CHAPTER 513–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES

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INTRODUCTION

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

This chapter sets forth the BMS requirements for payment of services provided to eligible WV Medicaid members under the Waiver Program for persons with Mental Retardation and/or Developmental Disabilities.

The policies and procedures set forth herein are the regulations governing the provision of services under the Waiver Program for Persons with Mental Retardation and Developmental Disabilities (MR/DD Waiver) of the Medicaid Program administered by the Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of WV.

513.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200 Definitions of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of the services in the MR/DD Waiver Program described in this chapter.

Active Treatment is a comprehensive training program which necessitates the availability of trained staff to aggressively and systematically address the acquisition of skills to improve, maintain or prevent the regression of basic activities of daily living as they relate to self-care, mobility, communication, learning, self-direction, and the capacity for independent living. Active treatment does not include services to maintain generally independent members who are able to function with little supervision or in the absence of a continuous active treatment program.

Activities of Daily Living (ADL's) are activities usually performed in the course of a normal day in an individual's life, such as eating, dressing, bathing and personal hygiene, mobility, and toileting.

Administrative Service Organization: (ASO) The Administrative Service Organization is responsible for assessing Waiver members' needs, functionality and supports and determining an individualized budget. The ASO also provides education for members, their families and providers. The ASO interfaces with the claims management system to ensure that purchased services are properly reimbursed.

Circle of Support is defined as a group of people with either a professional or personal vested interest in the member who offer either evaluation, planning, advocacy, or support to the member on an ongoing basis.

Critical Juncture is any time that there is a significant juncture in the member's life that requires a meeting of the Interdisciplinary Team. The occurrence may require that a service needs to be decreased, increased or changed. A critical juncture constitutes a change in the member's needs such as behavioral, mental health or physical health, service/service units, support, setting, or a crisis.

Developmental Disability is defined as persons with related conditions who have a severe, chronic disability that meets all of the following conditions: It is attributable to Cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. It is manifested before the person reaches age 22; it is likely to continue indefinitely; it results in substantial functional limitations in three or more of the following areas of major life activity: (1) Self-care, (2) Understanding and use of language, (3) Learning, (4) Mobility, (5) Self-direction and (6) Capacity for independent living. (Refer to Code of Federal Regulations 42, 435.1009).

Individual Program Plan (IPP) is an outline of proposed activities that primarily focus on the establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by persons with developmental disabilities. It is designed to ensure accessibility, accountability, and continuity of support and services. This service also ensures that persons with developmental disabilities have opportunities to make meaningful choices with regard to their life, and inclusion in the community. The IPP must include both paid and unpaid, or natural supports in the individual's life. The IPP (DD-5 – version 07-01-2006) is the critical document that combines all information from the evaluations to guide the service delivery process. The development of the IPP is a joint effort between the member and other individuals such as the professionals and natural supports involved in the member's life. The content of the IPP is guided by the member's needs, wishes, desires, and goals as stated or assessed by the member or the member's IPP team. Services identified in the plan are based upon medical necessity.

Intensive Support Setting (ISS) is defined as a residential home setting with one to three (1-3) people living in the home.

Interdisciplinary Team (IDT) is the member, legal representative (if applicable) and a group of professionals, paraprofessionals, and others who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the individual's needs and design appropriate services and specialized programs responsive to those needs. The IDT meetings are guided by the member's needs, wishes, desires, and goals.

Legally Responsible Adult is the parent of a minor child or a court appointed legal guardian for an adult or child.

Local Community is the home neighborhood or location where other community members carry out their local daily routine and activities.

Mental Retardation means significantly sub-average intellectual functioning which manifest itself in a person during his developmental period and which is characterized by his inadequacy in adaptive behavior. West Virginia Code §27-1-3.

Office of Behavioral Health and Health Facilities (BHHF) is the office that oversees services for people who are at risk for substance abuse, mental illness, or developmental disabilities.

Psychologist under Supervision for Licensure is an individual who is an unlicensed psychologist with a documented, completed degree in psychology at the level of a Ph.D., Psy.D. Ed.D., M.A., or M.S. or has met the requirements of, and is formally enrolled in, the WV Board of Examiners of Psychologists Supervision Program.

Therapeutic Consultant is a professional who provides behavioral assessment, behavioral goal or support plan development, member specific training of direct care providers, data analysis or interpretation, and re-assessment of behavioral progress related to therapeutic behavioral interventions. These professionals provide services indirectly to the member to meet the behavioral, therapeutic, and person-specific needs. Therapeutic Consultant services may be provided by agency personnel or through contracted providers of this service. Therapeutic Consultant Services is a required component for the oversight of any training program or direct care services. Additional qualifications may be necessary dependent upon the specific service.

Qualified Mental Retardation Professional is a professional with, at minimum, a bachelor's degree in a human service field and at least one year of experience working directly with persons with mental retardation and/or related conditions; and is a doctor of medicine or osteopathy, a registered nurse or an individual who holds at least a bachelor's degree in a human service field.

Specialized Family Care Provider (SFCP) is an independently certified provider who operates a home which has received certification through the DHHR Family Based Care Program. Both the home and provider are certified by a Family Based Care Specialist.

Waiver Program for Members with Mental Retardation and Developmental Disabilities (MR/DD Waiver Program) is WV's home and community-based services program for individuals who have mental retardation and/or developmental disabilities. It is administered by the Bureau for Medical Services (BMS) in collaboration with BHHF pursuant to a Medicaid waiver option approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for the Title XIX MR/ DD Waiver Program. The MR/DD Waiver Program is a health care coverage program that reimburses for services to instruct, train, support, supervise, and assist individuals who have mental retardation and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible in their lives. The MR/DD Waiver Program provides services in natural settings (local neighborhood shopping entities, banks, libraries, etc), homes and local communities where the member resides instead of Intermediate Care Facility/Mental Retardation (ICF/MRs).

513.2 PROVIDER PARTICIPATION

BMS contracts with an Administrative Services Organization (ASO), APS Healthcare, Inc. – West Virginia, and the Bureau for Behavioral Health and Health Facilities (BHHF). They both act as an agent of BMS. BHHF administers the operation of the MR/DD Waiver Program. The Administrative Service Organization will conduct education for providers, members, advocacy groups, and DHHR. The ASO will provide a framework and a process for the purchase of waiver.

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The ASO will provide authorization for services that are based on the member's assessed needs and will provide service registration information to the claims payer. BMS contracts with community behavioral health provider agencies for the provision of services for members.

Bureau for Medical Services
Office of Home and Community Based Services
is responsible for the
WV Title XIX Home & Community Based Services
MR/DD Waiver Program

BMS contracts with OBHS and APS Healthcare, Inc-WV to carry out distinct components of the Waiver Program

Bureau for Behavioral Health & Health Facilities Office of Behavioral Health Services manages for BMS
The program eligibility determination process
The Waiver Summary Review process for provider enrollment
The Quality Review program for assessing the quality of care and services
Provider education, technical assistance, and consultation

APS Healthcare, Inc. - West Virginia provides for BMS
A process for the fair and equitable distribution of available Waiver funds
State-of-the-art system for making service, support, and provider selections
Individual and family education
Provider education, technical assistance, and consultation

513.2.1 GENERAL

In order to participate in the WV Medicaid Program and receive payment from BMS, MR/DD Waiver Program provider agencies must meet the following requirements:

- Receive Certificate of Need approval from the WV Health Care Authority and/or CON Summary Review Committee
- Meet and maintain all applicable licensing, accreditation, and certification requirements

- Obtain a behavioral health license through the Office of Health Facilities Licensure and Certification (OHFLAC)
- Meet and maintain all BMS enrollment requirements including a valid provider agreement on file that is signed by the provider and BMS.

513.2.2 SPECIFIC REQUIREMENTS

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

- Meet and maintain the standards established by the Secretary of the U. S. Department of Health and Human Services (DHHS), and all applicable state and federal laws governing the provision of these services. Providers must receive Health Care Authority approval to provide behavioral health services via the Certificate of Need process (CON). Prevocational services and supported employment entities acknowledged by a Division of Rehabilitation Services vendor, and a MR/DD Waiver provider prior to July 1, 2006 will be granted a grandfather status.
- Ensure that the service was delivered and documentation meets regulatory standards before the claim is submitted for payment.
- Ensure that all required documentation is maintained at the agency on behalf of the State of WV and accessible for state and federal audits.
- Agency Administration is responsible for ensuring:
- All staff have the mandatory MR/DD Waiver Program training prior to the delivery of services.
- The agency hires and retains qualified professionals.
- The agency has evidence of implementing a utilization review and quality improvement process which includes verification that services have been provided and the quality of those services meets the standards of the MR/DD Waiver Program and all other applicable licensing and certification bodies.
- All agency documentation is current and meets state and federal standards.
- Assign an Agency Contact Person who is responsible for ensuring:
- Home and Day Program visits are made in accordance with MR/DD Waiver policy (service coordination provider agencies only)
- Annual level of care evaluations and submission to the state for level of care determination are completed for medical eligibility (service coordination provider agencies only)
- The staff are implementing the IPPs of all members in the MR/DD Waiver Program
- The provider agency must operate a credentialing process that ensures the qualifications of Therapeutic Consultant providers as referenced in Section 513.7.11

513.2.3 REPORTING REQUIREMENTS

Provider agencies must maintain an incident database, monitor trends, and take action if necessary.

Quarterly Incident Report Summaries must be submitted to BHHF within the following time-frames:

- January 1 through March 31; Report due to the State by April 15
- April 1 through June 30; Report due to the State by July 15
- July 1 through September 30; Report due to the State by October 15
- October 1 through December 31; Report due to the State by January 15.

Service Coordination Agency must submit the Member Exit/Transfer Form (DD-16). The DD-16 must include the last date of service provided.

Mortality Notification (DD-20) is due to the State MR/DD Waiver Office within seven days from the date of death.

The Service Coordination Agency must notify the State MR/DD Waiver Office in writing, if they are exceeding the maximum case load cap. The Service Coordination Agency must address the following in writing within forty eight (48) hours:

- The number of members per each Service Coordinator whose case load exceeds twenty members (e.g., Service Coordinator Name, # of members).
- The agency plan, including time lines for hiring and training new Service Coordinators
- The agency must include a back-up plan to cover emergencies.

The Service Coordination Agency must notify the State MR/DD Waiver Office of any changes in status (change of address, telephone number, service coordination provider, habilitation provider, etc)

- The Service Coordinator is required to notify the state waiver office of the transfer of a member to another service coordination agency **within two (2) working days.**
- The transferring agency is responsible for the notification.
- Lack of notification of the transfer will affect the prior authorization for service or registration of services to the correct service provider(s) and subsequent payment of claims for services.

513.2.4 REPORTING ALLEGED ABUSE AND NEGLECT

Anyone providing services to an MR/DD Waiver member who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 64 Series 11), WV State Code WV State Code§ 9-6-1, § 9-6-9, and § 49-6A-2 to 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. A Child Protective Services (CPS) or an Adult Protective Services (APS) Worker may be assigned to investigate the suspected or alleged abuse.

The provider must also report suspected incidence of abuse and neglect to OHFLAC. OHFLAC may be contacted at (304) 558-0050. OHFLAC may assist with referring the report to the proper authorities.

513.2.5 PROVIDER TRAINING

Individuals providing Service Coordination, Residential Habilitation, Day Habilitation, Pre-vocational, Supported Employment, Adult Companion II, Respite II, Nursing, Skills Specialist, and Behavioral Specialist/Analyst services must be trained in the following:

- Overview of Developmental Disabilities
- People First Language
- Normalization
- Sensitivity to Individual/Family Needs/Concerns
- Participant Rights and Confidentiality
- Recognition of and Reporting of Neglect and Abuse
- Positive Behavior Support
- Non-violent Crisis Intervention (not required for community residential habilitation)
- Current MR/DD Waiver Manual and Home and Community Based Waiver Services
- Current Certification in CPR
- Current Certification in First Aid
- Documentation
- Participant Specific Training in Health/safety and Habilitation Objectives Needed to Provide Direct Care Services
- Person-Centered Planning

Individuals providing Adult Companion 1 and Respite 1 must provide evidence that they have training in:

- Current Certification in CPR
- Current Certification in First Aid
- Recognition and Reporting of Neglect and Abuse
- Documentation

Additionally, individuals providing Service Coordination must have training in:

- Community Resources
- Home Visits
- Day Habilitation Visits
- Facilitation of IDT Meetings
- Developing/documenting an IPP

- Linkage, referral, and advocacy
- Crisis planning

Additionally, Skills Specialist and Behavioral Specialist/Analyst must have training in:

- Development of Task Analysis and/or Methodology
- Overview of Positive Behavioral Support
- Development of Behavioral Guidelines, Protocols, and Positive Behavioral Support Plans

Provider agencies must maintain a record of the training verification or recertification.

513.2.6 CRIMINAL INVESTIGATION BACKGROUND CHECK (CIB)

Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to the member. At a minimum, a state level criminal investigation background check must be conducted. An individual who is providing services or is employed by a provider cannot be considered to provide services nor can be employed if ever convicted of:

- Abduction
- Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
- Child/adult abuse or neglect
- Crimes which involve the exploitation of a child or an incapacitated adult
- Felony domestic battery or domestic assault
- Felony arson
- Felony or misdemeanor crime against a child or incapacitated adult which causes harm
- Felony drug related offenses within the last 10 years
- Felony DUI within the last 10 years
- Hate crimes
- Kidnapping
- Murder/ homicide
- Neglect or abuse by a caregiver
- Pornography crimes involving children or incapacitated adults including but not limited to, use of minors in filming sexual 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
- Purchase or sale of a child
- Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure.

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513.3 MEMBER ELIGIBILITY AND ENROLLMENT PROCESS

MEMBER ELIGIBILITY

- The member must have a determination of Medical Eligibility. Medical eligibility is determined by submitting an application packet to State MR/DD Waiver Office for member consideration.
- The member must have a determination of Financial Eligibility. Once medical eligibility is established, members make application at the local Department of Health & Human Resource (DHHR) office for assessment of financial eligibility.

MEMBER ENROLLMENT

Once financial eligibility is determined, the member is eligible to be enrolled in the MR/DD Waiver Program. The member must be a resident of the State of West Virginia. Members must meet both the medical and financial eligibility. The member may be enrolled in the Waiver program upon the availability of an allocation (slot).

513.3.1 APPLICATION AND MEDICAL ELIGIBILITY

- A member may obtain an application information packet from local Behavioral Health Centers, local/county DHHR Offices or the State MR/DD Waiver Office.
- Once the applicant completes the DD-14, he/she will submit the DD-14 to the selected MR/DD Waiver provider agency or the State MR/DD Waiver Office.
- Upon receipt of the DD-14, the Waiver provider agency will sign and date the DD-14.
- The Waiver provider agency will forward a copy of the DD-14 to the State Waiver office. Applications should be addressed to the Bureau for Behavioral Health and Health Facilities (BHHF), Waiver Department, 350 Capitol Street, Room 350, Charleston, WV 25301

The Application Form (DD-14) may be submitted as:

- An Application which indicates the individual requires services in 0 – 90 days and requires full eligibility determination within 90 days or
- A "Statement of Interest" which indicates the individual requires services beginning in 91 days or greater.
- The Application must be fully completed and a Service Coordination Agency selected by the applicant and/or legal representative to ensure processing without delay.
- Once the State MR/DD Waiver Office receives the application, it will be processed and the applicant will be placed on the Planning Registry when the member chooses over 90 days on the application (statement of interest). The Planning Registry is maintained by the State MR/DD Waiver office.

- The application process includes the preparation of the application packet and determination of medical eligibility and should occur within 90 days (45 days to complete the packet and 45 days to determine eligibility).
- The application process will begin upon the initial signature date indicating the receipt of the application (DD-14) by the Waiver provider agency. The provider must submit a completed packet to the State MR/DD Waiver office from this date of signature within a 45 day time frame.

Initial Application Packet

- A full initial application packet is the packet of required information and assessments which describe the applicant's needs. The Service Coordinator is responsible for arranging the assessments and compiling the required documentation for the full application packet. The Service Coordinator is then responsible for submitting the full application packet to the State MR/DD Waiver office within the mandatory time frames. If a member chooses to change agencies prior to the completion of the full application packet, the Service Coordinator is responsible for coordinating the packet with the new Service Coordinator and notifying the State Waiver office if the change in Service Coordinators constitutes a change in status of provider agencies.
- All MR/DD Waiver Program Services covered in this chapter are subject to a determination of medical necessity. Each initial application packet must have the following:
    - A Completed Annual Medical Evaluation (DD-2A).
    - A Completed Comprehensive Psychological Evaluation (DD-3) that includes clinical verification that the mental retardation and/or related condition with associated concurrent adaptive deficits were manifested prior to the age of 22, and are likely to continue indefinitely.

For the MR/DD Waiver program, individuals must meet the diagnostic criteria for medical eligibility not only by the relevant test scores, but also the narrative descriptions contained in the documentation.

The following evaluation may be submitted as applicable but is not a requirement for the application packet:

- A completed Social History (DD-4)
- Any other documentation or information as deemed necessary by DHHR for the determination of medical eligibility. For this program, individuals must meet the diagnostic criteria for medical eligibility not only by the relevant test scores, but also the narrative descriptions contained in the documentation. The following may be needed for specified age groups:
- IEP, for school-age children
- Birth to Three assessments for children age three and below.

The Initial Medical Evaluation (DD-2A), Psychological Evaluation (DD-3), and Informed Consent forms (DD-7 and DD-7A) are to be maintained on site at the local service coordination provider agency and made available for state or federal monitors to review.

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The State MR/DD Waiver office will make a final medical eligibility determination within 45 days of receipt of the packet. An eligible applicant will be enrolled into the Waiver program once the allocation (slot) is available. The applicant's right to a final eligibility determination within 90 days may be abrogated when a Service Coordination agency cannot complete a full application packet because the applicant or an examining physician delays or fails to take required action.

MEDICAL ELIGIBILITY

Medical Eligibility Criteria

The MR/DD State Waiver Office determines the medical eligibility for an applicant in the MR/DD Waiver Program. In order to be eligible to receive MR/DD Waiver Program Services, an applicant must meet the following medical eligibility criteria:

- Have a diagnosis of mental retardation and/or a related condition,
- Require the level of care and services provided in an ICF/MR (Intermediate Care Facility for the Mentally Retarded) as evidenced by required evaluations and corroborated by narrative descriptions of functioning and reported history. An ICF/MR provides services in an institutional setting for persons with mental retardation or related condition. An ICF/MR facility provides monitoring, supervision, training, and supports.

MR/DD State Waiver Office determines the level of care (medical eligibility) based on the Annual Medical Evaluation (DD-2A), the Psychological Evaluation (DD-3) and verification if not indicated in the DD-2A and DD-3, that documents that the mental retardation and/or related conditions with associated concurrent adaptive deficits were manifested prior to the age of 22, and are likely to continue indefinitely. Other documents, if applicable and available, that can be utilized include the Social History, IEP for school age children, Birth to Three assessments, and other related assessments.

The evaluations must demonstrate that an applicant has a diagnosis of mental retardation and/or a related developmental condition, which constitutes a severe and chronic disability. For this program individuals must meet the diagnostic criteria for medical eligibility not only by the relevant test scores, but also the narrative descriptions contained in the documentation. To be eligible, the member:

- Must have a diagnosis of mental retardation, with concurrent substantial deficits (substantial limitations associated with the presence of mental retardation), and/or
- Must have a related developmental condition which constitutes a severe and chronic disability with concurrent substantial deficits. Examples of related conditions which may, if severe and chronic in nature, make an individual eligible for the MR/DD Waiver Program include but are not limited to, the following:
- Any condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires services similar to those required for persons with mental retardation.
- Autism

- Traumatic brain injury
- Cerebral Palsy
- Spina Bifida
- Tuberous Sclerosis

Additionally, the member who has a diagnosis of mental retardation and/or related conditions and associated concurrent adaptive deficits must have the following:

- Manifested prior to the age of 22, and
- Likely to continue indefinitely.
- Must have the presence of a least three (3) substantial deficits out of five of the major life areas (term is defined in Title 42, Chapter IV, Part 435.1009 of the Code of Federal Regulations or CFR. Refer to Section 513.3.1, Functionality section for a list of the major life areas.

Functionality

- Substantially limited functioning in three (3) or more of the following major life areas; ("substantially limited" is defined on standardized measures of adaptive behavior scores as three (3) standard deviations below the mean or less than one (1) percentile when derived from non MR normative populations or in the average range or equal to or below the seventy fifth (75) percentile when derived from MR normative populations. The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological, the IEP, Occupational Therapy evaluation, etc.). Applicable categories regarding general functioning include:
  - **Self-care**
  - **Receptive or expressive language** (communication)
  - **Learning** (functional academics)
  - **Mobility**
  - **Self-direction**
  - **Capacity for independent living** (home living, social skills, employment, health and safety, community and leisure activities).

For applicable major life functioning areas, refer to Code of Federal Regulation (CFR): 42 CFR 435.1009.

Active Treatment

- Requires and would benefit from continuous active treatment.

Medical Eligibility Criteria: Level of Care

- To qualify for ICF/MR level of care, evaluations of the applicant must demonstrate:

- A need for intensive instruction, services, assistance, and supervision in order to learn new skills, maintain current level of skills, and increase independence in activities of daily living,
- A need for the same level of care and services that is provided in an ICF/MR institutional setting.

The applicant or legal representative will be informed of the right to choose between ICF/MR services and home and community-based services under the MR/DD Waiver Program and informed of his/her right to a fair hearing at the time of application (Informed Consent, DD-7).

Conditions Ineligible

- Substantial deficits associated with a diagnosis other than mental retardation or a related diagnosis do not meet eligibility criteria.
- Additionally, any individual needing only personal care services does not meet the eligibility criteria.
- Individuals diagnosed with mental illness whose evaluations submitted for medical eligibility determination indicate no previous history of co-occuring mental retardation or developmental disability prior to age 22. The member's clinical evaluators must provide clinical verification through the appropriate eligibility documentation that their mental illness is not the primary cause of the substantial deficits and the mental retardation or developmental disability occurred prior to the age of twenty-two (22).

513.3.2 FINANCIAL ELIGIBILITY

The applicant or legal representative must make an application for financial eligibility. However, it is the responsibility of the Service Coordinator to assist the member and ensure that the application is made. Written notification of medical eligibility for the MR/DD Waiver Program must be presented to the local/county DHHR where the member resides to ensure accurate Medicaid coding for the appropriate Waiver program.

An Economic Service (ES) Worker will take the application for financial eligibility (on a DHHR form labeled the ES-2 form) and the local/county DHHR office will determine financial eligibility for the MR/DD Waiver Program. If a person is Medicaid eligible and already has a medical card, the applicant, applicant's legal guardian, or the Service Coordinator must contact the local/county DHHR office once eligibility is established to ensure he/she is properly coded.

Individuals who are eligible for both Supplemental Security Income (SSI) and the MR/DD Waiver Program will not have to re-establish their financial eligibility every 6 months. Annual re-determination of financial eligibility for SSI benefits is used to re-establish financial eligibility for the MR/DD Waiver Program.

Financial Eligibility Criteria

The applicant must meet the following financial eligibility criteria:

- **Income**

The individual's monthly income may not exceed 300% of the current maximum monthly Supplemental Security Income (SSI) payment. The maximum monthly SSI payment may be found by contacting the local county DHHR office or local Social Security Administration office.

- Only the individual's personal income is considered for determination.
- The parent's income is not considered for determining financial eligibility.
- An individual does not have to be SSI eligible to become eligible for the MR/DD Waiver Program.

- **Assets**
  - An individual's assets, excluding residence and furnishings, may not exceed $2,000.
  - The parent's assets are not considered for determining financial eligibility.
  - Only the individual's assets are considered for determination.

513.3. 3 ENROLLMENT IN MR/DD WAIVER PROGRAM SERVICES

In order to be eligible to enroll in MR/DD Waiver Program Services, an applicant must meet both the medical and financial eligibility criteria. After medical and financial eligibility have been established, the member is ready for the enrollment process. This involves being approved for a Waiver allocation (slot).

Service Allocation (*Slot*) Criteria

The total number of allocations available for the current fiscal year is determined by BMS. The number of individuals to be served and the average cost of services per individual are established using formulas approved by CMS.

Service Allocation (*Slot*) Referral and Selection Process

Provided an allocation (slot) is available, the allocation process is based on:

- Chronological order by date of the state's receipt of the fully completed initial application packet
- The date of a fair hearing decision if medical eligibility is established as a result of a Medicaid fair hearing.

Eligibility Effective Date

The initial effective date of a Medical Card for an applicant who has not previously acquired one will be the latest of the following two dates (provided the member has a Waiver allocation):

- The date of medical eligibility (Psychological Evaluation, DD-3) which is established by the psychological evaluation or addendum (if the psychological is more than 90 days old) in an initial application packet

- The date on which the applicant made the application for financial eligibility at the local/county DHHR office.

Payment for medically necessary and medically appropriate MR/DD Waiver Program Services is available on behalf of eligible Medicaid members who have been determined in need of MR/DD Waiver Program Services, subject to the conditions and limitations that apply to these services. In order to be eligible to receive MR/DD Waiver Program Services, an applicant will:

- Meet the medical eligibility criteria as required by this section
- Meet the financial eligibility criteria as required by this section
- Be approved for a MR/DD Waiver Service Allocation (*slot*), as required by this section

Members enrolled in the MR/DD Waiver Services Program are excluded from enrollment in a Medicaid managed care program.

513.3.4 RE-DETERMINATION OF MEDICAL ELIGIBILITY

Re-determination of medical eligibility must be completed annually for each member. Pursuant to federal law, an individual must qualify for recertification at least annually. Eligibility determination must be made on current eligibility criteria, not on past Waiver eligibility. The fact that a recipient had previously received waiver services shall have no bearing. The date of the member's medical re-eligibility is the date the annual medical evaluation (DD-2A) was signed.

Annual Re-certification Application Packet

At minimum, the Annual Medical Evaluation (DD-2A), and the most current Psychological Evaluation (DD-3) must be submitted (see frequency requirements for psychological evaluation of adult or child). DHHR may also request any and all additional documents for the purpose of medical eligibility determination.

Frequency Requirement for Psychological Evaluation

- **Adults:** For adults age 18 and older, a comprehensive psychological evaluation is required triennially (once per three year intervals).
- **Children:** For children under 18 years of age, a comprehensive psychological evaluation is required triennially while a psychological update is required annually.

The Service Coordinator is responsible for submitting the annual re-certification application packet to the state Waiver Office. The state must review and approve the level of care needed prior to an individual becoming re-certified.

Once the annual re-certification packet is received by the state MR/DD Waiver office, the following transpires:

- The required evaluations (DD-2A, DD-3, etc) are reviewed by the State Waiver Office. If indicated, additional information may be requested provided the information is applicable and available as needed in order to determine recertification.
- Following annual eligibility determination, the State Waiver Office sends an eligibility re-certification notice to the member, the member's Service Coordination provider agency, and the member's local DHHR, Economic Service (ES) Worker, of the re-certification. The notification includes the member's effective date for medical eligibility.
- The local DHHR is then authorized to review the member's financial eligibility.

Failure of the service coordination provider to submit the Annual Re-certification Application packet to the State MR/DD Waiver office within 30 days of the expiration date of the member's eligibility may result in any of the following:

- Request to hold the submission of claims for reimbursement
- Loss of reimbursement for services provided
- Loss of Medicaid coverage for the member

Re-certification application packets should be addressed to the Bureau for Behavioral Health and Health Facilities, Waiver Department, 350 Capitol Street, Room 350, Charleston, WV 25301.

513.4 RIGHTS OF MEMBERS AND NEW APPLICANTS

- Applicants have a right to appeal a denial of medical eligibility.
- Members have a right to appeal an Individual Program Plan (IPP).
- Members have a right to appeal a denial of a covered service.
- Members have a right to appeal the termination of MR/DD Waiver services.
- Members have a right to obtain oral and written information on the agency's rights and grievance procedures for members served by the agency.
- All applicants/members must be given a choice between services either in an ICF/MR or by means of a home and community-based service under the MR/DD Waiver Program when Waiver services are determined to be a feasible alternative to institutional care (DD-7).
- The applicant/member and/or legal representative must also be informed of the right to choose between home and community-based service providers under the MR/DD Waiver Program and informed of his/her right to a fair hearing (Informed Consent DD-7A). Any change of provider will require a meeting of the Interdisciplinary Team.

513.5 MEMBER DISCHARGE

A member will be discharged from the MR/DD Waiver Program under the following conditions:

- A member's income or assets exceed the limits specified in Section 513.3.2 of this chapter. The county DHHR office must be contacted, in addition to the state MR/DD Waiver Program Coordinator's office, any time an individual's income or assets exceed the limits. The county DHHR office will close the Medicaid file upon notification of the increase in income or assets and notify the individual and the MR/DD Waiver Program office of termination of the medical card. The Service Coordinator is responsible for monitoring the member's assets and is also the responsible party for reporting when the member's income or assets exceed the limits specified in Section 513.3.2. The Service Coordinator may request information from the member's payee or member's legal representative to ensure that financial eligibility is not "lost" throughout the year due to excessive assets or other reasons.
- The evaluations, which are used by the MR/DD Waiver Program to determine a member's level of care (medical eligibility), demonstrate that he/she no longer requires an ICF/MR level of care and therefore, is not medically eligible for the MR/DD Waiver Program. The State MR/DD Waiver office will notify the member of termination of services and of his/her right to appeal.
- A member and/or his/her legal representative choose to terminate Waiver services. The Service Coordination provider agency must request the member and/or legal representative review and sign the Informed Consent (DD-7) indicating the choice to obtain other services and the Service Coordination provider agency must convene or participate in developing the IPP to transition the member to the new services. A copy of the DD-7 and the Exit/Transfer form (DD-16) must be sent to the state MR/DD Waiver Program office. (The State's MR/DD Waiver Program must be notified if the member and/or his/her legal representative do not want the Service Coordination provider agency to participate in the transition). **The DD-16 must also be signed by the member and/or legal representative.**
- Any time a member loses eligibility or chooses to leave the MR/DD Waiver Program, both the local DHHR office and the State MR/DD Waiver Program office must be informed of the date of the member's discharge from MR/DD Waiver services. The termination of MR/DD Waiver services may be appealed through the appeals process outlined in Section 513.6 of this chapter.
- Anytime a member successfully demonstrates increased competencies in daily independence, the member's IDT team may develop a transition plan that titrates the member's services in order to move to a lesser restricted level of care. When members transition from the Waiver program in this manner, the transition period may not exceed a six month time frame.

513.6 RIGHT TO APPEAL

If an applicant/member is determined not to be medically eligible by the State MR/DD Waiver office, a Notice of Decision and a Request for Hearing form will be issued to the applicant/member. The decision/denial may be appealed directly through the fair hearing process.

CHAPTER 513–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES

Appeal of a Denial of Service by the State MR/DD Waiver Program Office

The Statement of Rights is available at the State MR/DD Waiver Office, behavioral health providers, and local DHHR offices. The Statement of Rights is a detailed description of their right to apply for MR/DD Waiver services, receive a timely response and to be informed of their appeal rights. This document is included in the Application Information Packet.

If the appeal is not resolved by the State MR/DD Waiver Program Coordinator to the satisfaction of the appellant, the person may then appeal in writing to the Bureau for Behavioral Health and Health Facilities (BHHF), MR/DD Waiver Program, 350 Capitol Street Room 350, Charleston, WV 25301. BMS will arrange a hearing to resolve the matter.

If MR/DD Waiver services are terminated or reduced by the State, the member will receive a Notice of Decision and a Request for Hearing form. The termination and/or reduction of services may be appealed through the fair hearing process.

90 Days to Request a Hearing: The member has ninety (90) days to request a hearing after a Notice of Decision regarding eligibility has been received. Any member or authorized legal representative may request a hearing and must do so either by a written request or by using the "Request for Hearing" form (refer to Request for Fair Hearing form in Section 513.14: Attachment 1: MR/DD Waiver Documents).

When the member requests a hearing, the member has 13 Days to submit a request to BHHF to continue services. If services are terminated by the State and a hearing is requested, services will continue until a hearing decision is rendered. If an applicant/member wishes to appeal a decision they must submit the request for a hearing or pre-hearing conference within 13 days of receipt of the "Notice of Decision" to continue to receive services in the interim. When a member chooses to petition the appellate court following the final appeal decision on an MR/DD Waiver hearing, services are not continued while petitioning the appellate court.

Upon notice of denial, the Service Coordinator must arrange for an emergency IDT meeting to develop a "back-up" plan for transition. If the decision regarding eligibility (Level of Care) for the program is upheld by the hearing officer, on the date of the hearing decision, services under the MR/DD Waiver Program will cease. It is essential that upon notice of denial, that the Service Coordinator must arrange for the emergency IDT meeting to develop a "back-up" plan for transition. If the applicant/member is eligible financially for Medicaid services without the MR/DD Waiver program, other services may be available for the individual.

Any applicant/member who requests a fair hearing shall be entitled to a final administrative action within ninety (90) days of the date of the request for hearing, unless the applicant waives his or her request for a final administrative action within ninety (90) days.

If the applicant/member was denied MR/DD Waiver Program services, the applicant shall have the right to a second medical or psychological examination at the expense of the WV DHHR. Any additional documents pertinent to the condition affecting eligibility must be submitted 10 working days prior to the hearing.

The applicant/member shall have the right to access their waiver application file and copies shall be provided free of charge by BHHF.

If needed, BHHF will coordinate or assist in arranging transportation to the hearing.

If the decision regarding eligibility (Level of Care) for the program is reversed by the hearing officer, the person is eligible for enrollment into the program on the date of the written hearing provided an allocation (slot) is available.

Appeal of an Individual Program Plan (IPP)

If a team member disagrees with any aspect of the IPP, he/she may sign the plan but indicate his/her disagreement. The rationale for that disagreement shall be recorded on the relevant form. If a team member other than the participant wishes to appeal, permission must be obtained from the participant and/or his/her legal representative in order to initiate the appeal process.

If a team member chooses to appeal either the contents or lack of implementation of the IPP, the appeal shall be filed in accordance with the Service Coordination provider agency's (or other agency providing/denying the service) appeal process. If the person does not appeal the IPP, it can be implemented without any changes as prepared.

If the appeal is not resolved at the agency level to the satisfaction of the appellant, the person may then appeal in writing to the State MR/DD Waiver Program Coordinator within 5 working days of written notification of the decision from the local agency. The MR/DD Waiver Program Coordinator will review the IPP, the relevant evaluations and the written decision from the local agency to determine the appropriateness of the services and implementation as described in the IPP.

If the appeal is not resolved satisfactorily by the State MR/DD Waiver Program Coordinator, the person may then appeal to BHHF for a Medicaid fair hearing. The appeal should be forwarded to the Bureau for Behavioral Health and Health Facilities (BHHF), MR/DD Waiver Program, 305 Capitol Street Room 350, Charleston, WV 25301. Board of Review will arrange for a hearing to resolve the matter.

During the appeal process, only those services being appealed will continue as outlined in the previous IPP. All other services will be provided according to the most current IPP. If services being appealed are part of an initial IPP and have not previously been offered, the service being appealed cannot be offered to the member.

Appeal of a Budget Allocation by the Administrative Service Organization

The IDT must make every effort to purchase services within the budget allocated by the ASO. If the IDT cannot purchase all needed services within the budget, the Service Coordinator may contact the ASO with rationale for the need to negotiate a new budget. If negotiation is unsuccessful, the Service Coordinator may request a Second Level Negotiation with the ASO. Only the member or the member's guardian or healthcare surrogate may request a fair hearing.

513.7 DESCRIPTION OF COVERED SERVICES

CHAPTER 513–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES

Except for the limitations and exclusions listed below, BMS will pay for the following medically necessary and medically appropriate MR/DD Waiver Program Services provided to eligible Medicaid members by MR/DD Waiver Program provider agencies.

513.7.1 INDEX OF COVERED SERVICES

Procedure Description	Procedure Code	Section
Individual Program Development, Social Worker	T2024 -AJ	513.7.2
Individual Program Development, Service Coordinator	T2024-HN	
Individual Program Development, Skills Specialist, Residential Setting	T2024-UA-UH	
Individual Program Development, Skills Specialist, Day Setting	T2024-UA-UF	
Individual Program Development, Behavioral Specialist, Residential Setting	T2024-UB-UH	
Individual Program Development, Behavioral Specialist, Day Setting	T2024-UB-UF	
Individual Program Development, Behavioral Analyst, Residential Setting	T2024-UC-UH	
Individual Program Development, Behavioral Analyst, Day Setting	T2024-UC-UF	
Individual Program Development, Registered Nurse	T2024-TD	
Individual Program Development, Psychologist	T2024-AH	
Individual Program Development, Registered Dietician	T2024-AE	
Individual Program Development, Occupational Therapist	T2024-GO	
Individual Program Development, Physical Therapist	T2024-GP	
Individual Program Development, Speech Therapist	T2024-GN	
Individual Program Development, Physician	T2024-AM	
Service Coordination	T1016-HI	513.7.3
Transportation per mile	A0160-HI	513.7.4
Transportation per trip	A0120-HI	
Respite Care Contracted Level 1 1:1 ratio	T1005	513.7.5
Respite Care Contracted Level 1 1:2 ratio	T1005-UN	
Respite Care Contracted Level 1 1:3 ratio	T1005-UP	

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Procedure Description	Procedure Code	Section
Respite Care Agency Level 2 1:1 ratio	T1005-U4	
Respite Care Agency Level 2 1:2 ratio	T1005-U3	
Respite Care Agency Level 2 1:3 ratio	T1005-U2	
Residential Habilitation Community	T2017-UA	513.7.6.1
Residential Habilitation Agency 1:1 ratio	T2017-U4	513.7.6.2
Residential Habilitation Agency 1:2 ratio	T2017-U3	
Residential Habilitation Agency 1:3 ratio	T2017-U2	
Residential Habilitation Agency 1:4 ratio	T2017-U1	
Adult Companion Contracted Level 1 1:1 ratio	S5135	513.7.7
Adult Companion Contracted Level 1 1:2 ratio	S5135-UN	
Adult Companion Contracted Level 1 1:3 ratio	S5135-UP	
Adult Companion Agency Level 2 1:1 ratio	S5135-U4	
Adult Companion Agency Level 2 1:2 ratio	S5135-U3	
Adult Companion Agency Level 2 1:3 ratio	S5135-U2	
Day Habilitation 1:1 ratio	T2021-U4	513.7.8
Day Habilitation 1:2 ratio	T2021-U3	
Day Habilitation 1:3 ratio	T2021-U2	
Day Habilitation 1:4 ratio	T2021-U1	
Pre Vocational Training Individual	T2015	513.7.9
Pre Vocational Training Group	T2015-HQ	
Supported Employment Individual	T2019	513.7.10
Supported Employment Group	T2019-HQ	
Therapeutic Consultative Services Skills Specialist, Day	T2021-U7-UF	513.7.11.1
Therapeutic Consultative Services Skills Specialist, Residence	T2021-U7-UH	513.7.11.1
Therapeutic Consultative Services Behavioral Specialist, Day	T2021-U8-UF	513.7.11.

CHAPTER 513–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES

Procedure Description	Procedure Code	Section
		2
Therapeutic Consultative Services Behavioral Specialist, Residence	T2021-U8-UH	513.7.11.2
Therapeutic Consultative Services Behavioral Analyst, Day	T2021-U9-UF	513.7.11.3
Therapeutic Consultative Services Behavioral Analyst, Residential	T2021-U9-UH	513.7.11.3
Therapeutic Consultative Services Behavior Analyst, Psychologist, Day	T2021-U6-UF	513.7.11.3
Therapeutic Consultative Services Behavior Analyst, Psychologist, Residential	T2021-U6- UH	513.7.11.3
Extended Professional Services Registered Dietician	97802-AE-HI	513.7.12
Extended Professional Services Physical Therapist	97530-GP-HI	
Extended Professional Services Occupational Therapist	97530-GO-HI	
Extended Professional Services Speech Therapist (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual)	92507-GN-HI	
Extended Professional Services Speech Therapist (Treatment of Swallowing dysfunction and/or oral function for feeding)	92526 -HI	513.7.12
Extended Professional Services Licensed Psychologist (Consult)	T2025-HI	513.7.12
Skilled Nursing Services LPN 1:1 ratio	T1003-HI-U4	513.7.13
Skilled Nursing Services LPN 1:2 ratio	T1003-HI-U3	
Skilled Nursing Services LPN 1:3 ratio	T1003-HI-U2	
Nursing Services RN 1:1 ratio (restricted to skilled nursing services that can only be performed by a registered nurse)	T1002- HI	
Crisis Services	T2034	513.7.14
Environmental Accessibility Adaptations home	S5165	513.7.15
Environmental Accessibility Adaptations vehicle	T2039	

Procedure Description	Procedure Code	Section
Extended Physician Services Annual Medical Evaluation	99381-HI to 99387-HI and 99391-HI to 99397-HI	513.7.16.1
Psychiatric Diagnostic Interview Examination	90801-HI	513.7.16.2
Psychological Testing with Interpretation and report	96101-HI	513.7.16.3
Psychological Testing – Developmental Extended	96111-HI	513.7.16.4
Psychological Testing Developmental Testing – Limited	96110-HI	513.7.16.5
Social History Social History Update	H0031-HI H0031-HI-TS	513.13.17

513.7.2 INDIVIDUAL PROGRAM PLAN DEVELOPMENT (IPP)

PROCEDURE CODE:

T2024-AJ	Social Worker
T2024-HN	Service Coordinator
T2024-UA-UF	Skills Specialist, Day Setting
T2024-UA-UH	Skills Specialist, Residential Setting
T2024-UB-UF	Behavioral Specialist, Day Setting
T2024-UB-UH	Behavioral Specialist, Residential Setting
T2024-UC-UF	Behavioral Analyst, Day Setting
T2024-UC-UH	Behavioral Analyst, Residential Setting
T2024-TD	Registered Nurse
T2024-AH	Psychologist
T2024-AE	Registered dietician
T2024-GO	Occupational Therapist
T2024-GP	Physical Therapist
T2024-GN	Speech Therapist
T2024-AM	Physician

SERVICE UNITS: Event per specialty, minimum 2 events per IPP meeting allocated to Individualized member budget. To be considered a reimbursable event, physical attendance is required for the entire meeting.

SERVICE LIMITS:

This service occurs during the IPP meeting only.

The service does not include reviews of data or information prior to the meeting, notification of team meetings, drafts of strategies or interventions, or distribution of the IPP outside of the team meeting.

Day habilitation, residential habilitation, community residential habilitation, prevocational, adult companion and supported employment providers who attend IDT meetings must bill the service code for the respective service.

PRIOR AUTHORIZATION:

Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Individual Program Planning is the process by which the member and his/her IDT develop a plan based on a person centered philosophy. The team should be comprised of the member and his or her "Circle of Support". The circle of support may include the Service Coordinator, professionals, direct care providers, family members, guardian, and significant individuals in the member's life with a vested interest in the member. Section 513.7.2.1 specifically addresses minimum composition requirements of the IDT. The content of the IPP must be guided by the member's needs, wishes, desires, and goals.

The team, that includes the member, participates in the IPP meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a person centered plan. The Service Coordinator assumes the role of facilitator and coordinator for the meeting; however, the team is directed by the member utilizing a person centered approach to planning. IPP development occurs when the member is present.

The Individual Program Planning includes the development of the initial IPP, annual IPP and subsequent reviews or revisions of the IPP (to include quarterly reviews as warranted).

Any activity that occurs prior to the meeting or after the meeting is **not** considered Individual Program Planning. Activities provided before or after the meeting may meet the criteria for service coordination or Therapeutic Consultant service activities (see applicable sections).

SITE OF SERVICE

Individual Program Planning development may be provided at the office of a provider agency, the member's home, a residential or day program site, clinic or physician office or any other community setting available to the member. The meeting cannot occur at one location, then continue at another location.

This service code is restricted to the site of the IDT team meeting.

DOCUMENTATION

The IPP shall serve as documentation of the IDT team meeting. The team member's signature on the IPP constitutes participation in the team meeting. Team meeting minutes should be utilized to expand discussion of the meeting or record critical issues from the meeting. The IPP must include the signature of all participants of the IPP meeting, date of the meeting and the total time spent in the meeting for each team member. A copy of the IPP will be maintained in all participating provider agency records and distributed to all team members within fourteen (14) business days of the date of the IPP team meeting. A copy of the IPP will be distributed by the Service Coordinator to all team members. Goals and objectives that have been approved by the IDT may be written on the plan or attached to the IPP.

Failure to distribute the IPP by the Service Coordinator or maintain the original IPP in the service coordination agency record or a copy of the IPP in a provider agency file can result in disallowance for IPP Development Services.

SERVICE RESTRICTIONS

Residential Habilitation, Day Habilitation, Adult Companion, Respite, Prevocational or Supported Employment Service Providers are not eligible for this service. For participation in the IPP team meeting, refer to service descriptions and service restrictions for each specified service.

PROVIDER QUALIFICATIONS

Refer to provider qualifications for specific service for MR/DD Waiver service providers.

FREQUENCY OF REVIEW OF IPP

The IPP is to be developed on an annual basis. Minimally, the annual IPP must be reviewed at a six month interval. IPP reviews should occur on a quarterly basis. For those IDT teams that do not review the annual IPP quarterly, rationale must be given for not reviewing. The IPP must be reviewed at critical junctures (refer to definitions for critical juncture).

The psychologist and the registered nurse are required to attend the annual and six month review of the IPP. MR/DD Waiver does not require the psychologist and nurse to attend the quarterly review IPP meetings. For the quarterly meetings, both the psychologist and registered nurse may send recommendations to the Service Coordinator for review at the quarterly team meetings.

A physician, psychologist or a registered nurse may attend the meeting by interactive video (MDTV or webcam) and may bill for the IDT team meeting if attending for the entire event. The physician, psychologist, or the nurse may not bill for telephone conferencing. The service must not include facility ("set-up") cost or connection cost for the MDTV or webcam.

REVIEW OF THE INDIVIDUAL PROGRAM PLAN – PROGRAM MONITORING AND CHANGE

Once a member has been awarded a Waiver allocation, the member has 90 days to begin receiving services. The IPP should address implementation dates of services that are not to be implemented at the 90 day interval.

Situations that may warrant an earlier review include, but are not limited to:

- The member has successfully completed an objective(s) included in the IPP
- The member is regressing or losing skills already gained
- The member is failing to progress toward identified objectives after reasonable efforts have been made
- The member is being considered for training towards new objectives
- The member is having a minor or major occurrence in his/her life.
- The member experiences a critical juncture (See Section 513.1 for definition of critical juncture)

The review of the IPP needs to include:

- A summary of the treatment, training, or services provided
- Document the progress towards each objective
- Indicate problems that impeded progress, and
- Provide a decision to continue, modify, or discontinue current objectives.

513.7.2.1 INTERDISCIPLINARY TEAM (IDT) COMPOSITION

The IDT must be based on person centered philosophy. The development of the IPP by the IDT must be guided by the member's needs, wishes, desires, and goals.

At a minimum, the IDT consists of:

- The member
- His/her family and/or legal guardian as applicable
- A Service Coordinator
- At least one member of the team must be either the member's Skills Specialist or a Behavioral Specialist/Analyst
- Representatives of all agencies/providers who provide services to the individual
- A physician or registered nurse is required if the member is receiving skilled nursing services, or medical services that require RN oversight. The IDT may choose to invite the nurse and/or physician for other reasons when the team indicates that the need exists. The nurse is not required to attend quarterly meetings but may submit recommendations to the Service Coordinator for review

at the quarterly IDT meetings. The nurse may attend the IDT meeting by interactive video (MDTV or web cam). The service does not cover the facility ("set-up") cost or connection cost (not telephone conferencing). The nurse must not bill for telephone conferencing.

- A psychologist is required when the member has the need for specialized psychological evaluation and intervention due to co-existing (DSM IV TR Axis I diagnosis of Schizophrenia and other psychotic disorders and mood disorders) mental health disorders or behavioral needs. The only exception is if the member resides with a natural or adoptive family who addresses the DSM IV TR Axis I mental health disorder and/or behavioral needs independent of the MR/DD Waiver program through a physician/psychiatrist; and the team agrees to the exception. The psychologist is not required to attend the quarterly IDT meetings but may submit recommendations to the Service Coordinator for review at the quarterly IDT meetings. The psychologist may attend the IDT meeting by interactive video (MDTV or web cam). The service does not cover the facility ("set-up") cost or connection cost (not telephone conferencing). The nurse must not bill for telephone conferencing.

Other members of the IDT must be included, as necessary, to develop a comprehensive IPP and assist the individual. Such members may include:

- Professionals, such as a Physical Therapist, Occupational Therapist, Speech Therapist, Registered Dietician, Social Worker, etc.
- Paraprofessionals
- Direct service providers, such as Day Habilitation Program providers, Residential Habilitation providers, Respite providers, Adult Companion providers, Pre-vocational providers, Supported Employment providers, and LPN's responsible for habilitation programs when the member receives eight (8) hours or more nursing in one day, and counselor
- Service providers from other systems such as the local education agency/public schools, DRS, or Birth to Three (provided that no duplication of service exists)
- Family Based Care Specialist (when applicable)
- Advocate (when applicable)
- Involved parties such as friends, extended family, the representative payee and the individual's significant other

IDT MEETNG ATTENDANCE

Any individual who is part of the team is very important, therefore, attendance at the IDT meeting is extremely important. The IDT meeting attendance is a responsibility of each of the team members. Strong efforts must be made in scheduling an IDT to secure the attendance of all members of the Interdisciplinary Team. The IDT should only be rescheduled for extenuating circumstances. A total of two (2) requests to re-schedule the IDT may occur when extenuating circumstances exist. The IDT **must** be rescheduled **to occur** within 30 days of the expiration date. For rescheduling of the IDT, the following conditions exist:

- The Provider agencies may request to reschedule the IDT only once for an IPP.

- The member or member's legal representative (guardian) may request to re-schedule the IDT meeting only once for an IPP.
- The Service Coordinator is responsible for the coordination of the IDT meeting for the IDT team members.
- In extremely extenuating circumstances, family members, guardians or other team members may participate by teleconferencing if the family member, guardian or other team member does not bill for the time spent in the IDT. The member, the Service Coordinator, and the other designated members must be physically present during the IDT.
- The only exception to the IDT attendance is the registered nurse or the psychologist. The registered nurse or the psychologist may participate by interactive video (MDTV or webcam) and may bill for the service when they are present at the IDT for the entire event. All other team members may not participate or bill for the IDT event by means of interactive video (MDTV or webcam).
-

MEDICAID CANNOT REIMBURSE FOR SERVICES RENDERED WHEN THE IPP HAS EXPIRED OR IS INVALID

The IDT will convene at ninety (90) day intervals to develop, review, and update the IPP. The only exception is when the IDT has agreed to meet at longer intervals based on the needs of the member; such reviews shall occur at least every 180 days or every six (6) months. The annual, six month and quarterly IDT meetings are billable under the MR/DD Waiver Program.

REQUIRED SPECIAL MEETINGS

The IDT is also required to convene for the following events:

- **INITIAL OR TRANSFER MEETINGS**

  Seven (7) Day IDT Meeting – This is a mandatory meeting when a member first receives agency or Medicaid services. This is the plan initially developed within the first seven days of the intake interview.

  Thirty (30) Day IDT Meeting – The seven (7) day IPP must be finalized within thirty (30) days of the intake interview.

  Transitional IDT Meeting – Mandatory meeting when a member is having a change among services or service providers. (Example: a change in where the member lives, when a new service is being added or deleted or a change is being requested for a service provider).

- **CRITICAL JUNCTURE MEETINGS**

Critical Juncture is any time that there is a significant juncture in the member's life that requires a meeting of the Interdisciplinary Team. The occurrence may require that a service needs to be decreased, increased or

changed. A critical juncture constitutes a change in the member's needs such as behavioral, mental health or physical health, service/service units, support, setting, or a crisis.

Crisis IDT Meeting – This type of IDT Meeting occurs when a member is experiencing a crisis (example: behavioral, medical, housing and service provision). In the event that all team members cannot be present (for a crisis IDT meeting only), a written report of the crisis IPP must be disseminated to all members within five (5) working days. When the IDT has requested a prior authorization and the approval or denial is received by the Service Coordinator, the Service Coordinator may utilize the crisis IDT format to notify the IDT team members.

- **DISCHARGE MEETING**

Discharge Planning IDT Meeting - This type of meeting must be held when a member is being discharged from MR/DD Waiver Services. This must also occur if the member is transferring to services outside of the Waiver program. (Example: discharge from MR/DD Waiver services into an ICF-MR facility).

513.7.3 SERVICE COORDINATION

PROCEDURE CODE:	T1016-HI
SERVICE UNITS:	15 minutes
SERVICE LIMITS:	70 units per month up to a maximum of 840 units per year. A minimum of 20 units per month will be allotted on the member's budget.
PAYMENT LIMITS:	Service units shall be rounded on a monthly (not daily) basis
PRIOR AUTHORIZATION:	Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006, the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Service Coordination services are activities to establish, along with the member a life-long, person-centered, goal-oriented process for coordinating the supports (both natural and paid), range of services, instruction and assistance needed by persons with developmental disabilities. It is designed to ensure

accessibility, accountability and continuity of support and services. This service also ensures that the maximum potential and productivity of a person with developmental disabilities in making meaningful choices with regard to his/her life and his/her inclusion in the community are achieved.

SITE OF SERVICE

The provider may provide service coordination in any location in the home or community setting which allows the service coordinator to complete all necessary duties for the member.

PROVIDER QUALIFICATIONS

- Four (4) year degree in a human service field and one or more years experience in the MR/DD field.
- Four (4) year degree in a human service field and less than one (1) year of experience in the MR/DD field. (Restrictions - must be under the supervision of the Service Coordinator Supervisor. Clinical supervision involves review of clinical activities, review of case notes and review of treatment plans for six (6) months. This must be verified by supervisory documentation once per month).
- Four (4) year degree in a non-human service field and one (1) year experience in the MR/DD field. (Restrictions - must be under the supervision of the Service Coordinator Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for six (6) months. This must be verified by supervisory documentation once per month).
- No degree or two (2) year degree and is a Licensed Social Worker grandfathered in by the WV Board of Social Worker Examiners due to experience in the MR/DD field. (Restrictions - none)
- A Registered Nurse who has one or more years of experience working in the MR/DD field (Restrictions - must be under the supervision of the Service Coordination Supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for six (6) months. This must be verified by supervisory documentation once per month).
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to the member.

Providers must be a qualified mental retardation specialist. Providers must use the DD-17 for credentialing purposes. Credentials of the individual must be filed with the provider agency.

PROVIDER LIMITATIONS

- Service Coordination must not be provided by an agency that is not a Medicaid enrolled MR/DD Waiver provider.
- There is no secondary Service Coordination in the MR/DD Waiver Program. Another qualified Service Coordinator or a supervisor may act as a substitute Service Coordinator if the assigned Service Coordinator is unavailable with documentation as to the reason why substitute Service Coordination is needed. (Examples: vacation, sick leave, emergencies, etc).

DOCUMENTATION

Service recording or progress/case notes shall include, at a minimum, the following:

- Name of MR/DD Waiver member
- Service Code
- Date of service
- Duration of service
- Start and stop times
- Type of service delivered
- Type of activity (assessment, service planning, linkage, referral, advocacy, crisis response planning, service plan evaluation and travel)
- Type of contact (face-to-face, phone, written)
- Summary of service delivered
- Outcome and/or result of service
- Signature and credentials of provider.

SERVICE COORDINATOR RESPONSIBILITIES

The Service Coordinator shall perform the following activities:

- **Service Coordination Assignment**

  Each member will be assigned a single Service Coordinator.

- **Application and Eligibility Process**

- Accept referrals and provide the applicant and his/her family with the information necessary to choose between an institutional level of care in an ICF-MR facility or home and community-based services under the MR/DD Waiver Program. The Service Coordinator will conduct an interview with the applicant, his/her family, and/or legal representative to explain the choice between ICF/MR institutional and Waiver services and obtain a written informed consent for the applicant to receive Waiver services.
- Coordinate the initial medical evaluation (DD2), psychological evaluation (DD3), Social History (DD4) {if applicable and available}, IEP, psycho-educational assessment for school-age children {if applicable and available}, Birth to Three assessments {if applicable and available} as well as arrange/collect other necessary evaluations and information to establish eligibility.
- Submit the Annual Medical Evaluation (DD-2A) and psychological evaluation (DD3) {if applicable} for re-certification to the State office no later than thirty (30) days past the expiration date. Services may not be reimbursed if an individual's certification has expired past the thirty (30) day time frame.

It is the Service Coordinator's responsibility to ensure that the member's medical and financial eligibility is monitored and determined annually.

- Ensure application for financial eligibility at the DHHR office in the county where the applicant lives or ensure that the applicant, his/her family and/or legal representative make the financial application.
- Ensure that every six (6) months thereafter that the individual, his/her family, and/or legal representative re-establish financial eligibility at the county DHHR office or annually for individuals who are currently receiving SSI.
- Ensure the completion/maintenance of all required MR/DD Waiver evaluations (Annual Medical Evaluation, DD-2A and the Psychological Evaluation, DD-3); IPP, Consents and Rights and disseminate documents to IDT members as appropriate.
- Service Coordination providers must begin the discharge process and provide linkage to services appropriate to the level of need when a member is initially found to be ineligible for MR/DD Waiver Services.
- **Linkage/Referral and Rights**

  Provide oral and written information about the MR/DD Waiver Program provider agency's rights and grievance procedures for members served by the agency.

  Procure all medically necessary services for children through the age of twenty one (21) within and beyond the scope of the MR/DD Waiver Program, in accordance with the Federal regulations and mandate for the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

  Inform families or custodians of children less than three (3) years of age about the availability of Birth to Three Services. Medicaid will <u>not</u> reimburse these providers for Birth to Three Services for children enrolled in the MR/DD Waiver program. However, reimbursement may be available from other funding services.

  Act as an advocate for the member. The MR/DD Waiver Program must not be substituted for entitlement programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers). Therefore, it is necessary for the Service Coordinator to advocate with these systems to obtain the required and appropriate services.

  Provide education, linkage and referral to community resources.

  Promote a valuable and meaningful social role for the member in the community while recognizing the member's unique cultural and personal value system.

  Interface with the ASO on behalf of the member in regards to the assessment process, purchase of services, or budget process. Activities may include linkage, submission of information, coordination of choice of appropriate assessment respondents on behalf of the member, education and coordination of the most appropriate assessment setting that best meets the member's needs. The

Service Coordinator may also conduct communication with other service providers on the IDT to allow for continuity of services/payment for services, and timely budgeting of services. These activities promote an assessment and budget that reflects the needs of the member.

- **Development of the IPP and the IDT Meeting**

  Coordinate evaluations annually to be utilized as a basis of need and recommendation for services in the development of the IPP.

  Notify, convene, coordinate and chair the meeting with the IDT. The Service Coordinator and the individual may wish to coordinate the annual IPP with the planning process for other service systems.

  Coordinate the development of a new IPP at least annually, with a six (6) month up-date, and in accordance with the definition and requirements for IPPs stipulated in Section 513.7.2 of this chapter.

  Access the necessary resources detailed in the IPP, make referrals to qualified service providers and resources, and ensure that service providers implement the instructional (behavioral) and service objectives of the IPP.

  Monitor the instructional (behavioral) and service objectives to ensure that objectives are implemented according to the IPP.

  Disseminate copies of the IPP to the member or member's legal representative and all provider agencies indicated on the IPP.

  Disseminate evaluations or assessments to provider agencies indicated on the IPP.

- **Evaluation of the Implementation of the IPP and Services**

  Ensure health and safety of the member.

  Ensure the implementation of services as indicated on the IPP.

  Visit the member monthly at his/her residence to personally meet with the individual and service providers to verify that services are being delivered in accordance with the IPP in a safe environment, and check that documentation of services is occurring. Visits with the individual, his/her family and/or legal representative will be utilized by the Service Coordinator to update progress towards obtaining services and resources and discuss progress towards achieving objectives contained in the IPP. The Service Coordinator will also elicit information from the member, his/her family and/or legal representative on their assessment of services, achievements, and/or unmet needs.

  Visit the member at his/her day activity a minimum of every other month to verify that services are being delivered in accordance with the IPP, in a safe environment, and check that documentation of services is occurring. The Service Coordinator is encouraged to visit the supported employment setting if the visit will not be disruptive to the setting or member, assist with problem solving and engage in linkage and referral when needed.

Advocate on behalf of the member and his/her family within the behavioral health service delivery system and community services and resources.

Provide planning and coordination before, during and after crises.

Coordinate discharge/transitional planning meetings to ensure the linkage to new service provider and access to services when transferring services from one provider agency to another. Coordination efforts will continue until the transfer of service coordination is finalized.

Travel to and from home visits, day habilitation program visits, and other locations necessary to complete duties related to the IPP.

- **Self-Direction**

  Facilitate the member and/or family learning about self-directed service coordination, which they can then use to independently and fully participate in systems processes and obtain and advocate for needed resources and services.

  Work with the member, his/her family, providers, and others to initiate, facilitate, and maintain collaborative working relationships among individuals and service agencies.

- **Service Restrictions**

  Payee services are not reimbursable as a service coordination activity. Example: writing checks, maintaining bank account, paying the electric bill, etc. (linkage to the payee on behalf of the member is an acceptable service coordination activity).

  MR/DD Waiver Service Coordinators may not provide services for more than twenty (20) people, inclusive of all people served by the Service Coordinator at any time.

  The Service Coordinator must not provide Therapeutic Consultant services for members to whom they provide service coordination.

  Service Coordinators may not evaluate IPP implementation by means of review of "billing or billing documentation" or other auditing activities. (The Service Coordinator may not function as a billing person/auditor. The Service Coordinator may review/monitor implemented services. The Service Coordinator is required to monitor the instructional and service objectives to ensure that objectives are implemented according to the IPP and the SC is to ensure the implementation of services as indicated on the IPP).

513.7.4 TRANSPORTATION

PROCEDURE CODE: A0120-HI: Non-emergency transportation; mini bus, mountain area transports or other transportation systems.
A0160-HI: Non-emergency transportation; per mile- case worker or social worker

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Note: Case Worker is the same as a direct care worker/Social Worker is the same as a Service Coordinator.

SERVICE UNITS: 1 Trip - A0120-HI, 1 mile -A0160-HI

SERVICE LIMITS: 6 one-way trips per day and/or A0120-HI, 77 trips per month or 700 miles per month or up to 1300 miles per month with prior approval from ASO that is based on member's need.

PAYMENT LIMITS: Transportation can be billed concurrently only with Residential Habilitation, Day Habilitation, Respite, Pre-Vocational, Supported Employment, and Adult Companion.

PRIOR AUTHORIZATION: Transportation exceeding 700 miles per month must receive prior approval by the ASO. Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Transportation services are provided to a MR/DD member for the sole purpose of transporting the member **to or from a service that is reimbursed by Medicaid** such as Day Habilitation services, medical appointments, Respite Care and/or to or from specific Residential Habilitation activities which are detailed as an objective in the IPP.

Transportation services must be provided by drivers who meet the transportation provider qualifications described in this section.

Examples of one way trips include but are not limited to the following (A0120-HI):

- Community Based Programming: Member starts from his/her home, goes to the post office, travels to a store, and travels to a restaurant and returns home is one (1) trip.
- Facility Based Programming: Member starts from his/her home, goes to the facility based day program and stays for six (6) hours. This is one (1) trip. Member leaves the day program facility at the end of the day and returns home. This is one (1) trip.

PROVIDER QUALIFICATIONS

Drivers must be at least eighteen (18) years of age and have a valid driver's license (copy to be kept on file).

- Vehicles must have a valid state inspection sticker as applicable to the state and be inspected annually in accordance with State law.

- Drivers and vehicles must be insured as required by the regulations of the WV Department of Motor Vehicles (DMV) or the state in which the vehicle is registered.
- Drivers and vehicles for agencies must be in compliance with policies for qualifications for drivers and aides, safety regulations, emergency procedures and vehicle maintenance schedules of Section 11.1 of the licensing regulations for community behavioral health providers.

SITE OF SERVICE

To and from a Medicaid reimbursable service as outlined on the member's IPP.

DOCUMENTATION

- Community Residential Habilitation, Adult Companion and Respite providers must complete the Progress Report (DD-12).
- Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form. Specific locations where the activity(ies) took place must be documented.
- The agency must develop a system to document/justify the units of transportation billed (i.e. transportation log).
- The IPP (DD-5) must specify the maximum units to be used for each Waiver service within the total units to meet the transportation service designated on the IPP (DD-5). (Example: up to one hundred (100) units per month with a maximum of sixty (60) units for Community Residential Habilitation).

SERVICE RESTRICTIONS

- Transportation may not be billed in place of school-age entitlement services.
- Transportation may not be billed out-of-state with the exclusion of transportation billed on behalf of the member, who resides in a WV state border county and allows for access to community-based habilitation and vocational needs, and is general practice for any other state citizen to cross the state borders and is directly related to the IPP (e.g., Supported employment job site or store located within thirty (30) miles of WV's state border). If destination is beyond thirty (30) miles out of state for members living in a bordering county, the member must access "non-emergency" medical transportation services and must not access Waiver transportation for this type of trip. "Non-emergency" medical transportation (NEMT) would only be applicable for medical appointments. For members who do not live in bordering counties that travel out of state for medical appointments, it will also be necessary for them to access "non-emergency" medical transportation services for this type of trip.
- **Transportation must be directly linked to an IPP goal or objective or a medical service. (Transportation to dental and vision appointments must be addressed in the ISP). The IPP must address goals or objectives or medical services requiring transportation services to access the training or medical service. The IPP must also address the specific provider(s) responsible for providing the transportation.**

- The implementation of goals or objectives must be carried out in close proximity to the member's residence. If a setting is available for a reimbursable activity (i.e. habilitation, adult companion, respite) close to where the member resides, this setting must be utilized. Settings may include, but are not limited to stores, banks, libraries, work site, etc. Transportation must occur where the rest of the community typically does their local shopping or conducts local business utilizing the resources available in the member's neighborhood, town, city or county.
- Transportation must be exclusively for the member's specific needs that are addressed in the IPP and is not intended for the personal or work activities of a staff member or family members. This includes activities such as socialization, shopping, transporting or delivery needs of the staff member or family member.
- Transportation cannot be billed when the member is **NOT** in the vehicle.
- A0120-HI and A0160 -HI cannot be billed concurrently.
- A0120-HI may not be utilized when a provider is transported in a private vehicle (car) or agency vehicle (car). Only a van or "mini-bus "may be utilized with A0120-HI.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.5 RESPITE CARE

PROCEDURE CODE:	T1005	Respite Care Level I, 1:1 ratio
	T1005-UN	Respite Care Level I, 1:2 ratios
	T1005-UP	Respite Care Level I, 1:3 ratios
	T1005-U4	Respite Care Level II, 1:1 ratio
	T1005-U3	Respite Care Level II, 1:2 ratios
	T1005-U2	Respite Care Level II, 1:3 ratios
SERVICE UNITS:	15 minutes	
SERVICE LIMITS:	A Maximum combined limit of 6,912 units per IPP year for Respite Level I and Respite Level II	
PAYMENT LIMITS:	Specialized Family Care Providers who provide respite services may not provide respite at a 1:3 ratio.	
PRIOR AUTHORIZATION:		

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Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Respite Services are specifically designed to provide temporary substitute care for an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver.

Respite is designed to focus on the needs of the care-giver for temporary relief and to help prevent the breakdown of the care-giver due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite Care services consist of temporary care services for an individual who cannot provide for all of his/her own needs.

Respite Care Services may be billed concurrently with transportation.

RESPITE SERVICES

Respite Care may be used to:

- Allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members
- Provide assistance to the primary care-giver or member in crisis and emergency situations
- Ensure the physical and/or emotional well-being of the primary care-giver or the member by temporarily relieving the primary care provider of the responsibility of providing care.

Respite Care services must be provided by a Respite Care Provider who meets the Respite Care provider qualifications described in this Section. All Respite Care providers must have clinical oversight by a Therapeutic Consultant, either a Skills Specialist, or Behavior Specialist/Analyst who ensures the delivery of services in accordance with the MR/DD Waiver Program and the member's IPP.

Up to forty eight (48) units of Respite Care services per member per three (3) months may be charged, if necessary, for the purpose of training the Respite Care service provider in person-specific instruction (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Training received by the Respite Care provider must be provided by a Therapeutic Consultant, either the Skills Specialist or Behavior Specialist/Analyst.

In addition to the 48 units of training, the respite provider may utilize up to four (4) units of respite to participate in the development of the annual IPP and 4 units may be charged to participate in the 6-

month IPP review. Billing may occur only for program planning meetings required by the MR/DD Waiver Program as outlined above.

SITE OF SERVICE

An individual may receive Respite Care services in his/her residence from a qualified Respite Care provider.

An individual may receive Respite Care services out of his/her home in the following locations:

- The home of a Specialized Family Care Provider (SFCP).
- A group home licensed by OHFLAC to deliver services to people with developmental disabilities.
- An ICF/MR group home or facility.
- A general medical hospital when the member warrants the need for additional assistance by a familiar staff person that would not otherwise be provided by hospital staff. Respite CANNOT be billed if the member is in the hospital for psychiatric treatment.
- A Day Habilitation program licensed by OHFLAC to deliver services to people with developmental disabilities (where age appropriate).
- A licensed day care program (for children only on a short-term basis). Example: "Mother's-Day-Out" program when the member receives intermittent respite care at a day care program which does not occur on a daily or routine basis. When the primary care-giver works outside the home, the every day scheduled day care of the member is the responsibility of the primary care-giver and is not an eligible service activity for respite care.
- In the local public community environment.

DOCUMENTATION

Documentation shall include the following:

- Name of MR/DD Waiver member
- Content of the activity.
- Relationship of that activity to an objective on the IPP
- Actual time spent, including start and stop times for the day of service
- Date of service
- Staff to member ratio
- Signature and credentials of the staff providing the service.

The provider is required to utilize the Respite Documentation Form (DD-12). The summary on the DD-12 should discuss specifics of the task or activity and should not be a general description such as

"completing task analysis". Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.

SERVICE RESTRICTIONS

Respite Care services may not be used in a group home, ISS or a residence where the individual lives alone or with other service members because these settings have staff that may work shifts and are not the single primary care-giver for the individual. Respite Care services may only be used by the above settings in an emergency to allow the individual to go to another site for temporary care, or to cover services in a crisis while a new IPP is developed which covers the changes in the individual's circumstances and/or the services. As an exception, Respite Services may be utilized in a DD Crisis Respite Site location that is a BHHF contracted DD Crisis Respite site.

Respite is not intended for every day provision of care for a child or adult in the absence of a parent(s) or primary care-giver(s) when the parent(s) or caretaker(s) goes to work.

The same documentation is required for contracted services. A contract is required between the contracted provider and the provider agency.

The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

PROVIDER QUALIFICATIONS

The Therapeutic Consultant must assess and have oversight for "respite relevant training goals" only.

Respite Care Level I Providers are individuals contracted by an agency who have been chosen by the member or the member's legal representative. Providers may include Specialized Family Care Providers (SFCP) and/or biological or adoptive family members or relatives. The Respite Care Level 1 provider cannot reside with the member. Respite Care Level I is an optional service for Waiver providers.

Prior to the provision of services, the contracted Respite providers must submit verification of the following to the contracting provider:

- Contractor is a minimum of 18 years of age. Verification of age must be on file at the contracting provider agency.
- Current certification in CPR and First Aid. A copy of the certification card must be on file at the contracting provider agency.
- Training in health related issues (medication interactions, seizures, gastrostomy tubes, etc.) or respite relevant training procedures and protocols as needed by the member.
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to

the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

Respite Care Level II Providers must be employees of the behavioral health provider. The Respite Care Level II provider must not reside with the member. Respite Care Level II providers must meet the following requirements:

- Be at least 18 years of age. Verification of age must be on file at the provider agency
- High school diploma or GED
- Current certification in CPR and first aid. A copy of the certification care must be on file at the provider agency
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements

513.7.6 RESIDENTIAL HABILITATION

(RESIDENTIAL BASED SERVICES INCLUDES BOTH AGENCY RESIDENTIAL HABILITATION AND COMMUNITY RESIDENTIAL HABILITATION)

DEFINITION

Residential Habilitation Services are monitoring, support and training services delivered in a member's residence and the member's community that provide instruction and assistance to enable him/her to acquire and maintain skills which will allow him/her to live and socialize more independently. Residential Habilitation services also may include behavioral interventions to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. Residential Habilitation is a venue for active treatment.

Residential habilitation services must be developed exclusively to address the identified habilitation needs of the member. Activities should not be integrated to occur concurrently with personal or work activities of a staff member or family members. This includes such activities such as socialization, shopping, transporting or delivery needs of the staff member or family member. When a setting is available for a reimbursable residential habilitation activity in the neighborhood where the member resides, this setting must be utilized. (i.e. stores, banks, libraries, etc). Residential Habilitation services must occur where the rest of the community typically shops or conducts business utilizing the resources available in the member's neighborhood. Residential Habilitation services must be based on assessment that is person-centered/goal oriented and with meaningful/productive activities that are guided by the member's needs wishes, desires, and goals.

All Agency Residential services are provided under the supervision of a Therapeutic Consultant. Community Residential Habilitation services are provided under clinical oversight of the Therapeutic Consultant. A Therapeutic Consultant will either be a Skills Specialist or a Behavioral Specialist/Analyst.

The Skills Specialist or the Behavioral Specialist/Analyst will work in conjunction and/or collaboration with the designated Residential Habilitation provider(s) to ensure the implementation of Residential Habilitation Services. (See Section 513.7.11 of this chapter).

Examples of skills, which may be taught include, but are not limited to:

- Personal grooming
- Dressing
- Meal preparation
- Emergency skills
- Self-medication
- Social skills
- Interpersonal skills
- Household skills
- Community access skills
- Independent travel
- Independent living skills
- Communication skills
- Self-advocacy skills
- Mobility skills
- Fine/gross motor skills

Physical assistance to assist the individual to achieve a specific instructional objective, may be included as part of the instructional plan for the activity. Physical assistance must be an integral part of an instructional plan and secondary to the learning of a skill, to be reimbursed as part of a habilitation service.

SERVICE RESTRICTION

Residential Habilitation cannot replace the routine care and supervision which would be expected to be provided by a legally responsible care taker or for activities or supervision for which payment is made by a source other than Medicaid.

No more than 8 hours of supervision and monitoring at night may be provided for members living in group homes or ISS settings (1-3 living in the home). This is not available for members who reside in family homes.

Providers for Community Residential Habilitation Services can only be reimbursed for services that are considered extraordinary via the extraordinary care assessment (DD-25).

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MR/DD Waiver services may not replace federally mandated educational services. The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.6.1 COMMUNITY RESIDENTIAL HABILITATION

PROCEDURE CODE: T2017-UA

SERVICE UNITS: 15 minutes

SERVICE LIMITS: 496 units per month Limit of 496 units per month combined with T2017-U4, T2017-U3, T2017-U2, T2017-U1 and up to 744 units per month with prior authorization)

PAYMENT LIMITS: Only those services that have been identified as necessary in the Extraordinary Care Assessment are allowable for reimbursement. Any units in excess of 496 per month up to 744 units per month must be approved by the local waiver contact person prior to November 1, 2006 and by the ASO November 1, 2006 and beyond. The local Waiver contact person cannot authorize units in excess of four (4) hours after November 1, 2006.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Residential services above 496 units per month that includes Community Residential Habilitation or a combination of Community Residential Habilitation and Agency Residential Habilitation, needs prior authorization.

DEFINITION

Community Residential Habilitation services are support services delivered in a participant's residence and in the community which provide instruction and assistance to enable him/her to acquire and maintain skills which will allow him/her to live and socialize more independently. Residential Habilitation services may also include behavioral support to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. Training must be age appropriate, functional and natural in terms of materials, location and times.

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The Extraordinary Care Assessment and service requirements associated with the assessment are not necessary for Specialized Family Care providers and parents of adult children beyond 18 years of age who have not been appointed as legal representative for the member (guardian). The assessment and requirements are intended for natural parents, adoptive parents, or legal representatives who provide community residential habilitation services to the member.

PROVIDER QUALIFICATIONS

Residential service providers must have a minimum of the following qualifications:

- Be at least 18 years old with proof of age on file
- Be a Biological/Adoptive family member, or a Specialized Family Care Provider
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements
- Certification of CPR and First Aid
- Community Residential Habilitation services must have the oversight of a Therapeutic Consultant

Up to twelve (12) hours (forty eight {48} units) of Residential Habilitation services per three (3) months per member may be charged, if necessary, for the purpose of training the Residential Habilitation service provider in member-specific instructional (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only Therapeutic Consultants, either the Skills Specialist or Behavior Specialist/Analyst may provide training to Residential Habilitation providers.

Up to 1 hour (4 units) of Residential Habilitation may be charged by the Residential Habilitation service provider to participate in the development of the annual IPP, the quarterly review or 6-month IPP review. Billing may occur only for program planning meetings outlined above and only for the actual time participating in such meetings.

SITE OF SERVICE

Community Residential Habilitation is provided in the following settings:

- Biological /Adoptive/Natural family homes that is the primary residence of the member.
- Specialized Family Care Homes certified by the SFCP administered by WV University Center for Excellence in Disabilities (WVUCED) and DHHR, Bureau for Children and Families. A foster care home or an adult family care home is not an eligible setting for Community Residential Habilitation.

DOCUMENTATION

- Residential Habilitation providers must maintain detailed documentation (e.g., progress notes, daily activity logs, task analysis) for residential sites in the center's chosen format. Documentation must include the name of MR/DD Waiver member, specific activity provided, its relationship to an IPP

objective, task analysis, the actual time spent, including start and stop times, signatures and credentials of staff providing the service and the date of service.

- Community Residential Habilitation providers must complete the Community Residential Habilitation Documentation from (DD 12). The summary should discuss specifics of the task or activity and should not be a general description such as "completing task analysis". Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.

SERVICE RESTRICTIONS

- It is **not** the member's or the member's legal representative's responsibility to provide or arrange for Residential Habilitation services. It is the responsibility of the Service Coordination provider agency to provide or arrange for Residential Habilitation services with trained and qualified Medicaid providers.
- Routine monitoring or support is not considered assistance in community residential habilitation services. This service includes activities that are considered "active treatment". Members may receive Community Residential Habilitation in the form of assistance as they participate in activities at home or in the local community. This assistance provides the individualized support necessary for participation in the activity during brief episodes between training steps.
- Providers for community residential habilitation can only be reimbursed for services that are considered extraordinary via the extraordinary care assessment.
- Community Residential Habilitation may only be provided to individuals who live in the home with their biological or adoptive family. This service cannot be provided to individuals living in ISS or group home settings.
- Community Residential Habilitation providers may not bill for overnight supervision and monitoring.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.6.2 AGENCY RESIDENTIAL HABILITATION

PROCEDURE CODE:	T2017-U4, T2017-U3, T2017-U2, T2017-U1
SERVICE UNITS:	15 minutes
SERVICE LIMITS:	2616 monthly, combined service limits (Combined service limits include S5135, S5135 UN, S5135 UP Adult Companion Services Level 1-contracted and S5135-U4, S5135-U3, S5135-U2Adult Companion Services Level 2 - agency and Community Residential Habilitation T2017- UA) (Note: 507.6.1. caps Community Residential Habilitation {T2017-UA} in combination with Agency Residential habilitation {T2017 U4, T2017 U3, T2017 U2, and T2017} U1 to 496

units per month without prior approval/authorization and 744 units per month with prior authorization).
Staff / Member Ratio 1:1, 1:2, 1:3, and 1:4 Residential

A member living in a natural family home who has a legally responsible adult (court appointed guardian or parent) may only receive habilitation services that have been identified as necessary in the Extraordinary Care Assessment.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Agency Residential Habilitation services are support services delivered in a participant's residence and in the member's community which provide instruction and assistance to enable him/her to acquire and maintain skills which will allow him/her to live and socialize more independently. Residential Habilitation services may also include behavioral support to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. Training must be age appropriate, functional and natural in terms of materials, location and times.

Agency Residential Habilitation, Staff/Member Ratio 1:1 (T2017-U4), 1:2 (T2017-U3), 1:3 (T2017-U2), and 1:4 (T2017-U1) are a combination of the above services delivered by a staff member of a behavioral health center licensed by the OHFLAC. No other ratio combinations can be considered.

Up to twelve (12) hours (forty eight {48} units) of Residential Habilitation services per three (3) months per member may be charged, if necessary, for the purpose of training the Residential Habilitation service provider in member-specific instructional (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Only qualified professionals such as Therapeutic Consultant, Skills Specialist or Behavioral Specialist/Analyst may provide training to Residential Habilitation providers.

Up to one (1) hour (four {4} units) of Residential Habilitation may be charged by the Residential Habilitation service provider to participate in the development of the annual IPP, the quarterly review, or 6-month IPP review. Billing may occur only for program planning meetings outlined above and only for the actual time participating in such meetings.

Habilitation service providers must be employed staff of the licensed behavioral health provider agency which the member has chosen to provide the service(s). This requirement assures the credentialed staff has met specific professional and training requirements and is monitored by a licensed behavioral health provider and meets the criteria establishing an employee-employer relationship as specified by the U. S. Department of Labor (DOL).

Agency Residential Habilitation services must have oversight by a Therapeutic Consultant.

PROVIDER QUALIFICATIONS

Residential service providers must have a minimum of the following qualifications:

- Be at least 18 years old with proof of age on file;
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.) to deliver services;
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to the member; See Section 513.2.6 Criminal Investigation Background Check for further requirements
- Certification in CPR and First Aid.

SITE OF SERVICE

Residential Habilitation is provided in the following settings:

- The member's own home or apartment that is his/her primary residence. Residential Habilitation services may not be delivered in a residence that endangers the health or safety of the member or the staff.
- Biological or adoptive family homes that is the member's primary residence.
- Specialized Family Care Homes certified by the SFCP administered by the WV University Center for Excellence in Disabilities (WVUCED) and DHHR, Bureau for Children and Families. A foster care home or an adult family care home is not an eligible setting for Agency Residential Habilitation.
- Group homes licensed by OHFLAC to serve individuals with mental retardation and/or developmental disabilities.
- Individualized Support Settings (ISS) staffed or operated by a licensed behavioral health center serving people with mental retardation and/or developmental disabilities (ISS setting is defined as a home setting with one – three (1-3) people living in the home).
- Residential Habilitation services may also be carried over in the necessary local public community environments as specified in the IPP.
- The MR/DD Waiver Program is limiting the size of agency operated group homes. It is the policy of the MR/DD Waiver Program to support living arrangements which are **not** large congregate settings. Agency operated group homes with a four (4) bed capacity or above must receive special approval from DHHR.

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DOCUMENTATION

- Residential Habilitation providers must maintain detailed documentation (e.g., progress notes, daily activity logs, task analysis) for residential sites in the center's chosen format. Documentation must include the name of MR/DD Waiver member, specific activity provided, its relationship to an IPP objective, the actual time spent, including start and stop times, task analysis, signatures and credentials of staff providing the service and the date of service. When transportation is provided in conjunction with habilitation, the transportation must be linked to a goal on the IPP.
- A weekly schedule of activities that is linked to the training goals and objectives must be available for the Agency Residential Habilitation provider. The schedule must include the activity, the place, and general time frame that the activity is to occur. The schedule provides direction for staff implementing the training and consistency of training activities. Member's preference must be included in the development of the weekly schedule.

SERVICE RESTRICTIONS

- It is not the member's or the member's legal representative's responsibility to provide or arrange for Residential Habilitation services. It is the responsibility of the Service Coordination provider agency to provide or arrange for Residential Habilitation services with trained and qualified Medicaid providers.
- Members may receive Residential Habilitation in the form of assistance by staff as they participate in activities at home or in the local community. This assistance provides the individualized support necessary for participation in the activity. Unlike Residential Habilitation training, this assistance is not presented in a training format with formal training objectives. Based upon evaluations, the IDT (1) determines if the individual requires assistance to participate in non-training residential activities; (2) identifies on the ISP those activities for which this support would be provided; and (3) specifies the amount of support (units per month). Residential Habilitation assistance is to be provided in combination with daily Residential Habilitation training. A member must have a current residential training program to qualify for the Residential Habilitation assistance and is to be maintained as described in the documentation section of Residential Habilitation.
- A maximum of 8 hours per day (32 units) of monitoring and supervision may be provided to a member for overnight supervision. Overnight supervision must be provided by alert and "awake" staff. The need for monitoring and supervision must be supported by evaluations and included in the IPP. Justification for such services may include such factors as severe challenging behaviors or life-endangering medical conditions. Residential Habilitation monitoring and supervision in a family home or a Specialized Family Care Home (SFCH) may not be provided by a family member or the SFCP.
- Providers for Community Residential Habilitation can only be reimbursed for services that are considered extraordinary via the extraordinary care assessment.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.7 ADULT COMPANION SERVICES

PROCEDURE CODE:	S5135	Adult Companion Level I,	1:1 ratio
	S5135 UN	Adult Companion Level I,	1:2 ratios
	S5135 UP	Adult Companion Level I,	1:3 ratios
	S5135- U4	Adult Companion Level II,	1:1 ratio
	S5135- U3	Adult Companion Level II,	1:2 ratios
	S5135- U2	Adult Companion Level II,	1:3 ratios

SERVICE UNITS: 15 minutes

SERVICE LIMITS: 2616 monthly, combined service limits (Combined service limits includes T2017-UA, T2017-U1, T2017-U2, T2017-U3 and T2017-U4 Residential Habilitation).

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Adult Companion Services are non-medical care supervision, socialization, monitoring and assistance as determined by the IDT and specified in the IPP. The purpose of Adult Companion Services is two-fold:

- To participate in "non-training" activities in the member's local community that are planned and that do not occur during intermittent periods of time between training activities. Example: staff accompanying a member for a two (2) hour time-frame to a swimming activity at a local community pool.
- To provide assistance with activities that will not have a long-term benefit of training to the member. (Example: Staff placing groceries in a kitchen cabinet for a member who has cerebral palsy and is physically unable to reach the upper cabinets without assistance).

Adult Companion services are complimentary to, and not exclusive of Residential Habilitation, Day Habilitation, Prevocational or Supportive Employment services as specified by individual needs on the IPP.

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ADULT COMPANION SERVICES

Adult Companion services must have clinical oversight by a Therapeutic Consultant who ensures the delivery of services in accordance with the MR/DD Waiver Program and the IPPs of the members.

Adult Companion Level I Providers may be individuals contracted by an agency who have been chosen by the member or the member's legal representative. They may not reside with the member. Adult Companion Level I is an optional service for Waiver providers.

Conditions of Contracting:

Prior to the provision of services, the contracted Adult Companion Level I Provider must submit verification of the following to the contracting provider:

- The contractor is a minimum of 18 years of age;
- Current certification in CPR and First Aid. A copy of the certification card must be on file at the contracting provider agency;
- The contractor has training in health related issues (medication interactions, seizures, gastrostomy tubes, etc.) as needed per individual Waiver member;
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to the member. **CIB is required for Level I and Level II.** See Section 513.2.6 Criminal Investigation Background Check for further requirements

Adult Companion Level II Providers must be employees of the behavioral health provider chosen for the service and:

- Have a high school diploma or Graduate Equivalency Degree (G.E.D.);
- Be at least 18 years old with proof of age on file at the provider agency;
- Current certification in CPR and first aid. A copy of the certification card must be on file at the contracting provider agency;
- The contractor has training in health related issues (medication interactions, seizures, gastrostomy tubes, etc.) as needed per individual Waiver member;
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to the member. **CIB is required for Level I & Level II.**

SITE OF SERVICE

Adult Companion services are provided in the following locations:

- Locations in the member's local community (local public community environment) to implement those activities which support a member's needs and choices.
- Natural or Adoptive family homes or Specialized Family Care homes in which the member resides
- Group Homes (GH) licensed by OHFLAC to serve individuals who have a diagnosis of MR/DD. (GH = 4 members in one home)
- The MR/DD Waiver Program is limiting the size of agency operated group homes. It is the policy of the MR/DD Waiver Program to support living arrangements which are **not** large congregate settings.
- Individualized Support Setting (ISS) (ISS = 3 or less members in one home)
- BHHF Development Disability (DD) funded Crisis Respite sites

DOCUMENTATION- LEVEL I AND LEVEL II

- Adult Companion services are documented on an Adult Companion Services documentation form (DD-12) by the provider and monitored and reviewed by the Service Coordinator. Documentation shall include name of MR/DD Waiver member, the content of the activity, the relationship of that activity to an objective on the IPP, the actual time spent, including start and stop times, date of service, the staff to member ratio and the signature and credentials of the staff providing the service on the Adult Companion Services Documentation form (DD-12). The summary should discuss specifics of the task or activity and should not be a general description such as "completing task analysis". Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.

SERVICE RESTRICTIONS: LEVEL I AND LEVEL II:

- Adult Companion services shall **not** be billed concurrently with Residential Habilitation (agency), Community Residential Habilitation, Respite, Day Habilitation, Pre-Vocational Training and Supported Employment services.
- The member is required to have Habilitation Services (Residential Habilitation or Community Residential Habilitation Services) to access Adult Companion services.
- Adult Companion providers shall **not** provide services to members with whom they share a residence.
- This service is **not** to be provided by a family member residing with the member in a natural, adoptive or foster family setting.
- This service is **not** to be provided by a SFCP in a specialized family care setting.
- This service is **not** to be provided by a family member of a member residing in an agency-operated or agency- staffed residential home such as an ISS or a group home.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as

stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

- A staff member's home is not a site of service.

513.7.8 DAY HABILITATION PROGRAM

PROCEDURE CODE	T2021-U4, T2021-U3, T2021-U2, T2021-U1
SERVICE UNITS:	15 minutes
SERVICE LIMITS:	600 - 15 minute units per month up to an annual maximum of 7,200 units inclusive of staff/member ratios 1:1(U4), 1:2 (U3), 1:3 (U2), 1:4 (U1) these are the only ratios available for Day Habilitation
PAYMENT LIMITS:	See below
PRIOR AUTHORIZATION:	Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Day Habilitation is a structured program that is designed to promote the acquisition of skills or maintenance of skills for the member outside the residential home. Day Habilitation activities must occur during naturally occurring routines of the day for the member.

Day Habilitation activities in the plan must be developed exclusively to address the habilitation needs of the member. Activities should not be integrated to occur concurrently with personal or work activities of a staff member or family members. This includes such activities such as socialization, shopping, transporting or delivery needs of the staff member.

Day Habilitation services must be based on assessment, be person-centered/goal oriented, and with meaningful/productive activities that are guided by the member's needs wishes, desires, and goals.

DAY HABILITATION SERVICES

Day Habilitation services consist of programs of instruction/training, supervision and assistance, specialist services and evaluations provided by or under the direct supervision of a Therapeutic Consultant, as described in Section 513.7.11 of this Chapter.

Day Habilitation Program services include, but are not limited to:

- Development of self-care skills
- Use of community services and businesses
- Emergency skills
- Mobility skills
- Nutritional skills
- Social skills
- Communication and speech instruction (prescribed by a Speech Language Pathologist)
- Therapy objectives (prescribed by Physical Therapist, Occupational Therapist, etc.)
- Interpersonal skills instruction
- Functional academics such as recognizing emergency and other public signs, independent money management skills, etc.
- Citizenship, rights and responsibilities, self-advocacy, etc.
- Other habilitative services necessary for an individual to participate in activities in the community settings of his/her choice
- Self medication
- Independent living skills
- Volunteer services (volunteer work cannot replace a paid employment position).

Physical assistance to assist the individual to achieve a specific instructional objective may be included as part of the instructional plan for the activity. Physical assistance must be an integral part of an instructional plan and secondary to learning of a skill, to be reimbursed as part of a habilitation service.

When a setting is available for a reimbursable day habilitation activity (i.e. habilitation, adult companion, respite) in the neighborhood where the member resides, this setting must be utilized. (i.e. stores, banks, libraries, etc). Day Habilitation must occur where the rest of the community typically shops or conducts business utilizing the resources available in the member's neighborhood. Day Habilitation must be for the member's specific needs and is not intended for the socialization, shopping, transporting or delivery needs of a staff member or a family member. Members may participate in either community based day habilitation or facility based day habilitation. The facility based day habilitation program must be licensed by OHFLAC.

Up to 48 units of Day Habilitation Program services per 3 months may be charged, if necessary, for the purpose of training the Day Habilitation service provider in person-specific instructional (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Training received by the Day Habilitation provider must be conducted by a Therapeutic Consultant.

Up to 4 units of day habilitation service may be charged by the Day Habilitation service provider to actively participate in the development of the annual IPP and 4 units may be charged to actively participate in the 3, 6 , 9 month IPP update. Billing may occur only for program planning meetings required by the MR/DD Waiver Program as outlined above.

Day Habilitation Program services can be delivered in staff/member ratio of 1:1, 1:2, 1:3 and 1:4. No other ratio combinations can be granted. There must be sufficient numbers of competent, trained staff to provide active habilitation and to protect the individual's health and safety.

PROVIDER QUALIFICATIONS

Individuals providing Day Habilitation Program services must be employees (staff) of the licensed behavioral health provider (either community day habilitation or site-based day habilitation). This requirement assures the credentialed staff has met specific professional and training requirements, is monitored by a licensed behavioral health provider and meets the criteria establishing an employee-employer relationship as specified by the U. S. Department of Labor (DOL).

Day Habilitation Program service providers must have a minimum of the following qualifications:

- Be at least 18 years old with proof of age on file
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- Certified in CPR and First Aid
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to the member.
- See Section 513.2.6 Criminal Investigation Background Check for further requirements

SITE OF SERVICE

Day Habilitation takes place away from a person's home and may include activities in natural community environments to facilitate skills acquisition. Day Habilitation may be provided in a licensed, certified day program site or a natural setting in the community. All facility based day program sites must be licensed by OHFLAC.

DOCUMENTATION

Day Habilitation providers (employing organization) must maintain detailed documentation (e.g. progress notes, daily activity logs) for services provided in the provider's chosen format.

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Documentation shall include name of MR/DD Waiver member, the content of the activity, the relationship of that activity to an objective on the IPP, the actual time spent, including start and stop times, date of service, the staff to member ratio, schedule, task analysis and the signature and credentials of the staff providing the service.

A weekly schedule of activities that is linked to the training goals and objects must be available for the Day Habilitation provider. The schedule must include the activity, the place, and general time frame that the activity is to occur. The schedule provides direction for staff implementing the training and consistency of training activities. Member's preference must be included in the development of the weekly schedule.

SERVICE RESTRICTIONS

- Day Habilitation Services are analogous to work or instructional classes in skills of daily living necessary to assist the individual to be involved in the community. Individuals who have aged out of school must participate in Day Habilitation, Prevocational Training or Supported Employment programs.
- Day Habilitation services may not be delivered in a residential site except in rare circumstances where the individual cannot receive Day Habilitation services outside his/her home. Approval for day habilitation in a member's home must be requested and authorized from the ASO and the following conditions must be met:

  The services are overseen by a Therapeutic Consultant

  All service providers meet the qualifications for delivering Day Habilitation Services

  Day Habilitation and Residential Habilitation services are not delivered concurrently

  The Therapeutic Consultant must ensure the training of staff on appropriate training program goals and that activities occur in a normal, community setting.

  Ordered by a physician

- Day Habilitation may not take the place of federally funded educational services. Children who do not receive extended school year services may be eligible to receive Day Habilitation in the summer months. However, during the remainder of the year, school is considered the day habilitation and the child is not eligible for day activities under Waiver both during the week and on weekends (day activities include Day Habilitation, Prevocational Services and Supported Employment). The Title XIX MR/DD Waiver Home and Community Based Program cannot provide federal and state mandated education services. The only exception for this would be if Day Habilitation services would be deemed beneficial for the member directly before or directly after the traditional school day.
- Day habilitation services must be offered in the most integrated setting available. Ratios for day habilitation are 1:1, 1:2, 1:3, and 1:4. No other ratio combinations can be considered. A weekly schedule of activities that is linked to the training goals and objectives must be available for community day habilitation. The schedule must include the activity, the place, and the time that the

activity is to occur. The schedule provides direction for staff implementing the training and consistency of training activities. Member's preferences must be included in the development of the weekly schedule. This schedule is for the purpose of day habilitation activities only.

513.7.9 PREVOCATIONAL TRAINING

PROCEDURE CODE: T2015-Individual, T2015-HQ-Group
SERVICE UNITS: 60 minutes
SERVICE LIMITS: 115 1-hour units per month inclusive of both Individual and Group services.

PAYMENT LIMITS: MR/DD Waiver Prevocational Training services may not be substituted for those services available through DRS through a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation of a referral to the Division of Rehabilitation Services (DRS) must be maintained by the provider agency in the individual's record of service.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Prevocational Training Services are planned and designed to assist an individual to acquire and maintain basic work and work-related skills. The service must be an essential component of the IPP, and work activity must be a secondary or tertiary goal of the service, subordinate to the acquisition and retention of work and work-related skills.

PROVIDERS QUALIFICATIONS

- Must be at least 18 years old with proof of age on file.
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to

the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

- Certified in CPR and First Aid
- Must be employees (staff) of the licensed behavioral health provider or the Division of Rehabilitation Services acknowledged vendor.

PREVOCATIONAL TRAINING SERVICES

Prevocational Training service activities include but are not limited to, the following:

- Training the individual to follow directions and carry out assigned duties
- Assistance to acquire appropriate attitudes and work habits, such as socially appropriate behaviors on the work site
- Assistance to adjust to the production and performance standards of the workplace
- Mobility training as related to work or work skills
- Compliance with workplace rules or procedures
- Attendance to work activity
- Assistance with workplace problem solving
- Instruction in the appropriate use of work-related facilities (e.g., rest rooms, cafeteria/lunch rooms, and break areas.)

Individual services are delivered in a staff/member ratio of 1:1. Group services are delivered in staff/member ratio of 1: 2-4. No other ratio combinations can be considered. There must be sufficient numbers of competent, trained staff to provide pre-vocational training and to protect individual's health and safety.

Prevocational training services must be provided by paraprofessionals and supervised by a Therapeutic Consultant in accordance with the provider qualification and training requirements of this chapter. Paraprofessionals must also have documented training or experience in the implementation of Prevocational Training plans of instruction.

Up to 48 units of Day Habilitation Program services per 3 months may be charged, if necessary, for the purpose of training the prevocational service provider in person-specific instructional (i.e., behavior intervention plans, medical plans of care, specific instructional activities, etc.) and/or service objectives. Training received by the Prevocational Training provider must be conducted by a Therapeutic Consultant.

Up to four (4) units of prevocational training services may be charged by the Day Habilitation service provider to actively participate in the development of the annual IPP and four (4) units may be charged to actively participate in the 3, 6 , 9 month IPP update. Billing may occur only for program planning meetings required by the MR/DD Waiver Program as outlined above.

SITE OF SERVICE

Services may be delivered by day activity centers or adult day service programs operated by behavioral health providers which are licensed by OHFLAC, or acknowledged by a Division of Rehabilitation Services vendor prior to November 1, 2006 will be granted a grandfather status.

If any member is paid less than minimum wage the program must be certified by the Department of Labor and maintain a current sub-minimum wage certificate.

Services may be delivered by the pre-vocational provider in a community setting.

DOCUMENTATION

- Pre-vocational service providers must maintain detailed documentation (e.g., progress notes, daily activity logs) for services provided in the agency's chosen format. Documentation shall include name of MR/DD Waiver member, the content of the activity, the relationship of that activity to an objective on the IPP, the actual time spent, including start and stop times, date of service, the staff to member ratio, task analysis and the signature and credentials of the staff providing the service.
- A weekly schedule of activities that is linked to the training goals and objectives must be available for the Pre-Vocational provider. The schedule must include the activity, the place, and general time frame that the activity is to occur. The schedule provides direction for staff implementing the training and consistency of training activities. Member's preference must be included in the development of the weekly schedule.

SERVICE RESTRICTIONS

In order to access Pre-Vocational services under the MR/DD Waiver Program, one must determine if services are currently provided through Division of Rehabilitation Services (DRS). If services are not provided through DRS, a program funded under the Rehabilitation Act of 1973, the MR/DD Waiver Program provider agency must make a referral to DRS. A copy of the referral must be maintained by the provider agency in the individual's record of service. MR/DD waiver pre-vocational services must not be utilized concurrently with any DRS pre-vocational services.

The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.10 SUPPORTED EMPLOYMENT

PROCEDURE CODE: T2019-Individual, T2019-HQ-Group

SERVICE UNITS: 15 minute

SERVICE LIMITS: 576 - 15 minute units per month inclusive of both Individual and Group services.

CHAPTER 513–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES

PAYMENT LIMITS:

MR/DD Waiver Supported Employment services may not be substituted for those services available through Division of Rehabilitation Services (DRS) through a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation of referral, to DRS must be maintained by the provider agency in the individual's record of service.

PRIOR AUTHORIZATION:

Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Supported Employment Services are services that enable individuals to engage in paid, competitive employment, in integrated community settings. The services are for individuals who have barriers to obtaining employment due to the nature and complexity of their disabilities, regardless of age or vocational potential. The services are designed to assist individuals for whom competitive employment at or above the minimum wage is unlikely without such support and services and need ongoing post-employment support based upon the member's level of need.

PROVIDER QUALIFICATIONS

Supported employment service providers must meet the following criteria:

- Must be at least 18 years old with proof of age on file.
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- CPR and First Aid
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirement.

SUPPORTED EMPLOYMENT SERVICES

Supported Employment services include, but are not limited to:

- Vocational counseling (Example: Discussion of the member's on- the- job work activities)
- Job development and placement for a specific waiver member with the member present
- On-the-job training in work and work-related skills
- Accommodation of work performance task
- Supervision and monitoring by a job coach
- Intervention to replace inappropriate work behaviors with adaptive work skills and behaviors
- Retraining as jobs change or job tasks change
- Training in skills essential to obtain and retain employment, such as the effective use of community resources
- Transportation to and from job sites when other forms of transportation are unavailable or inaccessible.

Natural work setting supports are to be considered prior to the utilization of Supported Employment. Individual services are delivered in a staff/member ratio of 1:1. Group services are delivered in a staff/member ratio of 1:2-4. No other ratio combinations can be considered. There must be sufficient numbers of competent, trained staff to provide supported employment services and to protect individual's health and safety.

Supported Employment Services must be supervised by a Therapeutic Consultant. In addition to the primary training requirements as outlined in Section 513.2.5, paraprofessionals providing supported employment must have documented training or experience in implementation of Supported Employment plans of instruction.

- Trainers or job coaches must be employees of community behavioral health providers that are licensed by OHFLAC or community rehabilitation programs that are acknowledged by a Division of Rehabilitation Services vendor prior to July, 1, 2006 will be granted a grandfather status.

SITE OF SERVICE

Integrated community work setting.

DOCUMENTATION

- Supported Employment providers must maintain detailed documentation (e.g., progress notes, daily activity logs) in the center's chosen format for services provided. Documentation shall include name of MR/DD Waiver member, the content of the activity, the relationship of that activity to an objective on the IPP, the actual time spent, including start and stop times, date of service, the staff to member ratio and the signature and credentials of the staff providing the service.
- A weekly schedule of activities that is linked to the training goals and objects must be available for the Supportive Employment provider. The schedule must include the activity, the place, and general time frame that the activity is to occur. The schedule provides direction for staff

implementing the training and consistency of training activities. Member's preference must be included in the development of the weekly schedule.

SERVICE RESTRICTIONS

- In order to access supported employment services under the MR/DD Waiver Program one must determine if services are currently provided through DRS. If services are not provided through DRS, a program funded under the Rehabilitation Act of 1973, the MR/DD Waiver Program provider agency must make a referral to DRS. A copy of the referral must be maintained by the provider agency in the individual's record of service. MR/DD waiver supported employment services must not be utilized concurrently with any DRS pre-vocational services.
- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.11 THERAPEUTIC CONSULTATIVE SERVICES

(Therapeutic Consultative Services Includes Skills Specialist, Behavioral Specialist, and Behavioral Analyst-)

DEFINITION

Therapeutic Consultative services are services provided by a Qualified Mental Retardation Professional to develop and monitor a plan of intervention or instruction.

ROLE OF THERAPEUTIC CONSULTANT

Although not mandated, each member may have up to three (3) Therapeutic Consultants. In the absence of the member's Therapeutic Consultant due to illness or emergencies, a substitute Therapeutic Consultant from the same provider may provide the service in the interim. Services which are provided to the member during this absence require the documentation of the reason for the substitution on the progress note.

A Behavioral Specialist/Analyst will act as the Therapeutic Consultant if significant maladaptive issues are indicated by the ICAP assessments that require positive behavioral support intervention. The Behavioral Specialist/Analyst is responsible for both the maladaptive and the adaptive portions of the plan.

A Skills Development Specialist will act as the Therapeutic Consultant if there are no significant maladaptive issues present. The residential setting may have one consultant for the member and the day setting may have one (1) consultant for the member. The day setting includes Day Habilitation, Prevocational, and Supported Employment Services. A third Therapeutic Consultant may be added only if there is a second or third provider for a day setting activity.

An individual with Behavioral Specialist/Analyst credentials who provides therapeutic consultant services to a member whose assessments indicate no maladaptive behaviors will need to bill as a Skills Specialist.

In the event that there is more than one (1) Therapeutic Consultant, the Residential Therapeutic Consultant will act as the primary Therapeutic Consultant. Additional Therapeutic Consultants (up to two) may be necessary if the individual is also receiving services from different providers in a day setting such as day habilitation, prevocational, or supported employment services.

The Residential Therapeutic Consultant will be the primary Consultant responsible for coordinating the collaboration of the total habilitation plans and behavioral support plans, protocols, or guidelines. All habilitation plans (residential, day, prevocational/supported employment) must be developed in collaboration. The point of collaboration is the IDT.

All Therapeutic Consultant's involved with the member's habilitation plans must sign each part of the plan (residential, day, prevocational/supported employment) indicating the plans are consistent with adaptive training methodologies, strategies, areas of skill improvement and maladaptive issues or interventions. The ASO will provide ICAP adaptive and maladaptive finding to the IDT. The IDT may use these finding to assist in prioritizing the member's habilitation and training needs. Plans must be correlated with the results found in both the adaptive and maladaptive findings of the ICAP assessment. Therapeutic Consultants are responsible for the writing and collection of the habilitation plans, and training of the individuals who will be implementing the direct training with the member.

A Therapeutic Consultant must be a qualified mental retardation specialist. Providers must use the DD-17 for credentialing purposes. Any credential that the providers verify on this form must be filed with the provider agency.

SPECIALTY CONSULTANT FOR HEARING OR VISUAL IMPAIRMENT NEEDS

A provider who is certified or specially trained to provide mobility or adaptive training for an individual who is visually impaired or adaptive training for a member who is hearing impaired may be added to a member's team for consultation purposes only. Verification of the provider's qualifications as a Specialty Consultant for hearing or visual impairment must be maintained in the provider agency's files (example: certification or specialized training). This provider is a skills specialist and may bill for only skills specialist services. This provider may consult with the team for a total of **20 units per IPP year.** The Specialty Consultant may consult with the other Therapeutic Consultants on the team, assess the member, or make recommendations to the team regarding adaptations for training activities. Recommendations must be maintained in the member record in writing.

RESTRICTIONS

The Therapeutic Consultant must not be utilized as a direct care service provider for the member. The Therapeutic Consultant may coach or model the training activity as an integral part of the training of the direct service provider. Methods such as coaching or modeling are intermittent activities that do not occur over extended periods of time. However the direct service provider must be present during coaching or modeling of training activity.

The service is face to face with the exception of a crisis which can constitute the service being provided via teleconference. Crisis services are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavioral support planning, interventions, strategies and direct care.

513.7.11.1 SKILLS SPECIALIST:

PROCEDURE CODE: T2021-U7-UF 1:1 provider to member ratio - day

T2021-U7-UH 1:1 provider to member ratio – residential

SERVICE UNITS: 15 minutes

SERVICE LIMITS: 80 units per month; up to 140 units per month with ASO approval. Limits are combined for both day and residential settings. A minimum of 20 units will be allotted per month in the member's individual budget.

PAYMENT LIMITS: Providers without credentials for their area of specialty may not provide the service. The Residential setting consultant and the day setting consultant may collaborate no more than 8 units per calendar year for the purpose of plan development.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 5132.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Skills Specialist provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational providers, supportive employment providers. Also, the Skills Specialist provides training for respite and adult companion providers (if applicable for "respite-relevant" training objectives or health or safety training objectives only). This service is provided to members with the primary need for adaptive skills training and the absence of significant maladaptive behaviors. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction.

Skills Specialist Core Job Functions:

- Development of task analysis and person specific strategy or methodology for implementation of intervention or instruction plans for an individual (habilitation plans or staff/caretaker directions/guidelines). Example: How may the staff/caretaker create a successful environment for the person?
- Evaluate environment(s) for implementation of the plan which creates the optimal environment for learning. (TC should select the most suitable environment for the consumer's learning needs. For example, if the consumer has an aversion to noisy environments, the TC would be aware of this and would steer the consumer/team from training in such environments as possible)
- Train primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational, supported employment, adult companion, and respite providers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans or guidelines).
- Assessment, evaluation and monitoring of the effectiveness of intervention or instruction plans (habilitation plans or behavioral guidelines) for habilitation training.
- **Job placement activities with a limit of 20 units per quarter (for members receiving supported employment services only)**
- Pre-vocational and supported employment training
- Collect and evaluate data around targeted behaviors when this activity leads to a functional assessment and a behavior support plan (Skills Specialist may collect data to determine the need for a behavior specialist or a behavior analyst) Once the need for a behavior specialist/analyst is determined, the skills specialist would no longer provide the service.

PROVIDER QUALIFICATIONS

- Minimum of a Bachelor's degree in human service field such as psychology, social work, education, or counseling.
- Staff hired prior to November 1, 2006 may be grandfathered into the skills specialist position. Within one year all therapeutic consultants grandfathered into the position must have taken the "Overview of Positive Behavior Support" as developed by the WV Positive Behavior Support (PBS) network.
- Must be a qualified mental retardation professional.
- Must have one year professional experience working with individuals with mental retardation/developmental disabilities.
- Demonstrated competencies as determined by the provider that the individual can perform the core job functions of a skills specialist. Providers without one year post graduate professional experience may provide skills specialist services under the direct supervision of a QMRP professional with a Masters degree in social work, psychology or counseling or a licensed psychologist.
- Providers must have a Criminal Investigation Background Check. CIB results 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 provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements

SITE OF SERVICE

This service may be provided in the Skills Specialist's office, the individual's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Skills Specialist's service.

DOCUMENTATION

A detailed progress note or evaluation report for each service is required. The documentation should include the service code, description of the service, date, time spent, including start and stop times and signature and credentials of the Skills Specialist. All data obtained for a functional analysis must be maintained in the member's record. Service units are to be rounded on a monthly basis, not daily or weekly.

SERVICE RESTRICTIONS

- Does not apply to the direct training of the member (cannot provide direct services).
- Skills Specialist may not provide aquatic therapy, art therapy, dance therapy, music therapy, pet therapy, aroma therapy, and equestrian therapy. Additionally, skill building instruction or activities around these types of therapies may not be provided.

513.7.11.2 BEHAVIOR SPECIALIST

PROCEDURE CODE:	T2021-U8-UF	1:1 provider to member ratio - day
	T2021-U8-UH	1:1 provider to member ratio – residential
SERVICE UNITS:	15 minutes	
SERVICE LIMITS:	120 units per month; up to 200 units per month with ASO approval (combined with T2021U9 (Behavioral Analyst) A minimum of 20 units will be allotted per month in the member's individual budget (combined with T2021U9)	
PAYMENT LIMITS:	Providers without credentials for their area of specialty may not provide the service. The residential setting consultant and the day setting consultant may collaborate no more than 8 units per calendar year for the purpose of plan development	
PRIOR AUTHORIZATION:	Refer to Section 513.9, 513.10.1, 513.10.2, 513.11.1, and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent.	

Services not registered with the claims agent will not be reimbursed.
See Eligibility Criteria for the Service and prior authorization.

DEFINITION:

Behavioral Specialist provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational providers, supportive employment providers) for members *with significant maladaptive behaviors.* The plan of intervention will require a behavioral guideline, protocol, or plan dependent on the member's need. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction.

ELIGIBILITY CRITERIA FOR THE SERVICE

The following is a list of criteria that must be exhibited in order to receive this behavioral service. Once a targeted behavior is established, this service may be utilized for the purpose of behavioral tracking when the behavioral data leads to a positive behavior support plan or behavior protocol. One or more of the conditions must be met:

- Member must currently exhibit maladaptive behaviors or have a recent history of maladaptive behaviors that have occurred no more than one year from the date of implementation of the service (verification by historical evaluation, assessment behavior support plan, behavior plan or IPP only).
- Member may have a history of behaviors beyond the one year that have resulted in severe life threatening situations such as fire setting or arson or sexual assault or offending or behaviors that result in severe bodily harm to others. Eligibility for this criteria must be prior authorized by the ASO.
- Member must have identified behaviors on the IPP that require tracking of behavioral data for the functional assessment
- Member must have a functional assessment that outlines one or more specific targeted behaviors that are currently or will be addressed in a behavioral protocol or a positive behavior support plan **OR** member must have an ICAP rating of moderate, severe or critical on the maladaptive range
- Member may have an active behavior protocol in place if behaviors are infrequent or if the behaviors are not occurring at the time of implementation of the service **OR** member may have a behavior support plan in place.

Person Specific Strategies (Behavioral Guidelines)

A guideline is a written instruction for staff. Written instructions describe methods or interventions that have worked for the member in the past or methods/interventions that have not worked in the past. Written instructions may include "helpful hints" for direct support staff or family members who work directly with the member. The written instruction will address members with the following:

- Mildly challenging behaviors
- Behaviors that occur on an infrequent basis

- Behaviors that have occurred in the past
- Behaviors that are not life threatening

Person Specific Strategies (Protocol or Positive Behavior Support Plan)

A Positive Behavior Support Plan is a written document that summarizes strategies that assist in preventing challenging behavior(s) from occurring and helps the consumer learn new skills. The plan must be developed within a 90 day time frame. Development and implementation of a plan is as follows:

- Gather information, data collection/functional analysis
- Develop hypothesis
- Build a support plan
- Human rights committee approval
- Train staff
- Implement the plan
- Evaluate effectiveness and modify support plan- review data

Behavioral Specialist Core Job Functions:

- Responsible for all aspects of positive behavior support services
- Behavioral assessment or evaluation consisting of activities such as functional analysis of targeted behavior or analysis of behavioral data
- Behavioral support plan or protocol development
- Training of providers to implement behavioral plan
- Development of behavioral protocols and behavioral guidelines for direct care staff or families
- Development of task analysis and/or methodology for implementation of intervention or instruction to an individual
- Train primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational, supported employment, adult companion, and respite providers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans, behavior plans or protocols)
- Train primary care providers in the person-specific aspects and methods of a plan of intervention or instruction- habilitation plans (i.e., family, residential habilitation providers, day habilitation providers and respite providers)
- Job placement activities with a limit of 20 units per quarter (for members receiving either pre-vocational or supported employment services only)
- Train primary care providers in the person specific aspects and methods of a plan of intervention or instruction (habilitation plans) who provide prevocational and supported employment services

- Assessment, evaluation and monitoring of the effectiveness of intervention and instruction plans (habilitation plans, behavior plans, protocols)

PROVIDER QUALIFICATIONS

- Minimum of Bachelor's Degree in Human Service field such as psychology, social work, education, or counseling
- Staff hired prior to November 1, 2006 may be grandfathered into the behavior specialist position. Within one year all therapeutic consultants grandfathered into the position must have taken the "Overview of Positive Behavior Support" as developed by the WV Positive Behavioral Support (PBS) network.
- Minimum of two years professional work experience working with individuals with mental retardation and/or developmental disabilities.
- Must be a qualified mental retardation professional.
- Demonstrated competencies as determined by the provider that the individual can perform the core job functions of a skills development specialist.
- Providers must have a Criminal Investigation Background Check. CIB results 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 provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

SITE OF SERVICE

This service may be performed at the Behavioral Specialist's office, the individual's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Behavioral Specialist's services.

DOCUMENTATION

A detailed progress note or evaluation report for each service is required. The documentation should include the service code description of the service, date, time spent, including start and stop times and signature and credentials of the Behavior Specialist. All data obtained for a functional analysis must be maintained in the member's record. Service units are to be rounded on a monthly basis, not daily or weekly. The progress note must include an analysis of the data or problem, the clinical outcome, and the plan of intervention as the result of the analysis.

SERVICE RESTRICTIONS

- Does not apply to the direct training of the member (cannot provide direct services)
- Behavior Specialist may not provide aquatic therapy, art therapy, dance therapy, music therapy, and equestrian therapy. Additionally, skill building instruction or activities around these types of therapies may not be provided.

513.7.11.3 BEHAVIOR ANALYST

PROCEDURE CODE:

T2021-U9-UF Behavior Analyst (1:1 provider to member ratio) – Day
T2021-U9-UH Behavior Analyst (1:1 provider to member ratio) – Residential
T2021-U6-UF Behavior Analyst – Psychologist (1:1 provider to member ratio) – Day
T2021-U6-UH Behavior Analyst –Psychologist (1:1)

SERVICE UNITS: 15 minutes

SERVICE LIMITS 120 units per month; up to 200 units per month with ASO approval (combined with Behavioral Specialist T2021 U8)
A minimum of 20 units will be allotted per month in the member's individual budget (combined with T2021U8)

PAYMENT LIMITS: Providers without credentials for their area of specialty may not provide the service. The Residential setting consultant and the day setting consultant may collaborate up to 8 units per calendar year for the purpose of plan development

PRIOR AUTHORIZATION: Refer to Section 513.9, 513.10.1, 513.10.2, 513.11.1, and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

See Eligibility Criteria for the Service and prior authorization.

DEFINITION

Behavioral Analyst provides training in the person-specific aspects and method of a plan of intervention or instruction to the primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational providers, supportive employment providers). Also, the Skills Specialist provides training for respite and adult companion providers (if applicable for "respite-relevant" training objectives). This service is provided to members with the primary need for both maladaptive interventions and adaptive skills training. The Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction. The plan of intervention will require a behavioral guideline, protocol or plan dependent on the member's need. The

Therapeutic Consultant also provides evaluation/monitoring of the effectiveness of the plan of intervention or instruction.

ELIGIBILITY CRITERIA FOR THE SERVICE

The following is a list of criteria that must be exhibited in order to receive this behavioral service. Once a targeted behavior is established, this service may be utilized for the purpose of behavioral tracking when the behavioral data leads to a positive behavior support plan or behavior protocol. One or more of the conditions must be met:

- Member must currently exhibit maladaptive behaviors or have a recent history of maladaptive behaviors that have occurred no more than one year from the date of implementation of the service (verification by historical evaluation, assessment behavior support plan, behavior plan or IPP only).
- Member may have a history of behaviors beyond the one year that have resulted in severe life threatening situations such as fire setting or arson or sexual assault or offending or behaviors that result in severe bodily harm to others. Eligibility criteria must be prior authorized by the ASO.
- Member must have Identified behaviors on the IPP that require tracking of behavioral data for the functional assessment
- Member must have a functional assessment that outlines one or more specific targeted behaviors that are currently or will be addressed in a behavioral protocol or a positive behavior support plan **OR** member must have an ICAP rating of moderate, severe or critical on the maladaptive range
- Member may have an active behavior protocol in place if behaviors are infrequent or if the behaviors are not occurring at the time of implementation of the service **OR** member may have a behavior support plan in place

Person Specific Strategies (Behavioral Guidelines)

A guideline is a written instruction for staff. Written instructions describe methods or interventions that have worked for the member in the past or methods/interventions that have not worked in the past. Written instructions may include "helpful hints" for direct support staff or family members who work directly with the member. The written instruction will address members with the following:

- Mildly challenging behaviors
- Behaviors that occur on an infrequent basis
- Behaviors that have occurred in the past
- Behaviors that are not life threatening

Person Specific Strategies (Protocol or Positive Behavior Support Plan)

A Positive Behavior Support Plan is a written document that summarizes strategies that assist in preventing challenging behavior(s) from occurring and helps the consumer learn new skills. The plan must be developed within a 90 day time frame. Development and implementation of a plan is as follows:

- Gather information, data collection/functional analysis
- Develop hypothesis
- Build a support plan
- Obtain Human Rights Committee approval
- Train staff
- Implement the plan
- Evaluate effectiveness and modify support plan- review data

Behavioral Analyst Core Job Functions

- Responsible for all aspects of positive behavior support services
- Behavioral assessment or evaluation consisting of activities such as functional analysis of targeted behavior or analysis of behavioral data
- Behavioral support plan or protocol development
- Training of providers to implement behavioral plan
- Development of behavioral protocols and behavioral guidelines for direct care staff or families.
- Development of task analysis and/or methodology for implementation of intervention or instruction to an individual.
- Train primary care providers (i.e., family, residential habilitation providers, day habilitation providers, prevocational, supported employment, adult companion, and respite providers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans, behavior plans or protocols).
- Training in the person-specific aspects and methods of a plan of intervention or instruction provided to the individual and/or primary care providers (i.e., family, residential habilitation providers, day habilitation providers and respite providers).
- Job placement activities with a limit of 20 units per quarter (for members receiving either pre-vocational or supported employment services only)
- Pre-vocational and supported employment training
- Assessment, evaluation and monitoring of the effectiveness of intervention and instruction plans (habilitation plans, behavior plans, protocols)

PROVIDER QUALIFICATIONS

- Minimum of Master's Degree in human service field with a graduate level course work in applied behavioral analysis or positive behavioral support or;
- Minimum of Bachelor's Degree in human service field with a graduate level course work in applied behavioral analysis or positive behavioral support and;
- Minimum of three years professional work experience working with individuals with mental retardation and/or developmental disabilities and;
- Qualified Mental Retardation Professional;
- Demonstrated competencies (course work, training) in the area of positive behavior support and skills development.
- Providers must have a Criminal Investigation Background Check. CIB results 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 provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

SITE OF SERVICE
This service may be provided at the Behavioral Analyst's office, the individual's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Behavioral Analyst's services.

DOCUMENTATION
A detailed progress note or evaluation report for each service is required. The documentation should include the service code description of the service, date, time spent, including start and stop times and signature and credentials of the Behavior Analyst. All data obtained for a functional analysis must be maintained in the member's record. Service units are to be rounded on a monthly basis, not daily or weekly.

SERVICE RESTRICTIONS

- Does not apply to the direct training of the member (cannot provide direct services)
- Behavior Analyst may not provide aquatic therapy, art therapy, dance therapy, music therapy, and equestrian therapy. Additionally, Skill building instruction or activities around these types of therapies may not be provided.

513.7.12 EXTENDED PROFESSIONAL SERVICES

PROCEDURE CODE:	Occupational Therapist	1:1 ratio	97530-GO-HI
	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each15 minutes		
	Physical Therapist	1:1 ratio	97530-GP-HI

Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each15 minutes
Speech Therapist 1:1 ratio 92507-GN-HI
Treatment of speech, language, voice, communication, and/or auditory processing; event
Speech Therapist 1:1 ratio 92526 - HI
Treatment of swallowing dysfunction and/or oral function for feeding; event
Registered Dietician 1:1 ratio 97802-AE- HI
Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
Psychologist Consultant 1:1 ratio T2025
Consultative services to a member's Therapeutic Consultant when there are complex behavioral issues present.

SERVICE UNITS: 15 minute units of service except for Speech Therapist which is an event code

SERVICE LIMITS: Occupational Therapist, Physical Therapist, and Registered Dietician (30 units per month up to a maximum to 360 units annually. - Combined units with Occupational Therapist, Physical Therapist, Registered Dietician), Psychologist Behavioral Consult (4) units per year). Speech Therapist (4) events per month.

PAYMENT LIMITS: Providers without credentials for their area of specialty may not provide the service. Psychologist Behavioral Consult (T2025) is limited to four (4) units per year. This service is a consult by a licensed psychologist on the behavioral support plan and may not be utilized for the purpose of training of direct care staff, families, or other Therapeutic Consultants or Extended Professionals.

PRIOR AUTHORIZATION: Prior to November 1, 2006 refer to Section 513.9, 513.10.1, 513.10.2, 513.11.1, and 513.12.1. (Prior Authorization process). Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget.

The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior Approval required for:

- Occupational Therapist, Physical Therapist, and Registered Dietician: for any combined units above 30 per month.
- Speech Therapist: above 4 events per month
- Psychologist Behavioral Consult, above 4 units per year

DEFINITION

Extended Professional Services are those provided directly to the member which would not otherwise be provided by an alternative source. Extended Professional Services include Physical Therapy, Occupational Therapy, Speech/Language Therapy, Registered Dietician Services and Specialized Consultation to a Therapeutic Consultant by a Licensed Psychologist.

Professional Services:

Core Job Functions:

Must be performed by a fully licensed, certified and/or registered (e.g., physical therapist, speech/language, occupational therapist, registered dietician). A Certified Occupational Therapy Assistant (COTA) or a Licensed Physician Therapist Assistant (PTA) are not considered an Extended Professional.

Professional services must have a 1:1 ratio and consist of:

- Physical therapy
- Occupational therapy
- Speech and language therapy
- Dietary services by registered dietician.
- Specialized Consultative Services to a Therapeutic Consultant by a Licensed Psychologist (Limited to a member who has rating of moderate, severe, or critical on the annual ICAP rating of maladaptive behaviors or member is in crisis, a functional analysis may be utilized to assess the member's maladaptive behaviors).

Professional services cannot be conducted concurrently with the same member (i.e. physical therapy and occupational therapy being implemented with the member concurrently).

SITE OF SERVICE FOR ALL EXTENDED PROFESSIONAL SERVICES

This service may be provided in the Extended Professional's office, the member's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Extended Professional Services. It is the expectation of the extended professional to develop a home care plan.

DOCUMENTATION FOR ALL EXTENDED PROFESSIONAL SERVICES

A detailed progress note or evaluation report for each service is required. The documentation should include the description of the service, date, time spent, including start and stop times and signature and credentials of the extended professional. The service must be linked to a goal on the IPP for the therapy and an assessment of progress or lack of progress addressed in the documentation. Service units are to be rounded on a monthly basis, not daily or weekly.

513.7.13 SKILLED NURSING SERVICES

DEFINITION

Nursing services are services which only a Registered Nurse (RN) and/or Licensed Practical Nurse (LPN) can perform. Nursing services consists of nursing care which can be provided safely in the recipient's residence, day habilitation program, etc. The service must be provided by a registered nurse **under the direction of a physician** or a licensed practical nurse under the supervision of a registered nurse **and under the direction of a physician.** Services must be provided within the scope and standards of the West Virginia Nurse Practice Act.

SITE OF SERVICE

Skilled Nursing Services can be provided in the following settings:

- The participant's own home or apartment that is his/her primary residence
- Natural family homes that is his/her primary residence.
- Specialized Family Care Homes certified by the Specialized Family Care Program administered by WV University Center for Excellence in Disabilities (WVUCED) and DHHR, Bureau for Children and Families.
- Group homes licensed by OHFLAC to serve individuals with mental retardation and/or developmental disabilities.
- Individualized Support Settings (ISS) operated by a licensed behavioral health center serving people with mental retardation and/or developmental disabilities.
- Skilled Nursing services may also be carried over in the necessary local public community environments, as specified in the IPP.

Nursing services may not be delivered in a residence that endangers the health or safety of the participant or the staff. If applicable for the safety of the member there needs to be an assurance that the home has the following:

- Adequate electrical power including back-up power system (generator and/or battery);
- Adequate space for equipment and supplies;
- Adequate fire safety and adequate exits for medical and other emergencies;
- Clean environment to the extent that the individual's life and health is not at risk;

DOCUMENTATION

A detailed progress note or evaluation report for each service is required. The documentation should include the description of the service, member name, date, time spent, including start and stop times, and signature and credentials of the Nurse. Service units are to be rounded on a monthly basis, not daily.

SERVICE RESTRICTIONS

Nursing services are not intended to replace the natural supports of the member. Nursing is considered supportive to the care provided to an individual by the individual's family, foster parents, and/or delegated care-givers, as applicable. Nursing services shall be based on medical necessity. Increases in the level of care and number of hours or visits authorized shall be based on a change in the condition of the individual, limitation of the program, and the ability of the family, foster parents, or delegated care-givers to provide care.

The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

513.7.13.1 NURSING SERVICES BY RN

PROCEDURE CODE:	T1002- HI	RN	1:1
SERVICE UNITS:	15 minutes		
SERVICE LIMITS:	40 units per month		
PRIOR AUTHORIZATION:	Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective November 1, 2006, the service must be based upon the assessed need of the member, identified by the IDT, and included on the individualized Waiver budget. The ASO will register the service (s) with the claims agent. Services not registered with the claims agent will not be reimbursed. RN Services (only those services that can be completed by a RN) do not need prior authorization by the ASO. Nursing services must be physician ordered.		

DEFINITION

RN Skilled Nursing Services are restricted to those nursing services that are outside the scope and practice of a LPN. If the RN provides a Skilled Nursing service that is within the scope of practice for a LPN, the RN must utilize the LPN code.

Nursing services that may be provided by a Registered Nurse (RN) include but are not limited to:

- AMAP required RN duties
- Annual nursing assessment (all member's must have annual nursing assessment)
- Self-medication administration assessment
- Completing forms necessary for prior authorization for nursing services
- Nursing plan of care, including measurable goals/objectives
- Monthly nursing summaries
- Direct supervision of AMAPs, LPNs
- Work directly with physicians and specialists to plan medical treatment
- Train providers on client specific health and safety issues.

PROVIDER QUALIFICATIONS:

- Current WV registered nursing license
- CIB check. See Section 513.2.6 Criminal Investigation Check for further requirements.

513.7 13.2 SKILLED NURSING SERVICES LPN

PROCEDURE CODE:	T1003-HI-U4	LPN 1: 1
	T1003-HI-U3	LPN 1: 2
	T1003-HI-U2	LPN 1: 3
SERVICE UNITS:	15 minutes	
SERVICE LIMITS:	Based upon the medical need for skilled nursing, the member may receive up to 24 hours of skilled nursing (ratios combined) per day. The nurse will also be expected to provide habilitation training (which is active treatment) when the member receives 8 hours or more of skilled nursing services per day.	

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with All annual IPP's conducted on or after November 1, 2006, the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior authorization required for any services over 248 units (62 hours) per month (2 hours per day)

Nursing services must be ordered and implemented under the direction of a physician.

DEFINITION
Nursing services that must be provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) include but are not limited to: (Note: Reimbursement of these activities is at the LPN rate)

- Routine monitoring (data collection) of specific medical symptoms such as seizures, bowel habits, blood pressure, diet and exercise;
- Taking off physician orders if only nurses are administering medication;
- Ensuring physician orders are current, properly documented and communicated to direct care staff and others per agency policy;
- Direct nursing care including medication/treatment administration;
- Monitoring and review of MARs, medication storage and documentation (when no AMAPs are administering medication);
- Ensure medical appointments have been kept and information communicated to all others per agency policy;
- Assist in obtaining informed consent for medication and/or treatments;
- Facilitate procurement of and monitoring of medical equipment;
- Keeping emergency sheets updated and accurate;
- Training/education of members regarding health/medical issues.

If the member receives eight or more hours of skilled nursing services and the LPN is responsible for habilitation programs, the LPN may participate in the IPP and bill the LPN code.

PROVIDER QUALIFICATIONS:

- Current WV Nursing License
- CIB check. See Section 513.2.6 Criminal Investigation Background Check for further requirements.

513.7.14 CRISIS SERVICES

PROCEDURE CODE: T2034 - 2:1 staff to member ratio

SERVICE UNITS: Unit = 1 hour

SERVICE LIMITS: Limit of fourteen (14) days (annually by IPP year)

(A day is considered an event regardless of the number of hours that the crisis service was delivered)

Service may not be provided in a mental health crisis stabilization unit, psychiatric hospital, MR/DD Crisis Sites, ICF-MR facility, general medical hospital, natural family home or specialized family care home. Service may not be provided concurrently with residential habilitation, day habilitation, prevocational, supported employment, respite, or adult companion services.

PRIOR AUTHORIZATION:

Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006, the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. This service requires prior authorization by the ASO, and must meet the criteria as outlined in "Authorization" and "Behavioral Needs Criteria.

DEFINITION:

The goal of this service is to respond to a crisis immediately, assess the situation, and stabilize as quickly as possible. Crisis services are to be used if there is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavioral support planning, interventions, strategies and direct care. This service requires medical necessity (Refer to Behavioral Needs Criteria below). This service is a 2:1 ratio (staff to member ratio). The additional staff person is available for assurance of health and safety in the respective setting. Crisis services include formal training, informal training and behavioral support.

AUTHORIZATION:

The behavior support specialist may initiate the service by providing a written clinical justification within 48 hours or the next working day of the onset of crisis services.

A prior authorization request must be submitted within 72 hours of implementation of the service. The Service Coordinator must request the authorization from the ASO. If the crisis occurs on a Friday, the request may be submitted on a Monday.

The Service Coordinator must maintain a record of the authorization for service and clinical justification by the behavior support specialist.

Crisis Services are contingent upon the approval by the ASO. Services not approved by the ASO will not be reimbursed for payment.

Intensive Support Requirement:

Intensive Support Requirement is when a member requires an acute level of support during periods of time when the person is presenting episodes of unmanageable behaviors that require an intense level of behavioral or psychiatric care. An individual may display extreme, maladaptive behaviors that are not anticipated, are acute in nature and are beyond the daily behaviors that are addressed through other supports. Crises of this nature may be due to medication changes, reaction to situational stressors, or environmental trauma. By providing this service, an imminent admission to a hospital or institutional facility will be avoided while protecting the person from harming themselves or others. This service is not intended to be ongoing in nature and must include a plan of titration of the level of supports.

During crisis service the following training and support activities must be conducted

- Record behavioral data as indicated by the behavioral support plan or initial data collection assessment
- Implement the behavioral support plan, behavioral protocol or behavioral guidelines
- Ensure health and safety of the member

Crisis Services staff will implement the plan(s) that are directed at reducing the maladaptive behavior(s). This service may include behavioral interventions to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. All Crisis Services are provided under the supervision of a Behavioral Specialist/Analyst as described in Sections 513.7.11.2 or 513.7.11.3 of this chapter. Crisis Services may be provided for periods of up to fourteen (14) consecutive days per episode and may not exceed fourteen days in a total calendar year provided the service bas been authorized by the ASO.

Behavioral Needs Criteria for Crisis Services:

Definition

The member exhibits severe bodily harm, tissue damage, extreme property destruction or is an imminent safety concern for self or others. Member requires a behavioral support plan.

Member must have a maladaptive severity rating on the ICAP of four (4), which is described as an **extremely serious** and **critical problem**. The behavior is life threatening and the reduction in frequency of the targeted behavior requires vigilance and a highly structured environment. The ICAP must list the targeted behavior, score the frequency and score the severity of the behavior. During the transition to the ASO, members needing crisis services prior to the annual ASO ICAP assessment will require a functional assessment rather than the ICAP for this service. The functional assessment must indicate extremely serious and critical behaviors.

Member must have a functional assessment (ICAP or other functional assessment) that indicates extremely serious and critical behaviors in one (1) of the following areas in order to be eligible for crisis services.

In the event that the member has not received the ICAP assessment, another functional assessment may be utilized to determine Level 4 maladaptive behaviors in the areas of Hurtful to Self or others, destruction to property, and socially offensive behavior.

Eligible ICAP Criteria for Crisis Services:

Acceptable categories of Maladaptive Behaviors on the ICAP assessment for crisis services are as follows (must have a four (4) in one of the following areas to be eligible for crisis services):

- Hurtful to Self
- Hurtful to Others
- Destructive to Property
- Socially Offensive Behavior

Requirement:

- The development or adaptation and implementation of a Behavioral Support Plan.
- Every occurrence of the targeted behavior must be documented.
- Documentation of the targeted behavior on the ICAP or the functional assessment must be consistent with other assessments. When inconsistencies occur, a written explanation must accompany the IPP.

PROVIDER QUALIFICATIONS

Crisis Service providers must have a minimum of the following qualifications:

- Be at least 18 years old with proof of age on file
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- Current certification in CPR and First Aide
- Training in health related issues (medication interactions, seizures, gastrostomy tubes, etc.) as needed per individual waiver member.
- Criminal Investigation Background Check (CIB). CIB results 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 provider agency before placing an individual in a position to provide services to the member. See Section 513.2.6 Criminal Investigation Background Check for further requirements.
- Individuals providing Crisis Services must be employees (staff) of the licensed behavioral health provider
- Specific training on the implementation and documentation of Positive Behavior Support plans.

SITE OF SERVICE

Crisis Services are provided in the following settings:

- Group homes licensed by OHFLAC to serve individuals with mental retardation and/or developmental disabilities (group home is defined as a home setting where four (4) or more members reside).
- Individualized Support Settings (ISS) operated by a licensed behavioral health center serving people with mental retardation and/or developmental disabilities (ISS setting is defined as a home setting where one (1) to three (3) members reside).
- Crisis services may also be carried over into the necessary local public community environments, as specified in the IPP.
- This service may not be provided in settings such as a natural family, specialized family care and an adoptive family home.

DOCUMENTATION:

Following any use of crisis services, the individual's IPP will be reviewed and updated to reflect a plan for the prevention and interventions to ameliorate subsequent occurrences. The IPP must identify crisis early warning signals, triggers and the necessary services and supports to insure the health and safety of the individual. Any plan that involves the use of restrictive intervention will be approved by a behavior specialist or a behavior analyst and approved by the Human Rights Committee.

- Crisis Service providers must maintain detailed documentation (e.g., progress notes, daily activity logs, or behavioral data tracking forms) for residential sites in the center's chosen format. Documentation must include the name of MR/DD Waiver member, specific activity provided, its relationship to an IPP objective or targeted behavior, the actual time spent, including start and stop times, signatures and credentials of staff providing the service and the date of service.
- A written order is required by a behavioral specialist or behavioral analyst for this service.

SERVICE RESTRICTIONS:

- **This service is not intended for the use as an emergency response for routine and on-going behavioral challenges.**
- Staff/member ratio is 2:1, up to a maximum of 24 hours per day. A member may not receive residential habilitation, day habilitation, adult companion, more than 2 hours per day nursing, respite, prevocational services or supported employment services during the 24 hour day when the member is receiving crisis services. A member may only receive service coordination, Therapeutic Consultant, or transportation services during the daily 24 hour time-frame that crisis services are received.
- A maximum of 8 hours per day (32 units) of monitoring and supervision may be provided to a member. The need for monitoring and supervision must be supported by evaluations and included in the IPP.

- Justification for such services may include such factors as severe challenging behaviors or life-endangering medical conditions.
- Crisis services may not be provided outside of an ISS (Intensive Support Setting) or group home setting. An ISS setting is defined as a 1-3 person setting
- The provision of staff as the only support to the member may not be the only intervention provided under crisis services. Clinical interventions must be present in addition to the staffing support.
- This service may not be provided in a hospital, or a facility setting.

513.7.15 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

PROCEDURE CODE: S5165 (home), T2039 (vehicle)

SERVICE UNITS: One Unit equals $1

SERVICE LIMITS: A maximum of $1,000 per service year (Combined service limits include S5165 & T2039).

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Environmental Accessibility Adaptations are physical adaptations to the home and/or vehicle, required by the participant's plan of care or IPP, which are necessary to ensure the health, welfare and safety of the participant. The purpose of this service is accessibility to the home or vehicle only. Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service. Additionally, these adaptations enable the participant to function with greater independence in the home and without which the participant would require a more restrictive environment. Medicaid funds will be used only after all other non-family funding sources have been exhausted. In order to access this benefit:

- The IDT must meet and determine the needs of the participant and document these needs on the participant's IPP.

- The Service Coordinator will complete and submit a DD-19 form to the ASO to authorize the request for an Environmental Accessibility Adaptation covered by this benefit.
- Once the Agency Contact Person has reviewed the completed DD-19 form, the Service Coordinator may submit the appropriate billing to access this benefit.

Environmental Adaptations include but are not limited to:

- Supplies and installation of grab bars,
- Supplies and installation of ramp(s),
- Widening of doorways,
- Modification of bathroom facilities,
- Installation of specialized electric and plumbing systems where necessary to accommodate medical equipment and supplies,
- Vehicle modifications and/or lifts

Excluded are those adaptations or improvements to the home of general utility, and are not of direct medical or remedial benefit to the participant. For example (This is not an all inclusive list):

- Carpeting
- Roof repair
- Central air conditioning
- Capital Improvements
- Adaptations which add to the total square footage of the home

RESTRICTION

The service coordination provider agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for the cost of services must be issued to the vendor of the EAA service. The provider agency must maintain verification of payment to the vendor and a receipt verifying the service was provided.

SITE OF SERVICE

- Participant's Home – Non-agency operated residences for specific adaptations to meet the participant's needs
- Vehicle – Non-agency operated vehicles for specific adaptations to meet the participant's needs.

DOCUMENTATION

The Service Coordinator must attach the following items to the DD-19 form to be maintained in the participant's file (see Attachment 1 for DD-19):

- Copy of the IPP detailing the need for the Environmental Accessibility Adaptation.

- Copy of any assessments detailing the need for the Environmental Accessibility Adaptation.
- Written documentation supporting the denial or exhaustion of other non-Medicaid and non-family resources; and
- Any and all receipts and/or invoices for services rendered.
- The original DD-19 form must be maintained in the participant's file with the required attachments.
- The agency contact person is responsible for maintaining a single file with a copy of all DD-19 forms completed and submitted for reimbursement. This single file must have the attachments to the DD-19 form.
- The single file maintained by the service coordination agency contact person shall be made available for review by State and Federal monitors.
- All receipts and invoices must be kept on file. It is the Service Coordinator's responsibility to verify the Environmental Accessibility Adaptations have been purchased and/or provided.

SERVICE RESTRICTIONS

- Provider agencies will be reimbursed through billing Service Coordination for arranging and processing this service, not from the requested amount.
- The Service Coordination agency contact person and the Service Coordinator are responsible for ensuring the request is for only those adaptations covered by this benefit. Any reimbursements for non-covered adaptations will result in the amount of the request being deducted from the agency's Service Coordination billing.
- Licensed sites, agency operated sites, or public housing sites are responsible for providing ADA accessible housing. Therefore, this benefit is not allowable for ADA required improvements, state Fire Marshall requirements or OHFLAC requirements.
- Licensed sites or agency operated sites are responsible for providing accessible transportation to those participants who require transportation services.
- Routine durable medical equipment or routine communication devices are not considered environmental accessibility services through Waiver. These services may be otherwise available through Medicaid state plan services.

The following is a list of exclusions from this benefit (CMS exclusions):

- Carpeting
- Roof Repair
- Central Air Conditioning
- Adaptations which add to the total square footage of the home.
- This benefit is **not** to be utilized by combining the benefit allocated for more than one (1) participant for any Environmental Accessibility Adaptations.

- This benefit is not to be utilized by combining the benefit allocated to the member for more than one calendar year for any Environmental Accessibility Adaptations.

513.7.16 EVALUATION SERVICES

This section applies to evaluation services that are also offered outside of the Title XIX Home and Community Based Waiver Program. Extended Physician Services, Psychiatric Diagnostic Interview Examination, and Psychological Testing with interpretation and report, Psychological Testing, Developmental Testing with Interpretation and Report, and Psychological Testing Developmental Testing – Limited with Interpretation and Report (Annual Psychological Evaluation) are services that can be provided by the waiver provider if the staff member has the required credentials for the service.

513.7.16.1 EXTENDED PHYSICIAN SERVICES (Annual Medical Evaluation)

PROCEDURE CODE: 99381-HI to 99387-HI CPT codes for new member
99391-HI to 99397-HI CPT codes for established member

SERVICE UNITS: Event

SERVICE LIMITS: One evaluation annually

PAYMENT LIMITS: No one with credentials other than a medical or osteopathic physician licensed to practice in WV may perform or charge for this service.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

Extended Physician Services consist of a comprehensive annual medical evaluation performed by a medical or osteopathic physician licensed to practice in WV. The comprehensive annual medical evaluation must include:

- A physical and developmental examination
- Blood levels for medications (if applicable)

- Assessment of specialized medical care
- Recommendations for additional services.
- Diagnosis - mental and physical, with prognosis
- Recommendation, based on the examination as to ICF/MR level of care and services.
- Information should also be gathered from the individual or legal guardian on what he/she wants from services with relation to his/her goals for home life, day services, social life and/or other life areas. This service must include a recommendation that the individual requires an ICF/MR level of care and services and home and community-based services are appropriate, if the data supports such a recommendation.

This service is used when submitting an initial application packet and to re-establish medical eligibility for re-certification on an annual basis. The DD-2A must be fully completed.

Failure to submit annual medical evaluation (DD-2A) within 30 days of the expiration date for re-certification may result in the member losing eligibility for MR/DD Waiver services and the agency being responsible for non-reimbursable Waiver services.

SITE OF SERVICE

Physician's office, individual's home or other applicable community location

DOCUMENTATION

Completion of the annual medical evaluation (DD-2A) form for the evaluation

513.7.16.2 Psychological Evaluations (Triennial and Annual)

Each member must receive a psychological evaluation to determine medical eligibility. Both the DD-2 (physician's medical evaluation) and the DD-3 (psychological evaluation) are utilized in the determination of the need for ICF-MR level of care.

Specific testing instruments or assessments utilized by the psychologist are based upon the member's need. Procedure codes utilized by the psychologist are based upon the type of assessment or testing conducted by the psychologist and based upon the unique clinical needs of the member. The procedure code utilized by the psychologist is not dependent upon whether the evaluation is an annual or a triennial evaluation, but must be determined based upon the activity performed during the evaluation. Members may not have a need to utilize all service codes under Psychological Evaluations. The following codes may be utilized during the annual or the triennial psychological evaluations, provided the activity matches the code (Refer to 90801, 96101, 96111, 96110 for specific definitions and restrictions):

90801 Psychiatric Diagnostic Interview (intake)

96101 Psycho-diagnostic testing, with report

96110 Developmental Testing, limited

96111, developmental testing, extended

GENERAL DEFINITION OF NEURO-COGNITIVE TESTING:

Cognitive functioning

Cognitive processes

Visual motor responses

Abstract abilities

Adaptive and Maladaptive behavioral functioning

Results in an Outcome:

Administration of test- generates material that is formulated into a report that includes data, analysis of the data or results of the testing, and recommendations.

- A comprehensive psychological evaluation must be completed every 3 years for all members utilizing the DD-3 format.
- The comprehensive evaluation may be updated by a psychologist, the following 2 years by interviewing the individual, checking the individual's current status, completing adaptive behavior scales and updating all recommendations for children below 18 years of age. An annual psychological evaluation is not required for adults 18 years of age and older. The DD-3 format must be utilized.

Psychological Evaluation, **Triennial Services** must include:

- Intellectual testing
- Measures of adaptive behavior
- Interview with the individual
- Other age appropriate and/or disability-specific evaluation methods.

This service also includes a review of current status, recommendations for instructional services to increase skills and other therapeutic interventions, diagnostic impression(s), statement supported by evaluation results indicating if the individual requires an ICF/MR level of care based on his/her need for habilitative services and recommendation supported by evaluation results that home and community-based services are appropriate.

A comprehensive psychological evaluation must be completed every 3 years for all members. The comprehensive evaluation may be updated by a psychologist, the following 2 years by interviewing the individual, checking the individual's current status, completing adaptive behavior scales and updating all recommendations for children below 18 years of age. An annual psychological update is not required for adults 18 years of age and older.

Psychological Evaluations, Triennial services must be provided by a psychologist with at least a Master's degree in psychology from an accredited program and licensed to practice in WV or eligible to be licensed to practice in WV and under the supervision of a WV licensed psychologist.

The Psychological Evaluation, Annual Update service must include:

- Specific scores of a standardized adaptive behavior measure
- Observation of the person
- Prognosis statement regarding how the person will function with continued ICF/MR level of care
- DSM-IV format with an ICD-9 diagnosis
- Recommendations for adaptive training and behavioral supports.

This service must include training recommendations and a clear recommendation as to an appropriate placement. If the recommendation is for an alternative level of care, specific information to support the new placement must be included.

The Adaptive Behavior Scales previously mentioned must be completed on the Adaptive Behavior Scales for adults (ABS-RC: 2) and Adaptive Behavior Scales for children ages 3 to 18 years (ABS-S: 2). Children age three and below may utilize the Vineland Adaptive Behavior Scale or other age-appropriate standardized measurements of adaptive functioning.

Psychological Evaluation, Annual Update services must be provided by a psychologist with at least a Master's degree in psychology from an accredited program and licensed to practice in WV or eligible to be licensed to practice in WV and under the supervision of a WV licensed psychologist.

513.7.16.2.1 Psychiatric (Psychological) Diagnostic Interview Examination

PROCEDURE CODE:	90801-HI Psychiatric Diagnostic Interview Examination.
SERVICE UNITS:	Session/Event
SERVICE LIMITS:	Completed on individual new to the provider of the service with registration.
PAYMENT LIMITS:	No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform the testing.
PRIOR AUTHORIZATION:	Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective November 1, 2006, the service must be based upon the assessed need of the member, identified by the IDT and included on the individualized Waiver budget. The ASO will

register the service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed one event.

DEFINITION

Psychiatric diagnostic interview examination is an all-inclusive evaluation of a member's functional level(s), mental status, history and a disposition performed by a psychiatrist or psychologist. It may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.
NOTE: THIS CODE MAY ONLY BE USED WHEN THE MEMBER IS NEW TO THE PROVIDER.

SITE OF SERVICE

Psychologist's office, individual's home or other applicable community locations

DOCUMENTATION

Documentation must contain the completed evaluation (DD-3) signed by the psychiatrist or psychologist. The documentation must include place of evaluation and date of service. The license number of the psychiatrist or psychologist must also be present.

TRIENNIAL OR ANNUAL EVALUATIONS
This code may be utilized either for the triennial or annual evaluation and is dependent upon the member's needs. This service may not be provided unless the member is new to the provider agency.

513.7.16.2.2 Psychological Testing with Interpretation and Report

PROCEDURE CODE:	96101-HI
SERVICE UNITS:	1 hour (maximum of 4 hours)
SERVICE LIMITS:	One evaluation every three years for all members (adult and child). (Cannot be utilized within three year period with 96111)
PAYMENT LIMITS:	No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform this service.
PRIOR AUTHORIZATION:	Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent.

Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed one evaluation every three years.

DEFINITION

96101 psychological testing is a service that is provided per hour of the psychologist's or physician's time face-to face time with patient, includes the time interpreting test results and preparing the report. Psychological testing includes:

Psycho-diagnostic Assessment of the following, with interpretation and report:

- Emotionality
- Intellectual Abilities
- Personality
- Psychopathology

Examples include the MMPI, Rorschach, and the WAIS
The psychologist includes the results of the ABS assessment in his evaluation. Psychologist administers the WAIS, Wechsler Scales for the purpose of assessment of an ICF-MR level of care, adaptive training recommendations, and interpretation of testing results and report.

SITE OF SERVICE

Psychologist's office, individual's home or other applicable community locations

DOCUMENTATION

Documentation must contain the completed evaluation, signed by the qualified licensed psychologist. The psychologist license number, place of the evaluation, date of service and time spent must also be included in the documentation.

TRIENNIAL OR ANNUAL EVALUATIONS

This code may be utilized either for the triennial or annual evaluation and is dependent upon the member's needs and the testing conducted by the psychologist.

RESTRICTION

This service may not be utilized within a three year period with 96101.

If a Service Coordinator administers the ABS prior to the psychological evaluation and the Service Coordinator provides the results of the evaluation to the psychologist, the Psychologist may not bill for administering the ABS. The psychologist may include historical evaluations or assessments in the report but may not bill for an assessment he/she did not conduct. When a trained/qualified Service Coordinator administers the ABS, the Service Coordinator may bill service coordination because the ABS is an assessment. If the psychologist billed for the ABS, this would result in duplication of service/payment for the ABS activity.

The psychologist may bill 96101 for the assessments that he/she administered during he evaluation. The psychologist may bill for the interpretation of the "raw data" from the ABS and include it in his/'her report.

Psychologist includes the results of the ABS assessment in his evaluation. Psychologist administers the WAIS, Wechsler Scales for assessment of an ICF-MR level of care, adaptive training recommendations, interpretation of testing results and report.

513.7.16.2.3 Psychological Testing –Developmental Testing Extended with Interpretation and Report

PROCEDURE CODE:	96111-HI
SERVICE UNITS:	Event
SERVICE LIMITS:	One evaluation every three years for all members (adult and child). (Cannot be utilized within three year period with 96101)
PAYMENT LIMITS:	No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform a psychological evaluation.
PRIOR AUTHORIZATION:	Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be selected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed one evaluation every three years.

DEFINITION

Extended developmental testing includes the administration of standardized developmental instruments utilized for the assessment of behavioral functioning, with interpretation, and report in the following areas:

- Motor skills
- Language skills
- Social skills
- Adaptive skills

- Cognitive functioning

Examples of standardized developmental instruments include the ABS, Vineland, SIB, and others. This does not include standardized measures intellectual functioning such as the WAIS and others. This service is intended for adaptive and maladaptive behavioral assessment only. If this code is billed, the **psychologist must administer the assessment**. If the Service Coordinator administers the ABS, the psychologist may not bill this code.

SITE OF SERVICE

Psychologist's office, individual's home or other applicable community locations

DOCUMENTATION

Documentation must contain the completed interpretation and report, signed by the licensed psychologist. The psychologist license number, place of the evaluation, date of service and time spent must also be included in the documentation.

TRIENNIAL OR ANNUAL EVALUATIONS

This code may be utilized either for the triennial or annual evaluation and is dependent upon the member's needs and the testing conducted by the psychologist.

513.7.16.2.4 Psychological Testing Developmental Testing – Limited with Interpretation and Report

PROCEDURE CODE: 96110-HI

SERVICE UNITS: Event

SERVICE LIMITS: One evaluation annually for children under age 18. Adults are not required to have an annual psychological update unless the condition warrants an evaluation for treatment purposes. Annual psychological evaluations are not required for level of care determination for adults over 18 years of age. Children under the age of 18 are required to submit an annual psychological update for level of care determination

PAYMENT LIMITS: No provider with credentials other than those specified for a psychologist or a psychologist under supervision may perform this service.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective With all annual IPP's conducted on or after November 1, 2006, the services will be selected by the member in conjunction with his/her IDT. The services must be

based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed. Prior approval needed to exceed service limits.

DEFINITION

Developmental testing; limited with interpretation and report is intended for diagnostic screening only. Once a member has a confirmed diagnosis, it is no longer necessary to screen. The psychologist may determine that it is clinically necessary to administer extended developmental testing rather than administer limited testing. The provider may not bill 96110 prior to 96111 nor may the provider bill both codes concurrently. Limited developmental testing is not a screening tool for extended developmental testing. Members may never need this assessment.

Examples: Screening Test II, Early Language Milestone Screening, GARS, with interpretation and report. .If this code is billed, the **psychologist must administer the assessment**.

SITE OF SERVICE

Psychologist's office, individual's home, or other applicable community locations

DOCUMENTATION

Documentation must contain the completed interpretation and report, signed by the licensed psychologist. The psychologist license number, place of the evaluation, date of service and time spent must also be included in the documentation.

TRIENNIAL OR ANNUAL EVALUATIONS

This code may be utilized either for the triennial or annual evaluation and is dependent upon the member's needs and the testing conducted by the psychologist.

513.7.17 SOCIAL HISTORY

PROCEDURE CODE:	Initial Social History	H0031-HI
	Social History Update	H0031-HI-TS
SERVICE UNITS:	Event	
SERVICE LIMITS:	H0031-HI- At the time of enrollment, one comprehensive evaluation per member per provider per lifetime. H0031-HI-TS- Annually	
PAYMENT LIMITS:	The initial social history service must be provided by a Therapeutic Consultant with at least Bachelor's degree in social work from an accredited college and/or WV licensure in social work. The initial social history is required for all new enrollees of the program. An	

annual social history may be performed for evaluation and planning purposes but is not required for the annual determination of level of care (medical eligibility).

A social worker with a temporary license must be supervised by a Master's level, licensed social worker per state social work licensing policies and his/her work must be co-signed by the supervising social worker.

PRIOR AUTHORIZATION: Refer to Sections 513.9, 513.10.1, 513.10.2, 513.11.1 and 513.12.1. Effective with all annual IPP's conducted on or after November 1, 2006; the services will be elected by the member in conjunction with his/her IDT. The services must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member. Services selected must be within the boundaries of the individualized Waiver budget. The ASO will register the selected service(s) with the claims agent. Services not registered with the claims agent will not be reimbursed.

DEFINITION

An initial Social History is performed for the initial comprehensive evaluation and must include:

- Developmental history
- Family history and description of home and family life
- Educational history and achievements
- Functional/life/vocational skills status
- Recreational interests
- History of hospitalizations, and
- Legal status and other relevant information.

Information should also be gathered from the individual or legal guardian on what he/she wants from services with relation to his/her goals for home life, day services, social life and/or other life areas. This service must include a current social information review of historical social information, findings and assessments, recommendations and verification that the data supports such recommendations.

ANNUAL SOCIAL HISTORY

Only the Initial Social History is a requirement at the time of enrollment. Additional social history updates may be completed as indicated by the IPP team members.

SITE OF SERVICE

This service may be performed in the Social worker's office, individual's home or other applicable community location.

DOCUMENTATION

Completion of the Social History (DD-4) dated and signed exclusively by a licensed social worker or a temporary licensed social worker under the supervision of a licensed social worker.

513.8 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

GENERAL REQUIREMENTS

- MR/DD Waiver Program provider agencies must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information; Chapter 300, Provider Participation; and Chapter 800, General Administration of the Provider Manual. This can be found at the BMS Web Site (www.wvdhhr.org/bms).
- MR/DD Waiver Program provider agencies must comply with all other documentation requirements of this chapter.
- All required documentation must be maintained for at least five (5) years in the provider's file subject to review by authorized BMS personnel or contracted agents. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five (5) years whichever is greater.
- All required documentation and records must be available upon request by BMS or federal monitors, or contracted agents for auditing and/or medical review purposes. Record retention must be in accordance with the MR/DD Waiver Record Retention Guidelines as found in Attachment 1.
- Failure to maintain all required documentation and in the manner required by BMS, may result in the disallowance and recovery by BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to BMS upon request.
- Refer to DD 26 - Record Retention Guidelines.

SPECIFIC REQUIREMENTS

MR/DD Waiver Program provider agencies must maintain a specific record for all services received for each MR/DD Waiver Program member including, but not limited to:

- Each Service Coordinator Provider Agency is required to maintain all required MR/DD Waiver documentation on behalf of the State of WV and for state and federal monitors.
- All MR/DD Waiver Program forms as applicable to the policy requirement or service code requirement (forms located in the attachment a the end of the manual in Attachment 1).
- Agencies that wish to computerize any of the forms, DD-1 through DD-13, may do so. However, all basic components must be included and the name/number indicated on the form (refer to Chapter 300 for a description of general requirements for Medicaid record retention and documentation). This can be found on the BMS web site (www.wvdhhr.org/bms).

- All providers of Waiver services must maintain service progress notes, behavioral data collection, and/or attendance records to substantiate that services billed by the MR/DD Waiver Program provider agency were provided on the dates listed and were for the actual amount of time and number of units claimed. Specific documentation requirements are detailed in Section 513.7, Description of Covered Services.
- Day to day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for said service. Monitoring and review of services as related to the IPP or monthly summary (visit) are to be maintained in the service coordination agency record. In the course of monitoring of the IPP and services, the Service Coordinator may review or request specific day to day documentation. All documentation provided must meet the criteria for documentation as indicated in the policy manual such as date, actual time of service and number of units claimed.

513.9 DUAL PROCESSES FOR TRANSITION TO INDIVIDUAL WAIVER BUDGET

The member's current IPP, along with authorizations granted by the BHHF Waiver Department, will be valid until the member's annual IPP or there is a critical juncture of treatment that requires a service to be modified or added.

On November 1, 2006:

- QMRP 1 and/or QMRP 2 will be converted to a Therapeutic Consultant (refer to Section 513.7.11) that includes the Skills Specialist and Behavioral Specialist/Analyst.
- The QMRP 1 and/or QMRP 2 service that were previously utilized for QMRP nursing will be converted to Nursing Services that can only be completed by the RN (refer to Section 513.7.13.1).
- QMRP services utilized for attendance to IDTs will be converted to Individual Program Development (refer to Section 513.7.2).
- QMRP 3 will be converted into an Extended Professional service that includes Registered Dietician, Physical Therapist, Occupational Therapist and Speech Therapist (refer to section 513.7.12).
- Attendance to IDTs by the QMRP 3 will be converted to Individual Program Development (refer to section 513.7.2).
- QMRP 3 Services utilized for mental health conditions will need to be coordinated with the ASO to be transferred to providers of mental health services.
- Units of service for QMRP services previously authorized to the member will be granted for the Therapeutic Consultation services.
- Definitions, provider qualifications, site of service, documentation requirements and service restrictions for procedure codes will be in effect unless otherwise stated.

Beginning November 1 2006, the ASO will be responsible for the granting of prior authorizations at major junctions of treatment and at the time of the IPP.

CHAPTER 513–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES

Beginning July 1, 2006, the Administrative Service Organization (ASO) will conduct the assessments necessary to complete the member's individualized Waiver budget prior to the IPP. Each member will complete the assessment and budgeting process over the course of the year beginning July 1, 2006, and ending October 31, 2007. The assessment and budgeting process must be completed prior to the IPP. The process may be completed prior to the annual IPP. In the event that extenuating circumstances exist which prevents the member from participating in the independent assessment process conducted by the ASO, the current Prior Authorization (for services would continue until such time that the next 90 day quarterly IDT meeting is conducted (Example: IDT team may meet at the next 90 day quarterly meeting if the member is hospitalized).

The Individual Waiver Budget Process is as follows:

- Administrative Service Organization (ASO) provides member education on the process, the available services under the waiver program, available provider agencies in the area, general information on the program and the Individualized Waiver Budget
- ASO conducts an independent assessment in collaboration with the member (and member's legal representative, if applicable). The logistics of scheduling the assessment will be done in collaboration with the member and his/her legal representative if applicable, and the Service Coordinator
- Individualized Waiver Budget is developed by the ASO which is based on the objective assessed needs of the member
- ASO recommends the Individualized Waiver Budget to the Service Coordinator (with the results of the individualized assessments of the member).
- Service Coordinator reviews the budget with the IDT team and the team outlines the services, goals and objectives in the Individual Program Plan (IPP)
- Service Coordinator notifies the ASO of the specific service(s) and units of service(s) for registration with the claims agent
- Once the ASO has registered with the claims agent, the ASO will continue to register all services with the claims agent or respond to emergency requests for service changes that require registration with the claims agent.
- The ASO will monitor health and safety as it relates to requests for service authorizations (Example: Member lives in an ISS setting and cannot administer his/her own medication. The budget does not request nursing nor does the Service Coordinator identify if the home is provided with AMAP certified staff to assist the member with his/her medications)

CHAPTER 513–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES

513.10 PRIOR AUTHORIZATION

Prior authorization requirements governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, Provider Participation of the Provider Manual.

In order to receive payment from BMS, a provider shall comply with all prior authorization requirements. BMS in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

513.10.1 SERVICES REQUIRING PRIOR AUTHORIZATION

All services provided within the Title XIX MR/DD Waiver program must be registered with the ASO. The following services must be prior authorized before a member may receive the service or provider may bill:

- Exceeding the individual budget, **as assigned** by the ASO
- Exceeding of service limits or exceptions to service
- Waiver Nursing services that can be performed by a LPN (T1003 HI U4/U3/U2) **in excess of 248 units per month**
- Community Residential Habilitation in excess of 496 units per month with a maximum of 744 units per month
- Transportation in excess of 700 miles per month with a maximum of 1300 miles per month
- Respite in a general medical hospital (may not be provided in a psychiatric hospital or an acute care hospital with a distinct part psychiatric unit)
- In- home Day Habilitation
- Environmental Accessibility Adaptations
- Crisis Services

Prior authorization must be received from the ASO for any special requests for exceeding service caps, monthly ICF-MR cost, or service limits. Services provided without a prior authorization may not be billed and are subject to disallowance. In the event of an emergency after hours or on a weekend that constitutes a medical need for a service, the service may be offered. However, authorization must be obtained the next working day. Staffing in excess of 1:1 ratio cannot be considered except for Crisis Services.

513.10.2 SERVICE REGISTRATION/PRIOR AUTHORIZATION PROCESS

All services provided within the Title XIX MR/DD Waiver program must be registered through the Administrative Service Organization. Services requiring prior authorization (refer to Section 513.10.1) must be submitted to the ASO within 10 working days of the IPP meeting at which the services were chosen.

The Service Coordinator is responsible for ensuring that all **service registrations/** prior authorizations for all chosen providers are forwarded to the ASO. This process should be addressed during the Interdisciplinary Team Meeting.

513.11 SERVICE LIMITATIONS

Service limitations governing the provision of all WV Medicaid services will apply pursuant to Chapter 300, Provider Participation, of the Provider Manual and Section 513.2 of this chapter. In addition, the following limitations also apply to the requirements for payment of medically necessary and medically appropriate MR/DD Waiver Program Services described in this chapter.

- The MR/DD Waiver Program is designed to support individuals with mental retardation and/or developmental disabilities in their local communities. The program offers an alternative to placement in an ICF/MR facility.
- MR/DD Waiver services may be provided out-of-state to participants residing in border counties of the state of West Virginia. The out-of-state services provided must be located within thirty (30) miles of the West Virginia border. The service is made available with the following limitations:
  - All participants must live in West Virginia;
  - All MR/DD Waiver regulations and policies must be followed in the provision of the services. This includes the requirement that all providers be West Virginia licensed or certified as necessary;
  - The services provided must conform with the stated goals and objectives on the member's IPP; and
  - Individual Member budgets or limitations described in this manual must be followed

513.11.1 SERVICE EXCLUSIONS

In addition to the exclusions listed in Chapter 100, General Information, of the Provider Manual, BMS will not pay for the following services:

- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).

- Residential Habilitation payments may not be made for room and board or the cost of facility maintenance and upkeep
- Birth to Three services paid for by Medicaid for children enrolled in the MR/DD Waiver program
- MR/DD Waiver services may not be provided concurrently unless otherwise indicated in the service definition. For example Residential Habilitation services may not be provided concurrently with the individual's Day Habilitation Program, School services or Respite Care services.
- Personal care is not a habilitation service and may not be billed as such. (Personal Care is assistance in the form of hands-on assistance, as in actually performing a personal care task for the member such as personal hygiene, dressing feeding, nutrition, environmental support functions, and health-related tasks for the person).
- MR/DD Waiver services are not part of the Health Maintenance Organization's (HMO's) responsibility for coverage. They do not require Physician Assured Access System (PAAS) approval. MR/DD Waiver services provided must follow the guidelines set forth in this manual

513.11.2 MOUNTAIN HEALTH CHOICES

Members on the MR/DD Waiver program cannot be a member of the Mountain Health Choices program at this time.

513.12 BILLING PROCEDURES

Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement the amount of time documented in minutes must be totaled and divided by the minutes in a unit of service to arrive at the number of units billed. After arriving at the number of billable units, billing should take place on the last date in the service range. Billing cannot be rounded more than once within a calendar month. **The billing period can not overlap calendar months. Scheduled activities may not be rounded (e.g., Day Habilitation, Residential Habilitation, etc.)**

- MR/DD Waiver Program provider agencies must bill all third party liabilities such as a member's private insurance for those services that are covered by both private insurance and the Medicaid waiver program prior to billing Medicaid. Medicaid is considered a secondary insurance to an individual's private insurance.
- Claims will not be honored for services (inclusive of service code definitions) provided outside of the scope of Chapter 513 of the MR/DD Waiver policy manual or outside of the scope of federal regulations.

CHAPTER 513–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR MR/DD WAIVER SERVICES

513.12.1 PAYMENT AND LIMITATIONS PAYMENT

MR/DD Waiver Program providers must comply with the payment and billing procedures and requirements described in Chapter 600, Reimbursement of the Provider Manual.

Reimbursement via the Resource Based Relative Scale (RBRVS) is described in Chapter 600. CPT codes referenced in this manual are reimbursed by using the Resource Based Relative Scale (RBRVS). RBRVS rates are subject to change on an annual basis. It is also necessary to include a location code for CPT codes.

PAYMENT LIMITATIONS

- Medicaid is the payer of last resort. Therefore, private insurance must be billed first for those services covered by both private insurance and Medicaid. The Service Coordinator must inform the member, his/her family and/or his/her legal representative of this requirement.
- MR/DD Waiver services may not be charged while an individual is receiving services as an inpatient in a hospital, nursing facility or ICF/MR. As an exception, while a member is inpatient in a non-state operated hospital, the member may receive respite services when the member requires a support staff that is familiar with the member's individualized needs provided the service is not duplicated by the hospital. This service requires approval by the ASO.
- No services may be charged prior to an applicant's discharge from an ICF/MR or state institution. The only exception is Service Coordination and training to support staff provided by a Therapeutic Consultant, which may be billed starting 30 days prior to discharge. Allowable activities for the Therapeutic Consultant are assessment, evaluation, habilitation plan development, or behavioral support plan development, and training of direct support staff assigned to provide services at the time of discharge. The State MR/DD Waiver Coordinator must be notified of the actual date on which an applicant is discharged from an ICF/MR or state institution and begins to receive MR/DD Waiver services.
- Services provided during the initial evaluation process for completion of the application packet, such as Evaluations and Service Coordination, may be billed when the following criteria is present:
  - An allocation (*slot*) is available to the member
  - The psychological evaluation is within 90 days
  - The IPP is current and includes the services
  - The member is both medically and financially eligible
  - The date of service is not before the initial date of eligibility on the Medical card
- Ongoing services such as residential habilitation or day habilitation may be billed when the following criteria is in place:
  - An allocation *(slot)* is available to the member
  - Medical and financial eligibility are confirmed

- Medically necessary assessments have been completed and indicate a medical necessity for the service
- Services requiring a prior authorization have been prior authorized before the provision of service or submission of claims for said service.
- Registration by the ASO.

513.13 HOW TO OBTAIN INFORMATION

For information concerning procedure codes and diagnosis codes, refer to Chapter 100, General Information. In addition forms utilized by the waiver program may be located in Attachment 1.

513.14 ATTACHMENT 1: MR/DD WAIVER DOCUMENTS

The MR/DD Waiver Forms are as follows:

- DD-2A Annual Medical Evaluation
- DD-3 Comprehensive Psychological Evaluation
- DD-4 Social History
- DD-5A Initial Individual Program Plan
- DD-5 Individual Program Plan
- DD-7 Informed Consent (Choice of ICF/MR and MR/DD Waiver)
- DD-7A Informed Consent (Choice of Providers and Services)
- DD-9 Monthly Home Visit Report
- DD-9A Day Habilitation Visit Report
- DD-12 Documentation - Monthly Progress Report
- DD-13 Certification of Training for Habilitation Providers
- DD-14 Application
- DD-16 Member Exit/Transfer
- DD-17 Therapeutic Consultant Credentialing Form
- DD-19 Environmental Accessibility Adaptations Form
- DD-20 Mortality Notification
- DD-24 Request For Nursing
- DD-25 Extra-ordinary Care Instrument
- DD-26 Record Retention and Storage