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

CHAPTER 502 CHILDREN WITH SERIOUS EMOTIONAL DISORDER WAIVER (CSEDW)

TABLE OF CONTENTS

SECTION **PAGE NUMBER**

Background 5

Program Description 5

Policy 6

502.1 Bureau For Medical Services Contractual Relationships 6

502.2 Medical Necessity 7

502.3 Provider Enrollment And Participation Requirements 7

502.3.1 Enrollment Requirements: CBHC And LBHC Administration 7

502.3.2 Enrollment Requirements: Staff Qualifications 8

502.4 Criminal Background Checks 8

502.5 Clinical Supervision 8

502.6 Methods of Verifying Medicaid Requirements 9

502.7 Provider Reviews 9

502.8 Training and Technical Assistance 10

502.9 Other Administrative Requirements 10

502.10 Telehealth Services 12

502.11 Documentation and Record Retention Requirements 12

502.11.1 Confidentiality 13

502.11.2 HIPAA Regulations 13

502.12 Incident Reporting Requirements 13

502.13 Quality Improvement System (QIS) 15

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

502.13.1 Centers For Medicare And Medicaid Services (CMS) Quality Assurances 15

502.13.2 Quality Improvement Advisory (QIA) Council 16

Eligiblity And Enrollment 16

502.14 Applicant Eligibility and Enrollment Process 16

502.14.1 Application Process: Initial Eligibility Determination Process 17

502.14.2 Initial Medical Eligibility 19

502.14.2.1 Level Of Care Instruments 19

502.14.2.2 Diagnosis 19

502.14.2.3 Functionality 20

502.14.2.4 PRTF Level Of Care 20

502.14.3 Slot Allocation Referral And Selection Process 20

502.15 Annual Re-Determination of Waiver Eligibility Process 21

502.16 Rights, Responsibilities, Grievances, and Appeals 22

502.16.1 Rights 22

502.16.2 Responsibilities 22

502.16.3 Grievances And Complaints 23

502.16.4 Medical Re-Determination Eligibility Appeals 23

502.17 Transfer And Discharge 24

502.18 Person-Centered Service Plan (PCSP) Requirements 25

502.18.1 Person-Centered Service Planning Team (PCSPT) 26

502.18.2 PCSP Development 26

502.18.2.1 Seven Day PCSPT Meeting 28

502.18.2.2 Thirty Day PCSPT Meeting 28

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

502.18.2.3 Transfer/Discharge PCSPT Meeting 28

502.18.2.4 Significant Life Event PCSPT Meeting 29

502.19 Case Management Requirements 30

502.19.1 Member Choice Of Single Case Management Provider 30

Services 31

502.20 Case Management Services 31

502.20.1 Case Management 31

502.20.2 Case Management Service Activities 32

502.21 Crisis Services: Mobile Response 33

502.22 Day Services 35

502.22.1 Independent Living/Skills Building 35

502.22.2 Job Development 36

502.22.3 Supported Employment, Individual 37

502.23 Extended Professional Services: Specialized Therapy 38

502.24 Goods And Services 39

502.24.1 Assistive Equipment 39

502.24.2 Community Transition 39

502.25 Person-Centered Support 40

502.25.1 In-Home Family Therapy 40

502.25.2 In-Home Family Support 41

502.25.3 Peer Parent Support 42

502.26 Respite Care 44

502.26.1 Respite Care, In-Home 44

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

502.26.2 Respite Care, Out-Of-Home 45

502.27 Non-Medical Transportation 45

502.28 Service Limitations And Service Exclusions 46

502.29 Prior Authorizations 47

502.30 Billing Procedures 48

502.31 How to Obtain Information 48

Glossary 48

Change Log 53

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

BACKGROUND

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 Medicaid Program. The West Virginia Medicaid Program is administered pursuant to provisions of Title XIX of the Social Security Act and *Chapter 9 of the West Virginia Code.*

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 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 the BMS or its designee upon request.

This chapter sets forth requirements for payment of services provided under the Children with Serious Emotional Disorder Waiver (CSEDW) program to eligible West Virginia Medicaid members. These members may or may not be eligible for other Medicaid covered services found in other chapters of the BMS Provider Manual. Any service, procedure, item, or situation not discussed in this chapter must be presumed non-covered under the waiver.

All Medicaid enrolled providers should coordinate care if a Medicaid member receives different Medicaid services at different locations with other providers to help ensure that quality care is taking place and that safety is the forefront of the member's treatment.

PROGRAM DESCRIPTION

The CSEDW is a Medicaid Home and Community Based Services (HCBS) waiver program authorized under §1915(c) of the Social Security Act. The CSEDW provides services that are additions to Medicaid State Plan coverage for members ages three through 20 who are enrolled in the CSEDW program. The CSEDW permits WV to provide an array of HCBS that enables children who would otherwise require institutionalization to remain in their homes and communities.

This waiver prioritizes children/youth with serious emotional disorders (SED) who are :

1. In Psychiatric Rehabilitation Treatment Facilities (PRTFs) or other residential treatment providers either out-of-state or in-state; and
2. Other Medicaid-eligible children with SED who are at risk of institutionalization.

It is anticipated that this waiver will reduce the number of children housed both in-state and out-of-state in Psychiatric Residential Treatment Facilities (PRTFs) and shorten the lengths of stay for children who require acute care in PRTFs.

West Virginia defines the term "children with a serious emotional disorder" (CSED) as children with an SED who are ages three through 20 and who currently have or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria

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

specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM) (or International Classification of Disease (ICD) equivalent) that is current at the date of evaluation and results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, and/or community activities.

Members enrolled in the CSEDW may not enroll simultaneously in another West Virginia §1915(c) waiver. Medicaid members who are not willing to enroll with the identified MCO are not eligible to enroll in the CSEDW program.

All required documentation forms are available on the CSEDW website.

POLICY

502.1 BUREAU FOR MEDICAL SERVICES CONTRACTUAL RELATIONSHIPS

BMS operates the CSEDW in conjunction with the West Virginia Specialized Youth in Foster Care §1915(b) managed care program and utilization management will be managed by one identified Managed Care Organization (MCO).

BMS contracts with an Administrative Service Organization (ASO) that acts as an agent of BMS and administers the operation of the CSEDW Program. The ASO processes initial eligibility determination packets and conducts the annual reassessment to establish re-determination of medical eligibility. The ASO conducts education for CSEDW providers, persons, advocacy groups, and DHHR. At times, the ASO, in collaboration with BMS, will provide answers to policy questions, which will serve as policy clarifications. These policy clarifications will be posted on the CSEDW website under *Policy Clarifications*.

In order to facilitate coordination of care, the ASO is required to contact and confirm the member is enrolled with the identified MCO within two calendar days of being notified of slot availability for waiver enrollment. Medicaid members who are not willing to enroll with the identified MCO are not eligible to enroll in the CSEDW program.

The BMS contracts with a Medical Eligibility Contracted Agent (MECA) to determine initial and re-determination eligibility of prospective and active persons and to recruit and train licensed psychologists to participate in the Independent Psychologist Network (IPN). The ASO and the MECA work together to process initial applications and re-determination packets.

The West Virginia Medicaid Management Information System (MMIS) contractor is responsible for enrollment of all Medicaid providers who then must contract with the identified MCO to provide CSEDW services. All Medicaid providers must contract with the identified MCO prior to initiating CSEDW services with enrolled members.

Please refer to the CSEDW website for ASO and MECA contact information.

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

502.2 MEDICAL NECESSITY

All CSEDW services covered in this chapter are subject to a determination of medical necessity defined as services and supplies that are:

- Appropriate and medically necessary for the symptoms, diagnosis, or treatment of an illness
- Provided for the diagnosis or direct care of an illness
- Within the standards of good practice
- Not primarily for the convenience of the plan member or provider
- The most appropriate level of care that can be safely provided

Medical necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination:

1. Diagnosis (as determined by a physician or licensed psychologist)
2. Level of functioning
3. Evidence of clinical stability
4. Available support system
5. Appropriate level of care

Consideration of these factors in the service planning process must be documented and re-evaluated at regular service plan updates. Evidence-based diagnostic and standardized instruments may be administered at the initial evaluation and as clinically indicated. The results of these measures must be available as part of the clinical record, as part of the documentation of the need for the service, and as justification for the level and type of service provided.

Providers rendering services that require prior authorization must receive authorization before rendering all services. Prior authorization does not guarantee payment for services rendered. See Section 502.29, Prior Authorization.

502.3 PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

All Medicaid providers must meet the provider enrollment requirements in *Chapter 300, Provider Participation Requirements*.

To become a CSEDW provider agency, an agency must also apply for a Certificate of Need (CON) through an expedited Summary Review process and be approved by the West Virginia Health Care Authority. Then, the agency must obtain a Behavioral Health License through the Office of Health Facility Licensure and Certification (OHFLAC).

502.3.1 Enrollment Requirements: CBHC and LBHC Administration

Comprehensive Behavioral Health Centers (CBHC) and Licensed Behavioral Health Centers (LBHC) must develop and maintain a Credentialing Committee composed of the clinical supervisor and/or certified staff representative of the disciplines or practitioners within the agency. See Chapter 503, Licensed Behavioral Health Centers for duties and responsibilities of the committee.

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

502.3.2 Enrollment Requirements: Staff Qualifications

Psychologists who are on the West Virginia Board of Examiners of Psychologists approved list of supervisors may only bill for up to four supervised psychologists. Board Approved Supervisors may not "trade" supervisees for billing Medicaid services.

Independent case managers must be licensed to practice independently and must follow the internal regulations of their accrediting body, licensing board, and/or certification board.

Documentation including required licenses; certifications; proof of completion of training; collaborative agreements for prescriptive authority, if applicable; proof of psychiatric certification, as applicable; and any other materials substantiating an individual's eligibility to perform as a practitioner must be kept on file at the location where the services are provided.

Agency staff must have current CPR and First Aid cards, acceptable fingerprint-based checks, acceptable Federal Office of the Inspector General (OIG) Medicaid Exclusion List check, be over the age of 18, and be able to perform the tasks and meet training requirements as mandated by OHFLAC and the BMS. See Section 502.4 Criminal Background Checks of this manual for specific information related to fingerprint-based background check requirements.

Agency staff must also have the following training as required by the BMS and OHFLAC within one month of employment:

- Crisis intervention and restraint;
- Suspected abuse and neglect;
- Member rights;
- Crisis planning;
- Emergency and disaster preparedness;
- Infections disease/infection control;
- Person-centered/person-specific needs;
- Trauma-informed care and practice; and
- Cultural competency.

All further staff qualifications will be indicated under the service codes. All documentation for staff including college transcripts, certifications, credentials, background checks, and trainings should be kept in the staff's personnel file and the BMS, their contractors, or state and federal auditors may review them at any time.

502.4 CRIMINAL BACKGROUND CHECKS

Please see *Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for fingerprint-based background check requirements.

502.5 CLINICAL SUPERVISION

Clinical supervision's purpose for CBHCs and LBHCs is to improve the quality of services for every member while helping to ensure adherence to West Virginia Medicaid policy; therefore, the provider must

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

have a policy for clinical supervision. See Chapter 503, Licensed Behavioral Health Centers for clinical supervision requirements.

502.6 METHODS OF VERIFYING MEDICAID REQUIREMENTS

Enrollment requirements, as well as provision of services, are subject to review by the BMS and/or its contracted agents. The BMS contracted agents may promulgate and update utilization management guidelines that the BMS has reviewed and approved. These approved guidelines function as policy. Additional information governing the surveillance and utilization control program may be found in *Chapter 100, General Administration and Information* and are subject to review by state and federal auditors.

502.7 PROVIDER REVIEWS

The primary means of monitoring the quality of the CSEDW services is through provider reviews conducted by the OHFLAC and the ASO as determined by a defined 12-month review cycle.

The ASO performs on-site and desk documentation provider reviews, staff interviews, telephone satisfaction surveys with members who receive services and/or their parent/legal representative, and day service visits to validate certification documentation and address CMS quality assurance standards. Targeted on-site CSEDW provider reviews and/or desk reviews may be conducted by OHFLAC and/or the ASO in follow-up to incident management reporting, complaint data, corrective action plan, etc.

Upon completion of each provider review, the ASO conducts a face-to-face exit summation with staff as chosen by the provider to attend. Within two weeks of the exit summation, the ASO will make available to the provider a draft exit report and a Corrective Action Plan (CAP) to be completed by the CSEDW provider. If there are no potential disallowances identified, then a Corrective Action Plan is not necessary. If potential disallowances are identified, the CSEDW provider will have 30 calendar days from receipt of the draft exit report to send any necessary information/documentation, comments related to disallowances, and the completed Corrective Action Plan back to the ASO. If a Corrective Action Plan is not submitted within the 30-day comment period, BMS may place a hold on payments for services. After the 30-day comment period has ended, BMS will review the draft report and any comments submitted by the CSEDW provider and issue a final report to the CSEDW provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of CSEDW services. A cover letter to the CSEDW provider's Executive Director will outline the following options to effectuate repayment:

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

If the CSEDW provider disagrees with the final report, the CSEDW provider may request a document/desk review within 30 calendar days of receipt of the final report pursuant to the procedures in *Chapter 100, General Administration and Information* of the West Virginia Medicaid Provider Manual. The CSEDW provider must still complete the written repayment arrangement within 30 calendar days of receipt of the

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

final report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed, and set forth in detail the items in contention. The letter must be addressed to:

Bureau for Medical Services
Legal Department
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are identified during the ASO review, then the CSEDW provider will receive a final letter and a final report from the BMS.

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

Corrective Action Plan (CAP): In addition to the draft exit report sent to the CSEDW providers, the ASO will also send a draft CAP electronically. CSEDW providers are required to complete the CAP and electronically submit a CAP to the ASO for approval within 30 calendar days of receipt of the draft CAP from the ASO. BMS may place a hold on claims if an approved CAP is not received by the ASO within the specified time frame. The CAP must include:

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

502.8 TRAINING AND TECHNICAL ASSISTANCE

The BMS contracted agent develops and conducts training for CSEDW providers and other interested parties as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Trainings are approved by the BMS and available through both face-to-face and web-based venues.

502.9 OTHER ADMINISTRATIVE REQUIREMENTS

The provider must assure implementation of BMS policies and procedures pertaining to documentation and case record review, as well as the following:

- All documentation completed on a member must be recorded and maintained in the member's individual record, whether electronic or written, and must be legible.
- Staff must use uniform guidelines for case record organization, so similar information will be found in the same place from case record to case record and can be quickly and easily accessed. Copies of completed release of information forms and consent forms must be filed in the case record.

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

- Records must contain completed member identifying information. The member's person-centered service plan (PCSP) must comply with all person-centered planning requirements and must contain service goals and objectives which are derived from a comprehensive member assessment and must stipulate the planned service activities and how they will assist in goal attainment. Discharge reports must be filed upon case closure.
- Prior to the retrospective review, all records requested must be presented to the reviewers completing the retrospective review.
- If requested, the providers must provide copies of Medicaid member records within one business day of the request.
- Providers must facilitate the records access that is requested as well as equipment that may need to be utilized to complete the Comprehensive Retrospective Review Process.
- Providers must provide a point of contact throughout the Comprehensive Retrospective Review Process.
- In addition to the documentation requirements described in this chapter, CSEDW service providers must comply with the documentation and maintenance of records requirements described in *Chapter 100, General Administration and Information, Chapter 300, Provider Participation Requirements* and 64 CSR 11 Behavioral Health Centers Licensure.
- Documentation of the services provided in this manual must demonstrate only one staff person's time is billed for any specific activity provided to the member.
- Electronic signature is an acceptable form of submission as long as it contains a time and date stamp.
- Reimbursement is not available for a telephone conversation, electronic mail message (email), or facsimile transmission (fax) between a provider and a member except for case management services.
- Mandatory CSEDW program training for all agency staff must begin on the first day of employment and be documented on the Certificate of Training Form (WV-BMS-CSED-06).
- Providers must subcontract with licensed individual or group practices of the behavioral health profession as defined by the OHFLAC, if contracting occurs.
- Providers must maintain evidence of implementing a utilization review and quality improvement process which includes verification that services have been provided and the quality of those services meets the standards of the CSEDW program and all other applicable licensing and certification bodies.
- Providers must provide an assigned agency CSEDW contact person whose duties include:
    - Oversight of agency staff implementing the PCSPs of all members in the CSEDW program; and,
    - Communicating with BMS, the MCO and the ASO.
- Providers must implement the CSEDW Quality Improvement System (QIS) as further defined under Section 502.13 Quality Improvement System.
- Providers must maintain written policies and procedures to avoid conflict of interest (if agency is providing Case Management and other services) that must include at a minimum:
    - Education of Case Managers on general Conflict of Interest/Professional Ethics with verification
    - Annual signed Conflict of Interest Statements for all Case Managers and the agency director
    - Process for investigating reports on Conflict of Interest

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

    - Process for reporting to the BMS
    - Process for complaint to professional licensing boards for ethics violations
- Staff training documentation must include training topic, date, the beginning time of the training, the ending time of the training, the location of the training, the signature of the instructor, and the signature of the trainee. Internet training must include the person's name, the name of the internet provider, and a certificate of completion or other documentation showing successful completion. All documented evidence of training for all staff persons who deliver CSEDW services must be kept on file and available upon request.
- Prior to using an internet provider for training purposes, the name, web address, and course names must be submitted to the ASO for review. The ASO will respond in writing whether the training meets training criteria.
- Case managers are also required to receive initial and annual training in Conflict-Free Case Management.
- In addition, the agency must maintain documentation that any staff person who provides transportation services via personal vehicle abides by local, state, and federal laws regarding maintaining current vehicle licensing, insurance, registration, and inspections.

502.10 TELEHEALTH SERVICES

West Virginia Medicaid encourages providers that have the capability to render services through Telehealth to allow easier access to services for Medicaid members. To utilize Telehealth, providers will need to document that the service was rendered under that modality. When filing a claim, the provider will bill the service code and 02 place of service. Each service in this manual is identified as "Available" or "Not Available" for Telehealth. Some services codes give additional instruction and/or restriction for Telehealth as appropriate. Services provided through Telehealth must align with requirements in *Chapter 519.17, Telehealth Services*.

502.11 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention requirements governing the provision of all WV Medicaid services will apply pursuant to *Chapter 100, General Administration and Information* and *Chapter 300, Provider Participation Requirements* of BMS Provider Manual. Providers must also comply, at a minimum, with the following documentation requirements:

- Providers must maintain a specific record for all services received for each eligible member including, but not limited to: name, address, birth date, Medicaid identification number, pertinent diagnostic information, a current service plan signed by the provider, signature and credentials of staff providing the service, designation of what service was provided, documentation of services provided, the dates the services were provided, and the actual time spent providing the service by listing the start-and-stop times as required by service.
- All required documentation must be maintained for at least five years in the provider's file subject to review by authorized BMS personnel. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- Failure to maintain all required documentation may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to the BMS upon request.

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

- Providers must also comply with the specific documentation requirements for the program or service procedure, as described in this manual.
- The BMS recognizes that some providers use an electronic system to create and store documentation while other providers choose to use a hard copy-based system. Regardless of the system the provider is using, providers using an electronic-based system will require an electronic signature with a time date stamped on the documentation. Each service code in this manual describes the required documentation. All requirements must be met no matter the modality of system choice. Any document that is printed must have a handwritten signature and be dated.

502.11.1 Confidentiality

An appropriate release of information form must be obtained and approved prior to sharing information in any situation other than those described here. Access to medical records is limited to the member, parent/legal representative, authorized facility personnel, and others outside the facility whose request for information access is permitted by law and is covered by assurances of confidentiality and whose access is necessary for administration of the facility and/or services and reimbursement.

A member may review their medical record in the presence of professional personnel of the facility and on the facility premises. Such review is carried out in a manner that protects the confidentiality of other family members and other individuals whose contacts may be contained in the record. Access to medical records is limited and should be available on a medical need-to-know basis and as permitted under federal and state law and any relevant court rulings.

Pictures of Medicaid members may be used for identification purposes only (contained in the member medical record and medication administration record). Usage for any other purposes, including public displays, social media posts or for promotional materials, are prohibited. All Medicaid member information must be kept locked in a secure place.

502.11.2 HIPAA Regulations

Providers must comply with all requirements of the Health Insurance Portability and Accountability (HIPAA) and all corresponding federal regulations and rules. The enrolled provider will provide, upon request of the BMS, timely evidence and documentation that they are in compliance with HIPAA. The form of the evidence and documentation to be produced is at the sole discretion of the BMS. Additional information on HIPAA may be found in *Chapter 300, Provider Participation Requirements*.

502.12 INCIDENT REPORTING REQUIREMENTS

All incident reporting requirements for the CSEDW are adherent to state and federal guidelines and subject to change. The comprehensive and up-to-date incident reporting guidelines for this waiver are available on the CSEDW website. The CSEDW provider must also comply with any other reporting required for mandatory reporters or as part of their behavioral health license.

Anyone providing CSEDW services who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 64 Series 11), WV State Code§ 9-6-1, § 9-6-

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

9, and § 49-6A-2 to report the incident. Reports of abuse and/or neglect may be made anonymously by calling 1-800-352-6513, seven calendar days a week, 24 hours day.

The CSEDW provider must also report suspected incidence of abuse and neglect to OHFLAC by telephone at 304-558-0050 or reports may be faxed to 304-558-2515. OHFLAC may assist with referring the report to the proper authorities.

The CSEDW providers must utilize the MCO Incident Management System (IMS) immediately and within 24 hours of the provider becoming aware of the occurrence to track the types of incidents listed below for anyone the agency provides services to:

- **Simple Incidents:** Any unusual event occurring to a person that needs to be recorded and investigated for risk management or quality improvement purposes. Examples would be a minor assault by another person with injury resulting; seizures in an individual not prone to seizures; injuries of unknown origin; high rates of uncharacteristic self-injurious behavior with no significant negative outcome; suicidal threats or gestures without significant injury; medication error with minimal or no negative outcome; etc.
- **Critical Incidents:** Incidents with a high likelihood of producing real or potential harm to the health and well-being of the person or persons served but not involving abuse or neglect.
- **Abuse, Neglect, and Exploitation Incidents:** Incidents which meet the following definitions of abuse, neglect, or exploitation:
    - Abuse means any physical motion or action (hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs. It includes use of corporal punishment as well as the use of any restrictive intrusive procedure to control inappropriate behavior for purposes of punishment.
    - Abuse also includes psychological abuse which means humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.
    - Abuse also includes verbal abuse which means use of oral, written, or gestured language by which abuse occurs. This includes demeaning and derogatory terms to describe persons with disabilities. Verbal abuse includes, but is not limited to yelling or using demeaning, derogatory, vulgar, profane or threatening language; threatening tones in speaking; teasing, pestering, molesting, deriding, harassing, mimicking or humiliating a person in any way; and making sexual innuendo.
    - Neglect means a negligent act or pattern of actions or events that caused or may have caused injury or death to person, or may have placed a person at risk of injury or death that was committed by an individual responsible for providing services. Neglect includes, but is not limited to a pattern of failure to establish or carry out a person's individualized program plan or treatment plan that placed or may have placed a person at risk of injury or death; a pattern of failure to provide adequate nutrition, clothing or health care; failure to provide a safe environment; and failure to maintain sufficient, appropriately trained staff.
    - Exploitation means the unlawful expenditure or willful dissipation of the funds or assets the benefit of an incapacitated individual.

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

The case management provider must submit a Mortality Notification (WV-BMS-CSED-11) to the ASO within seven calendar days from the date of death and to OHFLAC within 24 hours of the death of the member or when the CSEDW provider becomes aware of the member's death.

If the case management provider is forced to exceed the maximum caseload cap of 20 members due to staff vacancy, the case management provider must notify the ASO within 48 hours of learning of the need to exceed the maximum by providing the following in writing to the ASO:

- The number of members per each case manager whose caseload exceeds 20 members (e.g. case manager name, # of members)
- The agency plan, including time lines for hiring and training new case managers
- The agency's back-up plan to cover emergencies that occur due to exceeding the maximum case load cap.

The case manager is responsible for submitting and maintaining accurate and current data including name, address, telephone numbers, Case Management provider, parent/legal representative name, and contact information, etc. of all individuals served.

The case manager is required to notify the MCO of a member's transfer to another case management provider or if the member chooses another service delivery system within two business days:

- The transferring agency is responsible for the notification by submitting the Person Transfer/Discharge Form (WV-BMS-CSED-10). This form must include the last date of service provided.
- Lack of notification of the transfer will affect the prior authorization for service or registration of services to the correct service provider(s) and subsequent payment of claims for services.

502.13 QUALITY IMPROVEMENT SYSTEM (QIS)

The BMS is responsible for building and maintaining the CSEDW QIS. The CSEDW provider is responsible for participating in all activities related to the QIS. The CSEDW QIS is used by BMS and the ASO as a continuous system that measures system performance, tracks remediation activities, and identifies opportunities for system improvement. Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for members receiving services, and then using the information to identify strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies.

The QIS is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met, and help ensure the active involvement of interested parties in the quality improvement process.

502.13.1 Centers for Medicare and Medicaid Services (CMS) Quality Assurances

The CMS mandates the CSEDW program guarantee the following six Quality Assurances:

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

1. **CSEDW Administration and Oversight:** The State Medicaid agency is actively involved in the oversight of the CSEDW, and is ultimately responsible for all facets of the CSEDW program
2. **Level of Care:** Members enrolled in the CSEDW have needs consistent with an institutional level of care
3. **Provider Qualifications:** CSEDW providers are qualified to deliver services/supports
4. **Person-centered Service Plan:** A member has a service plan that is appropriate to their needs and preference and receive the services/supports specified in the service plan
5. **Health and Welfare:** A member's health and welfare are safeguarded
6. **Financial Accountability:** Claims for CSEDW services are paid according to state payment methodologies specified in the approved waiver.

Data is collected and analyzed for all the Quality Assurances and sub-assurances based on West Virginia's Quality Performance Indicators, as approved by CMS. The primary sources of discovery include CSEDW provider reviews, Incident Management Reports, complaints and/or grievances of members who receive services or the parent/legal representative OHFLAC reviews, abuse and neglect reports, administrative reports, oversight of delegated administrative functions and interested party input.

502.13.2 Quality Improvement Advisory (QIA) Council

The QIA Council is the focal point of stakeholder input for the CSEDW program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies. The QIA Council's role is to advise and assist BMS, MCOs, and the ASO staff in program planning, development, and evaluation consistent with its stated purpose. In this role, the QIA Council uses the CSEDW Performance Indicators as a guide to:

- Recommend policy changes
- Recommend waiver priorities and quality initiatives
- Monitor and evaluate policy changes
- Monitor and evaluate the implementation of waiver priorities and quality initiatives
- Serve as a liaison between the waiver and interested parties
- Establish committees and work groups consistent with the QIA Council's purpose and guidelines

The QIA Council membership is comprised of members who formerly utilized CSEDW services, members who currently are utilizing CSEDW services or the parent/legal representative, service providers, advocates and other interested parties of people with SEDs.

ELIGIBILITY AND ENROLLMENT

502.14 APPLICANT ELIGIBILITY AND ENROLLMENT PROCESS

In order for an applicant to be found eligible for the CSEDW program, they must:

- Be an eligible West Virginia Medicaid member. Medicaid eligibility is independent of medical eligibility for the CSEDW and is not impacted by enrollment in the CSEDW.
- Choose HCBS over services in an institutional setting
- Choose to enroll with the identified MCO

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

- Meet CSEDW medical eligibility
- Be at least three years of age and not yet 21
- Be a resident of West Virginia, even if presently living out of state in a PRTF, and be able to provide proof of residency upon waiver application

Enrollment in the CSEDW program is dependent upon the availability of a funded CSEDW slot.

Initial medical eligibility is determined by the MECA through review of an Independent Psychological Evaluation (IPE) report completed by a member of the IPN; which must include background information, mental status examination, a measure of intelligence, adaptive behavior, achievement and any other documentation deemed appropriate.

If a slot is not available, the applicant is placed on a Managed Enrollment List (MEL) in the chronological order in which they were determined eligible. When a slot becomes available, the applicant is informed and may proceed with the enrollment process for the CSEDW program.

In the event that an individual is assigned to an MCO other than the Specialized Foster Care MCO while they are on the managed enrollment list, they are required to transfer to the Specialized Foster Care MCO when a funded slot becomes available.

502.14.1 Application Process: Initial Eligibility Determination Process

Each new applicant must follow the eligibility process listed below for medical eligibility. An applicant may obtain an Application Form (WV-BMS-CSED-1) from the MCO, CSEDW providers, local/county DHHR Offices, the ASO and on the CSEDW website.

Completed applications must be submitted to the ASO (information is located on the application). Upon receipt of the WV-BMS-CSED-1, the ASO time and date stamps the application.

The ASO contacts the applicant within three business days upon receipt of the WV-BMS-CSED-1 and provides a list of Independent Psychologists (IP) in the IPN trained by the MECA that are available within the applicant's geographical area. The applicant chooses a psychologist from the IPN and contacts the IP to schedule the appointment within 14 calendar days and submits an IPN Response Form to the ASO identifying the selected IP.

Psychologists in the IPN are identified and placed on an IPN list following documented training by the MECA. The IP is responsible for completing an IPE and uploading it to the required internet site within 60 calendar days of the receipt date of the IPN Response Form by the ASO. The evaluation includes assessments which support the diagnostic impressions offered and relevant measures of functioning. The IPE is utilized by the MECA to make a medical eligibility determination.

The MECA makes a final medical eligibility determination within 30 calendar days of receipt of the completed IPE that utilizes the current approved diagnostic system. A written decision is mailed to the applicant and/or their parent/legal representative by the ASO.

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

If an applicant is approved for medical eligibility by the MECA and a funded CSEDW slot is available, then the applicant is enrolled into the CSEDW program. If a slot is not available, then the applicant will be placed on a managed enrollment list until a funded slot allocation is available.

If an applicant is determined to not meet medical eligibility criteria by the MECA, a written Notice of Decision, a Request for Medicaid Fair Hearing form, and a copy of the IPE is mailed by certified mail by the ASO to the applicant or the parent/legal representative. This denial of medical eligibility may be appealed by the applicant or the parent/legal representative through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 calendar days of receipt of the Notice of Decision. The Notice of Decision letter also allows the applicant or the parent/legal representative to request a second medical evaluation.

If a second medical evaluation is requested, then it must be completed within 60 calendar days by a different member of the IPN. If an applicant is determined to be medically eligible and a slot is available, then the applicant is enrolled into the CSEDW program. If a slot is not available, then the applicant will be placed on a managed enrollment list until a funded slot is available.

If the applicant is again determined by the MECA to not meet medical eligibility criteria following the second medical evaluation, then the applicant or their parent/legal representative of the applicant will receive a written Notice of Decision, a Request for Medicaid Fair Hearing form and a copy of the second IPE by certified mail by the ASO. This second denial of medical eligibility may be appealed through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 calendar days of receipt of the Notice of Decision and a Medicaid Fair Hearing will be scheduled.

The applicant or parent/legal representative may request a pre-hearing conference at any time prior to the Medicaid Fair Hearing. At the pre-hearing conference, the applicant and/or the parent/legal representative and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the denial.

The applicant shall have the right to access their IPE used by the MECA in making the eligibility decision and copies shall be provided free of charge by BMS.

If the denial of initial medical eligibility is reversed by the Hearing Officer, the applicant will be placed on the managed enrollment list based on the date of the Hearing Officer’s decision. When a slot is available, the applicant will be enrolled in the program.

Any applicant denied medical eligibility may re-apply to the CSEDW program at any time.

The applicant’s right to a medical eligibility determination within 90 calendar days may be forfeited if the applicant fails to schedule and keep a timely appointment or does not submit follow-up information needed to complete the IPE to the IP within a reasonable timeframe specified by the IP. Examples of follow-up documentation requested by the IP may include, but may not be limited to:

- Individualized Education Program (IEP) plan for school aged children;
- Psychiatric and Psychological Evaluations;

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

- Outpatient therapy notes and progress notes;
- Records from Inpatient Psychiatric Hospitalizations, Partial Hospitalizations, or Residential Placements; and
- Any other additional documentation deemed necessary by the IP to complete the IPE.

502.14.2 Initial Medical Eligibility

To be medically eligible, the applicant must require the level of care and services provided within community and home and community-based settings as evidenced by required evaluations and other information requested by the IP or the MECA and corroborated by narrative descriptions of functioning and reported history.

In order to be eligible for CSEDW, an applicant must have:

- Eligible diagnosis;
- Functional impairment; and
- Require PRTF Level of Care.

The applicant must have the ability to respond to treatment services. That is, the applicant does not have an intellectual impairment that interferes with the applicant's ability to participate and to process information for the program in which they have been admitted, unless documentation reflects that the IQ score is suppressed due to psychiatric illness.

502.14.2.1 Level of Care Instruments

The applicant must have an IPE completed by an enrolled licensed psychologist or supervised psychologist that includes a full battery test of intellect, a measure of achievement, a Preschool and Early Childhood Functional Assessment Scale (PECFAS)/Child and Adolescent Functional Assessment Scales (CAFAS), and the Behavioral Assessment System for Children (BASC).

Children presently placed in an out-of-state PRTF may have their psychological evaluation completed by a licensed psychologist employed by or contracted with the PRTF of that state provided the psychological evaluation contains the necessary psychometric testing described above. The evaluation must be completed within 90 calendar days of submission of application in order to be considered current. Payment for the out-of-state evaluation is considered a part of the PRTF per diem.

502.14.2.2 Diagnosis

An eligible diagnosis is defined as a diagnosable mental, behavioral, or emotional disorder that meets the current DSM diagnostic criteria. Excluded diagnoses may include, but are not limited to, substance use/abuse disorders if primary, intellectual or developmental disabilities, organic brain syndromes, and social/emotional conditions (V codes). Additionally, ratings on the most current BASC must reflect T-scores greater than 70 in two or more of the Clinical Scales. The potentially eligible diagnosis must be supported by additional documentation provided (i.e., previous psychological evaluations, IEP, facility records, etc.).

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

The applicant must demonstrate an impairment in functioning that is due to an eligible diagnosis.

502.14.2.3 Functionality

The applicant must have a substantial impairment in functioning that is defined as a Youth Total score of 90 or above on the PECFAS/CAFAS. The applicant must demonstrate an ability to engage in activities of daily living but lack adequate emotional or behavioral stability to meet the demands of daily living. The PECFAS/CAFAS must reflect elevated scores as noted above. The presence of substantial impairment must be supported not only by relevant test scores, but also the narrative descriptions contained in the documentation submitted for review and other relevant information (i.e., previous psychological testing, the IEP, treatment records, discharge summaries, etc.).

Within the total score of 90, one or more of the following PECFAS/CAFAS subscales must be a score of 30:

- School/day care/work role performance
- Home role performance
- Community role performance
- Behavior toward others
- Moods/emotions
- Self-harmful behavior
- Substance use (CAFAS only)
- Thinking/communication

502.14.2.4 PRTF Level of Care

The applicant must require a PRTF level of care and specifically has either resided in a PRTF within the past six months, or through evaluations by the MECA it is determined that there is a reasonable indication that the applicant is in imminent (one month or less) danger of being placed in a PRTF.

502.14.3 Slot Allocation Referral and Selection Process

Provided a funded CSEDW slot is available, the allocation process is based on:

- The chronological order by date of the ASO’s receipt of the fully completed initial application (WV-BMS-CSED-1) which includes approval of eligibility from the MECA; or
- The date medical eligibility is established as a result of a Medicaid Fair Hearing decision.

Once a funded slot becomes available, the enrollee will receive an informational packet which includes a Freedom of Choice form (WV-BMS-CSED-2) on which the enrollee must indicate the choice to receive HCBS as opposed to services in an institution, as well as the chosen Case Management provider and must be returned to the ASO within 30 calendar days of receipt of the informational packet.

Upon receipt of the complete and signed Freedom of Choice form, the ASO will refer the member to their chosen Case Management provider. The Case Management provider may reject the referral only if:

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

- It appears to have been received in error; or
- The Case management provider is at maximum service capacity and unable to accept referrals until additional Case Managers are hired; or
- The case management provider is unable to meet the referred member's medical and/or behavioral needs.

Case management providers that reject referrals due to service capacity may not receive future referrals until the capacity/service issues are resolved.

The enrollee must access CSEDW direct care services within 180 calendar days of when the funded slot becomes available or the enrollee will be discharged from the program.

502.15 ANNUAL RE-DETERMINATION OF WAIVER ELIGIBILITY PROCESS

In order for a member to be re-determined eligible for CSEDW services, the member must continue to meet all eligibility criteria as previously defined. This waiver determination is independent of the financial eligibility process for Medicaid coverage.

All members presently receiving CSEDW services will be evaluated annually utilizing a CAFAS/PECFAS and the Child and Adolescent Needs and Strengths (CANS). In order to be found eligible, the member must have an eligible diagnosis as described above.

To be redetermined and to continue to meet medical eligibility, the member must have a substantial impairment as described in Section 502.14.2.3 Functionality of this manual. Functionality for the annual redetermination will be determined by the CAFAS/PECFAS and the CANS.

The Needs Domains of the CANS will be reviewed. Members that show "no evidence of need/no need for action" as defined by the CANS, may not require continued eligibility for the CSEDW program and eligibility for the CSEDW program may be terminated.

The ASO will conduct the reassessment for medical eligibility redetermination up to 90 calendar days prior to each member's anchor date. The anchor date is assigned by the ASO and is defined as the annual date by which the member's medical eligibility must be recertified and is determined by the anniversary date that is the first day of the month following the date when initial medical eligibility was established by the MECA.

At the time of the annual reassessment by the ASO, each member or parent/legal representative must complete the Freedom of Choice Form (WV-BMS-CSED-2) indicating their choice of level of care settings, Case Management agency, other providers of CSEDW services. If the member has a legal representative that did not attend the annual reassessment and complete the Freedom of Choice Form (WV-BMS-CSED-2), then it is the responsibility of the Case Manager to obtain the signature of the legal representative prior to or at the Person-Centered Service Planning Team (PCSPT).

The ASO, the member, the parent/legal representative, the Case Manager, and any other members of the PCSPT that the member wishes to be present will attend the annual reassessment. The ASO will work with the member and their team to complete the CANS.

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

The member and/or parent/legal representative shall sign an acknowledgment that they participated in the assessment and were given the opportunity to review and concur with the answers recorded during the assessment. If the member or parent/legal representative declines to sign the acknowledgment for any reason (e.g., he or she does not believe the answers were recorded accurately), the member or their parent/legal representative shall notify the ASO through their Case Manager within five calendar days of the assessment date, and the ASO shall resolve the issue by conferring with the member and/or parent/legal representative to come to an agreement on the answers on the assessment. If the member or parent/legal representative still disputes the answers on the assessment, then the issue can be appealed through a Medicaid Fair Hearing. The Assessment Data Modification Request (WV-BMS-CSED-13) form must be fully completed must cite the items in question.

502.16 RIGHTS, RESPONSIBILITIES, GRIEVANCES, AND APPEALS

The member retains all rights afforded to them under the law and the lists below are intended to be limited to their rights and responsibilities as a member participating in the CSEDW program. Each member is informed of these rights by their CSEDW Case Management agency upon enrollment and at least annually thereafter.

502.16.1 Rights

Members and/or their legal representatives have the right to:

- Choose between HCBS as an alternative to institutional care by the ASO through the completion of a Freedom of Choice form (WV-BMS-CSED-2) upon enrollment in the program and at least annually thereafter.
- Choose their CSEDW providers.
- Address dissatisfaction with services through the CSEDW provider’s grievance procedure.
- Access the Medicaid Fair Hearing process consistent with state and federal law.
- Be free from abuse, neglect and financial exploitation.
- Be notified and attend any and all of their PCSPT meetings, including Significant Life Event meetings.
- Choose who they wish to attend their PCSPT meetings, in addition to those attendees required by regulations.
- Obtain advocacy if they choose to do so.
- File a complaint with the ASO regarding the results of their reassessment.
- Have all assessments, evaluations, medical treatments, and PCSPs explained to them in a format they can understand, even if they have a legal representative making the final decisions in regard to their health care.
- Make decisions regarding their services.
- Receive reasonable accommodations afforded to them under the ADA.

502.16.2 Responsibilities

The member and/or their legal representative (if applicable) have the following responsibilities:

- To be present during PCSPT meetings. In extremely extenuating circumstances, the legal representative or other team members may participate by teleconferencing if they do not bill for the time spent in the PCSPT. The member must be present and stay for the entire meeting if they do not have a legal representative.

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

- To understand that this is an optional program and that not all needs may be able to be met through the services available within this program.
- To participate and supply correct information in the annual assessments for determination of medical eligibility.
- To comply with all CSEDW policies including monthly home visits by the case manager.
- To implement the portions of the PCSP for which they have accepted responsibility.
- To maintain a safe home environment for all service providers.
- To notify their case manager immediately if the member's living arrangements change, the member's needs change, the member is hospitalized or if the member needs to have a Significant Life Event meeting.

Failure to comply with these responsibilities may jeopardize the member's continuation of CSEDW services.

502.16.3 Grievances and Complaints

A member receiving services has the right to obtain oral and written information on the CSEDW provider agency's complaints and grievance policies. If the member or the parent/legal representative is dissatisfied with the quality of services or the provider of service, it is recommended that they follow the CSEDW provider agency's grievance process. If the issue is not resolved at this level, the member or the parent/legal representative may file provider complaints directly to the Secretary's office (DHHR) and OHFLAC outlines the process within the behavioral health regulations in Section 4.7, "Complaint Investigations".

In regard to the MCO, a complaint is defined as an expression of dissatisfaction made about an MCO decision or services received from the MCO when an informal grievance is filed; some complaints may be subject to appeal. Complaints are handled through the MCO 'Provider Services Department' and reported to BMS quarterly; though reporting can be more frequent if necessary. Grievance is defined as an expression of dissatisfaction, either in writing (formal) or orally (informal), regarding any aspect of service delivery provided or paid for by the MCO, other than those MCO actions that are subject to appeal. The term grievance also refers to the overall system that includes grievances and appeals handled at the MCO level and access to the State Fair Hearing process.

The MCO will complete an investigation for all grievances received and report the results to the BMS and to the member receiving services or the parent/legal representative.

502.16.4 Medical Re-Determination Eligibility Appeals

If a member is determined not to be medically eligible, then the ASO sends by certified mail to the member or parent/legal representative: a written Notice of Decision (termination), a Request for Hearing form that includes free legal resources, and the results of the reassessment. This notice is also sent to the member's case manager and MCO. The termination may be appealed through the Medicaid Fair Hearing process if the Request for Hearing form is submitted to the Board of Review within 90 calendar days of receipt of the Notice of Decision. If the member or parent/legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted within 13 calendar days of the member or the parent/legal representative receipt of the Notice of Decision. If the

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

Request for Hearing form is not submitted within 13 calendar days of the member or the parent/legal representative receipt of the Notice of Decision, reimbursement for all CSEDW services will cease.

After filing a request for a Medicaid Fair Hearing, the member receiving services, or their legal representative may also request a second medical evaluation (IPE). The second medical evaluation must be completed within 60 calendar days by a member of the IPN. The case manager, upon notification of the eligibility decision, must begin the discharge process by arranging for a Transfer/Discharge PCSPT meeting to develop a “back-up” plan for transition because reimbursement for CSEDW services will cease on the 13th day after receipt of the written Notice of Decision letter if the member or their parent/legal representative does not submit a Request for Hearing form.

If the member is again denied medical eligibility based on the second medical evaluation, the member or the parent/legal representative will receive a written Notice of Decision, a Request for a Fair Hearing Form and a copy of the second medical evaluation by certified mail from the ASO. The member’s Case Manager and MCO will also receive a notice. The member or their legal representative may appeal this decision through the Medicaid Fair Hearing process if the Request for Hearing form is submitted to the Board of Review within 90 calendar days of receipt of the Notice of Decision.

A pre-hearing conference may be requested by the member or the parent/legal representative any time prior to the Medicaid Fair Hearing and the ASO will schedule. If the member or the legal representative has obtained legal counsel, the BMS legal counsel will conduct the pre-hearing. At the pre-hearing conference, the member and/or their legal representative and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination.

If the denial of medical eligibility is upheld by the Hearing Officer who is a member of the Department’s Board of Review authorized to conduct hearings and render decisions on behalf of the Board of Review, services that were continued during the appeal process must cease on the date of the hearing decision. If the member is eligible financially for Medicaid services without the CSEDW Program, other services may be available for the individual. If the termination based on medical eligibility is reversed by the Hearing Officer, the individual’s services will continue with no interruption.

The member and/or parent/legal representative shall have the right to access their medical evaluation (IPE) used by the MECA in making the eligibility decision and copies shall be provided free of charge.

502.17 TRANSFER AND DISCHARGE

The member has the right to transfer or discharge Case Management and other services from the existing provider to another chosen provider at any time for any reason. Transfers and discharges must be addressed on the PCSP and approved by the member or parent/legal representative and a representative from the receiving provider as evidenced by their signatures on the PCSP signature sheet. During the transition from one provider to another, the PCSP must be developed and must specifically address the responsibilities and associated time frames of the “transfer-from” and the “transfer-to” providers. The case manager must complete and submit the Person Transfer/Discharge Form (WV-BMS-CSED-10) within seven calendar days to the MCO. If a transfer PCSP is found not to be valid, then the authorizations for services may be rolled back to the transfer-from provider until a valid PCSP is held. A CSEDW provider may not terminate services unless a viable PCSP is in place that effectively transfers

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

needed services from one CSEDW provider to another provider and is agreed upon by the member and/or their parent/legal representative and the receiving provider. Providers are prohibited from discriminating in any way against a member or parent/legal representative wishing to transfer services to another provider agency.

502.18 PERSON-CENTERED SERVICE PLAN (PCSP) REQUIREMENTS

Engaging in authentic Person-Centered Planning can be transformational to the member and supporters involved. This type of process is driven by the needs of the member and can create major positive life changes for an individual by increasing opportunities to be included in their local communities as a reciprocating member. This planning process is rooted in what is most important to the member and involves them directly with their community, network of connections, and close personal relationships in order to look at the innovative ways to attain specific life goals. The focus is entirely on the member; never the system. Numerous mainstream resources are unearthed, considered, researched, and used. These resources are only considered in relationship to how they will support the member in achieving the member's goals. Team members are invited to attend and often times do not have a professional relationship with the member (e.g. coworkers, family, community members, etc.). Meetings typically do not occur at a provider office, rather the member's home or private community setting. These meetings are meant to be interactive and can involve non-traditional means of visualizing goals and the various steps to achieve them, beyond clinical record keeping.

Service planning is to be conducted when multiple programs and services need to be coordinated by a team representative of the differing agencies and provider groups providing care to the member.

The initial service plan must be completed within seven calendar days of admission to a service. The plan must be completed by the Case Manager and the member and/or parent/legal representative.

Development of the initial plan without the entire PCSP team is not a billable service. See Section 502.18.2 PCSP Development for clarification and description of exceptions. The Initial PCSP describes the services and/or supports the member is to receive until the assessment process is complete and the Master PCSP is developed. This Initial PCSP must consist of the following at a minimum:

- Description of any further assessments or referrals that may need to be performed
- A listing of immediate interventions to be provided along with objectives for the interventions
- A date for development of a master service plan. The designated date must be appropriate for the planned length of service but at no time will that exceed 30 calendar days from the date of the signing of the initial plan
- The signature of the member and/or parent/legal representative, case manager, physician, and other persons participating in the development of the initial plan, each person's credentials, and start/stop times

The master PCSP goals and objectives must be based on problems identified in the initial assessment or in subsequent reassessment(s) during the treatment process. The master PCSP is developed within 30 calendar days of enrollment and must include:

- A statement or statements of the member-centered positive and outcome-oriented goal(s) of services in general terms;

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

- A listing of specific objectives that the service providers and the member hope to achieve or complete. It is expected that objectives be specific, measurable, realistic, and capable of being achieved in the time available in the projected duration of the program or service;
- The measurable component objectives that provide steps toward achievement of specified outcomes, with realistic dates of achievement specified for each;
- The technique(s) and/or services (intervention) to be used in achieving the objective;
- Identification of the individuals responsible for implementing the services relating to the statement(s) of objectives and their frequency of intended delivery;
- Discharge criteria;
- A date for review of the plan, timed in consideration of the expected duration of the program/service; and
- A signature page inclusive of credentials, the date, and start/stop times of attendance of all participants in the development of the plan.

Service plans must be flexible documents that are modified by the team as necessary and clinically appropriate. Service plans must be revisited at significant life events including changes in level of service to more intensive or less intensive types of care. When an intervention proves to be ineffective, the service plan must reflect consideration by the team of changes in the intervention strategy.

502.18.1 Person-Centered Service Planning Team (PCSPT)

The PCSPT consists of the member and/or parent/legal representative, the member's Case Manager, representatives of each professional discipline, provider and/or program providing services to that member (inter- and intra-agency), the MCO care coordinator (if requested) and anyone not listed who the member choses to participate. The case manager is ultimately responsible for facilitating the development of and subsequent updates to the PCSP document; the member’s case management agency cannot provide any additional CSEDW services. It is important to remember that, although coordination of the PCSP process is the responsibility of the Case Manager, development of the PCSP is the responsibility of the PCSPT.

Although the PCSP is driven by the member’s needs, goals and preferences, the case manager in conjunction with the PCSPT informs the member and the member’s parents/legal representatives of the available resources that may be included in the PCSP. CSEDW services will emphasize the importance of combining natural supports from the community with professionals to create a PCSP that supports the recovery of the member and the parents/legal representatives of the member. West Virginia utilizes a strengths model, which views the member and parent/legal representative as the expert on the strengths and needs of the member. These strengths and needs are then used to guide PCSP development in combination with the information gathered during enrollment. The PCSPT captures the strengths, needs, preferences, and desired outcomes of the member and decides frequency and duration of services and supports.

502.18.2 PCSP Development

If a member is served by multiple behavioral health providers, all providers must be invited to participate in the service-planning session. All members of the team must receive adequate notice, which is defined as at least seven calendar days prior to the treatment team meeting. If a member of the team does not

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

attend, the team decides whether to proceed in their absence. If the team elects to proceed, documentation must describe the circumstances.

The case manager is responsible for the scheduling and coordination of treatment team meetings, monitoring the implementation of the service plan, and for initiating treatment team meetings as the needs of the member dictates. Justification for the presence of each staff person participating in the meeting is the responsibility of the case manager. Participation time by staff persons may vary depending on the nature of their involvement and contribution to the team process. Service planning meetings must be scheduled at times and places that facilitate the inclusion of the member. The agency providing services to the member may bill for participation by any of their staff necessary for the service planning process. Participation by staff from other agencies is not billable by the agency coordinating the service planning session. Participation by family members is not billable. It is important to remember that, although coordination of the service planning process is the responsibility of the case manager, development of the service plan is the responsibility of the treatment team.

CSEDW providers must make the proper distinction between service planning and other activities related to case management for the member. The case manager may be involved in the development of individual program plans, such as residential plans, day treatment plans, work training plans, educational plans, etc. as called for by the member's master PCSP. These types of activities may constitute billable time for case management services.

Individual program plans for (i.e. day treatment, job development) and other organized programs are not billable as a separate activity, but are considered part of the services for which the plans were developed, and are covered under the definition of those services.

The PCSP reimburses for team member participation. A written service plan is a product of that process and serves as substantiation that the process took place.

Documentation: The following documentation is required for substantiation:

- The service plan signature page must include original, dated signatures (with titles and credentials) of all participating members of the treatment team, the member and/or parent/legal representative and must include the actual time all individuals listed participated by listing the start-and-stop times of their participation. Staff may participate for different lengths of time, depending on the nature of their involvement and contribution to the team process. This document is to be placed in the member's clinical record along with the completed service plan or service plan update.
- If a staff person from another agency participates in the service planning session, they must also list the agency they are representing on the signature page. Separate documentation must also be included in their agency’s clinical record in the form of an activity note that states the purpose for participating in the meeting, their signature and credentials, the location, date, and the actual time spent participating in the session by listing their start-and-stop times.

If the member and/or parent/legal representative does not attend the service planning meeting, the reason for the member's absence must be documented in the clinical record. If unable to attend, the service plan must be reviewed and signed within seven calendar days by the member or their parent/legal

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

representative. If the clinical record does not include a valid signature page with required signatures, the service plan will be invalid, and subsequently, no services provided under its auspices will be billable.

Many services, including service plan development, can be provided via telehealth (i.e. video conferencing). This delivery method is reimbursable as it is considered a face-to-face meeting. In extenuating circumstances, PCSPT members may participate by teleconferencing (i.e. telephone). Team members who attend by teleconference may not bill for the time spent in the PCSPT and the Case Manager must note on the signature sheet that they attended by phone. The Case Manager must obtain signatures within 10 days for any PCSPT member who attended the meeting via telehealth or teleconference. Please see *Chapter 519.17, Telehealth Services* for more information on telehealth requirements.

502.18.2.1 Seven Day PCSPT Meeting

This meeting is mandatory when a member receives a CSEDW slot. This is the initial meeting that occurs within the first seven calendar days of admission/enrollment and must include discussion of CSEDW services as well as other support services a member needs to live successfully in the community. This PCSP document must reflect a full range of planned services: Medicaid, non-Medicaid, and natural supports. This meeting must be documented on the Initial PCSP (WV-BMS-CSED-4) by the member's Case Manager. If services can be finalized at this meeting and a full range of planned services are documented, then the 30-Day PCSPT meeting will not be necessary.

502.18.2.2 Thirty Day PCSPT Meeting

The Initial PCSP must be finalized within 30 calendar days. The resulting master PCSP (WV-BMS-CSED-5) completed by the Case Manager identifies the comprehensive array of services necessary to fully support the member who receives CSEDW services. The PCSPT must meet up to 30 calendar days prior to the member's annual anchor date to develop the PCSP. The effective date of the annual PCSP will remain the annual anchor date even if the PCSP was held 30 calendar days earlier. The anchor date sets the clock for scheduling all subsequent PCSPs. The PCSP must be reviewed and approved by the PCSPT at least every 90 calendar days unless otherwise specified in the plan; however, the time between reviews shall not exceed 180 calendar days. The PCSP must be reviewed at Significant Life Event meetings.

502.18.2.3 Transfer/Discharge PCSPT Meeting

This meeting is held when a member transfers from one CSEDW provider to another or when the member no longer meets medical eligibility or does not want to participate in the program. When the member transfers from one agency to another, the transfer-from agency is responsible for coordinating the meeting and documenting the transfer. The member or their parent/legal representative, as well as the transfer-to agency, must agree to the transfer. The transfer-from agency must send the resulting PCSP to the transfer-to agency within 14 calendar days. The transfer-from agency must also submit a transfer and attach Transfer/Discharge Form (WVBMS-CSED-10) to the MCO within seven calendar days. If the resulting PCSP is found to be invalid because necessary team members did not attend, or necessary services were not addressed during the transfer, then the authorizations may be rolled back to the transfer-from agency until a valid PCSP is held.

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

The member may be discharged from the program for the following reasons including, but not limited to:

- Loss of financial or medical eligibility
- Direct-care services have not been provided for 180 continuous days. For example, the member is placed in psychiatric treatment for an extended period of time
- Unsafe environment: an unsafe environment is one in which the direct support worker 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:
    - The member or other household members repeatedly demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten the direct support staff or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals or verbal threats to harm the direct-care staff and/or other agency staff
    - The member or other household members display abusive use of alcohol and/or drugs and/or other illegal activities in the home
- The member is persistently non-compliant with the Person-Centered Service Plan
- The member no longer desires or requires services
- The member moves to another state
- The member can no longer be safely maintained in the community

502.18.2.4 Significant Life Event PCSPT Meeting

This meeting is held within 48 hours when there is a significant change in the member's assessed needs and/or planned services. A significant life event may be the result of a change in the member's medical/physical status, behavioral status, or availability of natural supports. The PCSP must be updated to include PCSPT recommendations, minutes, and signatures of all PCSPT members indicating their attendance and agreement or disagreement.
A face-to-face meeting must be held under any of the following circumstances including but not limited to:

- All team members do not agree with services or service mix
- The member calls for a meeting
- A new goal will be implemented for the member
- The member changes residential setting (example: moves from natural family to a Licensed Group Home, foster care, or institutional setting or vice versa)
- The member goes into crisis placement
- The member has a change in legal representative status
- The primary caregiver changes or passes away
- The member receives a new service not previously received
- The member receiving services has had a documented change in need between the times the annual reassessment was conducted

The case manager, in consultation with the member receiving services or their parent/legal representative and the PCSPT, should conduct a Significant Life Event meeting whenever the need is identified. For additional information on service authorizations refer to Section 502.16.4 Appeals and Service Authorizations.

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

502.19 CASE MANAGEMENT REQUIREMENTS

Case management providers must exhibit effective inter-agency coordination that demonstrates a working knowledge of other community agencies. This means the provider and its contracting agencies must be aware of the specific program goals of other human service agencies, and maintain current information regarding the types of services offered and limitations on these services. Similarly, providers must help ensure that other human service agencies are provided with accurate, up-to-date information regarding the provider's services, service limitations, and priorities within those services. The provider must be an enrolled as a West Virginia Medicaid provider and approved CSEDW provider. Independent case management agencies must be certified as independent case managers by the BMS. The provider must have a contract with the identified MCO and must coordinate care between the MCO care manager and all other CSED providers for each waiver participant.

Providers must maintain documentation of staff qualifications in staff personnel files. Documented evidence includes, but is not limited to transcripts, licenses, and certificates. Case Management providers must have a review process to ensure that employees providing case management services possess the minimum qualifications outlined above. The review process must occur upon hiring of new employees and on an annual basis to assure that credentials remain valid.

Case management providers must plan annual staff development and continuing education activities for its employees and contractors that broaden their existing knowledge in the field of mental health, substance abuse, and/or developmental disabilities and related areas.

Case management providers must credential their staff by an internal curriculum specific to case management prior to the staff assuming their case management duties.

Staff development and continuing education activities must be related to program goals and may include supporting staff by attendance at conferences, university courses, visits to other agencies, use of consultants, and educational presentations within the agency. Documentation of staff continuing education, staff development, and case management training must be maintained in staff personnel files. This documentation at a minimum must contain a description of the continuing education activities, and must be signed and dated by the case management trainer and the case manager.

Conflicts of interest are prohibited. A conflict of interest is when the case manager who represents the member who receives services has competing interests due to affiliation with a provider agency, combined with some other action. “Affiliated” means the case manager has either an employment, contractual or other relationship with a provider agency such that the Case Manager receives financial gain or potential financial gain or job security when the provider agency receives business serving CSEDW members.

502.19.1 Member Choice of Single Case Management Provider

At the time of enrollment, the annual redetermination assessment, and at any time it is requested by the member or parent/legal guardian, each member or parent/legal representative will be provided a list of contact information for all Medicaid-enrolled providers rendering case management services. The member must be given an opportunity to choose one approved case management provider and must

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

indicate this choice on BMS-approved CSED Waiver Freedom of Choice form. A signed copy of this form must be retained in the member's record and must serve as an enrollment, disenrollment, or re-enrollment of the member with the provider.

The BMS reimburses only for case management services provided by the Medicaid-enrolled provider chosen by the member.

A member may choose a new case management provider at any time. The effective date of the change of providers will be the first day of the month following the change.

SERVICES

The services under this waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

502.20 CASE MANAGEMENT SERVICES

Case management services help to ensure and coordinate a comprehensive set of supports, resources, and strategies for each member and family.

502.20.1 Case Management

Procedure Code: T1016-HA
Service Unit: 15 minutes
Telehealth: Available with 02 place of service location only when due to inclement weather and excluding the monthly face-to-face contact. Telehealth justification must be provided within the service note.
Service Limit: Up to 874 units per service plan year; caseloads capped at 20 members per case manager

Site of Service: This service may be provided in the member's family residence, a licensed CSEDW provider agency office, public community locations, or via telehealth as indicated above.

Staff Credentials: Bachelor's degree in Human Services with two years post-college documented work experience serving this population and certified to complete the CANS assessment. Independent providers must be certified to practice independently per the certification process approved by the BMS.

Definition: The case manager is responsible for engaging the member and family in a partnership of shared decision-making regarding the PCSP development and implementation throughout the member's enrollment in the CSEDW. The case manager helps ensure and coordinate a comprehensive set of supports, resources, and strategies for each member and family. They work closely with service providers to help assure that CSEDW services and clinical treatment modalities augment each other for optimal outcomes for members and parents/legal representatives. The case manager will lead the PCSPT through engagement and team preparation, initial plan development, plan implementation, and transition, and provide intensive case management. This includes the development and implementation of a transition plan for participants who will reach the waiver's maximum age limit.

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

The case manager, and the agency that employs them, cannot provide any other waiver or State plan services for the member. The agency providing case management must provide Freedom of Choice for all other waiver and State plan services providers.

Services provided in this category will be in response to specific goals in the member's PCSP and will not duplicate any other services provided to the member.

If, between regular service planning sessions, the member requires access to a service not previously mentioned on the case management section of their service plan, both the member, the parent/legal representative, and the member's case manager must agree and attach an addendum signed and dated by the case manager and the member and/or parent/legal representative addressing the needed service to the plan.

Documentation: A Medicaid-enrolled provider of case management services must maintain the following information/documentation:

- An individual permanent clinical record for each member receiving case management services.
- Evidence in each clinical record that the member is shown to be in a targeted population as defined under the Applicant Eligibility and Enrollment section of this policy.
- A clinical record that must include documentation specific to services/activities reimbursed as CSEDW Case Management. This includes a specific note for each individual case management service/activity provided and billed.

Each case note must include all components as identified in the CSED Waiver Case Management Form including, but not limited to:

- Be dated and signed by the case manager along with their credentials, e.g. BA, BSW
- Have relevance to a goal or objective in the member's PCSP
- Include the purpose and content of the activity as well as the outcome achieved
- Include a description of the type of contact provided (e.g., face-to-face, correspondence, telephone contacts)
- List the location the activity occurred
- List the actual time spent providing each activity by itemizing the start and stop time

502.20.2 Case Management Service Activities

Case management activities include, but are not limited to the following:

- Engages the member and parent/legal representative throughout CSEDW enrollment
- Assembles the PCSPT, including the member and their parent/legal representative
- Helps to identify strengths and needs of the member and parent/legal representative as a precursor to PCSP development
- Leads PCSP meetings
- Develops and updates PCSP in partnership with the member and parent/legal representative that is reflective of the member's and parent/legal representative's priorities, individualized, strengths based, related to all life domains, coordinated with any psychiatric treatment received through other providers, focused on developmental tasks, resiliency and wellness, inclusive of safety

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

issues, targeted to address assessment indicators (e.g., CANS), and oriented towards discharge readiness

- Administers the CANS to the member at any identified 'significant life event(s),' in preparation for the annual PCSP development, as well as for the member's six-month PCSPT meeting
- Works with the MCO care manager to identify service providers, natural supports, and other community resources to meet member and parent/legal representative needs and make necessary referrals to include behavioral health, health, and dental care providers
- Facilitates connections with identified resources and providers; advocacy which includes the process of helping to empower members and parents/legal representatives to initiate and sustain interactions that support their overall wellness, interceding on their behalf when necessary to gain access to needed services and supports
- Documents and maintains a record regarding the PCSP and all revisions to the PCSP
- Monitors the implementation of PCSP, making sure the member and parent/legal representative are receiving the services identified in PCSP; on-going assessment and documentation of the member and parent/legal representative's strengths and needs, progress towards achieving goals, and efficacy of delivered services
- Maintains communication among all team members
- Consults with the family and other team members to help make sure the services the member and parents/legal representatives are receiving continue to meet their needs, and assembles the team to make necessary adjustments and revisions
- Initiates and coordinates discharge and after-care planning; linkage and referral to services and supports as specified in the PCSP including but not limited to: identifying local resources and services for use during both enrollment and discharge planning, sharing information with the member and parent/legal representative on relevant resources and service providers, including local family support programs, advisors and advocates, engaging the member and parent/legal representative in making informed choices
- Meets in person monthly with the member and their parent//legal representative in the member's home to verify services are delivered and appropriately documented in a safe environment in accordance with the PCSP, and that the member receiving services continues to meet eligibility. The purpose of these visits is to determine progress of the member receiving services and resources, assess achievement of training objectives, identify unmet needs, and provide for the appropriate support as necessary
- Acts as the primary CSEDW contact for the member, parent/legal representative, or other PCSPT members
- Manages and warehouses all information related to member, parent/legal representative, or other PCSPT member issues, questions, critical incidents, etc. and will work to help ensure all such items are addressed
- Facilitates the development and implementation of an individualized transition plan for members who will reach the waiver's maximum age limit

502.21 CRISIS SERVICES: MOBILE RESPONSE

Procedure Code: H2017-HA
Service Unit: 15 minutes

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

Telehealth: Available with 02 service location, only when distance does not permit staff to reach the member within one hour. Telehealth justification must be provided within the service note.
Service Limit: Up to 56 units per calendar week

Site of Service: This service may be provided in the member's family residence, a licensed CSEDW provider agency office, public community locations, or via telehealth as indicated above.

Staff Credentials: Bachelor's degree in Human Services with one year of documented experience working with this population

Definition: Mobile Response services are 24-hour services designed to respond immediately to issues that threaten the stability of the member's placement and their ability to function in the community. This service is intended to be of very short duration and primarily to engage/link to other services and resources, e.g., intensive in-home supports and services. This service may only be delivered in an individual, one-to-one session. The service includes de-escalation, issue resolution support, and the development of a stabilization plan for any additional services that are needed to resolve the immediate situation. The Case Manager will remain the primary contact for CSEDW; however, the agency providing the In-Home Family Therapy will implement and oversee all Mobile Response activities; including primary point of contact for the service, on-call coverage, staff training and credentialing, referral, and data reporting. Written policy and procedures, as defined by BMS, specific to Mobile Response must be developed and maintained by any agency providing the service. The Case Management agency will be notified of any Mobile Response activities. Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member. family residence, a licensed CSEDW provider agency office, and/or public community locations.

Documentation: Providers must maintain a permanent clinical record for all members of this service in a manner consistent with applicable licensing regulations. Documentation must contain an activity note containing a summary of events leading up to the crisis, the therapeutic intervention used, and the outcome of the service. The activity note must include the signature and credentials of the staff providing the intervention, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. A physician, licensed psychologist, supervised psychologist, or the member's in-home family therapist must review all pertinent documentation within 72 hours of the conclusion of the crisis and document their findings. The note documenting this review must include recommendations regarding appropriate follow-up and whether the treatment plan is to be modified or maintained, the practitioner's signature with credentials, and the date of service. The signature will serve as the order to perform the service.

Exclusions: The following activities are excluded from being performed through the Mobile Response Service Code:

- Response to a domestic violence situation
- Admission to a hospital, Crisis Stabilization Unit (CSU), or PRTF
- Time waiting for transportation or the transportation itself
- Removal of a minor or an incapacitated adult from an abusive or neglectful household
- Completion of certification for involuntary commitment

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

502.22 DAY SERVICES

Documentation: Documentation for the following Day Services must contain an activity note describing the service/activity provided and the relationship of the service/activity to objectives in the member's PCSP. Documentation must include: the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. Documentation must show progress or lack of progress toward the achievement of goals and objectives that are the focus of the sessions.

The services must be specified in the Initial and/or master PCSP of the member. The plan may be incorporated into the Initial or master PCSP, or after referencing the service on the PCSP, be a separate plan created by the professional clinician. The plan must be signed by the clinicians responsible for implementing the service.

The plan must identify the specific, sequential, steps necessary toward identified skill acquisition identified in the goal and be related to previously assessed deficits of the member (e.g., hand over hand, instruction, demonstration, practice, independent implementation, and mastery). The steps identified must establish a means for measuring achievement of objectives within the specified time frame. The plan must establish a realistic time frame for skill acquisition. If objectives have not been achieved within a realistic time frame established by the PCSP, it must be discontinued or revised.

502.22.1 Independent Living/Skills Building

Procedure Code: H2033-HA
Service Unit: 15 minutes
Telehealth: Not Available
Service Limit: Up to 160 units per calendar week in combination with job development and Supported Employment. Recipients must be aged 15-20 to access this service

Site of Service: This service may be provided only in public community locations

Staff Credentials: Bachelor's or associate degree in Human Services and a minimum of one year of documented experience working with this population **OR** high school diploma or GED and a minimum of two years of documented experience working with this population

Definition: Independent Living/Skills Building (CMS defined: Day Habilitation) services focus on enabling the member to attain or maintain their maximum potential and shall be coordinated with any needed therapies in the individual's PCSP, such as physical, occupational, or speech therapy. Provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the member's PCSP. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day). Independent Living/Skills Building services will also utilize a Therapeutic Mentoring (TM) model to

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

facilitate the member's achievement of their goals of community inclusion and remaining in/returning to their home. TM offers structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs. The mentor works with the in-home therapist to explore a youth's interests and abilities and creates activities that build various life skills and result in linkages to community activities. Utilizing these model services will include coaching, supporting, and training the youth in age-appropriate behaviors, interpersonal communication, conflict resolution and problem solving, and are provided in community settings (such as libraries, stores, parks, city pools, etc.). Independent living/skills building can be related to activities of daily living, such as personal hygiene, household chores, volunteering, household management, money management/budgeting, and socialization, if these skills are affected by the waiver member's SED. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy and informed choice necessary to successfully function in the community. Services provided in this category will be in response to a specific goal(s) in the member's PCSP provided under the direction of the in-home therapist and will not duplicate any other services provided to the member.

502.22.2 Job Development

Procedure Code: T2021-HA
Service Unit: 15 minutes
Telehealth: Not Available
Service Limit: Up to 160 units per calendar week in combination with Independent Living/Skills Building and Supported Employment. Recipients must be aged 15-21 to access this service

Site of Service: This service may only be provided in community locations.

Staff Credentials: High school diploma or GED, indirectly supervised by In-Home Support staff person. Indirect supervision is defined as supervision provided by a licensed individual who monitors, but is not required to be present in the setting when services are rendered.

Definition: Job development (CMS defined: Prevocational Services) provides learning and work experiences, including volunteer work and personal care activities, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time that does not exceed one year and have specific outcomes to be achieved, as determined by the member and their PCSPT through an ongoing PCSP process. Members receiving Job development must have employment-related goals in their PCSP the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which a member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by members without disabilities is considered to be the successful outcome of Job development. Job development should enable each member to attain the highest level of work in the most integrated setting and with the job matched to the member's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills that lead to competitive and integrated employment including, but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow

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

directions; ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training. Participation in Job Development is not a required pre-requisite for supported employment services provided under the waiver. Many members, particularly those transitioning from school to adult activities, are likely to choose to go directly into supported employment. Similarly, the evidence-based Individual Placement and Support (IPS) model of supported employment for members with behavioral health conditions emphasizes rapid job placement in lieu of Job Development. Documentation is maintained in the file of each member receiving this service that a referral has been made to a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Member may utilize the CSEDW Non-Medical Transportation service for travel to and from the member's residence and their supported employment or job development sites. Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member.

502.22.3 Supported Employment, Individual

Procedure Code: T2019-HA
Service Unit: 15 minutes
Telehealth: Not Available
Service Limit: Up to 160 units per calendar week in combination with Independent Living/Skills Building and Job Development. Recipients must be aged 18-21 to access this service
Site of Service: This service may only be provided in public community locations

Staff Credentials: High School diploma or GED, indirectly supervised by In-Home Support staff person

Definition: Supported Employment - Individual Employment Support services are the ongoing supports to adult members who, because of their disabilities need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above West Virginia's minimum wage, at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by members without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported employment - individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job development, training and systematic instruction, job coaching, benefits and work-incentives, planning and management, transportation, asset development and career advancement services. Other workplace support services including services not specifically related to job skill training that enable the member to be successful in integrating into the job setting such as personal care activities. Documentation is maintained in the file of each member receiving this service that a referral has been made to a program funded under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2. Payments that are passed through to users of supported employment services. Member may utilize the CSEDW Non-Medical Transportation service for travel to and from the member's residence and their

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

supported employment or job development sites. Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member.

502.23 EXTENDED PROFESSIONAL SERVICES: SPECIALIZED THERAPY

Procedure Code: G0176-HA
Service Unit: $1.00
Telehealth: Not Available
Service Limit: Up to $500.00 per service plan year in combination with Assistive Equipment

Site of Service: This service may be provided in the member's family residence, a licensed CSEDW provider agency office, and/or public community locations.

Staff Credentials: Professional license, certification and/or skills training in the specific specialized therapy

Definition: Specialized Therapy refers to activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of a member's needs that arise as a result of their SED. The service is intended to assist the member in acquiring the knowledge and skills necessary to understand and address these treatment needs, e.g., developing and enhancing problem-solving skills, coping mechanisms, strategies for the member's symptom/behavior management. Specialized therapies are professional services that should promote full membership in the community and/or increase safety in the home environment and local public community and/or assist the individual in self-directing their services. Specialized Therapy services must be directed and provided by professionals who are trained, qualified, and/or certified to provide activity therapies. Providers of Specialized Therapy cannot treat their own family members. Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member and based on medical necessity.

Documentation: Documentation must contain an activity note describing the service/activity provided and the relationship of the service/activity to objectives in the member's PCSP. Documentation must include: the signature and credentials of the staff providing the service, place of service, date of service, and the actual time spent providing the service by listing the start-and-stop times. Documentation must show progress or lack of progress toward the achievement of goals and objectives that are the focus of the sessions.

The services must be specified in the Initial and/or Master PCSP of the member. The plan may be incorporated into the Initial or master PCSP, or after referencing the service on the PCSP, be a separate plan created by the professional clinician. The plan must be signed by the clinicians responsible for implementing the service.

The plan must identify the specific, sequential, steps necessary toward identified skill acquisition identified in the goal and be related to previously assessed deficits of the member (e.g., hand over hand, instruction, demonstration, practice, independent implementation, and mastery). The steps identified must establish a means for measuring achievement of objectives within the specified timeframe. The plan must

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

establish a realistic time frame for skill acquisition. If objectives have not been achieved within a realistic time frame established by the PCSP, it must be discontinued or revised.

502.24 GOODS AND SERVICES

Documentation: Documentation for equipment covered under the following Goods and Services must be specified in the Initial and/or master PCSP of the member. The plan may be incorporated into the Initial or Master Service Plan, or after referencing the service on the Service Plan, be a separate document created by the professional clinician. The plan must be signed by the clinicians responsible for implementing the service. Goods and services must be purchased from an established business or otherwise qualified entity or individual and must be documented by a dated and itemized receipt or other documentation.

502.24.1 Assistive Equipment

Procedure Code: T2035-HA
Service Unit: $1.00
Telehealth: Not Available
Service Limit: Up to $500.00 per service plan year in combination with Specialized Therapy
Site of Service: N/A

Definition: Assistive Equipment refers to an item or piece of equipment that is used to address the member's needs that arise as a result of their SED. The equipment should increase, maintain, or improve functional capabilities of the member, assist them to remain in the home and/or community and avoid an out-of-home placement.

Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member and based on medical necessity.

502.24.2 Community Transition

Procedure Code: T2038-HA
Service Unit: $1.00
Telehealth: Not Available
Service Limit: Up to $3,000 for a one time transition period; a transition period can last up to six months. Recipient must be aged 18 through 20 years to access this service.
Site of Service: N/A
Definition: Community Transitions Services are non-recurring set-up expenses for adult individuals who are transitioning from an institutional living arrangement to a living arrangement in a private residence where the member is directly responsible for their own living expenses. Allowable expenses are those necessary to enable a member to establish a basic household that do not constitute room and board and may include:

- Security deposits that are required to obtain a lease on an apartment or home
- Essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens

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

- Set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water
- Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy
- Moving expenses
- Necessary home accessibility adaptations
- Activities to assess need, arrange for, and procure needed resources

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the PCSP development process, clearly identified in the PCSP and the member is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.

Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member and based on medical necessity.

502.25 PERSON-CENTERED SUPPORT

Documentation: Documentation for In-Home Family Therapy and In-Home Family Support must indicate and support how often this service is to be provided. Within the Master PCSP, the intervention must be reflective of a goal and/or objective on the Plan. There must be an activity note describing each service/activity provided that includes the following:

- Date, location, and start/stop times of service
- Signature with credentials
- Reason/purpose for the service and relationship of the service to the member's identified behavioral health treatment needs
- Symptoms and functioning of the member
- Therapeutic intervention grounded in a specific and identifiable theoretical base that provides framework for assessing change that is directly related to the diagnosed condition that is the focus of the treatment
- Member's response to the intervention and/or treatment
- Plan for continued therapy

502.25.1 In-Home Family Therapy

Procedure Code: H0004-HO-HA
Service Unit: 15 minutes
Telehealth: Available with 02 service location and telehealth justification must be provided within the service note
Service Limit: Up to 8 units per day

Site of Service: This service may be provided in the member's family residence or via telehealth as indicated above

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

Staff Credentials: Staff qualified for this service are as follows: Licensed Psychologist (LP); Supervised Psychologist (SP); Licensed Professional Counselor (LPC); Licensed Graduate Social Worker (LGSW); Licensed Independent Social Worker (LICSW); Licensed Clinical Social Worker (LCSW); Licensed Social Worker (LSW); Board Certified Behavior Analyst (BCBA); Advanced Alcohol and Drug Counselor (AADC) and an Alcohol and Drug Counselor (ADC). Staff providing this service must have documented experience in trauma-informed care and using generally accepted practice of therapies recognized by national accrediting bodies for psychology, psychiatry, counseling, and social work.

Definition: In-Home Family Therapy consists of counseling and training services for the member and family provided by a mental health professional listed within the Staff Credentials section. This service includes trauma-informed individual and family therapy in the family home. It should assist the family to acquire the knowledge and skills necessary to understand and address the specific needs of the member in relation to their SED and treatment, such as developing and enhancing the family's problem-solving skills, coping mechanisms, and strategies for the member's symptom/behavior management.

In-Home Family Therapy providers will implement and oversee all Mobile Response activities; including primary point of contact for the service, on-call coverage, staff training and credentialing, referral, and data reporting. Written policy and procedures, as defined by the BMS, specific to Mobile Response must be developed and maintained by any agency providing the service. Additionally, the In-Home Family Therapist indirectly supervises the In-Home Family Support and Respite Care positions.

Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member.

502.25.2 In-Home Family Support

Procedure Code: H0004-HA
Service Unit: 15 minutes
Telehealth: Available with 02 service location and telehealth justification must be provided within the service note
Service Limit: Up to 8 units per day

Site of Service: This service may be provided in the member's family residence or via telehealth as indicated above

Staff Credentials: Bachelor's degree in Human Services with one year of documented experience working with this population

Definition: In-Home Family Support services allow the member and family to practice and implement the coping strategies introduced by the in-home therapist. The family support worker works with the member and family on the practical application of the skills and interventions that will allow the member and family to function more effectively. The family support worker assists the family therapist by helping the parent/child communicate their concerns; providing feedback to the therapist about observable family dynamics; helping the family and youth implement changes discussed in family therapy and/or parenting classes; providing education to the parent/legal representative regarding their child's mental illness; coaching, supporting, and encouraging new parenting techniques; helping parents/legal representatives

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

learn new parenting skills specific to meet the needs of their child; participating in family activities and supports parents/legal representatives in applying specific and on-the-spot parenting methods in order to change family dynamics. Additionally, the In-Home Family Support staff person supervises the Job Development and Supported Employment position(s).

Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member. The worker will be supervised by the therapist.

502.25.3 Peer Parent Support

Procedure Code: H0038-HA
Service Unit: 15 minutes
Telehealth: Available with 02 service location and telehealth justification must be provided within the service note
Service Limit: Up to 8 units per week

Site of Service: This service may be provided in the member's family residence, a licensed CSEDW provider agency office, and/or public community locations

Staff Credentials: High school diploma or GED **AND** lived experience as an individual or family member of a child with SED. The peer parent must also be a certified peer parent via the certification process approved by the BMS.

Definition: Peer parent support services are designed to offer support to the parent/legal representative with SED. The services are geared toward promoting parent/legal representative empowerment, enhancing community living skills, and developing natural supports. This service connects the parent/legal representative with a parent(s) who is raising or has raised a child with SED and are personally familiar with the associated challenges. Peer Parent Support providers are mentors who have shared experiences as the member, family, or both member and family and who provide support and guidance to the member and their family members. Peer Parent Support providers explain community services, programs and strategies they have used to achieve the waiver member's goals. It fosters connections and relationships which builds the resilience of the member and their family. This service, limited in nature, is aimed at providing support and advice based on lived experience of a family member or self-advocate. Peer parent support providers cannot mentor their own family members. Peer Parent Support services encourage members and their family members to share their successful strategies and experiences in navigating a broad range of community resources beyond those offered through CSEDW with other waiver members and their families. Service includes facilitation of parent or family member "matches" and follow-up support to assure the matched relationship meets peer expectations. Peer parent support providers will not supplant, replace, or duplicate activities that are required to be provided by the case manager, In-Home Family Therapy, or In-Home Family Support.

Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member.

Documentation: Documentation report must be maintained in the member's medical record and contain the following:

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

- Member name
- Date, location, and start/stop time of service/meeting;
- Activity note (describing each activity):
    - Self Help: Cultivating the member's ability to make informed, independent choices. Helping the member develop a network of contacts for information and support based on experience of the peer parent support. Assist in developing social skills, repairing, rebuilding, or establishing prevention networks.
    - System Advocacy: Assisting the individual to talk about what it means to have a substance use or co-occurring disorder to an audience or group. Assisting the individual with communicating about an issue related to their substance use and/or their recovery.
    - Individual Advocacy: Discussing concerns about medication at the individual's request. Assisting with developing independence in self-referral techniques, accessing appropriate care, and understanding clear communication and coordination with any health care provider.
    - Recovery Planning: Helping the member make appointments for all medical treatment when requested. Guiding the member toward a proactive role in health care, jointly assessing services, identifying triggers for use, developing a relapse plan, and building support network.
    - Crisis Support: Assisting the individual with the development of a personal crisis plan. Helping with stress management and developing positive strategies for dealing with potential stressors and crisis situations.
    - Relapse Prevention: Giving feedback to the member on early signs of relapse and how to request help to prevent a crisis. Assisting the member in learning how to use the crisis/relapse plan. Educating on relapse prevention and identifying relapse trigger, developing a relapse plan and prevention. Learn new ways to live life without the inclusion of drugs, skills building for such things as time management and connecting with prosocial activities.
    - Housing: Assisting the member with learning how to maintain stable housing through bill paying and organizing their belongings. Assisting the member in locating improved housing situations. Teaching the member to identify and prepare healthy foods according to cultural and personal preferences of the member and their medical needs.
    - Education/Employment: Assisting the member in gaining information about going back to school or job training. Facilitating the process of asking an employer for reasonable accommodation for psychiatric disability (mental health day, flex time, etc.)
- Type of Service:
    - Emotional: Should demonstrate empathy, caring, or concern to bolster a member's self-esteem and confidence.
    - Informational: Share knowledge and information and/or provide life or vocational skills training.
    - Instrumental: Provide concrete assistance to help others accomplish tasks.
- Signature and credentials of the staff providing the service and Facility where the provider is employed.
- Affiliation Support: Facilitate contacts with other people to promote learning of social and recreational skills, create community and acquire a sense of belonging.

NOTE: More than one activity can be utilized at any one service/meeting.

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

If there is a master PCSP, the intervention should be reflective of a goal and/or objective on the plan. The activity note must include the reason for the service, symptoms and functioning of the member, and the member's response to the intervention and/or treatment.

Peer parent support services may not be provided during the same time/at the same place as any other direct support Medicaid service. A fundamental feature of peer parent support is that the services are provided in the natural environment as much as possible.

502.26 RESPITE CARE

Documentation for in-home and out-of-home respite must be completed on the Direct-Support Service Log (WV-BMS-CSED-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Direct Support Progress Note (WV-BMS-CSED-07) to detail the issue. The Direct-Support Service Log (WV-BMS-CSED-07) must include all of the following items:

- Name of member who receives service
- Case management provider name and Signature of the staff person
- Date of service; start and stop times; total time spent
- Service code including modifier to indicate ratio of staff to members who receive services
- Indication (Y/N) of whether training was provided
- Transportation Log (WV-BMS-CSED-07) including beginning location (from) and end location (to) and total number of miles for the trip

502.26.1 Respite Care, In-Home

Procedure Code: T1005-HA
Service Unit: 15 minutes
Telehealth: Not Available
Service Limit: Up to 24 calendar days per year in combination with Out-of-Home Respite Care. Members residing in a foster care, facility, or independent living setting do not qualify for the service. Foster parents/homes are excluded from this service under the waiver, as the Title IV-E payment to foster care families should include respite. Waiver funds are not available to pay for room and board and supervision of children who are under the state's custody, regardless of whether the child is eligible for funding under Title IV-E of the Act. The costs are associated with maintenance and supervision of these children are considered a state obligation and not reimbursable via the waiver.

Site of Service: Must be provided in the member's home that may include biological homes, kinship homes, and adoptive homes. Respite may be provided in the local public community if delivery begins and ends in the member's home.

Staff Credentials: High school diploma or GED and must be indirectly supervised by the In-Home Family Therapist

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

Definition: Respite care services provide temporary relief to the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period. Service can be used to support the member in engaging in age-appropriate community activities, such as shopping, volunteering, attending concerts, etc.

Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member. The worker will be supervised by the therapist. The services under the waiver are limited to additional services not otherwise covered under the Medicaid State plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Service cannot be provided while the member is asleep.

502.26.2 Respite Care, Out-Of-Home

Procedure Code: T1005-HA-HE
Service Unit: 15 minutes
Telehealth: Not Available
Service Limit: Up to 24 calendar days per year in combination with In-Home Respite Care. Members residing in a foster care, facility, or independent living setting do not qualify for the service. Foster parents/homes are excluded from this service under the waiver, as the Title IV-E payment to foster care families should include respite. Waiver funds are not available to pay for room and board and supervision of children who are under the state's custody, regardless of whether the child is eligible for funding under Title IV-E of the Act. The costs are associated with maintenance and supervision of these children are considered a state obligation and not reimbursable via the waiver.

Site of Service: Provided in the local public community if delivery begins and ends in the member's certified therapeutic foster care home.

Staff Credentials: High school diploma or GED and must be supervised by the In-Home Family Therapist

Definition: Respite care services provide temporary relief to the member's regular caregiver and include all the necessary care that the usual caregiver would provide during that period. Please note waiver services may be furnished to children in foster care living arrangements but only to the extent that waiver services supplement maintenance and supervision services furnished in such living arrangements and waiver services are necessary to meet the identified needs of the children. Service can be used to support the member in engaging in age-appropriate community activities, such as shopping, volunteering, attending concerts, etc.

Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member.

502.27 NON-MEDICAL TRANSPORTATION

Members who receive CSEDW services should access Non-Emergency Medical Transportation (NEMT) services for State Plan (non-CSEDW) Medicaid services, such as doctors' appointments. For more information see BMS website under *Chapter 524, Transportation*.

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

Non-Medical Transportation services are only to be utilized for services covered under the CSEDW in this chapter.

Procedure Code: A0160-HA
Service Unit: 1 mile
Telehealth: Not Available
Service Limit: Up to 800 miles per month. Foster parents/homes are excluded from this service under the waiver, as the Title IV-E payment to foster care families should include transportation

Staff Credentials: Any person who provides transportation services via personal or agency vehicle(s) must abide by local, state, and federal laws regarding operation and maintenance of current licensing, insurance, registration, and inspections according to the West Virginia Department of Motor Vehicles.

Definition: Service offered in order to enable waiver members to be transported to and from local, public community locations for services specified in the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Services provided in this category will be in response to a specific goal(s) in the member's PCSP and will not duplicate any other services provided to the member.

Documentation: Documentation must be completed on the Direct-Support Service Log (WV-BMS-CSED-07) to include the items listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff person should complete the accompanying Direct Support Progress Note (WV-BMS-CSED-07) to detail the issue. The Direct Support Service Log (WV-BMS-CSED-07) must include all of the following items:

- Name of member who receives service
- Case management provider name and Signature of the staff person
- Date of service; start and stop times; and total time spent
- Service code including modifier to indicate ratio of staff to members who receive services
- Indication (Y/N) of whether training was provided
- Transportation Log (WV-BMS-CSED-07) including beginning location (from) and end location (to) and total number of miles for the trip

This service may be billed concurrently with day services, respite care services, or peer parent support. the number of miles per service must be included on the member's PCSP.

502.28 SERVICE LIMITATIONS AND SERVICE EXCLUSIONS

Services governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the Provider Manual and Section 502.18.2 PCSP Development of this chapter. Reimbursement for services is made pursuant to *Chapter 600, Reimbursement Methodologies.* The following limitations also apply to the requirements for payment of services that are appropriate and necessary for CSEDW services described in this chapter. CSEDW services are made available with the following limitations:

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

- All CSEDW regulations and policies must be followed in the provision of the services. This includes the requirement that all CSEDW providers be licensed in the State of West Virginia, enrolled in the West Virginia Medicaid program, and contracted with the MCO
- The services provided must conform with the stated goals and objectives on the member's PCSP
- Individual service and limitations described in this manual must be followed
- The CSEDW services may be provided within 30 miles of the West Virginia border to members residing in a West Virginia county bordering another state.
- In addition to the non-covered services listed in *Chapter 100, General Administration and Information* of the West Virginia Medicaid Provider Manual, the BMS will not pay for the following services:
  - The CSEDW program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973
  - Public school services, including children who are home-schooled, receive home-bound instruction, and children who are eligible for public school services but are not enrolled
  - Service payments may not be made for room and board or the cost of facility maintenance and upkeep
  - Birth-to-Three services paid for by Title C of Individuals with Disabilities Education Act (IDEA) for children enrolled in the CSEDW program
  - CSEDW services may not be provided concurrently unless otherwise indicated in the service definition
  - Telephone consultations
  - Meeting with the member or member's family for the sole purpose of reviewing evaluation and/or results
  - Missed appointments, including but not limited to, canceled appointments and appointments not kept
  - Services not meeting the waiver definition of Medical Necessity
  - Time spent in preparation of reports
  - A copy of medical report when the agency paid for the original service
  - Experimental services or drugs
  - Any activity provided for leisure or recreation
  - Services rendered outside the scope of a provider's license
- Reimbursement for CSEDW services cannot be made for services provided outside a valid PCSP. To be considered valid, the PCSP must be current (dated within the past year and reviewed quarterly by PCSPT), signed by all required PCSPT members, and include all provided services. The following are considered reasons for invalid PCSP:
  - Services provided when eligibility has not been established
  - Services provided when there is no PCSP
  - Services provided without supporting documentation
  - Services provided by unqualified staff
  - Services provided outside the scope of a defined service

502.29 PRIOR AUTHORIZATIONS

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the BMS Provider Manual.

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

General information on prior authorization requirements for additional services and contact information for submitting a request may be obtained by contacting the MCO.

502.30 BILLING PROCEDURES

Claims from providers must be submitted on the designated form or electronically transmitted to the fiscal agent and must comply with the following:

- Must include all information required to process the claim for payment
- The amount billed must represent the provider's usual and customary charge for the services delivered
- Claims must be accurately completed with required information
- By signing the Provider Enrollment Agreement, providers certify that all information listed on claims for reimbursement from Medicaid is true, accurate, and complete. Therefore, claims may be endorsed with computer-generated, manual, or stamped signatures
- Claim must be filed on a timely basis, i.e., filed within 360 calendar days from the date of service, and a separate claim must be completed for each individual member

502.31 HOW TO OBTAIN INFORMATION

Please refer to the CSEDW website for program contact information.

GLOSSARY

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

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

Abuse and Neglect: As defined in and West Virginia Code §9-6-1 and West Virginia code §49-1-201.

Agency Staff: Staff or contracted extended professional staff employed by a CSEDW provider to provide services to members in the CSEDW Program through the Traditional Option.

Amount: As it relates to service planning, the amount refers to the number of hours in a day a service will be provided. Example: Four hours per day.

Anchor Date: The annual date assigned by the ASO by which the member’s medical eligibility must be recertified and is determined by the anniversary date that is the first day of the month following the date when initial medical eligibility was established by the MECA.

Approved Medication Assistive Personnel (AMAP): An unlicensed staff person who meets the eligibility requirements to become an AMAP, has successfully completed the required training and

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

competency testing and has been deemed competent by the RN to administer medications to residents in the covered facilities in accordance with OHFLAC AMAP policy.

Case Management Agency (CMA): A privately operated for profit or nonprofit organization/agency licensed to do business in West Virginia, having a provider agreement with BMS and enrolled as a provider of case management services.

Case Manager (CM): A person (such as a social worker or nurse) who assists in the planning, coordination, monitoring, and evaluation of medical services for a member with emphasis on quality of care, continuity of services, and cost-effectiveness; also referred to as a caseworker.

Community Location: Any community setting open to the general public such as libraries, banks, stores, post offices, etc., within a justifiable proximity to the member's geographical area.

Community Integration: The opportunity to live in the community, and participate in a meaningful way to obtain valued social roles as other citizens.

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

Direct Care Staff: The individuals who provide the day-to-day care to Personal Care members. Sometimes referred to as homemakers or personal assistants.

Days: Calendar days unless otherwise specified.

Duration: As it relates to service planning, the duration is the length of time a service will be provided. Example: six months, three months, one month.

DSM: Abbreviation for the "Diagnostic and Statistical Manual of Mental Disorders," a comprehensive classification of officially recognized psychiatric disorders, published by the American Psychiatric Association, for use by mental health professionals to help ensure uniformity of diagnosis.

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

Fiscal Agent: The contracted vendor responsible for claims processing and provider relations/enrollment.

Freedom of Choice: The guaranteed right of a beneficiary to select a participating provider of their choice.

Frequency: As it relates to service planning, the frequency refers to how often a service is provided. Example: Monday – Friday, daily, etc.

Foster Child: The West Virginia DHHR defines a foster child as a child receiving 24-hour substitute care while placed away from his or her parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster

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

homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes.

GED: General Equivalency Development or General Equivalency Diploma that is used for educational testing services designed to provide a high school equivalency credential.

Goals: Statement of outcome with specific tasks and objectives to achieve those outcomes. Goals are set to help ensure that effective services are being provided to the member.

Home or Residence: The member's place of residence which includes a boarding home or home for the aged. Home does not include a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the intellectually disabled.

Home and Community Based Services (HCBS): Services which enable individuals to remain in the community setting rather than being admitted to an institution.

Human Services Degree: A master's or bachelor's degree granted by an accredited college or university in one of the following human services fields: Psychology; Nursing; Sociology; Social Work; Counseling/Therapy; Teacher Education; Behavioral Health; or other degrees approved by the WV Board of Social Work. **Note:** Some services require specific degrees as listed in the manual; see specific services for detailed information on staff qualification.

Incident: Any unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes.

Independent Psychologist (IP): A West Virginia licensed psychologist who is a West Virginia Medicaid Provider who performs comprehensive psychological evaluations independent of CSEDW providers and who is a person of the IPN trained by the MECA.

Independent Psychological Evaluation (IPE): An evaluation completed by a psychologist of the IPN which includes background information, behavioral observations, documentation that addresses the six major life areas, developmental history, mental status examination, diagnosis, and prognosis.

Independent Psychologist Network (IPN): West Virginia licensed psychologists who are enrolled West Virginia Medicaid providers and have completed the required IPN Training provided by the MECA training and agreed to complete the IPE as defined.

Indirect Supervision: Supervision provided by a licensed individual who monitors, but is not required to be present in the setting when services are rendered.

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

Internal Credentialing: An individual approved to provide Licensed Behavioral Health Center (LBHC) Services by the agency's working committee composed of experienced licensed and/or certified staff

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

representative of the appropriate disciplines or practitioners. A provider agency with few clinical staff may designate a credentialing officer.

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

Legal Representative: The parent of a minor child or a court appointed legal guardian for an adult or child, or anyone with the legal standing to make decisions for the member.

Licensed Psychologist: A psychologist who has completed the requirements for licensure that have been established by the West Virginia Board of Examiners of Psychologist and is in current good standing with the board.

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a comprehensive risk contract under the following:

- A Federally qualified Health Maintenance Organization (HMO) that meets the advance directive requirements of subpart I of part 489 of the Federal Register definition of a Federally Qualified HMO;
- Any public or private entity that meets the advance directive requirements and is determined to also meet the following conditions:
  - Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid members within the area serviced by the entity
  - Meets the solvency standards of Section 438.116

MCO Incident Management System (IMS): A web-based program used by CSEDW provider staff to report simple and critical abuse, neglect, and exploitation incidences to the BMS.

Medical Eligibility: The decision by the BMS or its agent that the health care status and treatment requirements as prescribed by a medical practitioner substantiate the level of care and criteria for the Waiver Program.

Member (aka person, user, client, beneficiary, recipient, or enrollee): An individual who is eligible to receive or is receiving benefits from Medicaid – or an individual who is enrolled in a managed care plan.

Member's Family Residence: A residence where the member has a 911 address and lives with at least one biological, adoptive, natural, or other family member and/or a certified Specialized Family Care Provider.

Office of Health Facility Licensure and Certification (OHFLAC): The state agency that inspects and licenses CSEDW providers to help assure the health and safety of CSEDW member. Licensed entities include but are not limited to behavioral health providers, CSEDW providers, facility-based day programs, group homes, supported employment facilities, and case management agencies.

Person-Centered Service Planning Team (PCSPT): The member and/or parent/legal representative, the member's Case Manager, representatives of each professional discipline, provider and/or program

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

providing services to that member (inter- and intra-agency), and MCO care coordinator (if requested) and others who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the individual's needs and design appropriate services and specialized programs responsive to those needs. The PCSPT meetings are guided by the member's needs, wishes, desires, and goals.

Physician: As defined in West Virginia Code §30-3-10, an individual who has been issued a license to practice medicine in the state of West Virginia by the West Virginia Board of Medicine and is in good standing with the board; or an individual licensed by the West Virginia Board of Osteopathy in accordance with West Virginia Code 30-14-6.

Pre-hearing Conference: A meeting requested by the applicant or member and/or legal representative to review the information submitted for the medical eligibility determination and the basis for the denial/ termination. A Medicaid Fair Hearing pre-hearing conference may be requested any time prior to a Medicaid Fair Hearing.

Prior Authorization: Prior approval necessary for specified services to be delivered for an eligible member by a specified provider before services can be performed, billed, and payment made. It is a utilization review method used to control certain services that are limited in amount, duration, or scope.

Professional Experience: A position that requires a minimum of a bachelor's degree or a professional license.

Public Community Location: Any community setting open to the general public such as libraries, banks, stores, post offices, etc. Facility-Based Day and Pre-Vocational sites are not considered public community locations.

Respite Care: Short term or intermittent care and supervision in order to provide an interval of rest or relief to family or caregivers.

Safe Environment: A place where people feel secure; where they are not at risk of being subject to harm, abuse, neglect or exploitation; and where they have the freedom to make choices without fear of recourse.

Significant Life Event: Any time that there is an event or change in the member's life that requires a meeting of the PCSPT. The occurrence may require that a service needs to be decreased, increased or changed. A significant life event constitutes a change in the member's needs such as behavioral, mental health or physical health, service/service units, support, setting, or a crisis.

Supervised Psychologist: An individual who is an unlicensed psychologist with a documented completed degree in psychology at the level of M.A., M.S., Ph.D., Psy.D. or Ed.D. and has met the requirements of, and is formally enrolled in, the West Virginia Board of Examiners of Psychologists Supervision program.

Telehealth: For purposes of Medicaid, telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the

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

distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
New Chapter	Chapter 502, Children with Serious Emotional Disorder Waiver (CSEDW)	February 1, 2020

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