CHAPTER 511—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR ICF/MR SERVICES

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CHAPTER 511–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR ICF/MR SERVICES

INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible participants. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

The policies and procedures set forth herein are the regulations governing the provision of Intermediate Care Facility for the Mentally Retarded Services (ICF/MR) in the Medicaid Program administered by the WV Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9, of the Public Welfare Law of WV.

This chapter sets forth the Bureau for Medical Services (BMS) requirements for payment of services provided by ICF's/MR to eligible West Virginia (WV) Medicaid members.

PROGRAM DESCRIPTION

Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) are part of the long term care continuum that provides care for individuals with mental retardation and/or developmental disabilities. The services provided are based on each member's needs, which vary according to age and level of mental retardation and developmental disabilities. In order for a facility to participate in the program, it must meet federal and state standards in the areas of client protection, facility staffing, active treatment, client behavior, health care services, physical environment, and dietetic services. ICF's /MR services in West Virginia are provided in small facilities throughout the state. Commonly, four (4) to eight (8) members reside in each of the ICF's/MR.

511.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200, Definitions of the Provider Manual. The following definitions also apply to the requirements for services described in this chapter.

Active Treatment - aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. Active treatment does not include services to maintain generally independent members who are able to function with little supervision or in the absence of a continuous active treatment program.

Individual Program Plan (IPP) (DD-5) is an outline of proposed activities that primarily focus on establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by persons with developmental disabilities and their families. It is designed to ensure accessibility, accountability, and continuity

of support and services. This service also ensures that persons with developmental disabilities have opportunities to make meaningful choices with regard to their life, and inclusion in the community. The IPP (DD-5) is the critical document that combines all information from the evaluations to guide the service delivery process. The completion of the IPP must be a joint effort among all parties involved in the member's life.

Individual Service Plan (ISP) is a specific breakdown of the service plan based upon assessments and needs which have been outlined.

Individual Habilitation Plan (IHP) establishes goals and identifies the discrete, measurable, criteria-based objectives the individual is to achieve; and the specific individualized program of specialized and generic strategies, supports, and techniques necessary to allow the individual to function with as much self-determination and independence as possible.

Interdisciplinary Team (IDT) is a group of professionals, paraprofessionals, and non-professionals 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.

Inventory for Client & Agency Planning (ICAP) assesses adaptive and maladaptive behavior and gathers additional information to determine the type and amount of special assistance that people with disabilities may need. The level of care an individual needs is based upon the results of the ICAP assessment. The service level determines the rate of reimbursement for the member.

511.2 PROVIDER PARTICIPATION: GENERAL REQUIREMENTS

In order to participate in the WV Medicaid Program and receive payment from the Bureau for Medical Services, the ICF/MR must:

- Meet and maintain all applicable licensing, accreditation, and certification requirements
- Meet and maintain all Bureau for Medical Services enrollment requirements
- Maintain a valid provider agreement on file that is signed by the provider and BMS upon application for enrollment into the WV Medicaid Program

511.2.1 SPECIFIC REQUIREMENTS

In addition to the provider requirements as set forth in Chapter 300, Provider Participation Requirements, the ICF/MR provider agencies must:

- Meet and maintain the standards established by the Secretary of the U.S. Department of Health and Human Services (DHHS), and all applicable Federal laws governing the provision of these services. This includes but is not limited to the Code of Federal Regulations and Federal Survey Procedures and Interpretative Guidelines for ICF's/MR .
- Be in compliance with all applicable state and local laws and regulations affecting the health and safety of the individuals, including fire prevention, building codes,

sanitation, medical practice acts, nurse practice acts, laws governing the procurement, storage, packaging, administration and accounting for drugs and other supplies, laws licensing professional clinical staff; communicable and reportable diseases, postmortem procedures, and all other applicable laws and regulations.

- Be certified by the Office of Health Facilities Licensure and Certification, (OHFLAC) as meeting the requirement of an ICF/MR and in compliance with relevant State and Federal Regulations. The ICF/MR must maintain standards necessary for licensure and certification. Reviews will be conducted at a minimum annually by OHFLAC. After completion of a certification survey, OHFLAC will report any deficiencies found during the survey to the ICF/MR and to the Office of Behavior and Alternative Health Care. The facility shall be responsible for the development and implementation of a plan of correction of any identified deficiency.

511.2.2 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

An ICF/MR must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information, Chapter 300, Provider Participation, and Chapter 800, General Administration of the Provider Manual. In addition to the documentation requirements described in this chapter, the following requirements also apply to payment of ICF/MR services:

- All required documentation must be maintained for at least five (5) years in the provider's file subject to review by authorized OHFLAC personnel, BMS personnel or contracted agents.
- Ensure that all required documentation is maintained by the provider on behalf of the State of West Virginia and is accessible for State and Federal audits
- Ensure that all documentation meets standards before the claim is submitted for payment

MEMBER RECORDS

- The ICF/MR must develop and implement policies and procedures governing the release of member information, including consents necessary from the member, or parents (if the member is a minor) or legal guardian.
- The ICF/MR must develop and maintain a record-keeping system that includes a separate record for each member and documents the member's health care, active treatment, social information, and protection of the member's rights.
- The ICF/MR must keep confidential all information contained in the members' records, regardless of the form or storage method of the records.
- Data relative to accomplishment of the criteria specified in the member's Individual Program Plan objectives must be documented in measurable terms. Data must be collected in the form and frequency required by the plan. Data must accurately reflect the member's actual individual performance.

- The ICF/MR must legibly document, date and sign significant events that are related to the member's Individual Program Plan and assessments that contribute to an overall understanding of the member's ongoing level and quality of functioning.
- Required documentation includes, but is not limited to, the member's functional status, health condition, accomplishments, activities or needs which affect the Comprehensive Functional Assessment, Individual Program Plan (Individual Service Plan – Individual Habilitation Plan). It also includes any occurrence(s) inside or outside the ICF/MR which provides information about the member's interactions, responses, progress, or problems beyond the specific parameters of the Individual Program Plan.
- The ICF/MR must provide a legend to explain any symbol or abbreviation used in a member's record.
- The ICF/MR must provide each identified residential living unit with appropriate aspects of each member's record.
- The ICF/MR must keep an up- to- date picture of the member in the record.
- Providers that wish to computerize any of the DD forms utilized by the ICF/MR program may do so, however, all basic components must be included and the name/number indicated on the form.
- Records must comply with HIPAA regulations.

PERSONNEL RECORDS

Written job descriptions shall be developed for each category of personnel, to include qualifications, line of authority, and specific duty assignments.

Current employee records shall be maintained and shall include:

- A resume of each employee's training and experience
- Evidence of required licensure, certification and/or registration.
- Evidence of education
- Records of in-service training and continuing education
- Documentation that staff has received the training outlined in Federal Code of Regulations and ICF Interpretive Guidelines.
- Documentation that the employee does not have a conviction of or prior employment history of child or adult abuse, neglect or mistreatment

511.3 SERVICE COVERAGE

The Bureau for Medical Services will pay an all-inclusive per diem rate. This rate represents an inclusive payment for all services and items that are required to be provided by the ICF/MR. This includes but is not limited to active treatment, individual program planning, health care services, dietetic service, routine adaptive equipment, routine durable medical equipment, etc.

Covered services that are part of the per diem rate include room and board, nursing services, non-covered drugs, medical supplies, accessories and equipment, rehabilitation services, such as

physical therapy and speech therapy, regular, special, or supplemental diets, day habilitation or day treatment, transportation and all other prescribed care necessary to meet the current health needs of the member**.**

Nursing Services include the handling of the individual by the nursing and attendant staff, the provision of restorative and/or rehabilitative services, medical supplies and treatment, personal hygiene, and the administration of medication and/or medical gases (such as oxygen) prescribed by the physician as part of the plan of care. The facility must provide such items as dressings, bandages, disposable diapers, catheters, bed pans, medicine chest supplies, wheelchairs (unless specialized), walkers, crutches, syringes, needles, etc. Supplies and equipment which are customarily provided by the ICF/MR facility for the care and treatment of members are covered services and are included in the facility costs for rate setting as part of the per diem rate.

No charges will be permitted by the facility to the ICF/MR member/patient or his family, guardian or to any other source over and above the established rate of payment to the facility for those services covered under the Medicaid program. Reimbursement by the program for the ICF/MR facility services determined to be medically necessary and appropriate constitutes payment in full for services.

511.3.1 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual.

511.3.2 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100 General Information of the Provider Manual, the Bureau for Medical Services will apply the following:

- Payment for services provided by an ICF/MR is available only on behalf of members who have been determined to be in need of ICF/MR services.
- Reimbursement will be based on the results of the ICAP.

511.3.3 CODES

The following revenue codes are to the utilized:

REVENUE CODE	CODE DESCRIPTION
0191	ICAP - Level 1
0192	ICAP - Level 2
0193	ICAP - Level 3
0194	ICAP - Level 4
0183	Leave of Absence - Therapeutic
0185	Leave of Absence - Hospitalization

511.3.4 SERVICES PROVIDED BY OUTSIDE SOURCES:

If an ICF/MR does not provide a required service, it may enter into a written agreement with an outside service, program, or resource to do so. The agreement must state clearly the following:

- The responsibilities, functions, objectives, and other terms agreed to by both parties
- Provide that the ICF/MR is responsible for assuring that the outside services meet the standards for quality of services
- The ICF/MR must assure that outside services meet the needs of each individual
- If living quarters are not provided in a facility owned by the ICF/MR, the ICF/MR remains directly responsible for the standards relating to the physical facility.

Required services provided by outside sources are included in the ICF/MR per diem, and cannot be billed separately.

511.4 BIILLING PROCEDURES

An ICF/MR must comply with the billing procedures and requirements described in Chapter 600, Reimbursement of the Provider Manual.

511.4.1 BILLING REQUIREMENTS

The ICF/MR must furnish the Bureau for Medical Services, Behavioral and Alternative Health Care Division with such information regarding any payments claimed for individuals under the program as the Bureau for Medical Services may request

Collect no more than the established rate of payment for the services rendered and billed to the program; i.e., the ICF/MR may not bill anyone for supplemental payments.

The ICF/MR must have a record-keeping capability sufficient for determining the cost of services.

511.4.2 PAYMENT LIMITATIONS

Reimbursement rates are based upon the cost report submitted by the ICF/MR provider and outcomes of the ICAP instrument. The ICAP must be administered by qualified staff with the competencies to administer the assessment.

511.4.3 MEDICAL LEAVES OF ABSENCE

Reimbursement will be paid for an ICF/MR resident who must be transferred to an inpatient hospital for care and treatment that can only be provided on an inpatient basis.

The maximum bed reservation for such authorized absences shall be limited to fourteen (14) consecutive days, provided the resident is scheduled to return to the ICF/MR facility following discharge from the hospital. If the bed is used during the member's absence for emergency or respite care, it will in no way jeopardize or delay the return of the hospitalized member to the facility. However, such short-term use of the bed is not encouraged and when utilized the bed in such a manner will count these days in addition to reservation days in reporting the total census.

511.4.4 NON-MEDICAL LEAVES OF ABSENCE

Reimbursement will be paid to an ICF/MR facility for a non-medical leave of absence for therapeutic home visits and for trial visits to other facilities. Such visits are encouraged, and the policies of the ICF/MR should facilitate rather than inhibit such absences. Non-medical absences shall be initiated as part of the member's individual plan of care at the request of the member, his parent(s), or his guardian with the approval of the QMRP. The Medicaid agency will pay to reserve a bed for up to twenty one (21) days per calendar year for a member residing in an ICF/MR when the resident is absent for therapeutic home visits or for trial visits to another community residential facility. If the member's bed is used during the member's absence for short-term emergency or respite care – which in no way would jeopardize or delay the member's return to the ICF/MR – no additional payment is allowed for such short-term use of the bed for emergency or respite care. The facility will count these days in addition to bed reservation days in reporting the total census.

511.5 MEMBER ELIGIBILITY

Medical Eligibility is determined by submitting an application packet to the Bureau for Medical Services, Office of Behavioral and Alternative Health Care for member consideration.

511.5.1 DOCUMENTS REQUIRED FOR DETERMINING MEDICAL ELIGIBILITY

The DD-1 (Identification and Demographic Information Face Sheet), DD-2A (Medical Evaluation), DD-3 (Psychological Evaluation), DD-4 (Social History) and DD-5 (Individual Program Plan) need to be submitted to the Bureau for Medical Services, Division of Behavioral and Alternative Health Care, for approval for each member for whom payment is requested. The DD-1, DD-2A, DD-3, DD-4, and DD-5 must be current and received by the Bureau for Medical Services, Division of Behavioral and Alternative Health within ninety (90) days of admission to the ICF/MR or authorization of payment.

511.5.2 ELIGIBILITY DETERMINATION OF MEMBERS PRIOR TO ADMITTANCE

Individuals seeking ICF/MR services may have their eligibility determined prior to their admittance to an ICF/MR facility.

To establish prior eligibility, a complete packet of required information must be submitted within thirty (30) days prior to placement in the ICF/MR facility. Packets may be submitted to the eligibility determination section of the Bureau for Medical Services. All submitted information must be clinically current.

The prior eligibility packet of information includes the DD-2A, DD-3, and DD-4 and must be submitted to the Bureau for Medical Services, Office of Behavioral and Alternative Health, to establish eligibility for each member for whom payment is requested.

Current is defined as

- DD-2A (Medical Evaluation) must be current within the past six months. Any Medical Evaluation dated in excess of 180 days upon receipt by the Bureau for Medical Services shall be considered out of date.

- DD-3 (Psychological Report) must have been completed within 90 days of the placement date. Any date of a psychological report in excess of 90 days upon recipient by the Bureau for Medical Services shall be considered out of date
- DD-4 (Social History) must have been completed within 180 days of the placement date. Any social history in excess of 180 days upon receipt by the Bureau for Medical Services shall be considered out of date,

When current information is received in its entirety an eligibility determination will be made as quickly as possible (maximum of 45 days) and the decision communicated to the recipient and to the provider that submitted the packet.

511.5.3 ELIGIBILITY DETERMINATION OF MEMBERS POST ADMISSION

Individuals seeking ICF's/MR services can have their eligibility determined after their admittance to an ICF/MR. To establish eligibility, a complete packet of required information must be submitted within thirty (30) days after placement in the ICF/MR facility. Packets must be submitted to the eligibility determination section of the Bureau for Medical Services. All submitted information must be clinically current. The post eligibility packet of information includes the DD-2A, DD-3, DD-4, and DD-5. Documents must be submitted to the Office of Behavior and Alternative Health Care of the WV Bureau for Medical Services.

Current is defined as

- DD-2A (Medical Evaluation) must be current within the past six months. Any Medical Evaluation dated in excess of 180 days upon receipt by the Bureau for Medical Services shall be considered out of date.
- DD-3 (Psychological Report) must have been completed within 90 days of the placement date. Any date of a psychological report in excess of 90 days upon recipient by the Bureau for Medical Services shall be considered out of date
- DD-4 (Social History) must have been completed within 180 days of the placement date. Any social history in excess of 180 days upon receipt by the Bureau for Medical Services shall be considered out of date,

When current information is received in its entirety an eligibility determination will be made as quickly as possible (maximum of 45 days) and the decision communicated to the recipient and to the provider that submitted the packet.

The initial DD-5 (IPP) must be developed within seven (7) days of intake (initial DD-5), and completed within thirty 30 days after the intake and submitted to the Bureau for Medical Services, Office of Behavioral and Alternative Health. Payment shall be delayed until the receipt of the DD- 5 (IPP).

The provider will assume the financial risk of providing services during the period that eligibility is being considered. In the event an individual is determined not to meet ICF's/MR eligibility there is no mechanism to reimburse the provider.

511.5.4 MEDICAL ELIGIBILITY CRITERIA

BMS through its contracted agent determines the medical eligibility for an applicant in the MR/DD Waiver Program. In order to be eligible to receive MR/DD Waiver Program Services, an applicant must have both a diagnosis of mental retardation or a related condition and also manifest concurrent substantial adaptive deficits.

1. Persons with **related conditions** means individuals who have a severe, chronic disability which is attributable to:

- cerebral palsy or epilepsy: or
- any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons; and the severe chronic disability
  - the mental retardation or related condition is manifested (both diagnosis and substantial deficits) before a person reaches twenty two (22) years of age and
  - the mental retardation or related condition is likely to continue indefinitely

2. The applicant must have substantial limits in three (3) or more of the following major life areas:
   - self care,
   - receptive and/or expressive language, (communication)
   - learning, (functional academics)
   - mobility,
   - self direction,
   - capacity for independent living, (home living, social skills, employment, health and safety, community use, leisure)
     - Substantial adaptive deficits is defined as scores on standardized measures of adaptive behavior three (3) standard deviations below the mean or less than one (1) percentile when derived from non MR normative populations or in the average range or below the seventy fifth (75^{th}) percentile when derived from MR normative populations.
     - The presence of substantial deficits must be supported by the additional documentation submitted for review (e.g. IEP, OT evaluations, narrative descriptions, etc.).

3. The applicant must have a need for an ICF/MR level of care that:
   - is certified by a physician (DD-2A) and,
   - is recommended by the evaluating psychologist (DD-3) and,

- Is identified by a licensed social worker (DD-4)

The applicant requires and would benefit from active treatment. Evaluations of the applicant must demonstrate a need for intensive instruction, services, assistance, and supervision in order to learn new skills and increase independence in activities of daily living.

511.6 OTHER ADMISSION REQUIREMENTS

An initial Inventory for Client and Agency Planning (ICAP) must be administered to a member within ninety (90) days of admission to an ICF/MR.

If a referred member already has an existing, clinically-current ICAP from another facility, the admitting ICF/MR has the option to use the current ICAP or complete one of its own.

The admitting ICF/MR provider must submit ICAP scores to the Bureau for Medical Services.

The rate of payment for the first 90 days will be the lowest of the currently used rates until the ICAP score is received. If the ICAP score results in a higher rate, payments will be adjusted.

511.7 ANNUAL RE-CERTIFICATION OF ELIGIBILITY

All members residing in an ICF/MR must be recertified for continued need. Recertification of the need for continued services must be made every twelve (12) months after certification. The ICF/MR is responsible for obtaining recertification documentation by the physician for each member for whom payment is requested under the Medicaid Program.

The ICF/MR must submit a copy of the current Annual DD-2A that provides the physician's certification of the continued need for ICF/MR level of care. The DD-2A must be current within the past 12 months. The subsequent DD-2A must be completed by the anniversary date of the previous DD-2A and be submitted within 30 days of completion. For example, if the submitted copy of the DD-2A is dated 09/15/03, then a new DD-2A will have to be completed no later than 09/15/04 and submitted by 10/15/04 for annual recertification.

Additional information may be requested as necessary which may include the DD-3, DD-4, DD-5 or other pertinent information .

This procedure is required annually. After review by the Office of Behavior and Alternative Care of the WV Bureau for Medical Services, notification of recertification will be submitted to the ICF/MR provider. The recertification date will be based on the actual date the DD-2A was completed by the physician and will extend for a period not to exceed one calendar year.

The ICF/MR provider will be responsible for maintaining the documentation of recertification in the member's chart.

511.8 ANNUAL SUBMISSION OF THE ICAP

From the admission date forward, an annual re-administration of the ICAP is required. The anniversary date for an annual re-administration of the ICAP will be (1) one year after the first submission of an ICAP. Providers may also administer an ICAP at a significant life change or juncture. The significant change shall not be acute in nature and if the condition will likely ameliorate in fewer than 6 months, then a resubmission of the ICAP would not be appropriate.

Any rate change would become effective the first day of the next calendar month after the administration of the ICAP.

511.9 TRANSFERS OF MEMBERS TO OTHER SITES

Transfers of members to other places are to be for good cause and completed in a time frame that allows the member and the member's family or guardian ample time to prepare for the transfer, unless there is an emergency.

Transfers should only occur when the ICF/MR cannot meet the member's needs, the member no longer requires an active treatment program in an ICF/MR setting, the member/guardian chooses to reside elsewhere, or when a determination is made that another level of service or living situation, either internal or external would be more beneficial.

Transfer between facilities within the same provider agency must be reported to the Bureau for Medical Services, Office of Behavior and Alternative Health Care Policy Units on the ICF/MR Discharge/Transfer Tracking Form (refer to form in Attachment) within 10 working days of the date of discharge/transfer from the facility.

511.10 DISCHARGE REQUIREMENTS FOR THE MEMBER

Upon discharging a member, an ICF/MR must:

- Prepare a final summary of the member's health, nutritional, social, behavioral, and functional status. This summary is to become a part of the member's permanent record.

  The summary can be presented to authorized agencies and persons with the consent of the member, the member's guardian or parent if the member is minor.

- Provide a post-discharge plan of care that will help the member adjust to the new living environment. Information must be sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement.

The Office of Behavior and Alternative Health Care of the WV Bureau for Medical Services must be notified within ten (10) working days of discharge by utilizing the ICF/MR Discharge/Transfer Tracking Form.

511.11 HOW TO OBTAIN INFORMATION: CPT, HCPCS, ICD-9, ETC.

For information on how to obtain information concerning procedure codes and diagnosis codes, please refer to Chapter 100, General Information of the Provider Manual. Additional information on the use of forms required by the ICF/MR program of services are found in the Attachments, as follows:

- DD-1 Identification and Demographic Information Fact Sheet
- DD-2A Medical Evaluation
- DD-3 Psychological Evaluation
- DD-4 Social History
- DD-5 Individual Program Plan

- ICF/MR Admittance/Discharge/Transfer Tracking Form

511.20 MANAGED CARE

West Virginia ICF/MR Program participants are exempt from managed care coverage. All services covered must follow guidelines set forth by Medicaid for reimbursement.

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ATTACHMENT I
DD-1
IDENTIFICATION AND DEMOGRAPHIC INFORMATION FACT SHEET
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ICF/MR PROGRAM

Identification and Demographic Information Fact Sheet

☞This form is being submitted: ☐ As part of an **full application**

Participants Name_____ Date:_____
First Last Middle Initial

Service Coordination Agency_____ SS#_____

Medicaid #_____ DOB_____ Sex: □Male □Female

Residential Provider_____ Phone_____

Address_____ County DHHR_____

Type of Residence: □NF □SFCH □GH □ISS □Other _____

Date of Residential Placement_____Prior Institutionalization □Yes □No

Name of Last Facility _____

Legal Representative_____

Address _____

Phone_____ Relationship to Participant_____

Monthly Average Income $_____

Financial Resources: □Trust □Medicaid □Medicare □Private Pay Insurance □SSI
□SSDI □SSA □Handicapped Children Services □Other

Service Coordinator_____Phone_____

Regional Advocate_____Phone_____

Representative Payee_____Phone_____

Client Needs Summary for ICF/MR Waiver

____ DD-1 (**Identification and Demographic Information Fact Sheet)**

____ DD2A **(Annual Medical Evaluation)**

____ DD3 **(Comprehensive Psychological Evaluation (Triennial)**

____ DD4 **(Social History)**

____ DD5 **(IPP)**

_____ **ICF/MR ADMITTANCE / DISCHARGE / TRANSFER TRACKING INFORMATION**

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ATTACHMENT II
DD-2A
ANNUAL MEDICAL EVALUATION
PAGE 1 OF 7

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

ANNUAL MEDICAL EVALUATION

County of Residence_____

Participant Name: _____ Birthdate:_____

Name of Behavioral Health Center: _____ Date: _____

Address of BHC: _____ SS#: _____

Location of Physical Exam: _____Medicaid #: _____

* **Illness/Accidents since Last Examination (Give dates and summarize):**

* **Allergies:**

* **CURRENT MEDICATIONS:**

Name of Medication	Date Started	Dosage	Frequency

* **LIST ANY PREVIOUS MEDICATIONS THAT COULD MOCK SYMPTOMS OR MIMIC MENTAL ILLNESS:**

Name of Medication	Date Started	Date Stopped	Dosage	Frequency

Participants Name _____Name of Behavioral Health Center _____ Date _____

*** LIST ANY OTHER MEDICATIONS THE PARTICIPANT IS USING OR USES FREQUENTLY (OVER THE COUNTER AND PRESCRIPTION):**

Name of Medication	Reason for Taking

*** NUTRITIONAL STATUS SUMMARY:**

LABORATORY PROCEDURES

TYPE OF TEST	DATE DONE	RESULTS - DATE REC.	TYPE OF TEST	DATE DONE	RESULTS - DATE REC.
URINALYSIS					
CBC					
SYPHILIS SEROLOGY					
HEPATITIS B (UNLESS IMMUNE)					
BLOOD SUGAR (AS INDICATED)					
MEDICATION BLOOD LEVELS (AS INDICATED)					

DENTAL EXAMINATION

DATE:

CONDITION OF MOUTH/GUMS:

CARIES:

DESCRIBE PROPHYLAXIS AND/OR REPAIR WORK COMPLETED:

_____ _____

SIGNATURE DATE

***This page may be mailed separately room the other pages of this medical report**

TEMERATURE:	HEIGHT	WEIGHT	B/P	PULSE	RESPIRATION

CODE: √ =NORMAL N = NOT DONE NA = NOT APPLICABLE X = ABNORMAL & DESCRIBE

SKIN		
SCALP		
EYES		
NOSE		
THROAT		
LYMPH NODES		
THYROID		
HEART		
LUNGS		
BREAST		
ABDOMEN		
EXTREMITIES		
SPINE		
GENITALIA		
RECTAL (MALES INCLUDE PROSTATE)		
BI-MAN. VAGINAL		
LYMPH		
ENDOCRINE		

N E U R O L O G I C A L		
ALERTNESS		
COHERENCE		
ATTENTION SPAN		
VISION		
HEARING		
SPEECH		
SENSATION		
COORDINATION		
GAIT		
MUSCLE TONE		
REFLEXES		
OTHER		

PROBLEMS REQUIRING SPECIAL CARE (Check appropriate blanks)

MOBILITY:		**CONTINENCE STATUS:**		**FEEDING:**	
Ambulatory	_____	Continent	_____	Feeds Self	_____
Ambulatory w/Human Help	_____	Incontinent	_____	Needs To Be Fed	_____
Ambul. w/Mechanical Help	_____	Not Toilet Trained	_____	Gastric Tube	_____
Wheelchair	_____	Catheter	_____	Special Diet	_____
Wheelchair/Self Propelled	_____	Ileostomy	_____		
Wheelchair w/Assistance	_____	Colostomy	_____		
Lifted Bed To Chair	_____				
Bedfast	_____				

PERSONAL HYGIENE:		**MENTAL AND BEHAVIORAL DIFFICULTIES:**		**OTHER:**
Self-Care	_____	Alert	_____	Unable to Communicate
			_____	
Independent	_____	Confused/Disoriented	_____	
Needs Assistance	_____	Irrational Behavior	_____	
Needs Total Care	_____	Needs Close Supervision	_____	

ADDITIONAL RECOMMENDATIONS:

SPEECH THERAPY	____	PHYSICAL THERAPY	____	OCCUPATIONAL THERAPY	____
TRACHEOSTOMY	____	OXYGEN THERAPY	____	IV FLUIDS	____
DIAGNOSTIC SERVICES	____	SOAKS, DRESSINGS,			
TRACTION, CASTS	____	OTHER:			

---------- Please Complete All Sections Below To Ensure Certification For The Program ----------

DIAGNOSTIC SECTION:

MENTAL: (List All Cognitive, Developmental, Behavioral, Emotional and/or Psychiatric Conditions)

PHYSICAL: (List Chronic and Handicapping Conditions As Well As Current, Acute and/or Communicable Conditions)

PROGNOSIS:

I certify that this Patient's Developmental Disability, Medical Condition and Related Health Needs Are As Documented Above and Patient Requires the Level of Care and Services Provided in an *Intermediate Care Facility for Individuals with Mental Retardation and/or Related Conditions ***Yes*** _____ ***No***_____

(Note: ICF/MR level of care means the individual needs a high level of habilitation training and supervision. This level of care does not have to occur in an institution and can be provided in a community setting.)

_____ _____ _____

Date **Physician's Signature Required** **License #**

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

Approved for ICF/MR Level of Care _____ Yes _____ No

Approved for Community Support Services _____ Yes _____ No

Name of Reviewer: _____ Date_____

DD – 2A ICF/MR

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ICF/MR SERVICES
JULY 1, 2004

ATTACHMENT III
DD-3
COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)
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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)

NAME:_____EVALUATION DATE:____/____/___

BIRTHDATE: ___/____/____AGENCY/FACILITY: _____

REASON FOR EVALUATION:_____

I. RELEVANT HISTORY:

A. Prior Hospitalization/Institutionalization

B. Prior Psychological Testing

C. Behavioral History

II. CURRENT STATUS:

A. Physical/Sensory Deficits

B. Medications (Type, frequency and dosage)

C. Current Behaviors

1. Psychomotor

2. Self-help

3. Language

4. Affective

5. Mental Status

6. Others (Social interaction, use of time, leisure activities)

III. CURRENT EVALUATION

A. Intellectual/Cognitive:

1. Instruments used:

2. Results:

3. Discussion:

B. Adaptive Behavior:

1. Instruments used: ABS I & II Others (list)

2. Results:

3. Discussion:

C. Other:

1. Instruments used:

2. Results:

3. Discussion:

D.. Indicate the individual's level of acquisition of these skills commonly associated with need for active treatment.

1.	Able to take care of most personal care needs.	yes ☐ no ☐
2.	Able to understand simple commands.	yes ☐ no ☐
3.	Able to communicate basic needs and wants.	yes ☐ no ☐
4.	Able to be employed at a productive wage level without systematic long term supervision or support.	yes ☐ no ☐
5.	Able to learn new skills without aggressive and consistent training.	yes ☐ no ☐
6.	Able to apply skills learned in a training situation to other environments or settings without aggressive and consistent training.	yes ☐ no ☐
7.	Able to demonstrate behavior appropriate to the time, situation or place without direct supervision.	yes ☐ no ☐
8.	Demonstrates severe maladaptive behavior(s) which place the person or others in jeopardy to health and safety.	yes ☐ no ☐
9.	Able to make decisions requiring informed consent without extreme difficulty.	yes ☐ no ☐
10.	Identify other skill deficits or specialized training needs which necessitates the availability of trained MR personnel, 24 hours per day, to teach the person to learn functional skills._____	

E. Developmental Findings/Conclusions

IV. <u>RECOMMENDATIONS:</u>

A. Training

B. Activities

C. Therapy/Counseling/Behavioral Intervention

.

V. DIAGNOSIS:

VI. PROGNOSIS:

VII. PLACEMENT RECOMMENDATIONS:

_____	_____
Signature of Supervised Psychologist	Signature of Licensed Psychologist
_____	_____
Title	License #/Title
_____	_____
Date	Date

DD-3 – ICF/MR

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ATTACHMENT IV
DD-4
SOCIAL HISTORY
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SOCIAL HISTORY

PARTICIPANT NAME:_____ DATE:_____

I. DEVELOPMENTAL HISTORY: Provide information summarizing personal growth from infancy through adolescence with attention to the development of his/her physical, social, and emotional competencies. As outlined below, if development is delayed, describe the circumstances or conditions associated with the delay and date of onset. If more space is needed, use back of this sheet and identify information by Roman Numeral and Letter.

a) Physical

b) Social

c) Emotional

II. FAMILY: List parents, spouse, children, siblings, significant others, and type of relationships, i.e., are they an available source of support and/or resources. Include description of family's socio-economic circumstances, and family composition. Past and current living arrangements, special problems, such as alcohol, substance abuse, and mental illness should be included.

III. EDUCATION/TRAINING: Describe education and training experiences, identify schools and programs attended, relationships with peers and teachers, any adjustment problems, levels of accomplishment and any other pertinent information.

IV. FUNCTIONAL STATUS: Describe levels of functioning relating to employment capabilities, work-related experiences, and assessment of skills relevant to the activities of daily living and self-care skills. Is applicant/participant now, or ever been gainfully employed? Indicate level of care recommendation.

V. RECREATION/LEISURE ACTIVITIES: Identify and describe recreational and leisure time activities, frequencies, accessibility, and degree of involvement.

VI. HOSPITALIZATIONS: List medical and psychiatric hospital dates and reason for admissions.

_____MR/DD_____Heart Disease_____Cerebral Palsy

_____Autism_____Diabetes_____Tuberculosis

_____Hepatitis_____Mental Illness_____Kidney Disease

_____Cancer_____Hypertension_____Metabolic Disease

_____Allergies_____Thyroid Disease_____Muscular Dystrophy

_____Epilepsy_____Other_____Other

Deceased Siblings (Cause of Death) _____

VIII. LEGAL STATUS: (Guardianship, committee, custody).

DD-4 New - July, 1985

Revised June 2001

IX. OTHER RELEVANT INFORMATION: (Family medical history; applicant/participant military service; religious preference; or significant events or circumstances not covered in other sections).

DATE	DATE
SIGNATURE OF TEMPORARY LSW	SIGNATURE/CO-SIGN OF DEGREED/LSW
LICENSE #/DEGREE	LICENSE #/DEGREE

DD-4 New - July, 1985

Revised June 2001

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ATTACHMENT V
DD-5
INDIVIDUAL PROGRAM PLAN
PAGE 1 OF 15

C O N F I D E N T I A L

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

INDIVIDUAL PROGRAM PLAN

_____ _____ ___/___/

PARTICIPANT AGENCY/FACILITY DATE

I. Evaluations and Assessments Performed: List the Dates Assessments Completed

Medical/ Nursing	Initial Medical Examination ____/____/____ Dental Exam ____/____/ Neurological Exam ____/____/____ Nutrition ____/____/____ Motor ____/____/ Speech ____/____/____ Nursing ____/____/____ Hearing ____/____/ Vision ____/____/____ Language ____/____/____ Other
Psychological	ABS ____/____/____ WAIS ____/____/____ CIIS ____/____/ WISC-R ____/____/____ Other _____ ____/____/
Habilitative/ Social	Social History ____/____/____ Training/Education ____/____/ Recreation/Leisure ____/____/____ Other _____ ____/____/ Habilitation - WVATTS ____/____/____ Brigance ____/____/ L.A.P. ____/____/

II Evaluation and Assessment Summary: (List Strengths/Needs in all Areas)

A. Medical/Health:	
Strengths	Needs

DD-5

New - July, 1985

Current - September,1993

C O N F I D E N T I A L

NAME _____ DATE ____/____/

II. (cont'd)

B. Psychological Strengths	Needs
C. Social Strengths	Needs

B. Psychological Strengths	Needs

C O N F I D E N T I A L

NAME _____ DATE ____/____/

II. (cont'd)

D. Habilitation Strengths	Needs
C. Other Strengths	Needs

D. Habilitation Strengths	Needs

F. Projected Date of Community Placement: _____/_____/

DD-5

C O N F I D E N T I A L

DATE ___/_____/

NAME _____

of _____ Page

III. Individual Service Plan (Staff Actions Based on Assessment Results)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

DD-5

C O N F I D E N T I A L

DATE ____/____/

NAME _____ ____ of

III. Individual Service Plan (Staff Actions Based on Assessment Results)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

REEVALUATION DATE _____ □ 3 MOS. □ 6 MOS. □ 9 MOS. □ 12 MOS.

_____ ____/____/____ _____ ____/____/____

PARTICIPANT DATE SERVICECOORDINATOR DATE

_____ ____/____/____ _____ ____/____/____

PARENT/LEGAL REPRESENTATIVE DATE SERVICE COORDINATOR DATE

DD-5

C O N F I D E N T I A L

DATE ___/___/

NAME _____

of

IV. Individual Habilitation Plan

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

DD-5

C O N F I D E N T I A L

DATE ____/____/

NAME _____

of

IV Individual Habilitation Plan

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

REEVALUATION DATE _____ 90 DAYS_____ 180 DAYS_____ ANNUAL

_____ ____/____/____ _____ ____/____/____

PARTICIPANT DATE SERVICE COORDINATOR DATE

_____ ____/____/____ _____ ____/____/____

PARENT/LEGAL REPRESENTATIVE DATE SERVICE COORDINATOR SUPERVISOR DATE

DD-5

CONFIDENTIAL

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

V. Signatures:

Participant's Printed Name/Role	**Signature**	**Agency**	**Agree**	**Disagree ***	**Time Spent**
Individual					
Parent/Legal Rep.					
Service Coordinator					
Physician/RN					
Psychologist					
Social Worker					
Advocate					
Day Program Supervisor					
QMRP					

*** IDT Member has disagreed with the IPP; rationale for disagreement is attached.**

CONFIDENTIAL

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

V. Signatures:

Participant's Printed Name/Role	Signature	Agency	Agree	Disagree*	Time Spent

*** IDT Member has disagreed with the IPP; rationale for disagreement is attached.**

CONFIDENTIAL

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

VI. RATIONALE FOR DISAGREEMENT WITH IPP:

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ATTACHMENT VI
DD-7
ICF/MR ADMITTANCE/DISCHARGE/TRANSFER
TRACKING INFORMATION
PAGE 1 OF 2

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

BUREAU FOR MEDICAL SERVICES

OFFICE OF BEHAVIORAL AND ALTERNATIVE HEALTH CARE

ICF/MR ADMITTANCE / DISCHARGE / TRANSFER TRACKING INFORMATION

MEMBER'S NAME_____ D.O.B._____

MEDICAID NUMBER _____SSN_____

CURRENT ADDRESS_____

_____COUNTY_____

CASE MANAGER _____ _____

DATE OF ADMITTANCE / DISCHARGE / TRANSFER **(please circle)** _____

NEW ADDRESS _____

_____COUNTY_____

NEW PROVIDER AGENCY _____

TELEPHONE NUMBER _____

NEW CASE MANAGER _____

REASON FOR TRANSFER / DISCHARGE _____

Signature of Person Completing Form Title

Printed Name Printed Title

Date Completed: _____

INSTRUCTIONS FOR DISCHARGE/TRANSDER: THIS FORM IS TO BE COMPLETED BY THE PROVIDER WHICH DISCARGES OR TRANSFERS THE INDIVIDUAL. IT MUST BE SUBMITTED TO THE BUREAU FOR MEDIAL SERIVCES, POLICY UNITS, 350 CAPITOL STREET – ROOM 251, CHARLESTON, WEST VIRGINIA 25301-3707, PHONE NUMBER 304-558-1708. FAX NUMBER 304-558 -4398 WITHIN 7 DAYS OF DISCHARGE/TRANSFER

B&AHC-ICF/MR -07

REVISED JANUARY 2002