CHAPTER 512–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TRAUMATIC BRAIN INJURY (TBI) WAIVER SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Date on all footers	Footer Date	October 24, 2013	February 1, 2013
Section 512.8.1.2(B)(3)	Initial Medical Evaluation	February 1, 2013	February 1, 2013
Section 512.8(F)	Member Eligibility	February 1, 2013	February 1, 2013
Section 512.3.8	Criminal Investigation Background Check and Restrictions and Medicaid Exclusion List	February 1, 2013	February 1, 2013
Section 512.2	Program Description	February 1, 2013	February 1, 2013
Entire Chapter	Entire Chapter	XXXX	February 1, 2012

Old Policy

512.2 PROGRAM DESCRIPTION

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

The TBI Waiver Program is a long-term care alternative which provides services that enable individuals to live at home rather than receiving nursing facility care. The program provides home and community-based services to West Virginia residents who are medically and financially eligible to participate in the program. Members must be at least 22 years of age and be inpatient in a licensed nursing facility, inpatient hospital, or in a licensed rehabilitation facility to treat TBI at the time of application. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, participant-direction, respect, and dignity and community integration. All members are offered and have a right to freedom of choice of providers for services. BMS contracts with APS Healthcare to implement the administrative functions of the Program.

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TBI Waiver services, eligible for reimbursement by Medicaid, are to be provided exclusively to the member, for necessary activities as listed in the Service Plan. They are not to be provided for the convenience of the household or others. Although informal supports are not mandatory in the TBI Waiver Program, the program is designed to provide formal support services to supplement, rather than replace, the member's existing informal support system.

TBI Waiver services include Case Management, Personal Attendant Services, Cognitive Rehabilitation Therapy, and Participant-Directed Goods and Services.

TBI Waiver members may choose from either the Traditional (Agency) Model or the Participant-Directed Model known as Personal Options for service delivery. In the Traditional Model, members receive their services from employees of a certified provider agency or an independent professional qualified to provide Cognitive Rehabilitation Therapy. In Personal Options, members are able to hire, supervise and terminate their own employees.

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Old Policy

512.3.8 Criminal Investigation Background Checks and Restrictions and Medicaid Exclusion List

At a minimum, a state level criminal investigation background check, which includes fingerprints, must be conducted by the West Virginia State Police initially and again every three years for all TBI Waiver provider staff with direct access to members including direct-care personnel (agency and Personal Options), Case Managers, and Cognitive Rehabilitation Therapists. If a prospective or current employee has lived out of state within the last five years, an FBI fingerprint-based criminal history check must also be conducted.

Prior to providing TBI Waiver services, required fingerprint-based checks must be initiated. TBI Waiver providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing services or is employed by a provider agency cannot be considered to provide services nor can be employed if ever convicted of:

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

If aware of a recent conviction or change in status, appropriate action must be taken by the agency (or PPL for Personal Options direct-care workers) and BMS notified about the change.

The OIG Exclusion List must be checked for every agency employee and Personal Options direct-care worker who provides Medicaid services prior to employment and monthly thereafter.

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

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

New Policy

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CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the licensed TBI Waiver provider before placing an individual in a position to provide services to the member.

If aware of a recent conviction or change in status of an agency staff member providing TBI Waiver services, the TBI Waiver provider (or PPL for Personal Options direct-care workers) must take appropriate action, including notification to BMS TBI Program Manager.

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

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

Old Policy

512.8 MEMBER ELIGIBILITY

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

A. Be 22 years of age or older.
B. Be a permanent resident of West Virginia.
C. Have a traumatic brain injury defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment.
D. Be approved as medically eligible for nursing facility level of care.
E. Score at a Level VII or below on the Rancho Los Amigos Levels of Cognitive Functioning Scale.
F. Be inpatient in a licensed nursing facility, inpatient hospital, or in a licensed rehabilitation facility to treat TBI at the time of application.
G. Meet the Medicaid Waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient.
H. Choose to participate in the TBI Waiver Program as an alternative to nursing facility care.

If an individual meets eligibility requirements, a slot must be available for him/her to participate in the program. If no slots are available, applicants determined medically eligible for the Program will be placed on the Managed Enrollment List. As slots become available, applicants on the Managed Enrollment List will be notified and provided detailed instructions on continuing the application process.

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F. Be inpatient in a licensed nursing facility, inpatient hospital, or in a licensed rehabilitation facility to treat TBI or living in a community setting at the time of application.
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Old Policy

512.8.1.2 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process:

A. An applicant shall initially apply for the TBI Waiver by having his/her treating physician (M.D. or D.O.) or specially trained neuropsychologist submit a Medical Necessity Evaluation Request form to APS Healthcare. The physician's/neuropsychologist's signature is valid for sixty (60) days. The referral source for the request may be from the applicant/applicant's representative, hospital or nursing facility, DHHR, the physician, social services agencies, or others.

B. The Medical Eligibility Evaluation Request form asks that the physician/neuropsychologist submit the applicant's identifying information including, but not limited to, the following:

    1. A statement that the individual's condition meets the entry level definition of TBI: a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment;
    2. A description of the functional deficits directly attributable to the TBI,
    3. The applicant is currently inpatient in a licensed nursing facility, inpatient hospital, or licensed rehabilitation facility for TBI, and;
    4. other pertinent medical diagnoses.

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C. Once a referral is received, APS Healthcare will send a letter of verification of its receipt to the applicant and/or their legal representative and the referring physician or neuropsychologist. If the Medical Eligibility Evaluation Request form is incomplete it will be returned to the referring physician or neuropsychologist for completion and resubmission, and the applicant will be notified. APS Healthcare will attempt to contact the applicant and/or their legal representative to schedule an assessment. APS Healthcare will make up to three attempts to contact the applicant. If it is determined that the applicant is not available, the referring physician or neuropsychologist and applicant and/or their legal representative will be notified that no contact could be made. If the referral is closed because of an inability to contact the applicant, a new referral will be required to re-initiate the process.

D. If contact is made, a letter will be sent to the applicant and contact person noting the contact was made and the date of the scheduled evaluation. If the applicant has identified a guardian or legal representative, no assessment shall be scheduled without presence of the guardian, legal representative or contact person. If the Medical Eligibility Evaluation Request form indicates that the applicant has severe dementia, no visit will be scheduled without the guardian, legal representative or contact person present to assist the applicant during the evaluation.

E. APS Healthcare completes the Pre-Admission Screening (PAS) and the Ranchos Los Amigos Scale. APS Healthcare staff will record observations and findings regarding the applicant's level of function. In those cases where there is a medical diagnosis question, APS Healthcare will attempt to clarify the information with the referring physician. In the event that APS Healthcare cannot obtain the information, it will be documented, and noted that supporting documentation from the referring physician was not received.

F. If it is determined that the applicant does not meet medical eligibility, the applicant, the referring physician or neuropsychologist, and applicant's representative, if applicable, will be notified by a Potential Denial letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS, Rancho Los Amigos Scale, and relevant TBI Waiver policy will also be included with the "Potential Denial" letter. The applicant will be given two weeks to submit supplemental medical information to APS Healthcare. Information submitted after the two-week period will not be considered.

G. If the review of the supplemental information by APS Healthcare determines that there is still no medical eligibility, the applicant and/or their legal representative (if applicable), and the referring physician or neuropsychologist will be notified by a Final Denial letter. The "Final Denial" letter will provide the reason for the denial. It will also include the applicable TBI Waiver policy manual section(s), a copy of the PAS and Rancho Los Amigos Scale, supplemental information documentation (if it has been supplied), notice of resources for free legal services, and a Request for Fair Hearing form to be completed if the applicant wishes to contest the decision.

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

I. If the applicant is determined medically eligible and a TBI Waiver slot is available, a notice of approved medical eligibility is sent to the applicant, the referring physician or neuropsychologist, and the applicant's legal representative, if applicable. Copies of the applicant's PAS and Rancho Los Amigos Scale are also sent at this time to the applicant and/or their legal representative (if applicable).

J. If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant and/or their legal representative (if applicable) and the referring entity informing them that a slot is not currently available. The applicant will be notified that they have been placed on the Managed Enrollment List.

K. When a TBI Waiver slot is available, APS Healthcare sends a Service Delivery Model Selection form advising the applicant to choose either Traditional or Personal Options. If the member chooses the Traditional Model, a Freedom of Choice Case Management Selection Form and a Freedom of Choice Personal Attendant Selection Form are also provided to the applicant and/or their legal representative (if applicable), advising him/her to choose a Case Management Agency and a Personal Attendant Service Agency. The forms are to be returned to APS Healthcare once selections are made.

L. APS Healthcare will notify both of the agencies selected, and provide them with a copy of the applicant's PAS and Ranchos Los Amigos Scale. The Case Manager must use the Initial Contact Log at this point. It provides the Case Manager with the ability to document their initial contact to assist with financial eligibility (Refer to *Section* **512.8.2**), Member Enrollment (Refer to Section 512.9) and the required seven day contact (Refer to *Section 512.10* **MEMBER ASSESSMENT**). If Personal Options has been selected APS Healthcare will notify PPL and provide them with a copy of the PAS and Ranchos Los Amigos Scale.

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2. A description of the functional deficits directly attributable to the TBI,
3. If the applicant is currently inpatient in a licensed nursing facility, inpatient hospital, or licensed rehabilitation facility for TBI,(does not apply if living in the community), and;
4. other pertinent medical diagnoses.

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Chapter 512–Covered Services, Limitations, and Exclusions for Traumatic Brain Injury (TBI) Waiver Services

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CHAPTER 512–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR TRAUMATIC BRAIN INJURY WAIVER SERVICES

INTRODUCTION

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

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

This chapter sets forth the BMS requirements for the Traumatic Brain Injury (TBI) Waiver Program provided to eligible West Virginia Medicaid members. Requirements and details for other West Virginia Medicaid covered services can be found in other chapters of the provider manual.

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

512.1 DEFINITIONS

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

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

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

Administrative Services Organization (ASO): the contract vendor, currently APS Healthcare, responsible for day-to-day operations and oversight of the TBI Waiver Program including conducting the medical evaluations and determining medical eligibility for applicants and members of the program

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Community Integration: the opportunity to live in the community, and participate in a meaningful way to obtain valued social roles as other citizens without disabilities.

Competency Based Curriculum: a training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum must have goals, objectives and an evaluation system to demonstrate competency in training areas.

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

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

Felony: a serious criminal offense punishable by imprisonment in a penitentiary for a period of at least one year.

Financial Exploitation: illegal or improper use of an elder's or incapacitated adult's resources. Examples of financial exploitation include cashing a person's checks without authorization; forging a person's signature; or misusing or stealing a person's money or possessions. Another example is deceiving a person into signing any contract, will, or other legal document.

Fiscal Agent: the contract vendor, currently Molina Medicaid Solutions, responsible for claims processing and provider relations/enrollment.

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

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

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

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

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

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

Neglect: "Failure to provide the necessities of life to an incapacitated adult" or "the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult"(See WV Code §9-6-1). Neglect would include inadequate medical care by the service provider or inadequate supervision resulting in injury or harm to the incapacitated member. Neglect also includes, but is not limited to: a pattern of failure to establish or carry out a member's individualized program plan or treatment plan that results in negative outcome or places the member in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the member.

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

Person-Centered Planning: a process-oriented approach which focuses on the person and his/her needs by putting him/her in charge of defining the direction for his/her life, not on the systems that may or may not be available.

Quality Management Plan: a written document which defines the acceptable level of quality, for a waiver agency and describes how plan implementation will ensure this level of quality through documented deliverables and work processes.

Remediation: act of correcting an error or a fault.

Representative Sample: a small quantity of a targeted group such as customers, data, people, products, whose characteristics represent (as accurately as possible) the entire batch, lot, population, or universe.

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

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Scope of Services: the range of services deemed appropriate and necessary for an individual member. Such services may include but are not limited to prevention, intervention, outreach, information and referral, detoxification, inpatient or outpatient services, extended care, transitional living facilities, etc.

Sexual Abuse: any of the following acts toward an incapacitated adult in which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the incapacitated individual may have suffered no apparent physical injury as a result of such conduct:

1) Sexual intercourse/intrusion/contact; and
2) Any conduct whereby an individual displays his/her sex organs to an incapacitated adult for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult, or for the purpose of affronting or alarming the incapacitated adult.

Sexual Exploitation: when an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult to display his/her sex organs for the sexual gratification of that individual or third person, or to display his/her sex organs under circumstances in which that individual knows such display is likely to be observed by others who would be affronted or alarmed.

512.2 PROGRAM DESCRIPTION

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

The TBI Waiver Program is a long-term care alternative which provides services that enable individuals to live at home rather than receiving nursing facility care. The program provides home and community-based services to West Virginia residents who are medically and financially eligible to participate in the program. Members must be at least 22 years of age and have a documented traumatic brain injury, defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in a total or partial functional disability and/or psychosocial impairment. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, participant-direction, respect, and dignity and community integration. All members are offered and have a right to freedom of choice of providers for services. BMS contracts with APS Healthcare to implement the administrative functions of the Program.

TBI Waiver services, eligible for reimbursement by Medicaid, are to be provided exclusively to the member, for necessary activities as listed in the Service Plan. They are not to be provided for the convenience of the household or others. Although informal supports are not mandatory in the TBI Waiver Program, the program is designed to provide formal support services to supplement, rather than replace, the member's existing informal support system.

TBI Waiver services include Case Management, Personal Attendant Services, Cognitive Rehabilitation Therapy, and Participant-Directed Goods and Services.

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TBI Waiver members may choose from either the Traditional (Agency) Model or the Participant-Directed Model known as Personal Options for service delivery. In the Traditional Model, members receive their services from employees of a certified provider agency or an independent professional qualified to provide Cognitive Rehabilitation Therapy. In Personal Options, members are able to hire, supervise, and terminate their own employees.

512.3 PROVIDER AGENCY CERTIFICATION

TBI Waiver provider agencies must be certified by APS Healthcare. A Certification Application must be completed and submitted to:

APS Healthcare, Inc.
100 Capitol Street, Suite 600
Charleston, WV 25301

An agency may provide Case Management, Personal Attendant Services and/or Cognitive Rehabilitation Therapy provided they maintain:

A. A separate certification and WV Medicaid provider number for each service;
B. Separate staffing; and,
C. Separate member files for Case Management, Personal Attendant and Cognitive Rehabilitation Therapy Services.

Conflicts of interest and self-referral are prohibited.

Certified TBI Waiver Case Management and Personal Attendant Service provider agencies must meet and maintain the following requirements:

A. A business license issued by the State of West Virginia.
B. A federal tax identification number (FEIN).
C. A competency based curriculum for required training areas for Personal Attendant direct care staff.
D. An organizational chart
E. A list of the Board of Directors (if applicable)
F. A list of all agency staff, which includes their qualifications.
G. A Quality Management Plan that is consistent with the Centers for Medicare & Medicaid Services' (CMS) quality framework and assurances. (Refer to http://www.hcbs.org/files/28/1377/QFramework.pdf).
H. A physical office that meets ADA standards.
I. Written policies and procedures for processing member grievances.
J. Written policies and procedures for processing member and staff complaints.
K. Written policies and procedures for member transfers.
L. Written policies and procedures for the discontinuation of member services.
M. Written policies and procedures to avoid conflict of interest (if agency is providing both Case Management and Personal Attendant Services).
N. Office space that allows for member confidentiality.
O. An Agency Emergency Plan (for members and office operations).
P. Policy for maintaining 24 hour contact availability. (Personal Attendant Agencies Only)

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Provider agencies will be reviewed by APS Healthcare within six months of initial agency certification, and annually thereafter. (Refer to *Section 512.3.2* **Initial/Continuing Certification of Provider Agencies**).

Agencies wishing to provide Cognitive Rehabilitation Therapy services to TBI Waiver members must maintain a current behavioral health provider license by the Office of Health Facilities and Certification (OHFLAC).

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

512.3.1 Office Criteria

TBI Waiver Case Management and Personal Attendant Service provider agencies must designate and staff at least one physical office within West Virginia. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

A. An agency office site can serve no more than eight contiguous counties in WV as designated in the application. (TBI Waiver providers wishing to make changes in the approved counties they serve **must** make the request in writing to APS Healthcare. APS Healthcare will make a determination on the request and inform the provider in writing. No changes in counties served can be made unless approved by APS Healthcare).
B. Meet ADA requirements for physical accessibility. (Refer to 28 CFR 36, as amended)
C. Be readily identifiable to the public.
D. Maintain a primary telephone number that is listed with the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone.)
E. Maintain an agency secure (HIPAA compliant) e-mail address for communication with BMS and APS Healthcare.
F. Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.
G. Contain space for securely maintaining member and personnel records. (Refer to *Common Chapter 800*, *General Administration*, and *Common Chapter 300*, *Provider Participation Requirements*, for more information on maintenance of records).
H. Maintain a 24-hour contact method (Personal Attendant Agencies only).

512.3.2 Initial/Continuing Certification of Provider Agencies

Following the receipt of a completed Certification Application, APS Healthcare will conduct an onsite review, if required, to verify that the applicant meets certification requirements. This requirement may be waived if the prospective provider is a current Licensed Behavioral Health Center or is enrolled as an Aged and Disabled Waiver, Personal Care, or Intellectual/Developmental Disabilities (I/DD) Waiver provider at the time of application. APS Healthcare will notify Molina, BMS' fiscal agent, upon satisfactory completion of the onsite review or verification of LBHC, Aged and Disabled Waiver, Personal Care or I/DD waiver status.

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Molina will provide the applicant with an enrollment packet which includes the TBI Provider Agreement. Once this process has been completed, Molina will assign a provider number. A letter informing the agency that it may begin providing and billing for TBI Waiver services will be sent to the agency and to APS Healthcare.

Persons employed by Medicaid members choosing Personal Options enter into a simplified provider agreement facilitated and signed by Public Partnerships, LLC (PPL) which acts as BMS' Fiscal Employer/Agent.

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

Once certified and enrolled as a Medicaid provider, TBI Waiver Case Management and Personal Attendant Service provider agencies must continue to meet the requirements listed in this chapter as well as the following:

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

Licensed Behavioral Health Centers providing Cognitive Rehabilitation Therapy must maintain a current licensure with OHFLAC.

512.3.3 Record Requirements

TBI Waiver providers must meet the following record requirements:

Member records:

A. The provider must keep a file on each Medicaid member.
B. Member files must contain all original documentation for services provided to the member by the provider responsible for development of the document (for example the Case Management Agency should have the original Service Plan, the complete Member Assessment, Contact Notes, Member Enrollment Confirmation, etc.)
C. Original documentation on each member must be kept by the Medicaid provider for five years, with any and all exceptions having been declared resolved by BMS, in the designated office that represents the county where services were provided.

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Personnel Records:

A. Original or legible copies of personnel documentation including training records, licensure, confidentiality agreements, criminal investigation background checks (CIB) etc. must be maintained on file by the provider.
B. Minimum credentials for professional staff must be verified upon hire and thereafter based upon their individual professional license requirements.
C. All documentation on each staff member must be kept by the provider in the designated office that represents the county where services were provided.
D. Verification that federal and state Exclusion Lists were checked as appropriate for the position.

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

512.3.4 Provider Certification Reviews

TBI Waiver provider agencies are required to submit designated evidence to APS Healthcare every 12 months to document continuing compliance with all Certification requirements as specified in this Chapter. This evidence must be attested to by an appropriate official of the provider agency (e.g., Executive Director or Board Chair). If appropriate documentation is not provided within 30 days of expiration of current certification, a Provisional Certification may apply. Provider agencies who receive a Provisional Certification will be required to have an onsite review by APS Healthcare prior to full re-certification. If deficiencies are found by APS Healthcare during document review, the provider must submit a corrective action plan within 30 days of notice of deficiency. If an approved corrective action plan and required documentation is not submitted within the required time frame, BMS may hold provider reimbursement until an approved corrective action plan is in place.

A percentage of providers will be randomly selected annually for an onsite review to validate certification documentation. Record selection will include a statewide representative sample of member records. The monitoring tools used by APS Healthcare to review member charts will be made available at www.apshealthcare.com The West Virginia Participant Experience Survey (PES) will also be conducted with those members whose charts are selected for review. A proportionate random sample will also be implemented to ensure that at least one member record from each provider site is reviewed.

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

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

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512.3.5 Personal Attendant Service Staff Requirements

Medicaid prohibits the spouse of a TBI Waiver member from providing Waiver services for purposes of reimbursement.

Personal Attendant Service staff and Personal Options direct care staff must be at least 18 years of age and must have completed the following competency based training before providing services to TBI Waiver members:

A. Cardiopulmonary Resuscitation (CPR) – must be provided by an agency nurse, or a certified trainer from the American Heart Association, American Red Cross, or other organizations approved by BMS. First Aid – must be provided by an agency nurse, a certified trainer or an approved internet provider.
B. Occupational Safety and Health Administration (OSHA) training – must use the current training material provided by OSHA.
C. Personal Attendant Skills – training focused on assisting individuals with Traumatic Brain Injuries with ADL's – must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
D. Abuse, Neglect and Exploitation - must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
E. HIPAA – training must include agency staff responsibilities regarding securing Protected Health Information - must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
F. Direct Care Ethics – training on ethics such as promoting physical and emotional well-being, respect, integrity and responsibility, justice, fairness and equity - must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
G. Member Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management and training specific to any member with special needs must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
H. Crisis Intervention Training.

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

Personal Options members may access their PPL Resource Consultant for training materials and assistance.

512.3.5.1 Annual Direct Care Staff Training

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

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

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B. First Aid, if provided by an agency RN, must be renewed within 12 months or less. If provided by a nationally recognized organization, current is defined by the terms of the certifying agency. Training will be determined current in the month it initially occurred. (Example: if First Aid training was conducted May 10, 2010, it will be valid through May 31, 2011.
C. OSHA, Abuse, Neglect and Exploitation, and HIPAA must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (See example above.)
D. 4 hours of training focusing on enhancing direct care service delivery knowledge and skills for people with traumatic brain injuries must be provided annually. Member specific on-the-job-training may be counted toward this requirement.

512.3.5.2 Training Documentation

Documentation for training conducted by an agency RN, social worker/counselor, or a documented specialist in the content area must include the training topic, date, beginning time of the training, ending time of the training, location of the training and the signature of the instructor and the trainee or for Personal Options, the member and/or their legal representative (if applicable). Training documentation for internet based training must include the employee's name, the name of the internet provider/trainer and either a certificate or other documentation proving successful completion of the training.

512.3.6 Case Manager Qualifications

A Case Manager must be licensed in West Virginia as a Social Worker, Counselor, or Registered Nurse and employed by a TBI Waiver Case Management Agency enrolled with Medicaid. Licensure documentation must be maintained in the employee's file. Documentation that covers all of the employee's employment period must be present (Example - if an employee has been with your agency for three years – documentation of licensure must be present for all three years).

512.3.7 Cognitive Rehabilitation Therapist Qualifications

Cognitive Rehabilitation Therapy (CRT) must be provided by Licensed Behavioral Health Centers (LBHCs) or independent Physicians, Neuropsychologists, Psychologists, Occupational Therapist, Speech Therapists, or Physical Therapists licensed to practice in the State of West Virginia. LBHC staff providing CRT can be licensed professionals from a wide range of disciplines including, but not limited to, counseling, education, medicine, neuropsychology, occupational therapy, physical therapy, psychology, recreation therapy, social work, special education and speech-language pathology. LBHC staff and independent professionals providing CRT to members must be certified or be in the process of attaining necessary credentials and/or experience for certification by the Society for Cognitive Rehabilitation (SCR). Staff in the process of attaining certification will have up to three years to finalize the certification process.

All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality agreements (Refer to *Common Chapter 100, General Information*,), and

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references shall be maintained on file by the provider. Provider agencies shall have an internal review process to ensure that employees providing TBI Waiver services meet the minimum qualifications.

512.3.8 Criminal Investigation Background Checks and Restrictions and Medicaid Exclusion List

At a minimum, a state level criminal investigation background check (CIB), which includes fingerprints, must be conducted by the West Virginia State Police initially and again every three years for all TBI Waiver provider staff providing direct-care services to members including direct-care personnel (agency and Personal Options), Case Managers, and Cognitive Rehabilitation Therapists. If a prospective or current employee has lived out of state within the last five years, an FBI fingerprint-based criminal history check must also be conducted.

Prior to providing TBI Waiver services, required fingerprint-based checks must be initiated. TBI Waiver providers **may** do a preliminary check utilizing on-line internet companies and use these results until the fingerprint results are received. An individual who is providing direct-care services by a TBI Waiver provider cannot be considered to provide services if ever convicted of:

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

CIB check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse, must be considered by the licensed TBI Waiver provider before placing an individual in a position to provide services to the member.

If aware of a recent conviction or change in status of an agency staff member providing TBI Waiver services, the TBI Waiver provider (or PPL for Personal Options direct-care workers) must take appropriate action, including notification to the BMS TBI Program Manager.

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

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

512.4 Voluntary Agency Closure

A provider agency may terminate participation in the TBI Waiver Program with 30 calendar day's written notification of voluntary termination. The written termination notification must be submitted to the BMS claims agent and to APS Healthcare. The provider must provide APS Healthcare with a complete list of all current TBI Waiver members that will need to be transferred.

APS Healthcare will provide selection forms to each of the agency's members, along with a cover letter explaining the reason a new selection must be made.

If at all possible, a joint visit with the member will be made by both the agency ceasing participation and the new one selected in order to explain the transfer process. Services must continue to be provided until all transfers are completed by APS Healthcare.

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

Personal Options members must notify PPL within 24 hours when an employee terminates their employment.

512.5 Involuntary Agency Closure

BMS may administratively terminate a provider agency from participation in the TBI Waiver program for violation of the rules, regulations, or for the conviction of any crime related to health care delivery. If the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the TBI Waiver program. After notice of intention to suspend or terminate enrollment under his/her authority, the provider may request a document/desk review. Refer to *Common Chapter 800, General Administration,* for more information on this procedure.

Prior to closure, the provider will be required to provide APS Healthcare with a complete list of all current TBI Waiver members that will need to be transferred. APS Healthcare will provide selection forms to each of the agency's members, along with a cover letter explaining the

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reason a new selection must be made. APS HealthCare will ensure that the transfer of all members is accomplished as safely, orderly and expeditiously as possible.

512.6 Additional Sanctions

If BMS or APS Healthcare receives information that clearly indicates a provider is unable to serve new members due to staffing issues, member health and safety risk, etc. or has a demonstrated inability to meet recertification requirements, BMS may remove the agency from the Provider Selection Forms and from the provider information on the APS Healthcare website until the issues/concerns are addressed to the satisfaction of BMS. Health and Safety deficiencies deemed critical may include other sanctions including involuntary agency closure.

512.7 INCIDENT MANAGEMENT

TBI Waiver providers shall have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the members they serve. The provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all members served. Incidents shall be classified by the provider as one of the following:

Abuse, Neglect, or Exploitation:

Anyone providing services to a TBI Waiver member who suspects an incidence of abuse or neglect, as defined in Section 512.1 of this Chapter, must report the incident to the local DHHR office in the county where the person who is allegedly abused lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office or by calling 1-800-352-6513, 7 days a week, 24 hours a day. This initial report must then be followed by a written report, submitted to the local Department of Health and Human Resources, within forty-eight (48) hours following the verbal report. An Adult Protective Services (APS) Worker may be assigned to investigate the suspected or alleged abuse.

Critical Incidents:

Critical incidents are incidents with a high likelihood of producing real or potential harm to the health and welfare of the TBI Waiver member. These incidents might include, but are not limited to, the following:

- Attempted suicide, or suicidal threats or gestures.
- Criminal activity that is suspected or observed by members themselves, members' families, health care providers, concerned citizens, or public agencies that does not compromise the health or safety of the member.
- An unusual event such as a fall or injury of unknown origin requiring medical intervention if abuse and neglect is not suspected.
- A significant interruption of a major utility, such as electricity or heat in the member's residence, but does not compromise the health or safety of the member.
- Environmental/structural problems with the member's home, including inadequate sanitation or structural damage that does not compromise the health or safety of the member.

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- Fire in the home resulting in relocation or property loss that does not compromise the health or safety of the member.
- Unsafe physical environment in which the Personal Attendant and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.
- Disruption of the delivery of TBI Waiver services, due to involvement with law enforcement authorities by the member and/or others residing in the member's home that does not compromise the health or safety of the member.
- Medication errors by a member or his/her family caregiver that do not compromise the health or safety of the member, such as medication taken that was not prescribed or ordered for the member, and failure to follow directions for prescribed medication, including inappropriate dosages, missed doses, or doses administered at the wrong time.
- Disruption of planned services for any reason that does not compromise the health or safety of the member, including failure of member's emergency backup plan.
- Any other incident judged to be significant and potentially having a serious negative impact on the member, but does not compromise the health or safety of the member.
- Any incident attributable to the failure of TBI Waiver provider staff to perform his/her responsibilities that compromises the health or safety of the member is considered to be neglect and must be reported to Adult Protective Services (APS).

Simple Incidents:

Simple incidents are any unusual events occurring to a member that cannot be characterized as a critical incident and does not meet the level of abuse or neglect. Examples of simple incidents include, but are not limited to, the following:

- Minor injuries of unknown origin with no detectable pattern
- Dietary errors with minimal or no negative outcome

512.7.1 Incident Management Documentation and Investigation Procedures

Any incident involving a TBI Waiver member must be entered into the West Virginia Incident Management System (WVIMS) within 24 hours of learning of the incident. The Agency Director or Case Manager will immediately review each incident report. All Critical Incidents must be investigated. As noted in Section 512.7, all incidents involving abuse, neglect and/or exploitation must be reported to Adult Protective Services, but also must be noted in WVIMS.

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

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

For Personal Options, PPL must report any incidents in the WVIMS within 24 hours of learning of the incident. As noted in Section 512.7, all incidents involving abuse, neglect and/or exploitation must be reported to Adult Protective Services, but also must be noted in WVIMS. APS Healthcare reviews each incident, investigates and enters outcomes of the investigation within 14 calendar days of the incident.

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

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

512.7.2 Incident Management Tracking and Reporting

Provider agencies must review and analyze incident reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the agency Quality Management Plan. The Quality Management Plan must be made available to APS Healthcare monitoring staff at the time of the provider monitoring review or upon request.

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

512.8 MEMBER ELIGIBILITY

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

A. Be 22 years of age or older.
B. Be a permanent resident of West Virginia.
C. Have a traumatic brain injury defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment.
D. Be approved as medically eligible for nursing facility level of care.
E. Score at a Level VII or below on the Rancho Los Amigos Levels of Cognitive Functioning Scale.
F. Be inpatient in a licensed nursing facility, an inpatient hospital, a licensed rehabilitation facility to treat TBI, or living in a community setting at the time of application.
G. Meet the Medicaid Waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient.
H. Choose to participate in the TBI Waiver Program as an alternative to nursing facility care.

If an individual meets eligibility requirements, a slot must be available for him/her to participate in the program. If no slots are available, applicants determined medically eligible for the Program will be placed on the Managed Enrollment List. As slots become available, applicants on the Managed Enrollment List will be notified and provided detailed instructions on continuing the application process.

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512.8.1 Medical Eligibility

APS Healthcare is responsible for evaluating medical eligibility, conducting assessments and determining if medical eligibility requirements for the TBI waiver program are met.

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

A. New applicants and existing members are medically eligible based on current and accurate evaluations.
B. The medical eligibility determination process is fair, equitable, and consistently applied throughout the State.

512.8.1.1 Medical Eligibility Criteria

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

Section	Description of Deficits	
#24	Decubitus; Stage 3 or 4	
#25	In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With Supervision are not considered deficits.	
#26	Functional abilities of individual in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)
d.	Grooming	Level 2 or higher (physical assistance or more)
e. f.	Continence, bowel Continence, Bladder	Level 3 or higher; must be incontinent.
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transfer	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)
#27	Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.	
#28	Individual is not capable of administering his/her own medications.	

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Applicants must also score at a Level VII or lower on the Ranchos Los Amigos Scale. Information on the Ranchos Scale can be found on the APS HealthCare web site at http://apshealthcare.com/publicprograms/west_virginia/WV_Participating_Providers.htm.

512.8.1.2 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process:

A. An applicant shall initially apply for the TBI Waiver by having his/her treating physician(M.D. or D.O.) or specially trained neuropsychologist submit a Medical Necessity Evaluation Request form to APS Healthcare. The physician's/neuropsychologist's signature is valid for sixty (60) days. The referral source for the request may be from the applicant/applicant's representative, hospital or nursing facility, DHHR, the physician, social services agencies, or others.

B. The Medical Eligibility Evaluation Request form asks that the physician/neuropsychologist submit the applicant's identifying information including, but not limited to, the following:

   1. A statement that the individual's condition meets the entry level definition of TBI: a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment;
   2. A description of the functional deficits directly attributable to the TBI;
   3. If the applicant is currently inpatient in a licensed nursing facility, inpatient hospital, or licensed rehabilitation facility for TBI, (does not apply if residing in the community) and;
   4. other pertinent medical diagnoses.

C. Once a referral is received, APS Healthcare will send a letter of verification of its receipt to the applicant and/or their legal representative and the referring physician or neuropsychologist. If the Medical Eligibility Evaluation Request form is incomplete it will be returned to the referring physician or neuropsychologist for completion and resubmission, and the applicant will be notified. APS Healthcare will attempt to contact the applicant and/or their legal representative to schedule an assessment. APS Healthcare will make up to three attempts to contact the applicant. If it is determined that the applicant is not available, the referring physician or neuropsychologist and applicant and/or their legal representative will be notified that no contact could be made. If the referral is closed because of an inability to contact the applicant, a new referral will be required to re-initiate the process.

D. If contact is made, a letter will be sent to the applicant and contact person noting the contact was made and the date of the scheduled evaluation. If the applicant has identified a guardian or legal representative, no assessment shall be scheduled without presence of the guardian, legal representative or contact person. If the Medical Eligibility Evaluation Request form indicates that the applicant has severe dementia, no visit will be scheduled without the guardian, legal representative or contact person present to assist the applicant during the evaluation.

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E. APS Healthcare completes the Pre-Admission Screening (PAS) and the Ranchos Los Amigos Scale. APS Healthcare staff will record observations and findings regarding the applicant's level of function. In those cases where there is a medical diagnosis question, APS Healthcare will attempt to clarify the information with the referring physician. In the event that APS Healthcare cannot obtain the information, it will be documented, and noted that supporting documentation from the referring physician was not received.

F. If it is determined that the applicant does not meet medical eligibility, the applicant, the referring physician or neuropsychologist, and applicant's representative, if applicable, will be notified by a Potential Denial letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS, Rancho Los Amigos Scale, and relevant TBI Waiver policy will also be included with the "Potential Denial" letter. The applicant will be given two weeks to submit supplemental medical information to APS Healthcare. Information submitted after the two-week period will not be considered.

G. If the review of the supplemental information by APS Healthcare determines that there is still no medical eligibility, the applicant and/or their legal representative (if applicable), and the referring physician or neuropsychologist will be notified by a Final Denial letter. The "Final Denial" letter will provide the reason for the denial. It will also include the applicable TBI Waiver policy manual section(s), a copy of the PAS and Rancho Los Amigos Scale, supplemental information documentation (if it has been supplied), notice of resources for free legal services, and a Request for Fair Hearing form to be completed if the applicant wishes to contest the decision.

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

I. If the applicant is determined medically eligible and a TBI Waiver slot is available, a notice of approved medical eligibility is sent to the applicant, the referring physician or neuropsychologist, and the applicant's legal representative, if applicable. Copies of the applicant's PAS and Rancho Los Amigos Scale are also sent at this time to the applicant and/or their legal representative (if applicable).

J. If the applicant is determined medically eligible and a slot is not available, a notice of approved medical eligibility will be sent to the applicant and/or their legal representative (if applicable) and the referring entity informing them that a slot is not currently available. The applicant will be notified that they have been placed on the Managed Enrollment List.

K. When a TBI Waiver slot is available, APS Healthcare sends a Service Delivery Model Selection Form advising the applicant to choose either Traditional or Personal Options. If the member chooses the Traditional Model, a Freedom of Choice Case Management

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Selection Form and a Freedom of Choice Personal Attendant Selection Form are also provided to the applicant and/or their legal representative if applicable), advising him/her to choose a Case Management Agency and a Personal Attendant Service Agency. The forms are to be returned to APS Healthcare once selections are made.

L. APS Healthcare will notify both of the agencies selected, and provide them with a copy of the applicant's PAS and Ranchos Los Amigos Scale. The Case Manager must use the Initial Contact Log at this point. It provides the Case Manager with the ability to document their initial contact to assist with financial eligibility (Refer to *Section* **512.8.2**), Member Enrollment (Refer to Section 512.9) and the required seven day contact (Refer to *Section 512.10* **MEMBER ASSESSMENT**). If Personal Options has been selected APS Healthcare will notify PPL and provide them with a copy of the PAS and Ranchos Los Amigos Scale.

512.8.1.3 Medical Re-evaluation

Annual re-evaluations for medical eligibility for each TBI Waiver member must be conducted. The process is as follows:

A. APS Healthcare will schedule an annual re-evaluation of the member's medical eligibility screening 12 months after initiation of services.
B. APS Healthcare will visit the member in his/her home or at an agreed location in order to complete the evaluation. C.APS Healthcare will evaluate the findings of the annual functional assessment to determine whether the member continues to meet medical eligibility for the TBI Waiver.
D. If the member has identified a guardian or legal representative, no visit shall be scheduled without presence of the guardian, legal representative or contact person.
E. Once an evaluation time is arranged, APS Healthcare shall send a letter to the member and/or their legal representative (if applicable), Case Management Agency and PPL (if applicable), noting the contact and date of the visit.
F. If APS Healthcare is unable to contact the member, a letter will be sent to the member and/or their legal representative (if applicable), Case Management Agency, and referring physician or neuropsychologist stating that the member's eligibility is in jeopardy if the evaluation cannot be performed and requesting that the member and/or their legal representative or Case Manager contact APS Healthcare to schedule an evaluation.
G. If the member meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the member and/or their legal representative (if applicable), the Case Management Agency and PPL (if applicable). This notice includes the approved budget, a notice of resources for free legal services, and a Request for Hearing form.
H. If it is determined that the member does not meet medical eligibility, the member and/or their legal representative (if applicable), the referring physician or neuropsychologist, the Case Manager and PPL (if applicable) will be notified by a Potential Denial letter. This letter will advise the member of the reason(s) for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the functional assessment and TBI Waiver policy will also be included with the "Potential Denial" Letter. The member will be given two weeks to submit supplemental medical information to APS Healthcare. Information submitted after the two-week period will not be considered.

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I. If the review of the supplemental information determines that there is still no medical eligibility, the member and/or their legal representative (if applicable) and Case Manager will be notified with a Final Denial letter. The "Final Denial" letter will provide the reason for the denial. It will also include the applicable policy manual section(s), a copy of the functional assessment, supplemental information documentation (if it has been supplied), notice of resources for free legal services, and a Request for Hearing to be completed if the member wishes to contest the decision. If the member elects to appeal any adverse decision, services shall continue at the current level only if the appeal is submitted within thirteen (13) days of the receipt of the notice, and only until a final decision is rendered by the administrative Hearing Officer.

The Case Management Agency is responsible for sending the Notice of Approved Continued Medical Eligibility to the Personal Attendant provider agency.

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

512.8.2 Financial Eligibility

The financial eligibility process starts once an applicant is determined to be medically eligible for TBI Waiver services and has returned the Service Delivery Model Selection Form to APS Healthcare. If the applicant selects the Traditional Model they must also return the Freedom of Choice Provider Selection Forms to APS Healthcare.

If the applicant has chosen the Traditional Model, the Case Management Agency that has been selected by the applicant will be notified, and a copy of the PAS and Ranchos Los Amigos Scale will be provided. Within three business days of receipt of this notification, the Case Manager must make an initial contact by telephone or face-to-face with the applicant. The applicant and/or Case Manager must submit a DHS-2 form to the county DHHR office to determine financial eligibility based on TBI Waiver criteria. A copy of the TBI Waiver Medical Eligibility Letter must be attached to the DHS-2 form. Financial eligibility cannot be initiated without this documentation.

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

The financial eligibility process must be initiated within 60 calendar days from the date the Case Management Agency receives the notification of selection letter. Case Managers must notify APS Healthcare when the financial eligibility process has been initiated. If the financial eligibility process is not initiated within the 60 calendar days, APS Healthcare will close the referral. If the applicant wants TBI Waiver services after the closure, a new Medical Eligibility Evaluation Request Form must be submitted to APS Healthcare. TBI Waiver services cannot be paid until an applicant's financial eligibility is established (or verified) and the enrollment process has been completed with APS Healthcare. (Refer to *Section* **512.9 MEMBER ENROLLMENT**).

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If the member has been a member of another waiver program, no services can be reimbursed prior to an applicant's closure from the other waiver program. The only exception is Case Management which may be provided 30 days prior to closure.

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

512.9 MEMBER ENROLLMENT

Once an applicant has been found medically and financially eligible, the Case Manager must request Member Enrollment from APS Healthcare by completing a Member Enrollment Request Form. APS Healthcare will complete the Member Enrollment and provide a Confirmation Notice to the Case Management Agency and the Personal Attendant Service provider agency. The member's Waiver case will be closed if services are not provided within 180 days of the date of enrollment in the Program.

No Medicaid reimbursed TBI Waiver services can be provided until the Case Management Agency is in receipt of the Member Confirmation Notice.

The Case Management Agency is responsible for maintaining a copy of the Member Enrollment Request Form and the Member Enrollment Confirmation Notice in the member file. The Personal Attendant Service provider agency (and LBHC if providing Cognitive Rehabilitation Therapy) is responsible for maintaining a copy of the Member Enrollment Confirmation Notice in the member file.

512.10 MEMBER ASSESSMENT

Assessment is the structured process of interviews which is used to identify the member's abilities, needs, preferences and supports; determine needed services or resources; and provide a sound basis for developing the Service Plan. A secondary purpose of the assessment is to provide the member a good understanding of the program, services, and expectations. Once Member Enrollment has been completed, the Case Manager will schedule a home visit within (7) seven calendar days to complete the Member Assessment.

The Case Manager must work with all service providers to ensure that the program meets the member's needs.

A new Member Assessment must be completed when a member's needs change. Changes in a member's needs are to be incorporated into the Service Plan. Case Managers are to share any changes in a member's assessment with all service providers listed on the members Service Plan. The Personal Attendant Service provider agency (and LBHC if providing Cognitive Rehabilitation Therapy) is to share any changes observed in the member with the case manager. A copy of all Member Assessments must be provided to the member and/or their legal representative (if applicable).

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512.11 SERVICE PLAN DEVELOPMENT

The Case Manager is responsible for development of the person-centered Service Plan in collaboration with the member and/or their legal representative (if applicable). Participation in the development of the Initial Service Plan is mandatory for the member and/or their legal representative if applicable) and Case Manager. The member and/or their legal representative (if applicable) may choose to have whomever else they wish to participate in the process (Personal Attendant Service provider agency staff, other service providers, informal supports, etc.).

The Service Plan meeting must be scheduled within seven (7) calendar days of the Member Assessment.

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

A copy of all Service Plans must be provided to the member and/or their legal representative if applicable) and the Personal Attendant Service provider agency. The Case Management Agency must have the original document in the member's file.

The member's Service Plan must contain reference to any other service(s) received by the member, regardless of the source of payment. A TBI Waiver provider agency that provides private-pay services to a member must ensure that documentation is maintained separately.

512.11.1 Six-Month and On-Going Service Plan Development

Participation in the six (6) month Service Plan and Annual Service Plan development is mandatory for the member and/or their legal representative if applicable), the Case Manager, and the Personal Attendant Service provider agency. The member and/or their legal representative (if applicable) may choose to have whomever else they wish to participate in the process (Cognitive Rehabilitation Therapist, direct care staff, family members, other service providers, informal supports, etc.).

512.11.2 Interim Service Plan Development

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

If the Case Management Agency develops an Interim Service Plan, the Personal Attendant Service provider agency must initiate direct care services within three (3) business days.

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512.12 COVERED SERVICES

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

A. Case Management
B. Personal Attendant Services
   i. Direct Care support
   ii. Transportation
C. Cognitive Rehabilitation Therapy
D. Participant-Directed Goods and Services

512.12.1 CASE MANAGEMENT

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

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

A. Evaluate social, environmental, service, and support needs of the individual.
B. In collaboration with the member and/or their legal representative (if applicable), develop and write an individualized Service Plan which details all services that are to be provided including both formal and informal (if available) services that will assist the member to achieve optimum function.
C. Coordinate the delivery of care, eliminate fragmentation of services, and assure appropriate use of resources.
D. Proactively identify problems and coordinate services that provide appropriate high quality care to meet the individualized and often complex needs of the member.
E. Provide advocacy on behalf of the member to ensure continuity of services, system flexibility, integrated services, proper utilization of facilities and resources, and accessibility to services.
F. Ensure that a member's wishes and preferences are reflected in the development of the Service Plan by working directly with the member and/or their legal representative if applicable) and all service providers.

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G. Inform members and/or their legal representatives (if applicable) of their rights, including information about grievance and Fair Hearing processes.
H. Assure that a member's legal and human rights are protected.

Case Management activities specific to Participant Direction include, but are not limited to:

A. Informing members of the availability of the Participant-Directed option.
B. Explaining general rights, risks, responsibilities and the member's right to choose the Participant-Directed Model.
C. Assist in determining if a legal/non-legal representative is desired and/or needed by the member.
D. Providing or linking members with program materials in a format that they can use and understand.
E. Explaining person-centered planning and philosophy to members.
F. Linking members with PPL for completion of the necessary paper work for Participant-Direction.
G. Explaining to the member the roles and supports that will be available.
H. Reviewing and discussing the member's budget, including the budget available for Participant-Direction.
I. Ensuring that members know how and when to notify the Case Manager about any operational or support concerns or questions.
J. Monitoring the members risk management activities.
K. Ensuring a seamless transition into the Participant-Directed Model if chosen.
L. Coordinating services provided by traditional provider agencies.
M. Notifying APS Healthcare and PPL of concerns regarding potential issues which could lead to member disenrollment.
N. Notifying APS Healthcare of concerns about the status of the health and welfare of participants.
O. Follow-up with the member regarding the submission of critical incidents.

512.12.1.1 Case Management Code, Unit, Limit and Documentation Requirements

Procedure Code: T1016 UB

Service Unit: **15 minutes**

Service Limit: **192 15 minute units annually**

Prior Authorization Required: **Yes**

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

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All documented evidence of Case Management staff qualifications such as licenses, transcripts, certificates, CIB checks, signed confidentiality statements and references shall be maintained on file by the provider agency. The agency must have an internal review process to ensure that Case Management staff providing TBI Waiver services meets the minimum qualifications as required by policy (Refer to Section **512.3.6 Case Manager Qualifications**).

512.12.1.2 Ongoing Case Management Services

The Case Manager is responsible for follow-up with the member to ensure that services are being provided as described in the Service Plan. Initial contact, via telephone or face-to-face, must be made within seven (7) calendar days after direct care services have begun by the Personal Attendant Service provider agency. At a minimum, a monthly telephone contact with the member and/or their legal representative (if applicable) and a home visit every six (6) months must be conducted to ensure services are being provided and to identify any potential issues. Monthly telephone contact must be documented on the Case Management Monthly Contact Form and include detailed information on the status of the member. If a member and/or their legal representative (if applicable) cannot be reached by telephone for the monthly contact, a home visit must be made. At a minimum, the Case Manager must complete a six (6) month Member Assessment and Service Plan. This must be a face-to-face home visit with the member.

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

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

512.12.1.3 Reporting

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

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512.12.2 PERSONAL ATTENDANT SERVICES

Personal Attendant Services are defined as long-term direct care and support services that are necessary in order to enable a member to remain at home rather than enter a nursing facility, or to enable an individual to return home from a nursing facility. The components of the Personal Attendant Service include Personal Attendant Direct Care Services and Transportation.

The functions of the Personal Attendant Service direct care staff include providing direct care services as defined by the member's Service Plan or the Spending Plan for Personal Options members, recording services and time spent with the member, communicating any member changes and completing all TBI Waiver training requirements.

Personal Attendant Service direct care staff duties and responsibilities as described in the Service Plan may include:

A. Assist member with ADLs.
B. Assist member with environmental tasks necessary to maintain the member in the home.
C. Assist member with completion of errands that are essential for the member to remain in the home (IADLs) — Examples: grocery shopping, medical appointments, Laundromat, and trips to the pharmacy. The member may accompany the Personal Attendant Service direct care staff on these errands.
D. Assist member in community activities. Activities provided in the community are limited to 30 hours per month. (Examples of community activities--visiting friends/relatives, going to a local community activity, etc.) Community activities must be documented on the Service Plan or Personal Options Spending Plan.
E. Report significant changes in members' condition to the Personal Attendant Service agency (or PPL if member is enrolled in Personal Options) and member's Case Manager.
F. Report any incidents to the Personal Attendant Service agency (or PPL if member is enrolled in Personal Options) and the member's Case Manager. (Examples: member falls (whether direct care staff was present or not), bruises (whether direct staff knows origin or not), etc.)
G. Report any environmental hazards to the Personal Attendant Service agency (or PPL if member is enrolled in Personal Options) and the member's case Manager. (Examples: no heat, no water, pest infestation or home structural damage).
H. Prompt for self-administration of medications.
I. Maintain records as instructed by the Personal Attendant Service agency (or PPL if member is. enrolled in Personal Options).
J. Perform other duties as assigned by the Personal Attendant Service agency (or member if enrolled in Personal Options) within program guidelines.
K. Accurately complete Personal Attendant Service worksheet and other records as instructed by the Personal Attendant Service agency.

Personal Attendant Service agency staff and employees of Personal Options participants cannot perform any service that is considered to be a professional skilled service or any service that is not on the member's Service Plan or for members enrolled in Personal Options the member's approved Spending Plan. Functions/tasks that cannot be performed include, but are not limited to, the following:

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A. Care or change of sterile dressings.
B. Colostomy irrigation.
C. Gastric lavage or gavage.
D. Care of tracheostomy tube.
E. Suctioning.
F. Vaginal irrigation.
G. Give injections, including insulin.
H. Administer any medications, prescribed or over-the-counter.
I. Perform catheterizations, apply external (condom type) catheter.
J. Tube feedings of any kind.
K. Make judgments or give advice on medical or nursing questions.
L. Application of heat.

If at any time a Personal Attendant is witnessed to be, or suspected of, performing any prohibited tasks, the Personal Attendant Service agency or PPL must be notified immediately.

More than one Personal Attendant Service provider agency can provide direct care services to a member. The agency the member selected on their Freedom of Choice Personal Attendant Service Selection Form is the primary agency and is responsible for coordinating services. The Service Plan must indicate which agency is the primary agency. There cannot be a duplication of services.

512.12.2.1 Personal Attendant Service (Direct Care support) Code, Unit, Limit and Documentation Requirements

Procedure Code: S5125 UB

Service Unit: 15 minutes

Service Limits: **Personal Attendant Services are limited by the member's budget.**

Prior Authorization Required: Yes

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

All documented evidence of Personal Attendant Service direct care staff qualifications such as licenses, transcripts, certificates, CIB checks, signed confidentiality statements and references shall be maintained on file by the provider agency. The agency must have an internal review process to ensure that Personal Attendant Service direct care staff providing TBI Waiver services meets the minimum qualifications as required by policy (Refer to *Section* **512.3 Personal Attendant Service Staff Requirements**).

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

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512.12.2.2 Transportation

Transportation is a component of the Personal Attendant Service and provides reimbursement for Personal Attendant direct care staff that performs essential errands for or with a member or community activities with a member.

The member may be transported by Personal Attendant Service agency direct-care staff in order to gain access to services and activities as specified in the Service Plan. Family, neighbors, friends, or community agencies that can provide this service, without charge, must be utilized first. However, if free transportation is not readily available and/or reliable, services must not be delayed and the provider must provide the transportation as specified in the member's Service Plan. Mileage can be charged for essential errands, activities related to the Service Plan and community activities (Refer to *Section* **512.12.2.2Transportation)**.

512.12.2.3 Transportation Code, Unit, Limit and Documentation Requirements

Procedure Code: A0160 UB

Service Unit: 1 unit - 1 mile

Service Limit: N/A

Prior Authorization: Yes

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

512.12.3 COGNITIVE REHABILITATION THERAPY

Cognitive Rehabilitation Therapy is therapy utilized for the development of cognitive skills to improve functional attention, memory, and problem solving including compensatory training in a context of direct one-to-one participant contact with the therapist.

512.12.3.1 Cognitive Rehabilitation Therapy Code, Unit, Limit and Documentation Requirements

Procedure Code: 97532 UB

Service Unit: **15 minutes**

Service Limit: **192 15 minute units annually**

Prior Authorization Required: **Yes**

Documentation Requirements: All contacts with, or on behalf of a member, must be documented within the member's record, including date and time of contact, a description of the

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contact, and the signature of the Cognitive Rehabilitation Therapist. Cognitive Rehabilitation Therapists may not bill for transportation services.

All documented evidence of Cognitive Rehabilitation Therapists qualifications such as licenses, transcripts, certificates, CIB checks, signed confidentiality statements and references shall be maintained on file. Provider agencies must have an internal review process to ensure that staff providing TBI Waiver services meets the minimum qualifications as required by policy (Refer to *Section* **512.3.7 Cognitive Rehabilitation Therapist Qualifications**).

512.12.4 PARTICIPANT-DIRECTED GOODS AND SERVICES

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

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

512.12.4.1 Participant-Directed Goods and Services Code, Unit, Limit and Documentation Requirements

Procedure Code: T2028 UB

Service Unit: As specified on member's Service Plan

Service Limit: $1000 Annually

Prior Authorization Required: No

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

512.13 MEMBER RIGHTS AND RESPONSIBILITIES

At a minimum, Case Management Agencies must communicate in writing to each member and/or their legal representative (if applicable)

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Their right to:

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

And their responsibility to:

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

512.14 MEMBER GRIEVANCE PROCESS

Members who are dissatisfied with the services they receive from a provider agency have a right to file a grievance. All TBI Waiver provider agencies will have a written member grievance procedure. APS Healthcare will explain the grievance process to all applicants/members at the time of initial application/re-evaluation. Applicants/members and/or their legal representative If applicable) will be provided with a Member Grievance Form at that time. Service providers will only afford members a grievance procedure for services that fall under the particular service provider's authority; for example, a Case Management Agency will not conduct a grievance procedure for Personal Attendant Service Agency activities, nor will a Personal Attendant Service Agency conduct a grievance procedure for Case Management Agency activities.

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A member may by-pass the level one grievance and file a level two grievance with APS Healthcare if he/she chooses. The grievance process is not utilized to address decisions regarding medical or financial eligibility, a reduction in services or case closure. These issues must be addressed through the fair hearing process.

The grievance procedure consists of two levels:

A. Level One: TBI Waiver Provider

A TBI Waiver provider has 10 business days from the date they receive a Member Grievance Form to hold a meeting, in person or by telephone. The meeting will be conducted by the agency director or their designee with the member and/or their legal representative (if applicable). The agency has five days from the date of the meeting to respond in writing to the grievance. If the member is dissatisfied with the agency decision, he/she may request that the grievance be submitted to APS Healthcare for a Level Two review and decision.

B. Level Two: APS Healthcare

If a TBI Waiver provider is not able to address the grievance in a manner satisfactory to the member and the member requests a Level Two review, APS Healthcare will, within 10 business days of the receipt of the Member Grievance Form, contact the member and/or their legal representative (if applicable) and the TBI Waiver provider to review the Level One decision. Level Two decisions will be based on Medicaid policy and/or health and safety issues.

512.15 TRANSFERS

A TBI Waiver member may request a transfer to another agency at any time. If a member wishes to transfer to a different agency a Member Request to Transfer form must be completed and signed by the member and/or their legal representative (if applicable). The form may be obtained from the current provider, the new provider, APS Healthcare or other interested parties. Once completed and signed by the member, the form must be submitted to APS Healthcare. APS Healthcare will then coordinate the transfer and set the effective date based on when required transfer documents are received.

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

Transferring Agency Responsibilities:

A. To continue providing services until APS Healthcare notifies them that the transfer has been completed.
B. If it is a Case Management transfer, to provide the receiving agency, on the day of the transfer, a copy of the current PAS, the Service Plan, a copy of the Member Enrollment Confirmation and any other pertinent documentation.
C. If it is a Personal Attendant Service transfer, to provide the receiving agency, on the day of the transfer, with a copy of the current PAS, the member's Service Plan and any other pertinent documentation.

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D. To maintain all original documents for monitoring purposes.

Receiving Agency Responsibilities:

A. Personal Attendant Service Agencies must meet with the member and/or their legal representative (if applicable) within 7 business days to review the Service Plan.
B. If it is a Case Management transfer, a Member Assessment must be conducted within seven (7) business days of the transfer effective date.
C. Develop the Service Plan within seven (7) business days of the transfer effective date.

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

Member transfers from traditional services to Personal Options, as well as, from Personal Options to traditional services are processed by APS Healthcare and will include both the Case Manager and Resource Consultant from PPL to ensure that all necessary documentation is shared and that there is no gap in the delivery of service.

512.15.1 Emergency Transfers

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

512.16 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services Form be submitted and approved by APS Healthcare:

A. No services have been provided for 180 continuous days – example, an extended placement in long-term care or rehabilitation facility.
B. Unsafe Environment – an unsafe environment is one in which the personal Attendant Service and/or other agency staff are threatened or abused and the staff's welfare is in jeopardy. This may include, but is not limited to, the following circumstances:
    1) The member or other household members demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a personal Attendant Service Agency staff or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals.
    2) The member or other household members display an abusive use of alcohol and/or drugs.

When APS Healthcare receives an unsafe closure request, they will obtain documentation from the provider to support the request. If documentation supports the request, APS Healthcare will first attempt to process the request as a transfer. To do so, APS Healthcare will require the member and/or their legal representative (if applicable) to sign a Consent for Release of

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Information Form. This will permit all information regarding the alleged unsafe circumstances to be disclosed to any agency the member wishes to transfer to. If the agency selected by the member is not willing to accept the member due to unsafe circumstances, the case will be closed. If at any time, the member removes the perceived threat from the service environment, services may continue. Referrals to Adult Protective Service will be made as required.

C. Member no longer desires services

The Request for Discontinuation of Services Form must be submitted to APS Healthcare for review. If APS Healthcare approves the discontinuation, APS Healthcare will send notification of discontinuation of services to the member and/or their legal representative (if applicable) with a copy to the Case Management Agency and PPL (if applicable). The notice shall include the reason and justification for the discontinuation of services. Fair hearing rights will also be provided except if the member no longer desires services. The effective date for the discontinuation of services is 13 calendar days from the receipt of the notification letter, if the member (or legal representative) does not request a hearing. If it is an unsafe environment services may be discontinued immediately.

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

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

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

512.17 DUAL PROVISION OF TBI WAIVER AND PERSONAL CARE (PC) SERVICES

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

A. Any PC services provided to an active TBI Waiver member must be approved by the reviewing agencies (Refer to H below), including the initial 60 hours. The Dual Service Provision Request must be completed.

B. The reviewing agency must document that the member has direct-care needs that cannot be met by the TBI Waiver.
C. All policy set forth in *Chapter 517, Personal Care Services*, must be followed. PC policy supersedes TBI Waiver policy for this request.
D. There must be a PC Plan of Care that reflects the TBI Waiver services provided and the additional Personal Care services to be provided. Personal Care services must also be

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reflected on the member's TBI Waiver Service Plan. These plans must be coordinated to ensure that services are not duplicated. PC and Personal Attendant services cannot be provided during the same hours on the same day. A service planning meeting between the Case Manager and Personal Care provider must be held with the member and/or their legal representative (if applicable) in the member's residence and documented on the Request for Dual Service Provision. For members participating in Personal Options, the meeting must include PPL and the member.

E. There must be a valid PAS and a valid PC Medical Eligibility Assessment (PCMEA) that documents the need for both services.
F. The Case Manager is responsible for the coordination of the two services.
G. Dual Service Provision Request Forms must be signed by the Case Manager, PC RN and the member and/or their legal representative (if applicable). Original signatures are required; i.e., "signature of member on file" is not acceptable.
H. All PC providers should submit requests to:

APS Healthcare
100 Capitol Street
Suite 600
Charleston, WV 25301

Documentation submitted must include a copy of the PAS and the PCMEA, TBI Waiver Service Plan and PC RN Plan of Care, and any documentation that supports the request. Additionally, a narrative describing how services will be utilized and verification that TBI Waiver and PC services will not be duplicated must be submitted. Approvals/denials will be based on the documentation submitted, appropriate program policy manuals, PC standards, and professional judgments. The member and/or their legal representative (if applicable), Personal Care and Personal Attendant Service providers, and the member's Case Manager will receive notification of denial or approval from the reviewing agency. If the request is denied or the hours approved are less than requested, the notification will include fair hearing information.

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

512.18 EXCLUDED SERVICES AND NON-REIMBURSABLE SITUATIONS

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

A. Services provided for other member(s) of the TBI Waiver member's household or to anyone who is not a TBI Waiver Program member.
B. Services provided by a Case Management Agency, Personal Attendant Service Agency or Cognitive Rehabilitation Therapy provider that are not included in the Service Plan.
C. Services provided to an individual who is not medically and financially eligible on the date(s) that service is provided.

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