimum credentials for professional staff (RN, Social Worker, etc.) must be verified upon hire and thereafter based upon their individual professional license requirements.
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.
D. Verification that OIG Medicaid Exclusion List was checked as appropriate for the position.

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

501.3.4 Provider Certification Reviews

Providers are required to submit designated evidence to BoSS every 12 months to document continuing compliance with all Certification requirements as specified under *Chapter 501.3* and all of its subparts. 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 BoSS either prior to or on the established date, a pay hold may be placed on the provider's claims until documentation is received and the provider may be removed from all selection forms. 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 may be taken to execute an emergency transfer of ADW members. 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 BoSS staff.

BoSS will review all submitted certification documentation and provide a report to BMS. BMS may request payback for certification requirements not met. The provider must remove employees who do not meet requirements from provision of services until certification standards are met and required documentation is approved by BoSS. If the documentation is not received within 30 days of the request, BMS may:

- 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 an ADW provider if all issues are not resolved within 60 calendar days.

A provider who is terminated from the ADW program for any of the reasons listed above may apply for recertification by contacting BoSS. Recertification includes a mandatory site visit by a BoSS monitor and a 6 month review.

A percentage of providers will be randomly selected annually for an onsite review to validate certification documentation.

Certification reviews will also include a statewide representative sample of member records. BoSS will review member records using the Personal Assistance/Homemaker Monitoring Tool and the Case Management Monitoring Tool. (These tools are available on BoSS' Web site at www.wvseniorservices.gov). The West Virginia Participant Experience Survey (PES) will also be conducted with those members whose charts are selected for review. A proportionate random sample will also be implemented to ensure that at least one member record from each provider site is reviewed.

Targeted onsite certification reviews may also be conducted based on Incident Management Reports and complaint data. In some instances, when member's health and safety are in question, a full review of all records will be conducted.

Completed reports will be made available to the provider agency or PPL within 30 calendar days of the Certification review. Providers have 30 days to respond to draft review findings or to submit a corrective action plan if requested. Sanctions will be imposed as findings dictate.

501.3.5 Staff Requirements

Medicaid prohibits the spouse of an ADW member from providing ADW services for purposes of reimbursement.

Personal Assistance/Homemaker direct care staff and Personal Options direct care staff must be at least 18 years of age and must have the following competency based training before providing services:

A. Cardiopulmonary Resuscitation (CPR) – must be provided by the agency nurse, or a certified trainer from the American Heart Association, American Red Cross, American Health and Safety Institute, or American CPR. Additional CPR courses may be approved by BoSS and can be found at http://www.wvseniorservices.gov/.

B. First Aid – may be provided by the agency nurse, a certified trainer or a qualified internet provider.

C. Occupational Safety and Health Administration (OSHA) training – must use the current training material provided by OSHA.

D. Personal Assistance/Homemaker Skills – training on assisting members with ADL's – must be provided by the agency RN.

E. Abuse, Neglect and Exploitation - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.

F. HIPAA – training must include agency staff responsibilities regarding securing Protected Health Information - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area or a qualified internet training provider.

G. Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity - must be provided by the agency nurse, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.

H. Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to any member special needs - must be provided by the agency nurse.

Personal Options members and their direct care employees may access a Resource Consultant for training materials and assistance.

501.3.5.1 Annual Staff Training

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

A. CPR is current as defined by the terms of the certifying agency.

B. First Aid, if provided by the American Heart Association, American Red Cross, or other qualified provider, is current as defined by the terms of that entity if provided by the agency RN, must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (Example: If First Aid training was conducted May 10, 2010, it will be valid through May 31, 2011.)

C. OSHA, Abuse, Neglect and Exploitation, and HIPAA must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (See example above.)

In addition, 4 hours of training focusing 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.

501.3.5.2 Training Documentation

Documentation for training conducted by the agency nurse, social worker/counselor, or a documented specialist in the content area must include the training topic, date, beginning time of the training, ending time of the training, location of the training and the signature of the instructor and the trainee or for Personal Options, the member (or legal representative). Training documentation for internet based training must include the person's name, the name of the internet 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 training entity is acceptable documentation for CPR and First Aid.

501.3.6 Professional Staff Qualifications

Professional Staff qualifications are defined below.

501.3.6.1 Registered Nurse Qualifications

A Personal Assistance/Homemaker Registered Nurse must be employed by a certified Personal Assistance/Homemaker agency and have a current West Virginia Registered Nurse license. Licensure documentation must be maintained in the employee's file. Documentation that covers all of the employee's employment period must be present. (For example – if an employee has been with the agency for 3 years – documentation of licensure must be present for all 3 years.) All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality agreements (Refer to *Common Chapter 100, General Information,*) and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing ADW services meet the minimum qualifications. The Office of Inspector General (OIG) Medicaid Exclusion List must be checked for every RN employee prior to employment and monthly thereafter. An agency cannot employ an RN on the OIG Medicaid Exclusion List. This list can be obtained at http://exclusions.oig.hhs.gov.

501.3.6.2 Case Manager Qualifications

A Case Manager must be licensed in West Virginia as a Social Worker, Counselor, or Registered Nurse. Licensure documentation must be maintained in the employee's file. Documentation that covers all of the employee's employment period must be present (example: If an employee has been with your agency for 3 years, the documentation of licensure must be present for all 3 years). All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality agreements (Refer to *Common Chapter 100, General Information*,), and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing ADW services meet the minimum qualifications. The OIG Medicaid Exclusion List must be checked for every case manager employee prior to employment and monthly thereafter. An agency cannot employ a case manager on the OIG Exclusion Exemption List. This list can be obtained at http://exclusions.oig.hhs.gov.

501.3.7 Criminal and Investigation Background Checks

For the ADW Program the Criminal Investigation Background Check consists of three things:

1. A fingerprint based criminal history check conducted by the WV State Police contracted entity and, in certain situations, an FBI fingerprint check through the National Crime Information Database (NCID);
2. A check of the U.S. Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE); and
3. A check of the WV DHHR Protective Services Record Check.

At a minimum, a state level criminal investigation background check which includes fingerprints must be initially conducted by the West Virginia State Police contracted entity and again every

three years for all ADW staff including direct-care personnel, case managers, RN's and anyone who has direct access to member(s). If the prospective employee has lived out of state within the last 5 years, the agency must also conduct an FBI I background check utilizing fingerprints through the NCID.

Prior to providing any ADW services, the prospective employee or the employer must have initiated the fingerprint check process with the WV State Police contracted entity. "Initiated" means the prospective employee has had a live fingerprint scan taken at an approved location or, if submitting hard copies of fingerprints, the day the copies are mailed for processing. ADW providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

A. Abduction
B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
C. Any type of felony battery
D. Child/adult abuse or neglect
E. Crimes which involve the exploitation of a child or an incapacitated adult, including financial exploitation
F. Felony arson
G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm
H. Felony drug related offenses within the last 10 years
I. Felony DUI within the last 10 years
J. Hate crimes
K. Kidnapping
L. Murder/ homicide
M. Neglect or abuse by a caregiver
N. Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, guardian or custodian, depicting a child engaged in sexually explicit conduct
O. Purchase or sale of a child
P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
Q. Healthcare fraud
R. Felony forgery

Results which include a history of Medicaid fraud or abuse or which may place members at risk of personal health and safety should be taken into consideration prior to employment.

If aware of a recent conviction or change in status, appropriate action must be taken and BMS notified about the change.

The OIG Medicaid Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Medicaid Exclusion List cannot provide Medicaid services. This list can be obtained at http://exclusions.oig.hhs.gov.

All ADW provider agency staff hired after the implementation date of this manual having direct contact with members must have a WVDHHR Protective Services Record Check. These must be initiated (sent to WVDHHR) on each individual upon hire. The Authorization and Release for Protective Services Record Check (BCF-PSRC 6/2005) is the official form available through the DHHR Bureau for Children and Families (BCF), Division of Children and Adult Services or at www.wvdhhr.org/bcf. An individual who has direct contact with a member cannot continue to be employed if the check discloses previous substantiated child or adult maltreatment by the individual. Documentation of the date that the form is submitted to BCF for processing must be in the Agency Staff's personnel file.

All payments for services provided by excluded providers will be recovered by BMS.

501.3.8 Voluntary Agency Closure

A provider may terminate participation in the ADW 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 BoSS. The provider must provide BoSS with a complete list of all current ADW members that will need to be transferred.

BoSS will provide selection forms to each of the agency's members, 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 BoSS.

The agency terminating participation must ensure that the transfer of the member is accomplished as safely, orderly and expeditiously as possible.

A Personal Options provider and/or member must notify the PPL when an employee terminates participation as a Personal Options provider.

501.3.9 Involuntary Agency Closure

BMS may administratively terminate a provider from participation in the ADW 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 ADW program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review. Refer to Common Chapter 800, General Administration, for more information on this procedure.

501.3.10 Additional Sanctions

If BMS or BoSS receives information that clearly 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 Selection Forms and from the provider information on the BoSS website until the issue(s) are addressed to the satisfaction of BMS. Health and Safety deficiencies deemed critical may include other sanctions including involuntary agency closure.

501.4 INCIDENT MANAGEMENT OVERVIEW

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

- **Anyone** providing services to an ADW member who suspects an incidence of abuse or neglect, as defined in Section 501.1, must report the incident to the local DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office or by calling 1-800-372-6513, 7 days a week, 24 hours day. This initial report must then be followed by a written report, submitted to the local Department of Health and Human Resources, within 48 hours following the verbal report. An Adult Protective Services (APS) Worker may be assigned to investigate the suspected or alleged abuse.

- Critical incident are incidents with a high likelihood of producing real or potential harm to the health and welfare of the ADW member. These incidents might include, but are not limited to, the following:
  - Attempted suicide, or suicidal threats or gestures. Suspected and/or observed criminal activity by members themselves, members' families, health care providers, concerned citizens, and public agencies that does not compromise the health or safety of the member.
  - An unusual event such as a fall or injury of unknown origin requiring medical intervention if abuse and neglect is not suspected.
  - A significant interruption of a major utility, such as electricity or heat in the member's residence, but does not compromise the health or safety of the member.
  - Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that does not compromise the health or safety of the member.
  - Fire in the home resulting in relocation or property loss that does not compromise the health or safety of the member.
  - Unsafe physical environment in which the homemaker and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.

- Disruption of the delivery of ADW services, due to involvement with law enforcement authorities by the ADW member and/or others residing in the member's home that does not compromise the health or safety of the member.
- Medication errors by a member or his/her family caregiver that do not compromise 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.
- Disruption of planned services for any reason that does not compromise the health or safety of the member, including failure of member's emergency backup plan.
- Any other incident judged to be significant and potentially having a serious negative impact on the member, but does not compromise the health or safety of the member.
- Any incident attributable to the failure of ADW provider staff to perform his/her responsibilities that compromises the health or safety of the member is considered to be neglect and must be reported to Adult Protective Services (APS).

- Simple incidents are any unusual events occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse or neglect. Examples of simple incidents include, but are not limited to, the following:
  - Minor injuries of unknown origin with no detectable pattern
  - Dietary errors with minimal or no negative outcome

501.4.1 Incident Management Documentation and Investigation Procedures

Any incidents involving an ADW member must be entered into the West Virginia Incident Management System (WVIMS) within 24 hours of learning of the incident. The Agency Director, designated RN, or Case Manager will immediately review each incident report. All Critical Incidents must be investigated. As noted in Section *501.4*, all incidents involving abuse, neglect and/or exploitation must be reported to APS but also must be noted in WVIMS.

An Incident Report documenting the outcomes of the investigation must be completed and entered into the WVIMS within 14 calendar days of the incident. Each Incident Report must be printed, reviewed and signed by the Director and placed in an administrative file. Providers are to report monthly if there were no incidents.

For Personal Options, PPL must report any incidents in the WVIMS within one business day of learning of the incident. BoSS reviews each incident, investigates and enters outcomes of the investigation within 14 calendar days of the incident.

The WVIMS does not supersede the reporting of incidents to APS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify APS (W.Va. Code §9-6-9a).

An agency is responsible to investigate all incidents, including those reported to APS. If requested by APS, a provider shall delay its own investigation and document such request in the online WVIMS.

501.4.2 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 BoSS monitoring staff at the time of the provider monitoring review or upon request.

PPL has a tracking/reporting responsibility defined in their contract with BMS

501.5 MEMBER ELIGIBILITY

Applicants for the ADW Program must meet all of the following criteria to be eligible for the program:

A. Be 18 years of age or older.
B. Be a permanent resident of West Virginia. The individual may be discharged or transferred from a nursing home in any county of the state, or in another state, as long as his/her permanent residence is in West Virginia.
C. Be approved as medically eligible for nursing home level of care.
D. Meet the Medicaid Waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient.
E. Choose to participate in the ADW Program as an alternative to nursing home care.

Even if an individual is medically and financially eligible, a slot must be available for him/her to participate in the program.

501.5.1 Medical Eligibility

APS Healthcare/IRG is the contracted entity that is responsibility for conducting medical necessity assessments to confirm a person's medical eligibility for waiver services.

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

A. New applicants and existing members are medically eligible based on current and accurate evaluations.
B. Each applicant/member determined to be medically eligible for ADW services receives an appropriate Service Level that reflects current/actual medical condition and short- and long-term service needs.
C. The medical eligibility determination process is fair, equitable, and consistently applied throughout the State.

501.5.1.1 Medical Criteria

An individual must have five deficits as described on the Pre-Admission Screening Form (PAS) to qualify medically for the ADW Program. These deficits are derived from a combination of the following assessment elements on the PAS.

Section	Description of Deficits	
#24	Decubitus; Stage 3 or 4	
#25	In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With Supervision are not considered deficits.	
#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. f.	Continence, bowel Continence, Bladder	Level 3 or higher; must be incontinent.
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transfer	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.)
#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.	

501.5.1.1(a) Service Level Criteria

There are four Service Levels for Personal Assistance/Homemaker services. Points will be determined as follows based on the following sections of the PAS:

Section	Description of Points
#23	Medical Conditions/Symptoms – 1 point for each (can have total of 12 points)
#24	Decubitus - 1 point
#25	1 point for b., c., or d.
#26	Functional Abilities: Level 1 - 0 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)

Section	Description of Points
	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.
#34	Dementia - 1 point if Alzheimer's or other dementia
#35	Prognosis – 1 point if Terminal

Total number of points possible is 44.

501.5.1.1(b) Service Level Limits

Traditional Service Levels

Level	Points Required	Range of Hours Per Month (for Traditional Members)
A	5-9	0 - 62
B	10-17	63 - 93
C	18-25	94 -124
D	26-44	125 -155

A member does not have to utilize the number of hours specified in their Service Level if their needs are being met through other means, such as informals. (Example: A member who is a Level C may only choose to access Level B hours of service due to informal supports that assist him/her.) This must be documented on the Service Plan and the Case Manager must monitor that all services on the Service Plan, including informal supports, are delivered.
The total number of hours may be used flexibly within the month, but must be justified and documented on the Plan of Care.

Personal Options Service Limits

Personal Options members have a monthly budget based on their Service Level. The Personal Options monthly budget can be used flexibly within the month but must be justified and documented on the approved Participant-Directed Service Plan/Spending Plan.

501.5.1.2 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process (as directed in 2005 Cyrus decree):

A. An applicant shall initially apply for the ADW program by having his/her treating physician (M.D. or D.O. only) complete and sign a Medical Necessity Evaluation Request Form. The referring physician, applicant, family member, advocate or other interested party, may submit this form by fax, mail or electronically to APS Healthcare/IRG. APS Healthcare/IRG will not process any Medical Necessity Evaluation Request Form if the physician's signature is more than 60 days old. If the Medical Necessity Evaluation Request form is incomplete, it will be returned to the physician for completion and resubmission, and the applicant will be notified.
B. APS Healthcare/IRG will attempt to contact the applicant (or legal representative) to schedule the assessment, allowing at least two weeks notification. If contact, is made, a notice shall be sent to the individual and/or contact person so noting scheduled home visit date and time.
C. APS Healthcare/IRG will make up to three attempts to contact the applicant. If unable to contact after 3 attempts, APS Healthcare/IRG will issue a potential referral closure letter to the applicant (or legal representative) and the referring entity. If no contact is made with APS Healthcare/IRG within 5 business days, the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral is required.
D. If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.
E. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.

501.5.1.2(a) Results of Initial Medical Evaluation

A. Approval

If the applicant is determined medically eligible and a slot is available, a notice of approved medical eligibility, including the maximum number of personal assistance/homemaker hours the person may receive and a copy of the PAS, is sent to the applicant and/or legal representative/designated contact and the referring physician. The notice will be sent by certified mail.

Additionally, APS Healthcare/IRG sends a Service Delivery Model Selection form advising the applicant to choose either Traditional or Personal Options. A Freedom of Choice Case Management Selection form and a Freedom of Choice Personal Assistance/Homemaker Selection form are also provided to the applicant (or legal representative), advising him/her to choose a Case Management Agency and a Personal Assistance/Homemaker Agency if he/she chooses the Traditional Model. The forms must be returned within 15 calendar days of the receipt of the certified letter to APS Healthcare/IRG. APS Healthcare/IRG will start the 15 day clock upon receipt of the signed Return Receipt (PS Form 3811). If the form is not returned within 15 days, APS Healthcare will make three attempts to contact the applicant by telephone. If contact is not made in 3 business days, the slot will be surrendered to the next person on the

Managed Enrollment List. If the applicant surrendering the slot still wants ADW services, a new Medical Request for Evaluation is required and the application process begins all over again.

APS Healthcare/IRG will notify the Case Management and Personal Assistance/Homemaker agencies selected, and provide them with a copy of the applicant's PAS. The Case Manager must use the Initial Contact Log at this point. It provides the Case Manager with the ability to document their initial contact to assist with financial eligibility (Refer to *Chapter 501.5.2*). Member Enrollment (Refer to Section 501.6) and the required 7 day contact (Refer to *Chapter 501.7*). If Personal Options has been selected APS Healthcare/IRG will notify BoSS and provide them with a copy of the PAS.

If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant (or legal representative) and the referring entity informing them a slot is not currently available and they will be contacted when one becomes available. When a slot becomes available, the applicant and/or the legal representative/designated contact will be sent a certified letter.

B. Denial

If it is determined that the applicant does not meet medical eligibility, the applicant (or legal representative) and the referring physician will be notified by a Potential Denial letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found. A copy of the PAS and ADW policy will also be included with the Potential Denial letter. The applicant will be given 2 weeks to submit supplemental medical information to APS Healthcare/IRG. Information submitted after the 2 week period will not be considered.

If the review of the supplemental information by APS Healthcare/IRG determines the applicant is not medically eligible, the applicant (or legal representative) and the referring physician will be notified by a Final Denial letter. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable ADW policy manual section(s), a copy of the PAS, supplemental information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing Form to be completed if the applicant wishes to contest the decision.

If the applicant's medical eligibility is denied and the applicant is subsequently found medically eligible after the fair hearing process, the date of eligibility can be no earlier than the date of the hearing decision.

501.5.1.3 Medical Reevaluation

Annual reevaluations for medical eligibility for each ADW member must be conducted. The process is as follows (as directed in 2005 Cyrus decree):

A. A Medical Necessity Evaluation Request Form must be submitted to APS Healthcare/IRG dated and signed by the member (or legal representative). The forms may be faxed to APS Healthcare/IRG but a copy of the original form with the

signatures must be maintained in the member's file. The Case Manager, or the member (or legal representative) must check the reevaluation line at the top of the form. A physicians signature is required only if there is a change in, or an additional, diagnosis.

B. The request can be submitted up to 90 calendar days prior to the expiration of the current PAS, and no later than 45 calendar days prior to the expiration of the current PAS. A member's medical eligibility is at risk if the PAS request is submitted less than 45 calendar days before it expires. The expiration of a PAS does not constitute a reason for member appeal.
C. After receiving the reevaluation request, APS Healthcare/IRG will attempt to contact the member (or legal representative) to schedule an assessment, allowing at least 2 weeks notification.
D. If the Medical Necessity Evaluation Request Form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition; or if he/she has a guardian, contact person or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.
E. If APS Healthcare/IRG makes the contact, a letter is sent to the member (or legal representative), Case Management Agency or PPL, noting the date and time of the assessment.
F. Nurses shall not render medical diagnoses. In those cases where there is a medical diagnosis question, the decision shall be based on medical evidence presented by appropriate medical professionals.
G. If APS Healthcare/IRG is unable to contact the member (or legal representative) within three attempts, a potential closure letter will be sent to the member (or legal representative), the Case Management Agency, or PPL.
H. If no contact is made with APS Healthcare/IRG within 5 business days of the date of the potential closure letter, APS Healthcare/IRG will send the final denial letter to the member and copy BoSS and the Case Management Agency or PPL. BoSS will close the case.

501.5.1.3(a) Results Of Medical Reevaluation

A. Approval

If the member meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the member (or legal representative), the Case Management Agency or PPL, if Personal Options is chosen. For members enrolled in the Traditional Model, this notice includes the approved Service Level and the maximum number of hours of service per month. For members enrolled in Personal Options, this notice includes the approved Service Level and the maximum budget level. All members also receive a notice of free legal services, and a Request for Hearing Form.

The Case Management Agency is responsible for sending the Notice of Approved Continued Medical Eligibility to the Personal Assistant/Homemaker Agency.

B. Denial

If it is determined that the member does not meet medical eligibility, the member (or legal representative), the referring physician, the Case Management Agency, or for Personal Options, PPL, will be notified by a Potential Denial letter. This letter will advise the member of the reason(s) for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS and ADW policy will also be included with the Potential Denial Letter. The member will be given 2 weeks to submit supplemental medical information to APS Healthcare/IRG; supplemental information received by APS Healthcare/IRG is given to the reviewing RN. Information submitted after the 2 week period will not be considered.
If the review of the supplemental information by APS Healthcare/IRG determines that there is still no medical eligibility, the member (or legal representative), referring physician, BoSS and the Case Management Agency or PPL will be notified with a Final Denial letter. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable policy manual section(s), a copy of the PAS, supplemental information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing Form to be completed if the applicant wishes to contest the decision.

If the member elects to appeal any adverse decision, benefits shall continue at the current level only if the appeal is mailed within 13 calendar days of the notice date, and shall continue only until a final decision is rendered by the administrative Hearing Officer. If the hearing decision affirms the denial of medical eligibility ADW services shall be terminated immediately.

Medicaid will not pay for services provided to a medically ineligible member.

501.5.2 Financial Eligibility

The financial eligibility process starts once an applicant receives notification that a slot is available and returns the Service Delivery Model Selection Form to APS Healthcare/IRG. If the applicant selects the Traditional Model they must also return the Freedom of Choice Case Management Selection form and the Personal Assistance/Homemaker Selection form to APS Healthcare/IRG.

If the applicant selects the Traditional Model, the Case Management Agency chosen by the applicant will be notified, and a copy of the PAS will be provided. Within 5 business days of receipt of this notification, the Case Manager must make an initial contact by telephone or face-to-face with the applicant and sign the DHS-2 form. The applicant and/or Case Manager must submit a DHS-2 form to the county DHHR office to determine financial eligibility based on ADW criteria. A copy of the Eligibility Determination page of the PAS must be attached to the DHS-2 form. Financial eligibility cannot be initiated without both documents. The Case Manager or BoSS, if Personal Options is selected, must enter an expiration date on the DHS-2 form. The expiration date will be 60 calendar days from the date it is signed.

If the applicant selects Personal Options, BoSS will mail the applicant a financial packet within 3 business days. The packet includes instructions on how to contact his/her local DHHR office to schedule a financial determination appointment, (or may also go as a walk-in) a copy of page 6 of the PAS, and a Personal Options DHS-2 form, which must be presented to the local DHHR office.

Factors such as income and assets are taken into consideration when determining eligibility. An applicant's gross monthly income may not exceed 300% of the current maximum SSI payment per month for participation in the ADW Program. Some assets of a couple are protected for the spouse who does not need nursing home or home and community based care and these assets are not counted to determine eligibility for the individual who needs care in the home.

The applicant has a total of 60 calendar days from the date the DHS-2 form is signed by the Case Manager or BoSS if Personal Options is selected to establish financial eligibility and enroll with BoSS. Applicants must establish financial eligibility at a local DHHR office. This is evidenced by the signed DHS-2 form by the staff at the local DHHR office verifying the applicant is either financially eligible or ineligible. This process can take up to 30 days for a final determination. Therefore, it is imperative the process begin immediately. If the applicant presents the DHS-2 form after the expiration date, financial eligibility for the ADW program will be denied.

Case Managers, or in the case of Personal Options, the applicant, must notify BoSS when the financial eligibility process has been initiated. If the financial eligibility process and enrollment are not completed within 60 calendar days, BoSS will close the referral and notify the applicant. The letter will include the reason for closure, the applicable ADW policy manual section(s), notice of free legal services, and a Request for Hearing form to be completed if the applicant wishes to contest the decision. The letter will outline specific timeframes for filing an appeal.

If the applicant wants ADW services after the closure, a new Medical Request for Evaluation to APS Healthcare/IRG is required and the application process started again. BMS will ensure that all closed referrals will be reviewed within 30 calendar days before releasing the slot to the next applicant on the Managed Enrollment List.

ADW services cannot be paid until an applicant's financial eligibility is established and the enrollment process has been completed with BoSS. (Refer to *Chapter 501.6*). If the member has been a member of another waiver program, no services may be charged prior to an applicant's discharge from the other waiver program. The only exception is Case Management which may bill 30 days prior to discharge.

Termination of the Medicaid benefit itself (e.g., the medical card) always requires a 13 calendar day advance notice prior to the first of the month Medicaid stops. Coverage always ends the last day of a month unless otherwise dictated by policy. Examples: 1) Advance notice for termination is dated January 27, Medicaid would end February 28. 2)

Advance notice is dated January 16, Medicaid ends January 31. This is true regardless of when ADW services end.

501.6 MEMBER ENROLLMENT

Once an applicant has been found medically and financially eligible, the Case Manager or Personal Options Program Manager must request Member Enrollment from BoSS by completing a Member Enrollment Request Form. BoSS will complete the Member Enrollment and provide a Confirmation Notice to the Case Management Agency and the Personal Assistance/Homemaker agency, or Personal Options Program Manager.

No Medicaid reimbursed ADW services may be provided until the Case Management Agency or the Personal Options Program Manager is in receipt of the Member Confirmation Notice. For monthly reporting purposes (Refer to *Chapter 501.11.4*) agencies are to report members as active the month they receive their Confirmation Notice for that member.

The Case Management Agency is responsible for maintaining a copy of the Member Enrollment Request Form and the Member Enrollment Confirmation Notice in the member file. The Personal Assistance/Homemaker agency is responsible for maintaining a copy of the Member Enrollment Confirmation Notice in the member file.

The Personal Options Program Manager sends the Member Enrollment Confirmation with the complete member referral to PPL. PPL will maintain a file which contains the Member Enrollment Confirmation Notice for Personal Options members.

501.7 MEMBER ASSESSMENT

Assessment is the structured process of interviews which is used to identify the member's abilities, needs, preferences and supports; determine needed services or resources; and provide a sound basis for developing the Service Plan and Plan of Care. A secondary purpose of the assessment is to provide the member a good understanding of the program, services, and expectations. There are 2 components to the Member Assessment: Case Management and RN Assessment. Whenever possible both of these assessments should be scheduled together.

Once Member Enrollment has been completed with BoSS, the Case Manager and the Personal Assistance/Homemaker RN will schedule a home visit within 7 calendar days to complete the Member Assessment.

The Case Manager and Personal Assistance/Homemaker RN must work together to ensure that the program meets the member's needs. They must communicate and share information/documentation including the Case Management Member Assessment and the Personal Assistance/Homemaker RN Member Assessment. Both providers are to maintain a copy of the entire Member Assessment (Case Management Assessment and Personal Assistance/Homemaker RN Assessment) in the member's record.

The Personal Assistance/Homemaker RN must complete a Personal Assistance/Homemaker RN Assessment at least every 6 months from the date of the Initial Personal Assistance/Homemaker RN Assessment or the Annual Personal Assistance/Homemaker RN Assessment.

The Personal Assistance/Homemaker RN must complete an Annual Personal Assistance/Homemaker RN Assessment. It can be completed no sooner than 60 calendar days before the 1 year anniversary of the current assessment.

A new assessment must be completed when a member's needs change. Changes in a member's needs are to be incorporated into the Service Plan and the Plan of Care. Case Managers are to share any changes in a member's assessment with the Personal Assistance/Homemaker Agency. The Personal Assistance/Homemaker Agency is to share any changes in the member's RN Assessment with the case manager.
A copy of all Member Assessments must be provided to the member (or legal representative).

501.8 SERVICE PLAN DEVELOPMENT

In the Traditional Model, the Case Manager is responsible for development of the person-centered Service Plan in collaboration with the member (or legal representative). Participation in the development of the Initial Service Plan is mandatory for the member (or legal representative) and Case Manager. The member (or legal representative) may choose to have whomever else they wish to participate in the process (Personal Assistance/Homemaker RN, other service providers, informal supports, etc.).

The Service Plan meeting must be scheduled within 7 calendar days of the Case Management Member Assessment.

The Service Plan must detail all services (service type, provider of service, frequency) the member is receiving, including any informal supports that provide assistance (family, friends, etc.) and address all needs identified in the PAS, the Member Assessment (Case Management Member Assessment and the Personal Assistance/Homemaker RN Assessment). The Service Plan must also address the member's preferences and goals. It is the Case Manager's responsibility to ensure that all assessments are reviewed with the member and considered in the development of the Service Plan.

A copy of all Service Plans must be provided to the member (or legal representative) and the Personal Assistance/Homemaker Agency. The Case Management Agency must have the original document in the member's file.

In Personal Options, the member (or legal representative) is responsible for the development of the Participant-Directed Service Plan. Participation in the development of the Initial Participant-Directed Service Plan, the 6 month Service Plan Update and the Annual Participant-Directed Service Plan is mandatory for the member (or legal representative) and the Resource Consultant. The member (or legal representative) may choose to have whomever else they

wish to participate in the process (direct care staff, other service providers, informal supports, etc.).

The member's Service Plan or Personal Options Participant-Directed Service Plan must contain reference to any other service(s) received by the member, regardless of the source of payment. An ADW agency that provides private-pay services to a member must ensure that documentation is maintained separately.

501.8.1 Six-Month and On-Going Service Plan Development

Participation in the 6 month Service Plan and Annual Service Plan development are mandatory for the member (or legal representative), the Case Manager, and the Personal Assistance/Homemaker RN. The member (or legal representative) may choose to have whomever else they wish to participate in the process (direct care staff, family members, other service providers, informal supports, etc.).

501.8.2 Interim Service Plan Development

In order to begin services immediately to address any health and safety concerns, an Interim Service Plan may be developed and implemented upon the completion of Member Enrollment. The Interim Service Plan can be in effect up to 21 calendar days from the date of Member Enrollment Confirmation to allow time for assessments to be completed, the Service Plan meeting to be scheduled and the Service Plan to be developed.

If the Case Management Agency develops an Interim Service Plan, the Personal Assistance/Homemaker RN must develop an Interim Plan of Care and initiate direct care services within 3 business days. (The Interim Plan of Care can only be used for a maximum of 21 days.)

501.9 PLAN OF CARE DEVELOPMENT

The Personal Assistance/Homemaker RN Assessment is used in conjunction with the PAS, the Member Case Management Assessment, and the Service Plan to develop the member's Plan of Care. The Plan of Care details how Personal Assistance/Homemaker services will be used to meet the direct care needs of the member.

Once the Personal Assistance/Homemaker RN has completed the Initial or Annual Personal Assistance/Homemaker RN assessment AND has received the Service Plan from the Case Manager, he/she must develop the member's Plan of Care based on identified needs and member preferences and initiate direct care services within 10 calendar days.

A copy of all Personal Assistance/Homemaker RN Assessments and member Plans of Care must be provided to the member (or legal representative) and the Case Management Agency. The Personal Assistance/Homemaker Agency must have the original document in the member's file.

501.10 COVERED SERVICES

The following services are available to ADW members if they are deemed necessary and appropriate during the development of their Service Plan and Plan of Care:

A. Case Management (Section 501.11)
B. Personal Assistance/Homemaker Services (501.12)
   a. Direct Care Staff (501.12.1)
   b. RN Assessment (501.12.2)
   c. Nursing Services (501.12.3)
   d. Transportation (501.12.4)
C. Participant-Directed Goods and Services (Personal Options Members Only) (*Chapter 501.13*)

501.11 CASE MANAGEMENT DEFINITION

Case management activities are indirect services that assist the member in obtaining access to needed ADW services, other State Plan services, as well as medical, social, educational and other services, regardless of the funding source. Case management responsibilities also include the development of the member's Service Plan, the ongoing monitoring of the provision of services included in the member's Service Plan, initiating the process to re-evaluate the member's medical eligibility, member health and welfare, and advocacy.

Applicants who chose Personal Options can either assume the responsibilities of the Case Manager or can purchase this service from a certified provider.

Case management includes the coordination of services that are individually planned and arranged for members whose needs may be life-long. The practice of case management helps to avoid duplication and provision of unnecessary services, and to ensure a balance of services. The Case Manager takes an active role in service delivery; although services are not provided directly by the Case Management Agency, the Case Manager serves as an advocate and coordinator of care for the member. This involves collaboration with the ADW member, family members, friends, informal supports, and health care and social service providers. Case Managers are to:

A. Evaluate social, environmental, service, and support needs of the individual.
B. Develop and write an individualized Service Plan which details all services that are to be provided including both formal and informal (if available) services that will assist the member to achieve optimum function.
C. Coordinate the delivery of care, eliminate fragmentation of services, and assure appropriate use of resources.
D. Proactively identify problems and coordinate services that provide appropriate high quality care to meet the individualized and often complex needs of the member.
E. Provide advocacy on behalf of the member to ensure continuity of services, system flexibility, integrated services, proper utilization of facilities and resources, and accessibility to services.

F. Ensure that a member's (or legal representative) wishes and preferences are reflected in the development of the Service Plan and Plan of Care by working directly with the member (or legal representative) and all service providers.
G. Assure that a member's legal and human rights are protected.

501.11.1 Case Management Code, Unit, Limit and Documentation Requirements

Procedure Code: G9002

Service Unit: All Case Management services provided within 1 month

Service Limit: **1 Unit per month.** Reimbursed at a monthly rate

Prior Authorization Required: No

Documentation Requirements: All contacts with, or on behalf of a member, must be documented within the member's record, including date and time of contact, a description of the contact, and the signature of the Case Manager. At a minimum, the Case Manager or Resource Consultant must make contact with the member (or legal representative) once per month and document the contact on the Case Management Monthly Contact Form or the Resource Consultant Monthly Contact Form. Case Management Agencies may not bill for transportation services.

501.11.2 Case Management Case Loads

Each provider must assure that there is an adequate number of qualified Case Managers for the number of members served. A full-time-equivalent Case Manager can serve no more than 75 active members; however, in situations where a provider has a vacancy due to staff turnover, a higher case load may not be sustained for more than 3 months.

501.11.3 Ongoing Case Management Services

The Case Manager is responsible for follow-up with the member to ensure that services are being provided as described in the Service Plan. Initial contact, via telephone or face-to-face, must be made within 7 calendar days after direct care services have begun by the Personal Assistance/Homemaker Agency. At a minimum, a monthly telephone contact and a home visit every 6 months must be conducted to ensure services are being provided and to identify any potential issues. Monthly telephone contact must be documented on the Case Management Monthly Contact Form and include detailed information on the status of the member.

If a member (or legal representative) cannot be reached by telephone for the monthly contact, a home visit must be made. At a minimum, the Case Manager must complete a 6 month Case Management Member Assessment and Service Plan. This must be a face-to-face home visit with the member.

Specific activities to assure that needs are being met also include:

A. Assure financial eligibility remains current.

B. Assure the health and welfare of the member.
C. Address changing member needs as reported by the member (or legal representative), Personal Assistance/Homemaker direct care staff and/or RN, or informal support.
D. Address changing needs determined by the monthly member contact.
E. Refer and procure any additional services the member may need that are not services the Personal Assistance/Homemaker Agency can provide.
F. Coordinate with all current service providers to develop the 6 month Service Plan and the Annual Service Plan (or more often as necessary). It is mandatory that the member (or legal representative), the Case Manager and the Personal Assistance/Homemaker Agency RN be present at the 6 month Service Plan meeting and the Annual Service Plan meeting.
G. Provide the Service Plan to all applicable service providers that are providing services to the member (or legal representative).
H. Provide copies of all necessary documents to the Personal Assistance/Homemaker Agency such as Member Enrollment, PAS, Assessments, etc.
I. Annually submit a Medical Necessity Evaluation Request to APS Healthcare/IRG.

501.11.4 Reporting

The Case Management Agency will complete and submit required administrative and program reports as requested by either BMS or BoSS. Monthly reports must be submitted by Case Management agencies to BoSS by the 6th business day of every month.

501.12 PERSONAL ASSISTANCE/HOMEMAKER

Personal Assistance/Homemaker services are defined as long-term direct care and support services that are necessary in order to enable a member to remain at home rather than enter a nursing home, or to enable an individual to return home from a nursing home.

The components of the Personal Assistance/Homemaker Service include Personal Assistance/Homemaker Direct Care Services, RN Assessment, Nursing and Transportation.

More than one Personal Assistance/Homemaker Agency can provide direct care services to a member. The agency the member selected on their Freedom of Choice Personal Assistance/Homemaker Selection Form is the primary agency and is responsible for coordinating services. The Service Plan must indicate which agency is the primary agency. Billable nursing units must be coordinated by the primary agency. There cannot be a duplication of services.

501.12.1 Personal Assistance/Homemaker (Direct Care Staff) Code, Unit, Limit and Documentation Requirements

Procedure Code: S5130

Service Unit: 15 minutes

Service Limits: Determined by Service Level Criteria and Service Level Limits (Refer to *Sections 501.5.1.1(a and b)*

Prior Authorization Required: Yes

Documentation Requirements: All services provided to a member must be documented on the Plan of Care and maintained within the member's record.

501.12.1.1 Personal Assistance/Homemaker (Direct Care Staff) Qualifications and Training

All documented evidence of Personal Assistance/Homemaker direct care staff qualifications such as licenses, transcripts, certificates, CIB checks, signed confidentiality statements and references shall be maintained on file by the provider. The provider must have an internal review process to ensure that Personal Assistance/Homemaker direct care staff providing ADW services meets the minimum qualifications as required by policy (Refer to *Chapter 501.3* and its subparts).

In Personal Options, all documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality statements, and references shall be maintained on file by PPL.

501.12.1.2 Personal Assistance/Homemaker (Direct Care Staff) Responsibilities

The functions of the Personal Assistance/Homemaker direct care staff include providing direct care services as defined by the member's Plan of Care or the Spending Plan for Personal Options members, recording services and time spent with the member, communicating to the RN any member changes and completing all ADW training requirements.

Personal Assistance/Homemaker direct care staff duties and responsibilities as described in the Plan of Care may include:

A. Assist member with Activities of Daily Living (ADL).
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 Personal Assistance/Homemaker direct care staff on these errands.
D. Assist member in community activities. Activities provided in the community should be determined by the member and the Case Manager at the Service Plan meeting and are limited to 30 hours per month. (Examples of community activities — visiting friends/relatives, going to a local community activity, etc.) Community activities must be documented on the Plan of Care. Prior authorization of additional units of Personal Assistance/Homemaker services will not be available to provide community activities.
E. Report significant changes in members' condition to the Personal Assistance/Homemaker RN or for Personal Options to PPL. Report any incidents to the Personal Assistance/Homemaker RN or for Personal Options, PPL. (Examples:

member falls (whether direct care staff was present or not), bruises (whether direct staff knows origin or not), etc.)

F. Report any environmental hazards to the Personal Assistance/Homemaker RN or for Personal Options to PPL. (Examples: no heat, no water, pest infestation or home structural damage).
G. Prompt for self-administration of medications.
H. Maintain records as instructed by the Personal Assistance/Homemaker RN or PPL.
I. Perform other duties as assigned by Personal Assistance/Homemaker RN within program guidelines.
J. Accurately complete Personal Assistance/Homemaker worksheet and other records as instructed by the Personal Assistance/Homemaker RN or PPL.

Personal Assistance/Homemaker staff cannot perform any service that is considered to be a professional skilled service or any service that is not on the member's Plan of Care or for members enrolled in Personal Options the Participant-Directed Service Plan. 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. Give 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 judgments or give advice on medical or nursing questions.
L. Application of heat.

If at any time a Personal Assistance/Homemaker is witnessed to be, or suspected of, performing any prohibited tasks, the Personal Assistance/Homemaker RN or PPL must be notified immediately.

501.12.2 RN Assessment Code, Unit, Limit and Documentation Requirements

Procedure Code: T1001

Modifier: UD

Service Limits: 1 event per calendar year (January - December)

Prior Authorization Required: No

Documentation Requirements: The Personal Assistance/Homemaker RN Initial and Annual Member Assessment and the member Plan of Care

501.12.3 Nursing Services Code, Unit, Limit and Documentation Requirements

Procedure Code: T1002

Modifier: UD

Service Unit: 15 minutes

Service Level: 6 units per month

Prior Authorization Required: No

Documentation Requirements: All contacts (except for the 6 month and annual visits) with, or on behalf of, a member must be documented using the Personal Assistance/Homemaker RN Member Contact Form and maintained within the member's record. The RN Assessment and Plan of Care must be complete.

501.12.3.1 Nursing Responsibilities

The RN responsibilities are:

A. If requested by the member (or legal representative) attends the Initial Service Plan meeting.
B. Attend the 6 month and Annual Service Plan meeting.
C. If requested by the member (or legal representative) attends the member's ADW medical eligibility appointments with APS Healthcare/IRG.
D. If the Case Management Agency develops an Interim Service Plan, the Personal Assistance/Homemaker RN must develop an Interim Plan of Care and initiate homemaker services within three business days.
E. Make a home visit with the member and Personal Assistance/Homemaker within 30 calendar days after Personal Assistance/Homemaker services begin.
F. Complete a Personal Assistance/Homemaker RN Assessment within 6 months from the date of the Initial or annual Personal Assistance/Homemaker RN Assessment.
G. Based on clinical judgment, complete a Personal Assistance/Homemaker RN Assessment to determine the need for changes in the Plan of Care such as following discharge from an acute care hospital, nursing facility or other residential setting. The RN must notify the Case Manager if additional services or changes in services are needed.
H. Review the Plan of Care to assure services were provided as described in the Service Plan before submitting billing under code S5130.
I. Review the Plan of Care to assure it has been completed per policy before submitting billing under code S5130.
J. Sign and date all accurately completed Plans of Care.
K. Provide member-specific training to Personal Assistance/Homemakers.

L. Complete a home visit with the member to assess any change in needs. Documentation must substantiate the need for the visit using the Personal Assistance/Homemaker RN Member Contact Form.
M. Attend any member Dual Service planning meetings. (Refer to *Section 501.18*)
N. Compile, prepare, and submit material that can be used to assess an ADW member's need for an increase in their Service Level. Service level changes can only be requested for members at Service Level A, B, or C, and only when there is a substantial change in the member's medical condition. In order to determine whether additional hours are warranted, a completed Request for Service Level Change must be submitted to APS Healthcare/IRG. Clinical documentation sufficient to support the request must be submitted, which may include applicable test results from a member's physician or hospital discharge summary. These documents must be on the letterhead of the physician and/or hospital and dated no later than 1 month prior to, or 1 month following, the request for an increased Service Level. Information that will not be considered includes any verbal or telephonic statements; or letters from family, neighbors, friends, or Case Management and Personal Assistance/Homemaker staff without attached physician's documentation or discharge summary. The request must be signed by both the Personal Assistance/Homemaker RN and the member (or legal representative). Original signatures are required; i.e., "signature of member on file" is not acceptable. This request may or may not result in a change in the Service Level. Notice of the determination will be sent to the member (or legal representative) and the Personal Assistance/Homemaker Agency, or if a Personal Option member, to PPL. The Personal Assistance/Homemaker Agency must notify the appropriate Case Management Agency of the Service Level determination.

Members who are appealing a denial of medical eligibility will remain at their current Service Level pending a Fair Hearing decision. APS Healthcare/IRG will not review a request for an increased Service Level for such members.

Administrative duties are not billable. These include but are not limited to:

A. Sending copies of any Personal Assistance/Homemaker RN Assessments or Plans of Care to the member (or legal representative) or the Case Management Agency.
B. Notifying the Case Management Agency if a member has been admitted to or discharged from an acute care hospital, nursing home, or other residential facility.
C. Being available to the Personal Assistance/Homemaker (direct care staff) for consultation and assistance at any time when the Personal Assistance/Homemaker (direct care staff) is providing services.
D. Completing and submitting required program reports to BMS, BoSS or APS Healthcare/IRG.
E. Telephone calls.

501.12.4 Transportation

Transportation provides reimbursement for Personal Assistance/Homemaker direct care staff that performs essential errands for or with a member or community activities with a member.

501.12.4.1 Transportation Code, Unit, Limit and Documentation Requirements

Procedure Code: A0160

Service Unit: 1 unit - 1 mile

Service Limit: N/A

Prior Authorization: No

Documentation Requirements: All transportation with, or on behalf of, a member must be included in the Plan of Care and documented on the Plan of Care and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity).

501.12.4.2 Transportation Services

The member may be transported by the Personal Assistance/Homemaker in order to gain access to services and activities as specified in the Plan of Care. Family, neighbors, friends, or community agencies that can provide this service, without charge, must be utilized first. Mileage can be charged for essential errands [Refer to *Chapter 501.12.1.2(C)*] activities related to the Service Plan and community activities [Refer to *Chapter 501.12.1.2(D)*].

501.13 PARTICIPANT-DIRECTED GOODS AND SERVICES CODE, UNIT, LIMIT AND DOCUMENTATION REQUIREMENTS

Procedure Code: T2028

Service Unit: As specified on Participant-Directed Service Plan

Service Limit: $1000 Annually

Prior Authorization Required: No

Documentation Requirement: Participant Directed Goods and Services receipts and other approved documentation per the PPL contract with BMS must be maintained on file with PPL. Must be in the Participant-Directed Spending Plan.

501.13.1 Participant-Directed Goods and Services

Participant-Directed Goods and Services are equipment, services or supplies not otherwise provided through the Medicaid State Plan that address an identified need in the Participant-Directed Service Plan. The member must budget for their approved good or service within their allocated budget.

The following are non-allowable services, equipment or supplies: gifts for staff/family/friends, payments to someone to serve as a representative, clothing, food and beverages, electronic entertainment equipment, utility payments, swimming pools and spas, costs associated with travel, comforters, linens, drapes, furniture, vehicle expenses including routine maintenance and repairs, insurance and gas money, medications, vitamins, herbal supplements, monthly internet service, yard work, illegal drugs or alcohol, household cleaning supplies, home maintenance and repair, pet care, respite services, spa services, experimental or prohibited treatments, education, personal hygiene, discretionary cash, and any other good or service that does not address an identified need in the Participant-Directed Service Plan, decrease the need for other Medicaid services, and/or increase the person's safety in the home and /or improve and maintain the member's opportunities for full membership in the community.

501.14 MEMBER RIGHTS AND RESPONSIBILITIES

At a minimum, Case Management Agencies or for Personal Options PPL must communicate in writing to each member (or legal representative)

Their right to:

A. Transfer to a different provider agency or to Personal Options.
B. Address dissatisfaction with services through the provider agency's or PPL's grievance procedure.
C. Access the West Virginia DHHR Fair Hearing process.
D. Considerate and respectful care from their provider(s).
E. Take part in decisions about their services.
F. Confidentiality regarding ADW services.
G. Access to all of their files maintained by agency providers.

And their responsibility to:

H. Notify the ADW Personal Assistance/Homemaker Agency or PPL within 24 hours prior to the day services are to be provided if services are not needed.
I. To notify providers or PPL promptly of changes in Medicaid coverage.
J. Comply with the Plan of Care or for Personal Options Members, comply with the Participant Directed Service Plan.
K. Cooperate with all scheduled in-home visits

L. Notify the ADW agencies or PPL of a change in residence or an admission to a hospital, nursing home or other facility.
M. Notify the ADW agencies or PPL of any change of medical status or direct care need.
N. Maintain a safe home environment for the agency or PPL to provide services.
O. Verify services were provided by initialing and signing the Plan of Care.
P. Communicate any problems with services to the provider agency or PPL.
Q. Report any suspected fraud to the provider agency or the Medicaid Fraud Unit at (304)558-1858.
R. Report any incidents of abuse, neglect or exploitation to the provider agency, PPL or the APS hotline at 1-800-352-6513.

S. Report any suspected illegal activity to their local police department or appropriate authority.

501.15 MEMBER GRIEVANCE PROCESS

Members who are dissatisfied with the services they receive from a provider agency have a right to file a grievance. All ADW agencies will have a written member grievance procedure. The APS Healthcare/IRG RN will explain the grievance procedure to all applicants/members at the time of initial application/reevaluation. Applicants/members (or legal representative) will be provided with a Member Grievance Form at that time. Service providers will only afford members a grievance procedure for services that fall under the particular service provider's authority; for example, a Case Management Agency will not conduct a grievance procedure for Personal Assistance/Homemaker Agency activities, nor will a Personal Assistance/Homemaker Agency conduct a grievance procedure for Case Management Agency activities. A member may by-pass the level one grievance if he/she chooses.
The grievance procedure consists of two levels:

A. **Level One: ADW Provider**
   An ADW provider has 10 business days from the date they receive a Member Grievance Form to hold a meeting, in person or by telephone. The meeting will be conducted by the agency director or their designee with the member (or legal representative). The agency has 5 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 BoSS for a Level Two review and decision.

B. **Level Two: BoSS**
   If an ADW provider is not able to address the grievance in a manner satisfactory to the member and the member requests a Level Two review, BoSS will, within 10 business days of the receipt of the Member Grievance Form, contact the member (or legal representative) and the ADW provider to review the Level One decision. Level Two decisions will be based on Medicaid policy and/or health and safety issues.

501.16 TRANSFER TO DIFFERENT AGENCY OR TO PERSONAL OPTIONS

An ADW member may request a transfer to another agency or to Personal Options at any time. If a member wishes to transfer to a different agency a Member Request to Transfer form must be completed and signed by the member or legal representative. The form may be obtained from the current provider, the new providers, BoSS or other interested parties. Once completed and signed by the member, the form must be submitted to BoSS. BoSS will then coordinate the transfer and set the effective date based on when required transfer documents are received. For case management transfers, the effective date of transfer will be the first date of the next month if the transfer is received by the 17th of the month.

At no time should the transfer take more than 45 calendar days from the date that the member signed transfer request is received at BoSS, unless there is an extended delay caused by the member in returning necessary documents.

Transferring Agency Responsibilities:

A. To continue providing services until BoSS notifies them that the transfer has been completed.
B. If it is a Case Management transfer, to provide the receiving agency, on the day of the transfer, a copy of the current PAS, DHS-2, the Service Plan, a copy of the Member Enrollment Confirmation and any other pertinent documentation.
C. If it is a Personal Assistance/Homemaker transfer, to provide the receiving agency, on the day of the transfer, with a copy of the current PAS, DHS-2, the Plan of Care and any other pertinent documentation.
D. To maintain all original documents for monitoring purposes.

Receiving Agency Responsibilities:

A. If it is a Personal Assistance/Homemaker transfer, a Personal Assistance/Homemaker Member RN assessment must be conducted within 7 business days of the transfer effective date. When a member transfers agencies, the receiving agency Personal Assistance/Homemaker RN cannot bill for an Initial Assessment (billing code T1001, Modifier UD) if one has been completed within the calendar year). They can bill for a Personal Assistance/Homemaker RN Assessment using T1002.
B. Develop the Personal Assistance/Homemaker RN Plan of Care within 7 business days of the transfer effective date.
C. If it is a Case Management transfer, a Case Management Member Assessment must be conducted within 7 business days of the transfer effective date.
D. Develop the Service Plan within 7 business days of the transfer effective date.

The Service Plan and existing Plan of Care from the transferring agency must continue to be implemented until such time that the receiving agency can develop and implement a new plan to prevent a gap in services.

Personal Option transfers are processed by BoSS.

501.16.1 Emergency Transfers

A request to transfer that is considered an emergency, such as when a member suffers abuse, neglect, or harm, will be reviewed by BoSS, and BoSS will take appropriate action. The Case Management Agency, the Personal Assistance/Homemaker Agency that the member is transferring from or the Personal Options member/representative must submit supporting documentation that explains why the member is in emergency status. BoSS will expedite the request as necessary, coordinating with the member and agencies involved.

501.17 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services Form be submitted and approved BoSS:

A. No services have been provided for 100 continuous days – example, an extended placement in long-term care or rehabilitation facility.
B. Unsafe Environment – an unsafe environment is one in which the personal assistance/homemaker and/or other agency staff are threatened or abused and the staff's welfare is in jeopardy. 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 personal assistance/homemaker 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.

Note: When BoSS receives an unsafe closure request, they will attempt to process the request as a transfer. To do so, BoSS will require the member (or legal representative) to sign Consent for Release of Information Form. This will permit all information regarding the unsafe circumstances to be disclosed to other agencies and APS Healthcare/IRG. If another agency is not willing to accept the member due to unsafe circumstances, the case will be closed.

C. The member is persistently non-compliant with the Plan of Care.
D. Member no longer desires services

The Request for Discontinuation of Services Form must be submitted to BoSS. BoSS will review all requests for a discontinuation of services. If it is an appropriate request, and BoSS approves the discontinuation, BoSS will send notification of discontinuation of services to the member (or legal representative) with a copy to the Case Management Agency or F/EA. Fair hearing rights will also be provided except if the member (or legal representative) no longer desires services. The effective date for the discontinuation of services is 13 calendar days after the date of the BoSS notification letter, if the member (or legal representative) does not request a hearing. If it is an unsafe environment services may be discontinued immediately.

All discontinuation of services (closures) must be reported on the Case Management Monthly Report to BoSS.

The following do not require a Request for Discontinuation of Services Form but must be reported on the Case Management Monthly Report:

A. Death
B. Moved Out of State
C. Medically Ineligible
D. Financially Ineligible

501.18 DUAL PROVISION OF ADW AND PERSONAL CARE (PC) SERVICES

Approval of the provision of both ADW and PC services to the same person will be considered if the following criteria are met:

A. Any PC services provided to an active ADW member must be approved by the reviewing agencies (Refer to H below), including the initial 60 hours. The Dual Service Provision Request must be completed.
B. An ADW member must be receiving services at Service Level D. (Otherwise, additional hours of Personal Assistance/Homemaker direct care services may be requested through a Request for Service Level Change.)
C. All policy set forth in *Chapter 517, Personal Care Services*, must be followed. PC policy supersedes ADW policy for this request.
D. There must be a PC RN Plan of Care and a Personal Assistance/Homemaker RN Plan of Care. For Personal Options, there must be a PC RN Plan of Care and a Participant-Directed Service Plan. These plans must be coordinated to ensure that services are not duplicated. PC and Personal Assistance/Homemaker services cannot be provided during the same hours on the same day. A service planning meeting between the Case Manager Personal Assistance/Homemaker RN, and PC RN must be held with the member or the legal representative in the member's residence and documented on the Request for Dual Service Provision. For Personal Options, the meeting must include PPL and the member.
E. There must be a valid ADW PAS and a valid PC Medical Eligibility Assessment (PCMEA) that documents the need for both services.
F. The ADW Case Manager is responsible for the coordination of the two services. For Personal Options, the member is responsible for the coordination of the 2 services.
G. Dual Service Provision Request Forms must be signed by the Case Manager, ADW RN, PC RN and the member (or legal representative). For Personal Options, the Dual Service Provision Request Form must be signed by the member (or legal representative) and the PC RN. Original signatures are required; i.e., "signature of member on file" is not acceptable.
H. All PC providers should submit requests to:

   Innovative Resource Group (IRG)
   100 Capitol Street
   Suite 600
   Charleston, WV 25301

I. Documentation submitted must include a copy of the ADW PAS and the PCMEA, ADW PAS and PC RN Plans of Care (for Personal Options the Participant-Directed Service Plan), current RN assessments (if applicable for Personal Options) from both agencies, and any documentation that substantiates the request. Additionally, a narrative describing how services will be utilized and verification that ADW and PC services will not be duplicated must be submitted. Approvals/denials will be based on the documentation submitted, appropriate program policy manuals, PC standards, and professional judgments. The member (or legal representative), PC RN, Personal Assistance/Homemaker RN, Case Manager or PPL will receive notification of denial or

approval from the reviewing agency. If the request is denied or the hours approved are less than requested, the notification will include fair hearing information.

J. BMS will conduct post-payment review of these combined services for duplication or inappropriate services. BoSS and BMS will review compliance during the agency monitoring process.

501.19 EXCLUDED SERVICES AND NON-REIMBURSABLE SITUATIONS

Medicaid will only reimburse agencies for ADW services that are defined as required services on the member's Service Plan or Participant-Directed Service Plan (Refer to *Common Chapter 300, Provider Participation Requirements*, for more information about reimbursement.) The following services are not reimbursable:

A. Services provided for other member(s) of the ADW member's household or to anyone who is not an ADW Program member.

B. Services provided by a Case Management Agency or Personal Assistance/Homemaker that are not included in the Service Plan, Plan of Care or Participant-Directed Service Services provided to an individual who is not medically and financially eligible on the date(s) that service is provided.