

Dear Participant, Parent, Provider, or Advocate:

The Bureau for Medical Services (BMS), commonly known as Medicaid, is in the process of updating the current Title XIX MR/DD Waiver Manual to comply with the Waiver renewal granted by the Centers of Medicare and Medicaid (CMS), the federal agency who has oversight for the program.

Over the last several weeks a workgroup of stakeholders from the Quality Assurance and Improvement Advisory Council, along with MR/DD Waiver, APS Healthcare, and BMS staff have been working on a draft of the manual. The next step we want to take is to make the working draft of the manual available to stakeholders around the state to get gather additional input. Once the working draft of the manual is completed, it will be published on the BMS web site for a thirty day comment period. Once the comment period is completed and all comments are considered, the manual will be finalized. At this point, it will become official policy for the MR/DD Waiver Program.

We have scheduled the following dates, times, and locations for individuals to provide input.

December 15th 9: 00 am – 12:00 pm and 1:00 pm – 3:00 pm
Kanawha County DHHR, 4190 Washington St. East Conference Room a, Charleston

December 19th 9:00 am – 12: 00 pm and 1:00 pm – 3:00 pm
Mountain .State University @ Frederick Room, 214 Viking Way, Suite 208, Martinsburg

December 20th 9:00 am – 12:00 pm and 1:00 pm – 3:00 pm
Ohio County DHHR, 407 Main Street, Wheeling

December 21th 9:00 am – 12: 00 pm and 1:00 pm – 3:00 pm
Nicholas County Senior Center , 800 Valentine Rd., Summersville

In the event that you cannot attend one of the above meetings, please submit your request in writing either by sending them to ATTN: Tiffany Fooce, Bureau for Behavioral Health and Health Facilities (BHBF), 350 Capitol Street, Room350, Charleston, WV 25301, faxing them to 558 -1008 or emailing to TiffanyFooce@wvdhhr.org. You may also submit your comments to Tiffany Fooce via telephone 304-558-3742.

We very much appreciate your time and consideration. If you have any questions, please call Tiffany Fooce at (304) 558-3742.



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PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

Introduction	Section	Changes
Introduction	500	None
Definitions	501	IPP, Legally Responsible Adult, Specialized Family Care Provider MR/DD Waiver Program
Provider Participation	502	Language to include role of APS Healthcare, Inc.
General	502.1	Added CON, State Licensure Requirements, Added specificity to BMS enrollment requirements
Specific Requirements	502.2	Pre-Vocational Services – Added specificity Responsibilities for Agency Administration and Agency Contact Person
Reporting Requirements	502.3	Added cased load size for service coordinator – Added specificity to Changes in Status
Documentation and Record Retention	502.4	Added BMS Web Site Address
Service Limitations	502.5	Added specificity to services that involve distances greater than 30 miles from border
Service Exclusions	502.6	Added language from WV State Code §44A1-8(a). – Court appointed guardian cannot be reimbursed for services
Member Eligibility	503	Added 4 th step to member eligibility
Application	503.1	Date application process begins Change in content of requirements for Initial Application Packet Added definitions for Major Life Areas Added Specificity to Medical Eligibility Criteria
Financial	503.2	Re-worded for better clarity
Service Allocation Approval	503.3	Re-worded for better clarity
Re-determination	504	Change in content requirements for Initial Application Packet
Rights of Members	505	Re-worded for better clarity
Member Discharge	506	Added member needs to sign for termination from MR/DD Waiver Program
Right to Appeal	507	Re-worded for better clarity Change in content if decision is upheld by



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Introduction	Section	Changes
		Hearing Officer Member needs to give permission to appeal
Reporting Alleged Abuse and Neglect	508	Re-worded for better clarity
NEW SECTION – Dual Processes for Transition to Individual Waiver Budget	509	Each member will continue to operate under their current IPP where prior authorizations agree granted by the Bureau for Behavioral Health and Health Facilities (BHBF). APS Health Care, Inc. will begin their role 07-01-2006 and complete the first year by 06-30-2007. When a member’s IPP is completed after 07-01-2006 they will no longer access their authorization through BHBF.
Prior Authorization	509.1	Changed from 509 – No changes
Services Requiring Prior Authorization	509.2	Beginning with member next IPP, (after April 1, 2004) Community Residential Habilitation services must meet the guidelines for “extraordinary” level of care. Any excess of four (4) hours per day must be approved by BHBF -
Prior Authorization Process	509.3	BHBF roles for each member will continue until APS Healthcare, Inc’s process is fully implemented for each member – Effective After July 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 AOS will register the service(s) with the claims agent.
Interdisciplinary Team (IDT) Composition	510	Changes in Content of who IDT Composition Specificity in reasons IPP can be rescheduled
Billing Procedures	512	Added specificity
Payment and Limitations	512.1	
Description of Covered Services	513	No change
Service Coordination	513.1	Prior Authorization Language Re-worded for clarity Added Specificity
Residential Habilitation	513.2	



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Introduction	Section	Changes
Community Residential Habilitation	513.2.1	<p>Prior Authorization</p> <p>Addition – legally responsible adults may only be reimbursed for services that have been identified as necessary in the Extraordinary Care Assessment</p> <p>Effective April 1, 2006 activities need to take place in neighborhood where member resides</p>
Agency Residential Habilitation	513.2.2	<p>Prior Authorization</p> <p>Addition : A member who has a legally responsible adult may only receive services that have been identified as necessary in the Extraordinary Care Assessment</p> <p>Effective April 1, 2006 activities need to take place in neighborhood where member resides</p>
Adult Companion Services	513.3	<p>Prior Authorization</p> <p>Added ratios</p> <p>Effective April 1, 2006 activities need to take place in neighborhood where member resides</p>
Annual Medical Evaluation Extended Physician Services	513.4	Prior Authorization
Psychiatric Diagnostic Interview Examination – 90801	513.5	NEW: To be utilized with a new member – includes a history, mental status, and a disposition, and may include communication with family or other sources. This
Psychological testing with interpretation and report 96100	513.6	NEW: utilized for triennial – can utilized either this code or 96111 (Developmental Testing – extended)
Psychological testing – Developmental Testing – Extended with interpretation and report 96111	513.7	Utilized for triennial – can utilized either this code or 96100 (Psychological Testing)
Psychological testing – Developmental Testing – Limited with interpretation and report 96110	513.8	NEW: Utilized for annual updates only; replaces QMRP III service. 96100 and 96111 need to be used for triennials
Initial Social History	513.9	<p>Previously 513.7</p> <p>Prior Authorization</p> <p>Change – Not a requirement for Initial Medical Eligibility – Is done at time of</p>



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Introduction	Section	Changes
		enrollment.
QMRP Services	513.10	<p>Previously 513.8</p> <p>Prior Authorization</p> <p>QMRP is replaced by specific Specialty area</p> <p>Skills development Specialist *</p> <p>Positive Behavioral Support Specialist*</p> <p>(each member will either have one Skills Development Specialist or Behavioral Support Specialist (not both))</p> <p>Positive Behavioral Support Specialist – more specificity for role.</p> <p>Professional Services (O.T., P.T., S.T. and R.D)</p>
Day Habilitation Services	513.11	<p>Previously 513.9</p> <p>Prior Authorization</p> <p>Ratio 1:1, 1:2,; 1:3, and 1:4</p> <p>Effective April 1, 2006 activities need to take place in neighborhood where member resides</p>
Pre Vocational Training	513.12	<p>Previously 513.10</p> <p>Prior Authorization</p> <p>Changes in language of Referral to DRS</p>
Supported Employment	513.13	<p>Previously 513.11</p> <p>Prior Authorization</p> <p>Changes in language of Referral to DRS</p>
Transportation	513.14	<p>Previously 513.12</p> <p>Prior Authorization</p> <p>Specificity – Must be directly linked to an IPP goal or objective or a medical service (addressed on the IPP)</p> <p>Effective April 1, 2006 activities need to take place in neighborhood where member resides</p> <p>Re-worded for clarity -</p>
Respite Care	513.15	<p>Previously 513.13</p> <p>Prior Authorization</p>



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Introduction	Section	Changes
		Added ratios
Nursing	513.16	Previously 513.14 Involved Nursing Previously 513.15 Intermittent Nursing Change back to one code – Will re-visit this in March 2006. We are still working out logistics re: State plan services for individuals age 21 and under.
Environmental Accessibility Adaptation	513.17	Previously 513.16 Prior Authorization
Crisis Services	513.18	NEW CODE
Individual Program Plan Development (IPP)	513.19	NEW CODE Separate out from QMRP, etc. Will have own code for attendance to IPP meetings.
Training	513.20	Separated into on section

CHAPTER 500–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS, FOR DRAFT 12/05/05 MR/DD WAIVER SERVICES

500 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).



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This chapter sets forth the BMS requirements for payment of services provided to eligible WV Medicaid members under the Waiver Program for Mentally Retarded and Developmentally Disabled persons.

The policies and procedures set forth herein are the regulations governing the provision of services under the Waiver Program for Mentally Retarded and Developmentally Disabled Persons (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.

501 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 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) -: 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 bowel and bladder control.

Individual Program Plan (IPP) is an outline of proposed activities that primarily focus on establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and assistance needed by persons with developmental disabilities and their families. It is designed to ensure accessibility, accountability, and continuity of support and services. This service also ensures that persons with developmental disabilities have opportunities to make meaningful choices with regard to their life, and inclusion in the community. The IPP (DD-5 – version 04-01-2006) is the critical document that combines all information from the evaluations to guide the service delivery process. The completion of the IPP must be a joint effort among all parties involved in the member's life.

Interdisciplinary Team (IDT) is a group of professionals, paraprofessional, and non-professionals who possess the knowledge, skill, and expertise necessary to accurately identify the comprehensive array of services required to meet the individual's needs and design appropriate services and specialized programs responsive to those needs.

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

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

Psychologist under Supervision for Licensure is an individual who:



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- 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.
- Has met the requirements of, and is formally enrolled in, the WV Board of Examiners of Psychologists Supervision Program

Qualified Mental Retardation Professional (QMRP) Each member's active treatment program must be incorporated into the IPP, coordinated, and monitored by a qualified mental retardation professional who meets the qualifications set forth in Title 42, Chapter IV, Part 483.430 (a) of the Code of Federal Regulations (CFR). Additional qualifications may be necessary dependent upon the member's assessed need. The QMRP provides training to the direct provider on implementation of IPP goals and objectives.

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 Mentally Retarded and Developmentally Disabled Persons (MR/DD Waiver Program) is WV's home and community-based services program for individuals who have mental retardation and or developmental disabilities, administered by BMS in collaboration with OBHS pursuant to a Medicaid waiver option approved by the Center for Medicare and Medicaid Services (CMS). 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 (such as the local neighborhood shopping entities, banks, libraries, etc), homes and local communities where the member resides instead of Intermediate Care Facility/Mental Retardation (ICF/MRs).

502 PROVIDER PARTICIPATION

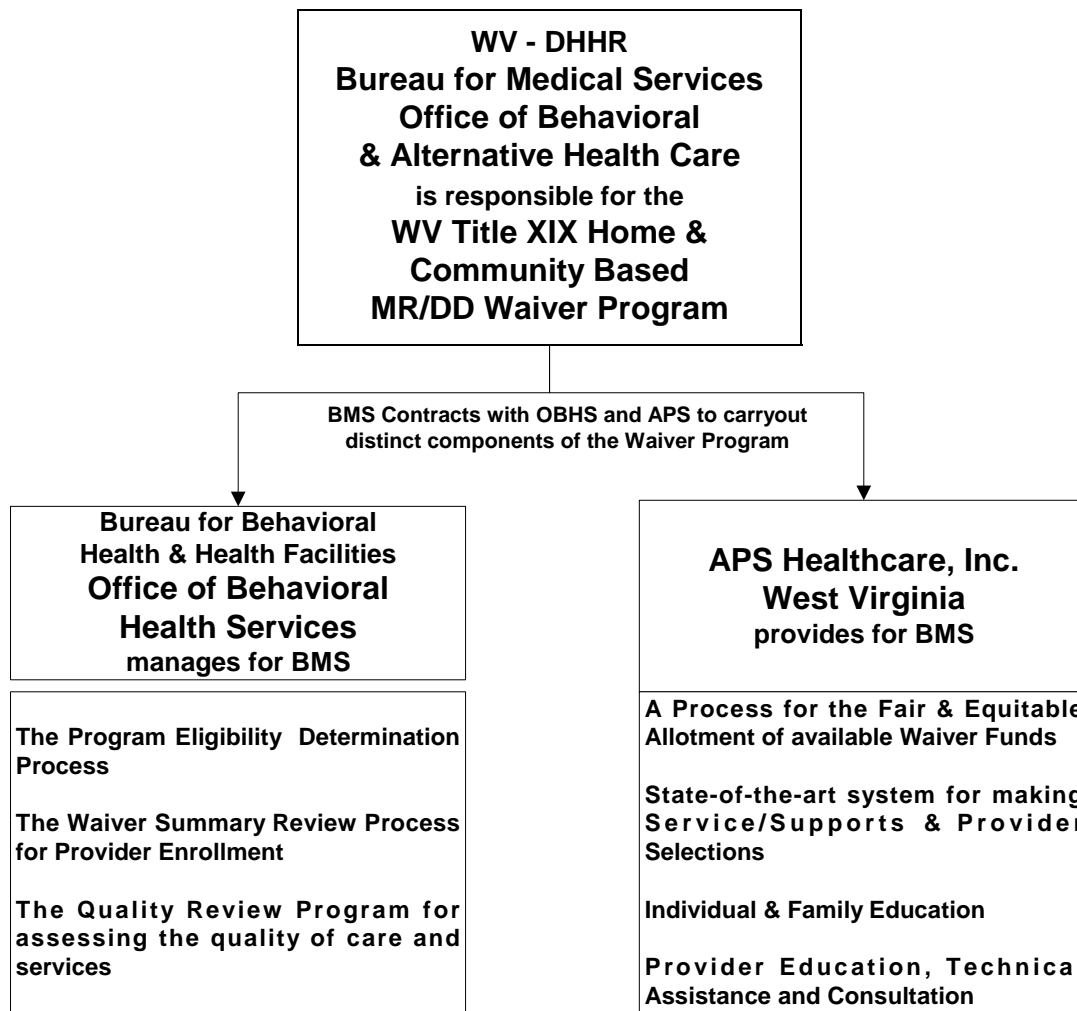
Acting as the agent of BMS, BHHF administers the operations of the MR/DD Waiver Program. BMS contracts with an Administrative Services Organization and the Bureau for Behavioral Health and Health Facilities (BHHF). They both act as an agent of the Bureau for Medical Services. BHHF administers the operation of the MR/DD Waiver Program. The Administrative Service Organization will conduct training for providers, consumers, advocacy groups, and DHHR. APS will provide a framework and a process for the purchase of waiver services based on assessed needs and will provide service registration information to claims payer. BMS contracts with community behavioral health provider agencies for the provision of services for program members.



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502.1 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:

- Meet and maintain all applicable licensing, accreditation, and certification requirements
- Receive Certificate of Need approval from the WV Health Care Authority and/or CON Summary Review Committee
- Obtain a behavioral health license through the Office of Facility Health, License, 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.

502.2 SPECIFIC REQUIREMENTS



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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). In addition, they must have full behavioral health license issued by Office of Health Facility Licensure and Certification (OHFLAC). **Prevocational services and supported employment entities acknowledged by a Division of Rehabilitation Services vendor prior to February 1, 2006 will be granted a grandfather status.**
- Ensure that the service was delivered and documentation meets 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 qualified professionals
 - The agency is 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
 - Annual Level of Care evaluations and submission to the State for Level of Care determination (medical eligibility)
 - 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 QMRP providers as referenced in **513.10**

502.3 REPORTING REQUIREMENTS

- Quarterly Incident Report Summaries must be submitted to OBHS within the following time-frames:
 1. January 1 through March 31. Report due to the State by April 15
 2. April 1 through June 30. Report due to the State by July 15
 3. July 1 through September 30. Report due to the State by October 15
 4. October 1 through December 31. Report due to the State by January 15.



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- Member Exit/Transfer Form (DD-16). The DD-16 must include the last date of service provided.
- Mortality Notification (DD-20)
- The Service Coordination Agency must notify the State MR/DD Waiver Office in writing, if they are exceeding the maximum caseload cap. The Service Coordination Agency must put the following in writing within 48 hours:
 - The number of members per each Service Coordinator whose caseload 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.
- Changes in status (change of address, telephone number, service coordination provider, habilitation provider, etc)

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 700, General Administration of the Provider Manual. This can be found on the Bureau for Medical Services 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 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 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 the 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.

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 are included in Attachment 1 of this manual.



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- 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 Bureau for Medical Services 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, 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

502.5 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 516 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. The out-of state services provided must be located within thirty (30) miles of the West Virginia border. This applies to all situations that involve distances greater than the thirty (30) miles of the West Virginia border. The service is made available with the following limitations:
 - A. All participants must live in West Virginia;
 - B. 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;
 - C. The services provided must conform with the stated goals and objectives on the member's IPP; and
 - D. Individual Member budgets or limitations described in this manual.

502.6 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:



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- 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
- 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.
- Court Appointed Guardian cannot be reimbursed for service pursuant to West Virginia Code §44A1-8(a) (under research)
- Legally Responsible Adult cannot be reimbursed for services except for Community Residential Habilitation Services that are considered “extra-ordinary”.

503 MEMBER ELIGIBILITY

The member eligibility and enrollment process consists of four steps:

- FIRST STEP: Medical Eligibility
- SECOND STEP: Notification of Available Allocation
- THIRD STEP: Financial Eligibility
- FOURTH STEP: Member Enrollment (Waiver allocation)

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). Medical eligibility is determined by submitting an application packet to BMS for member consideration. Once medical eligibility is established, members make application at the local Department of Health & Human Resource office for assessment of financial eligibility.

503.1 APPLICATION

- A member may obtain an application information packet from: Local Behavioral Health Centers, Local/County Department of Health & Human Resource Office or the State MR/DD Waiver Office.
- 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.



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- 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. 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).
- Once the applicant completes the DD-14, he/she will submit the DD-14 to the selected MR/DD Waiver provider agency.
- 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.
- A 45 day 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 service needs. The Service Coordinator is responsible for arranging the assessments and compiling the required documentation for the full application packet. Then the Service Coordinator is responsible for submitting the full application packet to the State MR/DD Waiver office within the mandatory time lines. 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-2)
 - A completed triennial Psychological Evaluation (DD-3)
 - A completed Social History (DD-4) (if available)
 - IEP, **psycho-educational assessment** for school-age children
 - Birth to Three assessments, if applicable
 - **If not indicated in the documents listed above, verification 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.**



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- Any other documentation or information the provider agency or the applicant indicates as pertinent to determine eligibility

The Annual Medical Evaluation (DD-2), 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.

- The State MR/DD Waiver office will make a final eligibility determination within 45 days.
- An eligible applicant will be enrolled into the Waiver program once the allocation 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 Criteria

BMS determine 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 24 hour supervision, training, and supports.
 - BMS determines the level of care based on the Annual Medical Evaluation (DD-2A), the Psychological Evaluation (DD-3), IEP and psycho-educational assessment for school age children, birth to three assessments if applicable, verification if not indicated in other 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, and other documents as requested.

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.

Medical Eligibility Criteria: Diagnosis

Diagnosis

- Must have a diagnosis of mental retardation, in conjunction with 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.



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- 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
 - Tuberos Sclerosis
- Additionally, 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.

The diagnosis of mental retardation must cause the presence of a least three (3) substantial deficits as that term is defined in Title 42, Chapter IV, Part 435.1009 of the Code of Federal Regulations (CFR). Substantial deficits associated with a diagnosis other than mental retardation or a related diagnosis do not meet eligibility criteria. Additionally, an individual diagnosed with mild mental retardation or an eligible related condition needing only personal care services does not meet the eligibility criteria. Individuals diagnosed with mental illness must provide clinical verification through the appropriate eligibility documentation that their mental illness is not the primary cause of their substantial deficits.

Functionality

- Substantially limited functioning in three or more of the following major life areas: (Substantial limits is defined on standardized measures of adaptive behavior scores as three (3) standard deviations below the mean or less than 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 by all of the documentation submitted for review, i.e., the IEP, Occupational Therapy evaluation, narrative descriptions, etc.)
 - Self-care- refers to basic activities such as dressing, toileting, feeding, bathing, and simple meal preparation..
 - Receptive or expressive language (communication) - refers to the ability to communicate by any means whether verbal, nonverbal/gestures, or assistive devices.



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- Learning (functional academics)- A general cognitive competence and ability to acquire new behaviors, perceptions and information; applying experience to new situations.
- Mobility- refers to the ability to use fine and gross motor skills; the ability to move one's person from one place to another with or without mechanical aids
- Self-direction- refers to the ability to make choices and initiate activities, the ability to choose an active life style or remain passive, and the ability to engage in or demonstrate an interest in preferred activities.
- Capacity for independent living)- encompasses the ability to perform routine household chores, exhibit social skills, understand basic first aid and emergency response, appreciate danger, make use of community services, shop for necessary items, and engage in leisure activities, ability to engage in work activity as age-appropriate

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 and 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 must 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 (Informed Consent, DD-7).

503.2 FINANCIAL

- The applicant or legal representative may make an application. However, it is the responsibility of the Service Coordinator to see that the initial application is made. Written notification of medical eligibility for the MR/DD Waiver Program must be presented to the local/county Department of Health and Human Resources (DHHR) 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 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



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An **Economic Service Worker** in the DHHR office in the county/**local area** where the individual resides determines financial eligibility. In order to be eligible to receive MR/DD Waiver Program Services, an 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 assests is considered for determination**

503.3 SERVICE ALLOCATION (**Slot**) APPROVAL

In order to be eligible to receive MR/DD Waiver Program Services, an applicant must be approved for a Waiver allocation (slot).

Service Allocation (**Slot**) Criteria

- BMS determines the number of allocations based on the total number of allocations available for the current fiscal year. The number of individuals to be served and the average cost of services per individual are established using formulas developed by BMS and CMS.

Service Allocation (**Slot**) Referral and Selection Process

- Allocation is based on chronological order by date of State receipt of the Initial Application Packet.
- Members receiving a medical eligibility decision as the result of a Medicaid Fair Hearing will be granted an allocation (*slot*) effective on the date of the fair hearing decision.

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:

- 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 application for financial eligibility at the local/county DHHR office**



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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 must:

- 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 managed care program.

504 RE-DETERMINATION

The member must meet medical eligibility on an annual basis, thus re-determination of medical eligibility must be completed annually. Date of medical eligibility is the date the annual medical evaluation (DD-2) was signed.

Annual Re-certification Application Packet

At minimum, the Annual Medical Evaluation (DD-2), and the most current Psychological Evaluation (DD-3) must be submitted. Any other documents/information the agency/applicant deems is pertinent for re-determination may be submitted.

- For adults age 18 and older, a comprehensive psychological is required triennially (once per three year intervals). An adaptive functioning assessment must be a part of the psychological.
- For children under the age 18 years of age, a comprehensive psychological evaluation is required triennially while a psychological update is required annually. An adaptive functioning assessment (exclusive of the ICAP) must be a part of the triennial psychological and the annual update of the psychological.

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

As per contract agreement, the agencies are responsible to provide all services outlined in the IPP until certification is re-established. Providers may not provide nor submit claims for services provided after the date of the annual re-certification and financial eligibility when the member or the provider agency has failed to seek and receive re-certification or determination of financial eligibility.

Once the annual re-certification packet is received by the State MR/DD Waiver office, then:

- The required evaluations (DD-2, DD-3, etc) are reviewed by BMS. If indicated, additional information may be requested as needed in order to determine recertification.
- BMS sends a memorandum to the member's local Department of Health & Human Resources Economic Service (ES) Worker informing him/her of re-certification. The ES Worker is then authorized to review the member for financial eligibility for services.



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- A copy of the memorandum is also sent to the member and the Service Coordination provider agency. This memorandum includes the member's effective date of recertification of medical eligibility.

Failure to submit the Annual Re-certification Application packet to the MR/DD Waiver office located at 350 Capitol Street, Room 350, Charleston, WV 25301 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 Medical Card through the West Virginia DHHR (Medicaid coverage).

505 RIGHTS OF MEMBERS

- Members have a right to appeal an Individual Program Plan (IPP).
- Members have a right to appeal a denial of 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 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.
- 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-7).
- Members have the right to choose a provider agency or agencies. Member choice must be verified on the DD-7A.

506 MEMBER DISCHARGE

An individual will be discharged from the MR/DD Waiver Program under the following conditions:

- An individual's income or assets exceed the limits specified in Section 504.5 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 evaluations, which are used by the MR/DD Waiver Program to determine an individual's level of care (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 Program office will notify the individual of termination of services and of their right to appeal.



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- An individual and/or his/her legal representative choose to terminate Waiver services. The Service Coordination provider agency must request the individual and/or legal representative complete 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 individual to the new services. A copy of the DD-7 and the Exit/Transfer from (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 individual 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 guardian.**
- Any time an individual loses eligibility for, or chooses to leave, the MR/DD Waiver Program, both the local Department of Health & Human Resource office and the State MR/DD Waiver Program office must be informed of the date of the individual's discharge from MR/DD Waiver services. The termination of MR/DD Waiver services may be appealed through the appeals process outlined on Section 507 of this chapter.

507 RIGHT TO APPEAL

If an applicant is determined not 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. The decision/denial may be appealed through the fair hearing process.

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

- 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 Bureau for Medical Services, Board of Review, Bldg 6 Room 817B, State Capitol Complex, Charleston, WV 25305. BMS will arrange a hearing to resolve the matter.
- 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. Attachment 1 contains a copy of the Statement of Rights. The Statement of Rights was developed pursuant to the Benjamin H. vs. Secretary Joan Ohl class action suit.
- If MR/DD Waiver services are terminated or reduced by the State (BMS and/or the MR/DD Waiver office), the individual 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.
- Ninety (90) days shall be afforded to request a hearing after a Notice of Decision has been received. Any recipient 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.
- If services are terminated by the State, and a hearing is requested, services will continue until the hearing is held. 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



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continue to receive services in the interim. **Services are not continued while petitioning appellate court.**

- Any applicant 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 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.
- The applicant shall have the right to access their **waiver application** file and copies shall be provided free of charge **by BHHF**.
- DHHR will assist in arranging transportation to the hearing, if needed.
- If denied, the applicant may request a second medical evaluation and submit the evaluation to the State Waiver Office and the assigned hearing officer. Any additional documents pertinent to the condition affecting eligibility may be submitted 10 working days prior to the hearing.
- **If a decision for termination is upheld by the Hearing Officer, a period of not more than 90 days from the date of the hearing will be allowed for transition discharge services. Only Targeted Case Management may be billed during this time if the member is eligible for Medicaid. Plans for discharge need to begin immediately upon receipt of certified letter.**
- **Upon notice of denial, the service coordinator must arrange for an emergency IDT meeting to develop a “back-up” plan for transition.**
- **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 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, the IPP can be implemented without any changes as prepared. **If a team member other than the participant wishes to appeal, permission must be obtained from the participant and/or their legal guardian in order to initiate the appeal process.**
- 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. 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 the Bureau for Medical Services, c/o Board of Review, State Capitol Complex, Bldg 6, Room 817B, Charleston, WV 25305. BMS will arrange 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.**



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Appeal of an Individualized Budget:

- 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 (Refer to 507, Appeal of an Individual Program Plan, IPP).
- Based upon clinical need, the member may contact the ASO to re-negotiate the Individual Waiver Budget.
- If MR/DD Waiver services are terminated or reduced by the State (BMS and/or the MR/DD Waiver Office), the termination and/or reduction of services may be appealed through the fair hearing process (Refer to 507, Appeal of a Denial).

508 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 State Law (Title 64 Series 11) and State Code (Chapter 9, Article 6) to report the incident to:

- 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.
- OHFLAC may also be contacted at (304) 558-0050 to assist with referring the report to the proper authorities.

509 DUAL PROCESSES FOR TRANSITION TO INDIVIDUAL WAIVER BUDGET

The current prior authorization process (Sections 509.1, 509.2, 509.3) will be in place until which time the member has been granted their individualized waiver budget by APS Health care and the Interdisciplinary Team meets to develop the Individual Program Plan. The prior authorization process will no longer be needed after 06/30/2007.

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 June 30, 2007. The assessment and budgeting process must be completed prior the IPP. The process may be completed prior to the annual IPP or the 6 month IPP review. In the event that extenuating circumstances exist which prevents the member from participating in the independent assessment process conducted by the ASO, the current PA 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, available provider agencies in the area, general information, and the Individualized Waiver Budget



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- ASO conducts an independent assessment in collaboration with the member (and member's legal representative, if applicable)
- Individualized Waiver Budget is developed in collaboration with the member (and member's legal representative, if applicable)
- ASO recommends the Individualized Waiver Budget to the Service Coordinator
- 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. BHHF will not provide a prior authorization for services beyond this point.

509.1 PRIOR AUTHORIZATION (BHFF)

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.

509.2 SERVICES REQUIRING PRIOR AUTHORIZATION (BHFF)

The following services must be prior authorized at the state level before a member may receive the service or a provider may bill:

- Exceeding the monthly ICF/MR cost of \$6,400
- Waiver Nursing services (all)
- Exceeding of service limits or exceptions to service.
- Community Residential Habilitation in excess of four (4) hours per day with a maximum of six (6) hours per day.

The completed Waiver Integrated Summary (DD-1A) must be submitted to the state for approval of any special requests for exceeding service caps or limits. Services provided without a state issued prior authorization cannot be billed and are subject to non-reimbursable services.

509.3 PRIOR AUTHORIZATION PROCESS (BHFF)

In order to obtain prior authorization (PA) for MR/DD Waiver Program Services, MR/DD Waiver program provider agencies must:

- Submit prior authorization requests on the Waiver Integrated Summary (DD-1A)



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- Prior authorization requests are to be submitted no less than 10 working days prior to the provision of services. If further clarification of a request is required by the prior authorization review team, the implementation date of the prior authorization may go back to the original date indicated for service provision on the prior authorization request.
- No prior authorization will be retroactive when received after the provision of services, or if the PA request is **not** submitted at least ten (10) working days prior to the provision of services.

510 INTERDISCIPLINARY TEAM (IDT) COMPOSITION

At a minimum, the annual IDT consists of:

- The member
- His/her family and/or legal guardian
- A physician or registered nurse is required if the member is receiving skilled nursing services on the Waiver Program **or if the person has a medical need.**
- A psychologist when the member has the need for specialized psychological evaluation and intervention due to co-existing mental health disorders or behavioral challenges are present.
- A service coordinator.
- **Representatives of all agencies/providers who provide services to the individual**
- Other members of the IDT must be included, as necessary, to develop a comprehensive IPP and assist the individual. **At least one member of the team must be a QMRP.** Such members may include:
 - Professionals, such as Physical Therapist, Occupational Therapist, Speech Therapist, etc.
 - Paraprofessionals
 - Direct service providers, such as Day Habilitation Program providers, Residential Habilitation providers, and counselor
 - Service providers from other systems such as the local education agency/public schools, DRS, or Birth to Three
 - Family Based Care Specialist (when applicable)
 - Advocate (when applicable), and
 - Involved parties such as friends, extended family, the representative payee, and the individual's significant other.

Attendance **at the IDT meeting** is extremely important. **The IDT should only be rescheduled for extenuating circumstances such as death in the family, hospitalization, or major illness.** **If the IDT meeting occurs after the end-date on the IPP, services may not be reimbursed.** **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.**

Team members may participate in the Interdisciplinary team through video conferencing. Teleconferencing is not acceptable. (under research)



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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.

The IDT is also required to convene for the following events. These meetings are billable under the MR/DD Waiver Program as long as all required IDT members have been notified.

- Seven Day IDT Meeting – This is a mandatory meeting when a member first receives Medicaid services. This is the plan initially developed within the first seven day 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. **An example is the Change in Residence meeting.**
- Crisis IDT Meeting – This type of IDT Meeting occurs when a member is experience a crisis (example: behavioral, medical, housing, and service provision)
- Discharge Planning IDT Meeting – This type of meeting must be held for all changes in community residence for MR/DD Waiver members.

512 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 provider agencies must comply with the billing procedures and requirements described in Chapter 600, Reimbursement of the Provider Manual.
- **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 500 of the MR/DD Waiver policy manual or outside of the scope of federal regulations.**

512.1 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.



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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 who are familiar with the member's individualized needs, provided the service is not duplicated by the hospital. This service requires state approval.
- 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 QMRP, which may be billed starting 30 days prior to discharge. Allowable activities for the QMRP are assessment, evaluation, habilitation, or behavioral support plan development, and training of direct support staff assigned to provide services at the time of discharge. The 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.
- Units of service are to be rounded on a monthly not daily or weekly basis. Example: 2 hours (or 16 units) with 10 minutes remaining of service coordination. At the end of the month, the provider agency may bill
- 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 is available to the member
 - Medical and financial eligibility is 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.



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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.

513.1 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.
PAYMENT LIMITS:	Service units shall be rounded on a monthly (not daily) basis
PRIOR AUTHORIZATION:	Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

DEFINITION

Service Coordination services are activities to establish a 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 the maximum potential and productivity of a person with developmental disabilities, his/her ability to make meaningful choices with regard to his/her life, and his/her inclusion in the community are achieved.

SITE OF SERVICE

Any location required, in order to complete all necessary duties for the member.

PROVIDER QUALIFICATIONS

- Four year degree in a human service field and one or more years experience in the MR/DD field
- Four year degree in a human service field and less than one 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 year degree in a non-human service field and one 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 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



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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)

PROVIDER LIMITATIONS

- Service Coordination may not be provided by an agency that is not a Medicaid enrolled MR/DD Waiver provider.
- There is no secondary Service Coordination on 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
- 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:

- 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 and 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.



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- Coordinate the initial medical evaluation (DD2), psychological evaluation (DD3) {if applicable}, Social History (DD4 {if applicable}, IEP- psycho-educational assessment for school-age children {if applicable}, birth to three assessments {if applicable}, if not indicated in other documents listed, verification 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, as well as arrange/collect other necessary evaluations and information to establish eligibility. Evaluations must support the individual's requirement of an ICF/MR level of care, the need for intensive instruction, supervision, support, and assistance to achieve independence and inclusion, and recommendation of home and community-based services.
- Submit the Annual Medical Evaluation (DD-2A), psychological evaluation (DD3) {if applicable}, for re-certification to the State office no later than 30 days past the expiration date. Services may not be reimbursed if an individual's certification has expired past the 30-day time frame.
- 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 **ADDITIONAL RESEARCH NEEDED**
- Ensure that every six 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. **ADDITIONAL RESEARCH NEEDED**
- 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 level of need when a member is found to be ineligible for MR/DD Waiver Services.

Linkage/Referral and Rights:

- Provide oral and written information on 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 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 & Treatment (EPSDT) Program.
- Inform families or custodians of children less than three years of age about the availability of Birth to Three Services. Medicaid will not reimburse these providers for Birth to Three Services for children enrolled in the MR/DD Waiver. However, reimbursement may be available from other funding services.
- 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



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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.

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 6 month up-date, and in accordance with the definition and requirements for IPPs stipulated in Section 510 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.
- Visit the individual monthly at his/her residence to personally meet with the individual and service providers to evaluate the status of progress towards the IPP instructional (behavioral) and service objectives, verify that services are being delivered in a safe environment and check documentation of services. 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 individual, his/her family and/or legal representative on their assessment of services, achievements, and/or unmet needs.
- Visit the individual at his/her Day Program every other month to monitor day activity (day habilitation, prevocational, and supported employment) to evaluate the status of progress towards the IPP instructional (behavioral) and service objectives, verify that services are being delivered in a safe environment and check documentation of services. The Service Coordinator is encouraged to visit the supported employment setting if the visit will not be disruptive to the setting or member.



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- Advocate on behalf of the individual and his/her family within the behavioral health service delivery system and community services and resources.
- Provide planning and coordination during 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 individual 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 individual, 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 20 people, inclusive of all people served by the Service Coordinator, at any time.
- The service coordinator must not provide QMRP services for members to whom they provide service coordination.

513.2 RESIDENTIAL HABILITATION

DEFINITION

Residential Habilitation Services are monitoring, support, and training services delivered in a member's residence and the 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. **The QMRP supervises or works in conjunction with the designated Residential Habilitation supervisor to ensure the implementation of Residential Habilitation Services. (See Section 513.10 of this chapter).**

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

- Personal grooming
- Dressing
- Meal preparation



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- 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.

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.

513.2.1 COMMUNITY RESIDENTIAL HABILITATION

PROCEDURE CODE:	T2017-UA
SERVICE UNITS:	15 minutes
SERVICE LIMITS:	16 units (4 hours) per day. Also when combined with T2017-U4, T2017-U3, T2017-U2, T2017-U1
PAYMENT LIMITS:	A legally responsible adult may only be reimbursed for services that have been identified as necessary in the Extraordinary Care Assessment. Any units in excess of four (4) hours per day need to be approved by BHHF. The locals Waiver contact person may not authorized units in excess of four (4) hours.

PRIOR AUTHORIZATION. Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.



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DEFINITION:

Refer to **513.2.2** Agency 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.

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
- **Criminal Investigation Background Check (CIB)**

Up to 12 hours (48 units) of Residential Habilitation services per 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 (QMRPs) 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 and the 3-month 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

Residential Habilitation is provided in the following settings:

- Biological or adoptive family homes.
- 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 is not an eligible setting for Community Residential Habilitation.

DOCUMENTATION

- Residential Habilitation providers must maintain detailed documentation (e.g., progress notes, daily activity logs) 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, signatures and credentials of staff providing the service, and the date of service.



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- Community Residential Habilitation providers must complete the Residential Habilitation Tracking Form (DD-8) and the Community Residential Habilitation Documentation Form (DD 12).

SERVICE RESTRICTIONS

- 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 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. Example: The provider prompts the member to begin the activity, with no response from the member. The provider waits five (5) minutes, and prompts the member again. During the five (5) minute wait, the provider assists the member to the toilet (which is not a current training activity but is a necessary assistance). The five (5) minutes between prompting of the activity is considered “assistance”. Routine monitoring or support is not considered assistance in Community Residential Habilitation services.

513.2.2

AGENCY RESIDENTIAL HABILITATION

PROCEDURE CODE:
SERVICE UNITS:
SERVICE LIMITS:

T2017-U4, T2017-U3, T2017-U2, T2017-U1
 15 minutes
 96 daily, 2616 monthly, combined service limits (Combined service limits include S5135-UA, Adult Companion Services Level 1 and S5135-UB, Adult Companion Services Level 2) A member, who has a legally responsible adult may only receive habilitation services that have been identified as necessary in the Extraordinary Care Assessment.

PRIOR AUTHORIZATION:

Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF). Effective after July 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.

DEFINITION

Agency 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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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.

Up to 12 hours (48 units) of Residential Habilitation services per 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 (QMRPs) 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 and the 3-month 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).

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)

SITE OF SERVICE

Residential Habilitation is provided in the following settings:

- The member's own home or apartment. 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.
- 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 is not an eligible setting for Community Residential Habilitation.
- 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.
- Residential Habilitation services may also be carried over in the necessary local public community environments, as specified in the IPP.



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- 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.

DOCUMENTATION

- Residential Habilitation providers must maintain detailed documentation (e.g., progress notes, daily activity logs) 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, signatures and credentials of staff providing the service, and the date of service.

SERVICE RESTRICTIONS

- It is the responsibility of the Service Coordination provider agency to provide or arrange for Residential Habilitation services with trained and qualified Medicaid providers.
- Staff/Member Ratio 1:1, 1:2, 1:3, and 1:4 Residential Habilitation up to a maximum of 24 hour (96 units per day). A maximum of 2616 units per month for all levels of Residential Habilitation (inclusive of Community Residential Habilitation, and Adult Companion services).
- 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. 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 SFCH and requires an explanation of why the family supports are not available to the member for the purpose of night-time monitoring.

513.3 ADULT COMPANION SERVICES

PROCEDURE CODE:	S5135-UAU4 =	Adult Companion Level I,	1:1 ratio
	S5135-UAU3 =	Adult Companion Level I,	1:2 ratio
	S5135-UAU2=	Adult Companion Level I,	1:3 ratio
	S5135-UBU4=	Adult Companion Level II,	1:1 ratio



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	S5135-UBU3=	Adult Companion Level II,	1:2 ratio
	S5135-UB U2=	Adult Companion Level II,	1:3 ratio
SERVICE UNITS:		15 minutes	
SERVICE LIMITS:		96 daily, 2616 monthly, combined service limits (Combined service limits includes T2017UA, T2017U1, T2017U2, T2017U3 and T2017U4 Residential Habilitation).	
PRIOR AUTHORIZATION:		Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.	

DEFINITION

Adult Companion Services are non-medical care supervision, socialization, monitoring, and assistance. The purpose of Adult Companion Services is twofold:

- To participate in “non-training” community activities that are planned and that do not occur during intermittent periods of time between training activities. Example: Staff accompanying a member for a two 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 50 year old member who has cerebral palsy and is unable to reach the upper cabinets without assistance.

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

ADULT COMPANION SERVICES

Adult Companion services must be supervised by a QMRP 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,
- that 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).



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

- Be at least 18 years old with proof of age on file at the provider agency

SITE OF SERVICE

Adult Companion services are provided in the following locations:

- Community locations to implement those activities which support a member's needs and choices.
- Natural or adoptive family homes or Specialized Family Care homes
- 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.
 - As of June 1, 2001, new sites larger than four beds will **not** be reimbursed through the MR/DD Waiver Program.
- Individualized Support Setting (ISS) (ISS = 3 or less members in one home)
- OBHS DD funded Crisis Respite sites
- Crisis Residential Unit sites

DOCUMENTATION- LEVEL I AND LEVEL II

Adult Companion services are documented on an Adult Companion Services Tracking form (DD-8) 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).

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, Day, Supportive Employment, or Prevocational) 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.



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- This service is not to be provided by a family member of a member residing in an agency-operated home.

513.4 EXTENDED PHYSICIAN SERVICES (Annual Medical Evaluation)

PROCEDURE CODE: 99381 to 99387 CPT codes for new member
99391 to 99397 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: Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

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
- Current medications
- 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 annual basis.



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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

513.5 Psychiatric Diagnostic Interview Examination

PROCEDURE CODE: 90801
SERVICE UNITS: Session/Event
SERVICE LIMITS: Completed on individual new to the provider of the service
PAYMENT LIMITS: No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform or submit a claim.

PRIOR AUTHORIZATION: No authorization required. Effective after July 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.

DEFINITION Psychiatric diagnostic interview examination by a psychologist includes a history, mental status, and a disposition, and may include communication with family or other sources. This code is to be utilized with a member new to the provider of the service.

513.6 Psychological Testing with interpretation and report

PROCEDURE CODE: 96101 (previously 96100)
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 or submit a claim.

PRIOR AUTHORIZATION: No authorization required. Effective after July 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



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agent. Services not registered with the claims agent will not be reimbursed.

513.7 PSYCHOLOGICAL TESTING – DEVELOPMENTAL TESTING WITH INTERPRETATION AND REPORT

PROCEDURE CODE:	96111-
SERVICE UNITS:	per 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 96101)
PAYMENT LIMITS:	No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform or submit a claim a triennial psychological evaluation.
PRIOR AUTHORIZATION:	No authorization required. Effective after July 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.

DEFINITION

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 under 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.

SITE OF SERVICE



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PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

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

DOCUMENTATION

Completion of the Psychological Evaluation (DD-3)

DEFINITION

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.

SITE OF SERVICE

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

DOCUMENTATION

Written report signed and dated exclusively by the psychologist. License number must also be present.

513.8 Psychological Testing Developmental Testing – Limited with Interpretation and Report

PROCEDURE CODE:	96110
SERVICE UNITS:	per hour, maximum of 4 hours
SERVICE LIMITS:	One evaluation for 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 only.



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PAYMENT LIMITS:

Children under the age of 18 are not required to submit an annual psychological update for level of care determination. No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform or submit a claim.

PRIOR AUTHORIZATION:

No authorization required. Effective after July 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.

DEFINITION

Developmental Testing by a psychologist including limited developmental testing with Interpretation and report. Developmental testing includes, but is not limited to: Developmental Screening Test 11, early Language Milestone Screen and other developmental screening instruments. Documentation requires scoring and interpretation of testing and a written report including finding and recommendations.

Psychological Evaluation, Annual Update service must include:

- Specific scores of a standardized adaptive behavioral measure
- Observation of the person
- Prognosis statement regarding how the person will function with continued ICF/MR level of care
- DSM-IV TR format with diagnostic codes and descriptors on all five axes
- Recommendations for adaptive training and behavior supports, for instructional services to increase skills and other therapeutic interventions,
- Recommendations supported by evaluation results indicating if the individual requires an ICF/MR level of based on his/her need for habilitative services,
- 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 under 18 years of age. An annual psychological evaluation is not required for adults 18 years of age and older.

Psychological Evaluations 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.

SITE OF SERVICE

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



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DOCUMENTATION

Completion of the Psychological Evaluation (DD-3)

513.9 INITIAL SOCIAL HISTORY

PROCEDURE CODE:	H0031-HI
SERVICE UNITS:	Event
SERVICE LIMITS:	At the time of enrollment, one comprehensive evaluation per member per provider per lifetime.
PAYMENT LIMITS:	The Initial Social History service must be provided by a QMRP 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:	Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

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,



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findings and assessments, recommendations, and verification that the data supports such recommendations.

ANNUAL SOCIAL HISTORY

Only the Initial Social History is a requirement. Additional Social History Updates may be completed as indicated.

SITE OF SERVICE

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.

513.10 PROFESSIONAL SERVICES (QUALIFIED MENTAL RETARDATION PROFESSIONALS OR QMRP SERVICES)

PROCEDURE CODE: Skills Development Specialist T2021 U7,
Positive Behavioral Support Specialist T2021, U8,
Professional Service: Occupational Therapist G0152
Physical Therapist G0151, Speech Therapist G0153
Registered Dietician S9470

SERVICE LIMITS: Skills Development Specialist - 140 units monthly up to a maximum of 720 units annually.
Positive Behavioral Support Specialist, - 140 units monthly up to a maximum of 720 units annually.
Professional Services: (Occupational Therapist, Physical Therapist, Speech Therapist, Registered Dietician) 40 units per month up to a maximum of 480 units annually.

PAYMENT LIMITS: Providers without credentials for their area of specialty may not provide the service.

PRIOR AUTHORIZATION: Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.



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DEFINITION

Skills Development Specialist:

Core Job Functions:

- Development of task analysis and/or methodology for implementation of intervention or instruction to an individual.
- 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, and Day Habilitation providers).
- Evaluation/monitoring of the effectiveness of plan of intervention or instruction.

Service Restrictions:

- Does not apply to the direct training of the member (cannot provide direct services)

Provider Qualifications:

- QMRP with at least a bachelor's degree and one (1) year of supervised work experience providing services to individuals with mental retardation and/or developmental disabilities. Must have demonstrated competencies to perform duties of a skills development Specialist.

Positive Behavioral Support Specialist

Core Job Functions:

- Behavioral plan development (QMRP must have documentation that demonstrates competency in this area)
- Behavioral assessment or evaluation consisting of activities such as functional analysis of targeted behaviors and analysis of the behavioral data.
- Behavioral support plan development and training of providers to implement behavioral plan development of behavioral protocols and behavioral guidelines for direct care staff or families.
- The Positive Behavior Support Specialist is responsible for all aspects of Positive Behavior Support Services.
- Development of task analysis and/or methodology for implementation of intervention or instruction to an individual.
- 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, and Day Habilitation providers).
- Evaluation/monitoring of the effectiveness of plan of intervention or instruction.

The Positive Behavioral Support Plan



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- Maximum of 30 days for data collection/functional analysis (30 days from the date that the team identifies need)
- Maximum of 15 days to review the data and develop the plan
- Maximum of 15 days to train staff (and Human Rights Committee approval) and implement

Behavioral Guidelines

- A guideline for staff to working with an individual with challenging behavioral that have occurred in the past but may not be occurring presently or frequently. Should be used with non life threatening behaviors to make staff aware of what could occur. The guideline could describe what has worked and what has not worked. (Helpful hints on working with the individual)

Behavioral Protocol

- The protocol, like the Positive Behavioral Support Plan, is proactive, data driven and addresses safety issues. The protocol describes written step by step directions for staff to follow.

The following is required when the ICAP maladaptive severity rating is:

SEVERITY RATING	REQUIREMENT
<p>ICAP maladaptive severity rating of Two (a moderate problem)</p> <p>Objectionable, unacceptable behavior found to be a problem in all environments</p>	<ul style="list-style-type: none"> • Problem is documented as an objective on the annual IPP • Development and implementation of a Behavioral Protocol
<p>ICAP maladaptive severity rating of three (a severe problem)</p> <p>Frightening, repulsive, dangerous behavior. Reduction of frequency requires constant vigilance and a highly structured environment</p>	<ul style="list-style-type: none"> • The Behavioral Objective has to be given the highest level of priority for implementation for the resident on the IPP • Development and implementation of a Behavioral Support Plan
<p>ICAP maladaptive severity rating of four (a critical)</p>	<ul style="list-style-type: none"> • The Behavioral Objective has to be given the highest level of priority for implementation for the



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SEVERITY RATING	REQUIREMENT
<p>Problem) A behavior which is life threatening, Reduction of frequency requires constant vigilance and a highly structure environment.</p>	<p>individual on the IPP</p> <ul style="list-style-type: none"> • Development and implementation of a Behavioral Support Plan • Every occurrence of the targeted behavior must be reported via the incident report system.

Service Restrictions:

- Does not apply to the direct training of the member. (cannot provide direct services)

Provider Qualifications:

Minimum of a Bachelors degree in a Human Service field and a minimum of one year experience working with individuals with mental retardation and/or developmental disabilities. The provider must have demonstrated competencies (course work, training) in the area of positive behavior Support and skills development.

Professional Services:

Core Job Functions:

QMRP licensed, certified and/or registered (e.g., physical therapist, speech/language, occupational therapist, registered dietician).

- Professional services consist of:
 - Physical therapy
 - Occupational therapy
 - Speech and language therapy
 - Dietary services by registered dietician.

SITE OF SERVICE (INCLUSIVE FOR ALL QMRP SERVICES)

The QMRP's office, the individual's home or other community locations which provide the proper equipment and physical facilities to deliver the specific QMRP services

DOCUMENTATION (INCLUSIVE FOR ALL QMRP 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 QMRP. Service units are to be rounded on a monthly basis, not daily or weekly.



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513.11 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.

Up to 24 units (6 hours) of these services may be charged in one day

PAYMENT LIMITS: See below

PRIOR AUTHORIZATION: Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

DEFINITION

The purpose of day habilitation is to offer a structured program that is designed to promote the acquisition of skills or maintenance of skills outside the residential home. Day habilitation activities must occur during naturally occurring routines of the day for the member. It must be based on assessment, be person-centered/goal oriented, and with meaningful/productive activities.

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 QMRP, as described in Section 513.8 of this Chapter.

Day Habilitation services provided under the MR/DD Waiver Program include the following services and are subject to the requirements described below:

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



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- Social skills
- Communication and speech instruction
- 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

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.

The implementation of goals or objectives must be done in close proximity to the member's residence. If a setting is available for reimbursable activity (i.e. habilitation, adult companion, respite) to occur in the neighborhood where the member resides, this setting must be utilized. (i.e. stores, banks, libraries, etc). Transportation must occur where the rest of the community typically shops or conducts business utilizing the resources available in the member's neighborhood. Transportation must be for the member's specific needs and is not intended for the socialization or shopping needs of a staff member or a family member.

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 QMRP.

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 6 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 may be delivered in Staff/Member Ratio of 1:1, 1:2, 1:3 and 1:4. There must be sufficient numbers of competent, trained staff to provide active habilitation and to protect 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



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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).

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.)
- Criminal Investigation Background Check (CIB)-

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. 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.

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 State MR/DD Waiver Office and the following conditions must be met:
 - The services are overseen by a QMRP
 - All service providers meet the qualifications for delivering Day Habilitation services
 - Day Habilitation and Residential Habilitation services are not delivered concurrently
 - The QMRP(s) must ensure the training of staff on appropriate training program goals and that activities occur in a normal setting. Waiver is a home and **community-based** service.
 - Ordered by a physician



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- 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 week ends (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.
- 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. 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.

513.12 PREVOCAATIONAL 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.
Up to 5 units of these services may be charged in 1 day.

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: Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

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.

Pre-vocational 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.)
- Criminal Investigation Background Check (CIB)



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- 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 1:1. Group services are delivered in staff/member ratio 1:2-6. 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 minimally provided by paraprofessionals and supervised by a QMRP, 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.

SITE OF SERVICE

Services may be delivered by day activity centers or adult day services programs operated by community behavioral health providers which are licensed by OHFLAC, or a community rehabilitation program certified by DRS. 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.

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, and the signature and credentials of the staff providing the service.

SERVICE RESTRICTIONS

In order to access pre-vocational services under the MR/DD Waiver Program, one must determine if services are currently provided through DRS. If services are 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 a referral, must be maintained by the provider agency in the individual's record of service. —MR/DD waiver pre-vocational services can not be utilized concurrently with any DRS pre-vocational services.



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513.13 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.
 Up to 32 units of these services may be charged in one day.
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 *referral*, to DRS must be maintained by the provider agency in the individual's record of service.

PRIOR AUTHORIZATION: Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

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.

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.)
- Criminal Investigation Background Check (CIB)

Service Activities-

Supported Employment services include, but are not limited to:

- Assessment and planning
- 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



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- 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 1:1. Group services are delivered in a staff/member ratio 1:2-6. 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 QMRP who is a job development specialist or has received Supported Employment training. In addition to the primary training requirements as outlined in Chapter 500, 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 certified by DRS.

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.

SERVICE RESTRICTIONS

In order to access pre-vocational services under the MR/DD Waiver Program, one must determine if services are available through DRS. If services are available 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 a referral, *current DRS status*, case closure, or denial must be maintained by the provider agency in the individual's record of service. *—MR/DD waiver pre-vocational services can not be utilized concurrently with any DRS pre-vocational services.*

513.14 TRANSPORTATION

PROCEDURE CODE:	A0120-HI, A0160-HI
SERVICE UNITS:	1 Trip-A0120, 1 mile-A0160
SERVICE LIMITS:	6 one-way trips per day-A0120, 77 trips per month 1300 miles per month-A0160



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PAYMENT LIMITS:

Transportation can be billed concurrently with Residential Habilitation, Day Habilitation, Respite, Pre-Vocational, Supported Employment, Service Coordination, and Adult Companion.

Transportation may not be billed in place of school-age entitlement services.

Transportation may not be billed concurrently with any other reimbursable services except those listed above.

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 grocery store located within 30 miles of WV's state border.)

Transportation must be directly linked to an IPP goal or objective or a medical service. The IPP must address goals or objectives or medical services requiring transportation services to access the training or medical service.

The implementation of goals or objectives must be done in close proximity to the member's residence. If a setting is available for reimbursable activity (i.e. habilitation, adult companion, respite) to occur in the neighborhood where the member resides, this setting must be utilized. (i.e. stores, banks, libraries, 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 for the member's specific needs and is not intended for the socialization or shopping needs of a staff member or a family member.

If destination is beyond 30 miles out of state, the member must access "non-emergency medical transportation services and must not access Waiver transportation for this type of trip.

PRIOR AUTHORIZATION:

Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

DEFINITION



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Transportation services are provided to a MR/DD member for the sole purpose of transporting the member to or from a Medicaid reimbursable service 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 this Section.

PROVIDER QUALIFICATIONS

Drivers must be at least 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 **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 providers must complete the Residential Habilitation Tracking form (DD-8)
- Respite providers must complete the Monthly Progress Report (DD-12)
- 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 100 units per month with a maximum of 60 units for Community Residential Habilitation.)

513.15 RESPITE CARE

PROCEDURE CODE:

T1005-UAU4=	Respite Care Level I,	1:1 ratio
T1005-UAU3=	Respite Care Level I,	1:2 ratio
T1005-UAU2=	Respite Care Level I,	1:3 ratio
T1005-UBU4=	Respite Care Level II,	1:1 ratio
T1005-UBU3=	Respite Care Level II,	1:2 ratio
T1005-UBU2=	Respite Care Level II,	1:3 ratio

SERVICE UNITS:

15 minutes



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PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

SERVICE LIMITS:	A Maximum combined limit of of 6,912 units per year for Respite Level I and Respite Level II
PAYMENT LIMITS:	See below
PRIOR AUTHORIZATION:	Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

DEFINITION

Respite Services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other primary caregiver of a member. This service is provided on a short-term basis because of the absence or need for routine or periodic relief of the primary caregiver. Respite is designed to focus on the need of the caregiver for temporary relief and to help prevent the breakdown of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite is not intended for routine day care.

Respite Care services consist of temporary care services for an individual who cannot provide for all of his/her own needs. The services are used on a short-term basis due to the absence of or need for relief of the primary care provider(s).

Respite Care may be used to:

- Allow the primary care provider to have planned time for him/herself and/or other family members
- Provide assistance to the primary care provider or member in crisis and emergency situations
- Ensure the physical and/or emotional well-being of the primary care provider or the member by 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 be supervised by a QMRP who ensures the delivery of services in accordance with the MR/DD Waiver Program and the member's IPP.

Up to 48 units of Level 2 (Agency) Respite Care services per member per 3 months may be charged, if necessary, for the purpose of training the Respite Care 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 Respite Care provider must be provided by a QMRP.

Up to 4 units of respite may be charged by the Level 2 (Agency) Respite Care service provider 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



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PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

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 home of a 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.
- 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 a parent of a minor child must work, the routine day care of the member is the responsibility of the parent and is not an eligible service activity for respite care.
- In the local public community environment.

DOCUMENTATION

Respite Care services are documented on a Respite Tracking Form (DD-08) 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 for the day of service, date of service, the staff to member ratio, and the signature and credentials of the staff providing the service on the Respite Documentation Form (DD-12).

SERVICE RESTRICTIONS

Respite Care services may not be used as a routine service 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.

Respite care services may be billed concurrently with transportation.

PROVIDER QUALIFICATIONS

All Respite Care services must be assessed and monitored by a QMRP for “respite relevant” training goals only.

- **Respite Care Level I** Providers may be individuals contracted by an agency, SFCP and/or biological or adoptive family members or relatives who do not reside with the member. Respite Care Level I is an optional service for Waiver providers.



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PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

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

- That 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
- 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)
- **Respite Care Level II** Providers must be employees of a behavioral health provider and must meet the following requirements:

Current certification in CPR and first aid. A copy of the certification card must be on file at the contracting provider agency

- Be at least 18 years old with proof of age on file at contracting provider agency
- Criminal Investigation Bureau (CIB) background check.

513.16 SKILLED NURSING SERVICES (still open to further research)

PROCEDURE CODE:	T1002- HI U4	RN	1:1
	T1002- HIU3	RN	1:2
	T1002- HIU2	RN	1:3

(RN Skilled Nursing Services are restricted to those nursing services that are outside the scope and practice of an LPN. RN Services may only be provided by a Registered Nurse. If the RN provides a Skilled Nursing service that is within the scope of practice for a LPN, the RN will be reimbursed at an LPN rate).

T1003 HI U4	LPN	1:1
T1003 HI U3	LPN	1:2
T1003 HI U2	LPN	1:3

SERVICE UNITS: 15 minutes

SERVICE LIMITS: The member is not eligible for separate respite or habilitation services if the member receives 8 hours or more hours of skilled nursing services 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



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PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

NOTE: Eight (8) hours or more of nursing services per day requires the completion of the “Nursing Acuity/Psychosocial Grid”. See Nursing Services provided Eight (8) hours per day for detailed score requirements per hours of nursing services.

PRIOR AUTHORIZATION: Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

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 the direction of a physician. Services must be provided within the scope and standards of the West Virginia Nurse Practice Act.

Waiver Nursing services include but are not limited to:

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

- Nursing services provided while on call; communicating with staff via phone, fax, or in person regarding immediate medical needs of the member – service requires an assessment be made.
- Follow-up of medical/incident reports that requires assessment;
- Annual nursing assessment; self-med administration assessment;
- Completing forms necessary for prior authorization for nursing services;
- Nursing plan of care- including measurable goals/objectives
- Participation/attendance at annual IDT meetings and as needed at emergency and other IDT meetings. (need to be determined by team with recommendation by RN)
- Monthly nursing summaries
- Assist in obtaining informed consent for medication and / or treatments
- On call for AMAPs 24/7, nursing responsibilities regarding AMAPs
- Supervision of AMAPs, LPNs
- Working directly with physicians and specialists to plan medical treatment;
- Training/Education of families, direct care staff regarding medical/health issues.

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



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- Direct nursing care including medication/treatment administration;
 - Monitoring and review of MARs, medication storage and documentation (when no AMAPs are administering medication).
 - Ensuring physician orders are current, properly documented, and communicated to direct care staff and others per agency policy;
 - Ensure medical appointments have been kept and information communicated to all others per agency policy;
 - Routine monitoring (data collection) of specific medical symptoms such as seizures, bowel habits, blood pressure, diet and exercise; (No assessment required)
 - Facilitate procurement of and monitoring of medical equipment;
 - Keep emergency sheets updated and accurate;
 - Training/education of members regarding health/medical issues.
- Communicating with direct care staff, service coordinators, etc. to assess member's immediate medical concerns over the phone or in person
 - Routine monitoring of specific medical symptoms such as seizures, bowel habits, blood pressure, diet and exercise
 - Taking off physician orders
 - 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
 - Ensure MR/DD Waiver required medical appointments have been completed
 - Assist in obtaining informed consent for medication and/or treatments
 - Facilitate procurement of and monitoring of medical equipment
 - Keeping emergency sheets updated and accurate.
 - Working directly with physicians and specialists to plan medical treatment
 - Follow-up of medical/incident reports that involve medical care (direct care)
 - Ensuring physician orders are current, properly documented, and communicated to direct care staff and others per agency policy

SITE OF SERVICE

Skilled Nursing Services can be provided in the following settings:



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- The participant's own home or apartment. Involved Nursing services may not be delivered in a residence that endangers the health or safety of the participant or the staff.
- Biological and adoptive family homes.
- Specialized Family Care Homes certified by the Specialized Family Care Program administered by The WV University Center for Excellence in Disabilities (WVUCED) and DHHR, Bureau for Children and Families.
- Group homes licensed by the 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

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 caregivers, 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 caregivers to provide care.

Members requiring ongoing nursing care due to the intense medical need of the member and nursing activities that cannot be performed by a non-medical, non-licensed nursing staff will be not be eligible for respite services. Nursing care will be considered "respite" care for the family.

QUALIFICATIONS: Current WV nursing License

CIB check

NURSING SERVICES PROVIDED EIGHT (8) HOURS PER MORE PER DAY: requires all of the following:

- Physician's plan of care (signed and dated) with all of the following:
 - Diagnosis and procedure
 - Medical History
 - Approximate length of time Involved nursing services will be needed;
 - Medical justification for services requested, including orders;
 - Documentation that the individual is medically stable except for acute episodes that the Involved nursing can manage.



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B. Plan of Care (The plan is initiated by the involved nurse providing services, or nursing agency, with input from the prescribing physician). Copies of the Plan of care and nursing notes must be maintained in the individual's home. The plan consists of documentation of a comprehensive assessment of individual's capabilities and written instructions detailing service the individual will receive including all of the following;

1. Proposed start of care date;
2. Description of medial limitations must include interventions, goals and measurable objectives with timeframes.
3. Medications including purpose, dose, frequency, and route
4. Technology dependent:
 - a. Mechanical ventilator support is necessary for at least eight hours/day;
 - b. Oxygen supplementation for ventilator dependent individual at or below an inspired fraction of 40% (FI O₂ of 0.40)
 - c. Non-ventilator: tracheostomy care (frequency of wound care/dressing changes) / suctioning (frequency and depth of suctioning)
 - d. Oxygen
 - e. Tube feedings (NG tube, G-tube, J-tube) requires type and frequency of product given. Include bolus feeding or continuous infusion via pump.
 - f. Intravenous infusions (type of line, frequency, duration of infusion, gravity or pump)
5. Activity limitations per physician order.
6. Describe teaching needed, delegation, assignment of care and availability of involved nurse.
7. List equipment and supplies necessary for the individual's care.
8. Additionally, Nursing Services provided eight (8) hours or more per day the completion of the Nursing Acuity Grid/Psychosocial Grid with a score meeting one of the following: DO WE WANT THIS?
 - a. 61 points and above- up to 24 hours per day of nursing services
 - b. 50-6- points – up to 16 hours per day of nursing services
 - c. 40-49 points - up to 12 hours per day of nursing services
 - d. 30-39 points- up to 8 hours per day of nursing services

. Home environmental requirements:

- e. Adequate electrical power including back-up power system;
- f. Adequate space for equipment and supplies
- g. Adequate fire safety and adequate exits for medical and other emergencies;
- h. Clean environment to the extent that the individual's life and health is not at risk;
- i. Working telephone available 24 hrs/day;
- j. Notification to power companies, fire department, and other pertinent agencies of the presence of a special needs person in the household, to ensure appropriate response in case of power outage or other emergency.

Site of Service:



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- k. The participant's own home or apartment.
- l. Group homes licensed by the OHFLAC to serve individuals with intellectual disabilities and/or developmental disabilities.
- m. Individualized support settings (ISS) operated by a licensed behavioral health center serving people with intellectual disabilities/developmental disabilities.
- n. Group homes licensed by the OHFLAC to serve individuals with intellectual disabilities and/or developmental disabilities
- o. Involved nursing may also be carried over in the necessary local public community environments, as specified in the IPP.

Documentation:

A detailed progress note for each service provided 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 per event.

Service Restrictions:



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Nursing services are not intended to replace the natural supports of the member.

Available only to MR/DD Waiver members over the age of 21. Children under 21 years of age must access nursing service by means of the

Medicaid state Plan and are not eligible for MR/DD Waiver Nursing services. The West Virginia Medicaid Program has contracted with West Virginia Medicaid Institute (WVMI) to prior authorize this service for individuals under 21.

513.17 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

PROCEDURE CODE:	S5165 (home), T2039 (vehicle)
SERVICE UNITS:	One Unit equals \$1
SERVICE LIMITS:	A maximum of \$1,000 per calendar year (Combined service limits include S5165 & T2039).
PRIOR AUTHORIZATION:	Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

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. 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 **Service Coordination Agency Contact Person** 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),



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- 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

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:

- 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.
- A copy of the DD-19 is located in Appendix A of this manual.
- 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.



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PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

SERVICE RESTRICTIONS

- The amount requested for the benefit must be **paid in full** to the provider of the Environmental Accessibility Adaptation, up to the limit of the benefit.
- 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.
- **What is excluded 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.

513.18 CRISIS SERVICES (service becomes effective 07-01-2006)

PROCEDURE CODE: T2034 2:1 staff to member ratio

SERVICE UNITS: Unit = 1 Day, 14 Day Limit

SERVICE LIMITS: Limit of fourteen (14) days annually.

May not be provided in a mental health crisis stabilization unit, psychiatric hospital, ICF-MR facility, general medical hospital



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May not be provided concurrently with residential habilitation, day habilitation, prevocational, supported employment, respite, or adult companion services.

PRIOR AUTHORIZATION: Prior to July 1, 2006 refer to Section 509.3 (Prior Authorization process BHHF) Effective after July 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.

DEFINITION:

The goal of crisis services is to respond immediately, assess the situation, and stabilize as quickly as possible. Crisis service is a short-term acute service that utilizes positive behavioral support planning, interventions, strategies, adaptive training, and direct care. When extraordinary circumstances are present, up to two staff members may be available to the member when medical necessity exists (see Behavioral Needs Criteria below). For 2:1 staffing, the additional staff person is available for assurance of health and safety in the respective setting.

AUTHORIZATION:

- A psychologist must order the service within 72 hours of the onset of the crisis services
- A prior authorization request must occur within 72 hours of implementation of the service. The service coordinator must request the authorization from the ASO.
- The service coordinator must maintain a record of the psychologist authorization for service.

Intensive Support Requirement:

Intensive Support Requirement: is when a member requires an acute level of support during periods of time in which the person is presenting episodes of unmanageable and/or inappropriate behaviors that require an intense level of behavioral or psychiatric care. An individual may display extreme, maladaptive behaviors that are not anticipated, are temporary 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 (**see service restriction for direct care staff**) :



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- 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
- Provide adaptive skills training in conjunction with behavioral support
- 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 Positive Behavioral Support Specialist as described in Section 516.8 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 calendar year.

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.

Members who meet the criteria for a very severe level of behavioral needs (Level 4), meet medical necessity, the member’s individualized behavioral needs, and authorization for the service may receive staff to member ratios as follows:

[Redacted]

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.)

Criminal Investigation Background Check (CIB)

Refer to 513.20, Provider Training, for specific requirements in positive behavioral support training.

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.
- Individualized Support Settings (ISS) operated by a licensed behavioral health center serving people with mental retardation and/or developmental disabilities.
- Crisis services may also be carried over in the necessary local public community environments, as specified in the IPP.



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PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

- 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 psychologist or psychiatrist and approved by the Human Rights Committee.

- Crisis Service providers must maintain detailed documentation (e.g., progress notes, daily activity logs) 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 psychologist or a psychiatrist for this service.
- 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, 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, QMRP, or transportation services during the daily 24 hour time-frame that crisis services are received.
- Crisis services include the activities of habilitation training and behavioral support.
- 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
- This service is not intended to be provided to individuals who reside in natural or adoptive family homes, specialized family care homes,
- This service is not intended for use as an emergency response to routine and ongoing behavioral challenges.
- Direct care staff cannot be the sole behavioral intervention without accompanying activities as outlined in the definition of the service (see crisis service definition).
- This service may not be provided in a hospital or facility setting.

513.19 INDIVIDUAL PROGRAM PLAN DEVELOPMENT (IPP)

PROCEDURE CODE: T2024U7= **Service Coordinator, Skills Development Specialist** **Social Worker**



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PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

T2024U8= Behavioral Support Specialist, Nurse

T2024U9= Psychologist, Physical Therapist, Occupational Therapist, Speech Language Pathologist, Physician

SERVICE UNITS: Up to 2 Hours per event

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.

PRIOR AUTHORIZATION:

Effective after July 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.

DEFINITION:

IPP development is the process by which a team develops a person centered plan for the member. The team is also known as the member’s “circle of support” . A “Circle of Support” is defined as “a group of people with either a professional or personal vested interested in the member who offer either evaluation, planning, advocacy, or support to the member on an ongoing basis”. The circle of support may include the service coordinator, professionals, direct care providers, family members, guardian, and significant individuals with a vested interest in the member.

This group 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, outline treatment options and training goals, and prepare 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 IPP Plan Development 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 IPP Plan Development. Activities provided before or after the meeting may meet the criteria for service coordination or QMRP service activities (See sections).



TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

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.

DOCUMENTATION:

The IPP shall serve as documentation of the IPP team meeting. The team member’s signature on the IPP constitutes participation in the team meeting. Team meeting minutes may 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, the total time spent in the meeting for each team member. If a staff person participates in an IPP team meeting from another provider agency, the staff person must record the attendance on a progress note, date of attendance, provider agency responsible for the IPP, and total time of participation in the IPP. A copy of the IPP will be maintained in all participating provider agency records and distributed to the member within fourteen (14) 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. 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 may 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.

510.3

The annual IPP is to be reviewed annually and once per six months or significant treatment junctures.

513.20 PROVIDER TRAINING

Individuals providing Service Coordination, Residential Habilitation, Day Habilitation, Pre-vocation, Supported Employment, Adult Companion II, Respite II, Nursing, Skills Development Training, and Positive Behavioral Support Specialist must be trained in:

- Overview of Developmental disabilities
- People First Language
- Normalization



TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

- 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
- Current MR/DD Waiver Manual
- 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

Additionally, individuals providing Service Coordination must have training in:

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

Additionally, Individuals providing Skills Development Training and Positive Behavioral Support must have training in:

- Development of task analysis and/or methodology
- Individuals providing Adult Companion I and Respite I must have training in:
- Participant Specific training in health/safety and habilitation objectives needed to provide direct care services, individuals must complete all provider training prior to the delivery of services.

Provider agencies must maintain record of the training verification.

514 HOW TO OBTAIN INFORMATION

For information concerning procedure codes and diagnosis codes, refer to Chapter 100, General Information. In addition, Attachment 1 contains the following:

- DD-2A Annual Medical Evaluation **NEW FORM**
- DD-3 Comprehensive Psychological Evaluation
- DD-4 Social History
- DD-5 Individual Program Plan **NEW FORM**
- DD-7 Informed Consent (Choice of ICF/MR and MR/DD Waiver)
- DD-7A Informed Consent (Choice of Providers and Services)



TITLE XIX MR/DD WAIVER MANUAL - WORKING DRAFT ONLY



PURPOSE OF THIS DRAFT IS TO SOLICIT INPUT FROM STAKEHOLDERS

- DD-8 Residential Habilitation Tracking Form
- DD-9 Monthly Home Visit Report
- DD-9A Day Habilitation Visit Report
- DD-10 Adult Companion Services Tracking Form
- DD-11 Respite Tracking Form
- DD-12 Monthly Progress Report
- DD-13 Certification of Training for Habilitation Providers
- DD-14 Application
- DD-16 Member Exit/Transfer
- DD-17 QMRP Credentialing Form
- DD-19 Environmental Accessibility Adaptations Form
- DD-20 Mortality Notification

**West Virginia Department of Health and Human Resources
ICF/MR Level of Care Evaluation**

Initial **Annual Renewal** **Title XIX MR/DD Waiver**

Service Coordination Agency: _____

Address: _____

Service Coordinator: _____

Contact Person: _____

Date: _____

I. DEMOGRAPHIC INFORMATION

1. Individual's Full Name		2. Sex: <input type="checkbox"/> F <input type="checkbox"/> M	3. Medicaid #	
4. Address (including Street/Box, City, State & Zip)				
5. County	6. Social Security #	7. Birthday (MM/DD/YY)	8. Age	9. Phone
10. Spouse's Name		11. Address (if different from above)		
12. Check if applicant has any of the following: a. <input type="checkbox"/> Guardian d. <input type="checkbox"/> Power of Attorney g. <input type="checkbox"/> Other _____ b. <input type="checkbox"/> Committee e. <input type="checkbox"/> Durable Power of Attorney c. <input type="checkbox"/> Medical Power of Attorney f. <input type="checkbox"/> Living Will Name & Address of Representative: _____ _____				
Phone:()				
13. Living Arrangement <input type="checkbox"/> Natural/adoptive family <input type="checkbox"/> Specialized family care provider <input type="checkbox"/> ISS – One person (Intensive support setting) <input type="checkbox"/> ISS – 2 person (Intensive support setting) <input type="checkbox"/> ISS – Three person (Intensive support setting) <input type="checkbox"/> Group Home (4 or more persons)				
14. Description of current living arrangements, including formal and informal support(i.e. family, friends, other services) _____ _____ _____				
15. Significant Health History – (include recent hospitalization(s) and/or surgery(s) with dates, history of infectious disease) _____ _____ _____ _____				

II. MEDICAL ASSESSMENT

NAME: _____

DATE: _____

16. Height	Weight	BP	P	R	T
-------------------	---------------	-----------	----------	----------	----------

17. Allergies:

CODE: √ = NORMAL N = NOT DONE NA = NOT APPLICABLE X = ABNORMAL (PLEASE DESCRIBE)

SKIN		
EYES/VISION		
NOSE		
THROAT		
MOUTH		
SWALLOWING		
LYMPH NODES		
THYROID		
HEART		
LUNGS		
BREAST		
ABDOMEN		
EXTREMETIES		
SPINE		
GENITALIA		
RECTAL (MALES INCLUDE PROSTATE)		
BI-MANUAL VAGINAL		

NEUROLOGICAL

ALERTNESS		
COHERENCE		
ATTENTION SPAN		
SPEECH		
SENSATION		
COORDINATION		
GAIT		
MUSCLE TONE		
REFLEXES		
VISION		
DENTAL		
HEARING		

NAME _____

DATE _____

MEDICAL ASSESSMENT II, CONT.

Problems requiring Special Care (check all appropriate blanks)

MOBILITY
 Ambulatory _____
 Ambulatory w/human help _____
 Ambul. w/mechanical help _____
 Wheelchair self propelled _____
 Wheelchair w/assistance _____
 Transfer w/assistance _____
 Bedfast _____

CONTINENCE STATUS
 Continent _____
 Incontinent _____
 Not Toilet trained _____
 Catheter _____
 Ileostomy _____
 Colostomy _____

FEEDING
 Feeds self _____
 Needs to be fed _____
 Gastric/J tube _____
 Special Diet _____

PERSONAL HYGIENE/SELF CARE
 Needs total care _____
 Independent _____
 Needs Assistance _____

MENTAL AND BEHAVIORAL DIFFICULTIES
 Alert _____
 Confused/Disoriented _____
 Irrational behavior _____
 Needs close supervision _____

Self-injurious behavior _____
EPS/TD _____
Unable to communicate _____

ADDITIONAL RECOMMENDATIONS

VISION THERAPY _____
SPEECH THERAPY _____
OCCUPATIONAL THERAPY _____
PHYSICAL THERAPY _____
SOAKS, DRESSINGS _____
TRACTION, CASTS _____
LABS ORDERED _____

OXYGEN THERAPY _____
SUCTIONING _____
TRACHEOSTOMY _____
VENTILATOR _____
DIAGNOSTIC SERVICES _____

IV FLUIDS _____

Please Complete All Sections Below to Ensure Certification For The Program

DIAGNOSTIC SECTION

AXIS I: (List all Emotional and/or psychiatric conditions)

AXIS II: (List all Cognitive, Developmental conditions and personality disorders)

AXIS III: (List ALL medical conditions)

PROGNOSIS:

I certify that this patient's developmental disability, medical condition and related health needs are as documented above AND the Patient requires the level of care and services provided in an "intermediate care facility" for individuals with mental retardation and/or related conditions.

YES _____ **NO** _____

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

DATE

PHYSICIANS SIGNATURE

LICENSE #

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

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

Name of Reviewer: _____ Date _____

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
COMPREHENSIVE PSYCHOLOGICAL EVALUATION (TRIENNIAL)**

NAME: _____ EVALUATION DATE: ___/___/___

BIRTHDATE: ___/___/___ AGENCY/FACILITY: _____

REASON FOR EVALUATION: _____

I. RELEVANT HISTORY:

- A. Prior Hospitalization/Institutionalization
- B. Prior Psychological Testing
- C. Behavioral History

II. CURRENT STATUS:

- A. Physical/Sensory Deficits
- B. Medications (Type, frequency and dosage)
- C. Current Behaviors
 - 1. Psychomotor
 - 2. Self-help
 - 3. Language
 - 4. Affective
 - 5. Mental Status
 - 6. Others (Social interaction, use of time, leisure activities)

III. CURRENT EVALUATION

- A. Intellectual/Cognitive:
 - 1. Instruments used:
 - 2. Results:
 - 3. Discussion:
- B. Adaptive Behavior:
 - 1. Instruments used: ABS I & II Others (list)
 - 2. Results:
 - 3. Discussion:
- C. Other:
 - 1. Instruments used:

- 2. Results:
- 3. Discussion:

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

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

E. Developmental Findings/Conclusions

IV. RECOMMENDATIONS:

- A. Training
- B. Activities
- C. Therapy/Counseling/Behavioral Intervention

V. DIAGNOSIS:

VI. PROGNOSIS:

VII. PLACEMENT RECOMMENDATIONS:

Signature of Supervised Psychologist

Signature of Licensed Psychologist

Title

License #/Title

Date

Date

DD-3
Revised July 2004

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
SOCIAL HISTORY**

PARTICIPANT NAME: _____

DATE: _____

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

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

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

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

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

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

VII. FAMILY MEDICAL HISTORY (Identify relationship to the participant):

_____ MR/DD	_____ Heart Disease	_____ Cerebral Palsy
_____ Autism	_____ Diabetes	_____ Tuberculosis
_____ Hepatitis	_____ Mental Illness	_____ Kidney Disease
_____ Cancer	_____ Hypertension	_____ Metabolic Disease
_____ Allergies	_____ Thyroid Disease	_____ Muscular Dystrophy
_____ Epilepsy	_____ Other	_____ Other

Deceased Siblings (Cause of Death) _____

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

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

DATE

DATE

SIGNATURE OF TEMPORARY LSW

SIGNATURE/CO-SIGN OF DEGREED/LSW

LICENSE #/DEGREE

LICENSE #/DEGREE

DD-4
Revised July 2004

MY PLAN (WORKING DRAFT)
A PERSON CENTERED PLAN FOR:

Demographics

Name: Address: Phone Number: Emergency Phone #: Date of Birth:	Social Security Number: Medicaid ID Number: Additional Insurance: Marital Status:
Legal Guardian: No <input type="checkbox"/> Yes <input type="checkbox"/> Full <input type="checkbox"/> Limited <input type="checkbox"/> Name: Address: Phone:	Health Care Surrogate, Medical Power of Attorney: No <input type="checkbox"/> Yes <input type="checkbox"/> Name: Address: Phone:
Payee: No <input type="checkbox"/> Yes <input type="checkbox"/> Conservator: No <input type="checkbox"/> Yes <input type="checkbox"/> Name: Name: Address: Address: Phone: Phone:	Provider Agencies by Service (except SC) : Residential: Day (or Prevocational/supported employment): Respite: Adult Companion: QMRP: Nursing:
Interdisciplinary Team Meeting Date:	IPP Review Date:
Date Current Plan Begins:	Date Next Plan Begins:
SC Name: SC Provider Agency: SC Telephone #, ext: SC e-mail:	(N/A if non-applicable) Date of Positive Behavior Support Plan: Date of HRC Approval: Date of Behavior Protocol: Date of Behavior Guidelines: Date of Crisis Plan:
Level of Care: Date of DD-2A: Date of DD-3: Other Information:	Other:

PROMPTS FOR “MY GOALS/DREAMS” AND “MY CIRCLE OF SUPPORT”

The following is a series of questions or prompts for the service coordinator to begin facilitation of the development of the overall goals/dreams of the participant and identification of the participant's circle of support. This section (page 2 only) is for discussion at the annual IPP team meeting and may be prepared prior to the team meeting, then, reviewed with the remainder of the team members. No other section of the IPP may be completed prior to the team meeting. This series of prompts must be provided or billed as a service coordination activity and must not be provided or billed as an IPP team meeting activity.

What I did last year: *(Include achievements, special events, progress on goals, etc.)*

I like to spend time with: *(This could be a family, friends, church members, employers, providers, classmates, etc. Include how contact is made such as on the phone, visiting, or letters, and also how to assist the person in their contact with others – what supports are needed.)*

During my leisure time I like to: *(Include continuing and developing new leisure activities and any club affiliations, also include activities specific to an individual's culture.)*

The things that I am good at are: *(My strengths and abilities are. List things I do well, that I can do, or enjoy doing, or that others feel I am good at doing.)*

In order to be more independent, I would like to continue working on and/or learn how to: *(This may include things taught through a variety of sources such as the school, community, enrichment programs; or include independent living skills such as hygiene, cooking, or skills for community access, or skills for achieving vocational interests. Include what assistance is needed – how can the team support such goals?)*

Things that are extremely important to me are: *(List possessions and activities specific to an individual's culture and religious practices.)*

The things I never want in my life are: *(There may be things or situations that make me mad, sad, scared or confused. It might be people I don't want to be around, fear of animals, foods that I don't like, or anything that would cause me undue stress.)*

My core support team members are: *(Include natural supports, friends, family members, or professionals providing evaluation or support.)*

What I want to accomplish within the plan year and who will help me:

(Include things like taking a trip with my family and/or provider, earning money, learning to self-medicate; get a piece of special equipment.)

My long-term goals for the future are:

(What would make me happy? What do I want to work toward the most? What would make my life better? These are things I want to do in the future.)

Transitions in the future are:

(Include things like guardian changes, change in residence, and change in school.)

MY DREAMS/GOALS



COMMUNITY



HOME AND SUPPORTS

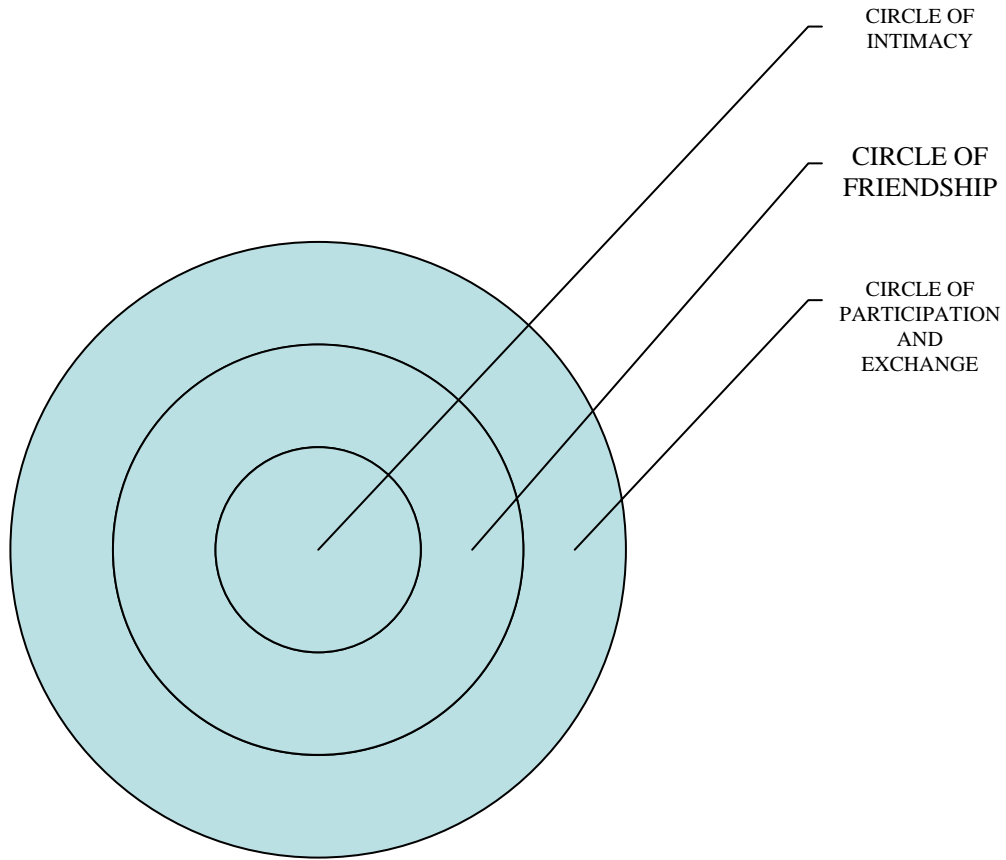


FRIENDS



FAMILY

CIRCLE OF SUPPORT



CIRCLE OF INTIMACY _____

CIRCLE OF FRIENDSHIP _____

CIRCLE OF PARTICIPATION/EXCHANGE _____

Assessment and Evaluation Information

Evaluation	Date of Evaluation	Professional Recommendation
DD-2A		
DD-3, ABS		
DD-4		
PT		
OT		
ST		
ABS		
Extraordinary Care Assessment		
Nursing		
Other		

ICAP and/or SIS

Adaptive Behaviors	Score	Maladaptive Behaviors	Score
Motor Skills		Internalized	
Social/Communication Skills		Asocial	
Personal Living Skills		Externalized	
Community Living Skills		General	
Functional Limitations and Needed Assistance	Score	Functional Limitations and Needed Assistance	Score
Supports and Services	Score	Supports and Services	Score

Individual Services Plan

May Utilize More Than One Page

Service	Availability/Accessibility	Provider
	Yes	
	No	
Frequency of Service	Plan of Action	Start Date/End Date
Service	Availability/Accessibility	Provider
	Yes	
	No	
Frequency of Service	Plan of Action	Start Date/End Date
Service	Availability/Accessibility	Provider
	Yes	
	No	
Frequency of Service	Plan of Action	Start Date/End Date
Service	Availability/Accessibility	Provider
	Yes	
	No	
Frequency of Service	Plan of Action	Start Date/End Date

**UNIVERSAL OBJECTIVE PAGE
(HABILITATION SERVICES ONLY)**

Use as many of these sheets as necessary

Member Name		Provider	
--------------------	--	-----------------	--

My Goal is:

Start Date:

End Date:

Goal Number	My Objective is	Method(s)

What are the barriers that slow my progress?

My Goal is:

Start Date:

End Date:

Goal Number	My Objective is	Method(s)

What are the barriers that slow my progress?

NOTE: ATTACH TASK ANALYSIS/METHOD FORMS, CRISIS PLAN, BEHAVIORAL SUPPORT PLAN, BEHAVIORAL PROTOCOL, OR BEHAVIORAL GUIDELINES TO THE PLAN

SIGNATURES

Relationship (Print Name)	Signature	Date Attended/Time	Agree	Disagree
Participant				
Parent/Guardian				
Service Coordinator				
Physician				
Psychologist				
RN				
Others (include members of my Circle of Support in this category, or PT, OT, ST, etc)				

**IDT member has disagreed with My Plan; rationale attached*

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
INFORMED CONSENT TO A CHOICE OF ALTERNATIVES BETWEEN
INSTITUTIONAL AND WAIVER HOME AND COMMUNITY-BASED SERVICES**

NAME:

AGENCY/FACILITY

- _____1. The findings and results of the evaluations and needs have been discussed with the participant and/or family or legal representative.
- _____2. Alternative plans for providing services to meet the participant's needs have been discussed and a choice of services between ICF/MR and community-based MR/DD Waiver services has been presented to the participant and/or family or legal representative.
- _____3. The participant and/or family or legal representative have chosen ___ICF/MR ___Community-based MR/DD Waiver as described by the Service Coordinator.
- _____4. The participant and/ or family or legal representative have requested that an Individual Program Plan be developed for their approval.
- _____5. The right to a fair hearing and the agency and state appeal process have been discussed with the participant and/or family or legal representative.
- _____6. A copy of the MR/DD Waiver Manual has been offered to the participant and/or family or legal representative and he/she has _ accepted _ refused the copy of the handbook.

I, consent for the state DHHR to disclose Case Status Information and/or Eligibility Information to Behavioral Health Providers for Treatment, Payment, and Health Care Operations as is necessary to assist in the provision of Title XIX MR/DD Waiver Services.

_____ Participant
Date Parent or Legal Guardian Date _____

_____ Service Coordinator Date SC Supervisor Date

_____ Witness Date

DD-7

Revised December 2005 **WORKING DRAFT**

**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
INFORMED CONSENT TO A CHOICE OF
MR/DD WAIVER PROVIDERS AND MR/DD WAIVER SERVICES**

NAME:

AGENCY/FACILITY

- _____ 1. The right to choose among all qualified providers has been discussed with the participant and/or family or legal representative.
- _____ 2. All enrolled service coordination agencies in the participant's catchment area have been discussed with the participant, family and/or legal representative.
- _____ 3. The participant and/or family or legal representative have chosen as their service coordination agency.
- _____ 4. The right to choose among all available MR/DD Waiver services to meet the participant's needs have been discussed with the participant and/or family or legal representative.
- _____ 5. The participant, family and/or legal representative has been informed of their right to a fair hearing if denied service(s) and the provider(s) of their choice.
- _____ 6. A copy of the MR/DD Waiver Reference Guide to Providers has been offered to the participant, family and/or legal representative have _____ accepted _____ refused a copy of the Reference Guide.

_____ Participant
Date Parent or Legal Guardian Date _____

_____ Service Coordinator Date SC Supervisor Date

_____ Witness Date

DD 7-A

Revised December 2005 **WORKING DRAFT**

**MR/DD WAIVER PROGRAM
RESIDENTIAL HABILITATION, ADULT COMPANION, AND RESPITE TRACKING FORM**

Participant Name

Service Coordination Agency

Provider Name

Service Coordinator Name

Provider Address: _____

TYPE OF RESIDENCE: Natural Family Specialized Family Care Home Group Home ISS

In the spaces below, write in number of hours under the date that the participant received community residential habilitation, adult companion, respite and/or related transportation services.

THIS REPORT IS FOR THE MONTH OF _____, 2_____.

Code	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

SERVICE CODES: Residential Habilitation

T2017-UA= Community Residential Habilitation

Adult Companion

- S5135-UAU4= Adult Companion Level I, 1:1 ratio
- S5135-UAU3= Adult Companion Level I, 1:2 ratio
- S5135-UAU2= Adult Companion Level I, 1:3 ratio
- S5135-UBU4= Adult Companion Level II, 1:1 ratio
- S5135-UAU3= Adult Companion Level II, 1:2 ratio
- S5135-UBU2= Adult Companion Level II, 1:3 ratio

Transportation

A0160=Transportation I A0120=Transportation II

Respite

- T1005-UAU4= Respite Care Level I, 1:1 ratio
- T1005-UAU3= Respite Care Level I, 1:2 ratio
- T1005-UAU2= Respite Care Level I, 1:3 ratio
- T1005-UBU4= Respite Care Level II, 1:1 ratio
- T1005-UBU3= Respite Care Level II, 1:2 ratio
- T1005-UBU2= Respite Care Level II, 1:3 ratio

ABSENCE CODES: Hospitalization= H Home Visit= HV Respite Care=RC Illness= I Other= O

I certify that the above documented services were delivered for the participant in accordance with the Individual's Program Plan (DD-5) and the regulations governing the Title XIX MR/DD Waiver Program. No services are claimed that were not provided to the participant.

Provider Signature Date Completed

Service Coordinator Signature Date Reviewed

MR/DD Waiver
Monthly Service Coordination Visit
Residential Habilitation for ISS/Group Home

Today's Visit Date: ___/___/___
Next Planned Visit Date: ___/___/___
Last IPP Team Review: ___/___/___
Date of Next IPP Review: ___/___/___
Service Code: _____

I. WAIVER PARTICIPANT INTERVIEW

NAME OF WAIVER PARTICIPANT: _____ age _____
ADDRESS: _____

- 1) Is the participant safe, neat and clean? **YES** **NO**
1a) If no, list intervention: _____
- 2) Do you have any concerns or recommendations about your services? **YES** **NO**
2a) If yes, list: _____
- 3) List next months community integration events or special plans you have: _____
- 4) What has improved over the last month for you? _____

II. HABILITATION PROVIDER INTERVIEW

- 1) Describe the overall status report of the participant given by the provider: _____
1a) List any concerns with sleep patterns: _____
1b) List any concerns with appetite: _____
1c) List any concerns with behaviors: _____
- 2) List dates and outcomes of past months medical and/or other therapy appointments.
(Include any hospitalizations, diagnostic changes, needs for referral for prior authorization, side effect monitoring, illnesses....)
2a) _____
2b) _____
2c) _____
- 3) Were there any medication changes over the month? **YES** **NO**
3a) List if yes: _____
3b) If yes, was the Waiver RN and IDT team notified? **YES** **NO**
- 4) List Dates/Purposes of Upcoming Appointments: _____
- 5) Has the participant progressed in any areas? **YES** **NO** *Specify:* _____
- 6) Has the participant regressed in any areas? **YES** **NO** *Specify:* _____
- 7) Is there a current, complete, and signed copy of the IPP on site? **YES** **NO**
- 8) Is liaison work requested between the day and residential habilitation settings? **YES** **NO**
7a) If yes, state purpose: _____
- 9) Do you have the necessary equipment/ materials to provide active treatment services? **YES** **NO**
9a) If no, list needed items: _____
- 10) Is all adaptive equipment in working condition? **YES** **NO** *Specify:* _____
10a) If no, targeted resolution date: _____

III. OVERSIGHT AND ACCOUNTABILITY OBSERVATION

- 1) List any concerns with staffing/services: _____
 1a) Specify plans for resolution of any concerns: _____
- 2) Is there a back up plan in the event of habilitation provider and/or participant illness? **__ YES __ NO**
 2a) If no, specify plans for resolution: _____

IV. STATUS OF LAST MONTHS REQUESTS FOR SC FOLLOW-UP

- SC Task #1: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task #2: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task #3: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task # 4: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____

V. ADDITIONAL REQUESTS FOR SC FOLLOW UP

- 1) _____ 2) _____
- 3) _____ 4) _____

VI. ENVIRONMENTAL ASSESSMENT

- 1) Is the home sanitary and safe? **__ YES __ NO**
 1a) Specify any needed improvements: _____
 1b) Targeted Resolution Date: _____ Other: _____
- 2) Are any environmental modifications needed? **__ YES __ NO**
 2a) If yes, then specify: _____
 2b) Targeted Resolution Date: _____ Other: _____
- 3) Does the person have adequate crisis prevention, intervention and response plans? **__ YES __ NO**
 3a) If no, then specify plans for improvement: _____
 3b) Targeted Resolution Date: _____ Other: _____
- 4) Are there effective evacuation and disaster response plans in place? **__ YES __ NO**
 4a) If no, then specify plans for improvement: _____
 4b) Targeted Resolution Date: _____ Other: _____

VII. SERVICE TIME

Travel TO Start Time: _____ : _____ Travel TO End Time: _____ : _____
 Visit START Time: _____ : _____ Visit END Time: _____ : _____
 Travel FROM Start Time: _____ : _____ Travel FROM End Time: _____ : _____
 TOTAL Number of Miles: _____ TOTAL Number of Minutes: _____

VIII. SIGNATURE SECTION

Participant Signature	Date:	Habilitation Provider Signature	Date:
		(Check One) <input type="checkbox"/> Witness or <input type="checkbox"/> Guardian	
Service Coordinator Signature	Date:	Signature	Date:

I. WAIVER PARTICIPANT INTERVIEW

NAME OF WAIVER PARTICIPANT: _____ age _____
ADDRESS: _____

- 1) Is the participant safe, neat and clean? **YES** **NO**
1a) If no, list intervention: _____
- 2) Do you have any concerns or recommendations about your services? **YES** **NO**
2a) If yes, list: _____
- 3) List next months community integration events or special plans you have: _____
- 4) What has improved over the last month for you? _____

II. HABILITATION PROVIDER OR PARENT/GUARDIAN INTERVIEW

- 1) Describe the overall status report of the participant given by the provider: _____
1a) List any concerns with sleep patterns: _____
1b) List any concerns with appetite: _____
1c) List any concerns with behaviors: _____
- 2) List dates and outcomes of past months medical and/or other therapy appointments.
(Include any hospitalizations, diagnostic changes, needs for referral for prior authorization, side effect monitoring, illnesses....)
2a) _____
2b) _____
2c) _____
- 3) Were there any medication changes over the month? **YES** **NO**
3a) List if yes: _____
3b) If yes, was the Waiver RN and IDT team notified? **YES** **NO**
- 4) List Dates/Purposes of Upcoming Appointments: _____
- 5) Has the participant progressed in any areas? **YES** **NO** *Specify:* _____
- 6) Has the participant regressed in any areas? **YES** **NO** *Specify:* _____
- 7) Is there a current, complete, and signed copy of the IPP on site? **YES** **NO**
- 8) Is liaison work requested between the day and residential habilitation settings? **YES** **NO**
7a) If yes, state purpose: _____
- 9) Do you have the necessary equipment/ materials to provide active treatment services? **YES** **NO**
9a) If no, list needed items: _____
- 10) Is all adaptive equipment in working condition? **YES** **NO** *Specify:* _____
10a) If no, targeted resolution date: _____

III. OVERSIGHT AND ACCOUNTABILITY OBSERVATION

- 1) List any concerns with staffing/services: _____
 1a) Specify plans for resolution of any concerns: _____
- 2) Is there a back up plan in the event of habilitation provider and/or participant illness? **__ YES __ NO**
 2a) If no, specify plans for resolution: _____

IV. STATUS OF LAST MONTHS REQUESTS FOR SC FOLLOW-UP

- SC Task #1: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task #2: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task #3: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task # 4: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____

V. ADDITIONAL REQUESTS FOR SC FOLLOW UP

- 1) _____ 2) _____
- 3) _____ 4) _____

VI. ENVIRONMENTAL ASSESSMENT

- 1) Is the home safe? **__ YES __ NO**
 1a) Specify any needed improvements: _____
 1b) Targeted Resolution Date: _____ Other: _____
- 2) Are any environmental modifications needed? **__ YES __ NO**
 2a) If yes, then specify: _____
 2b) Targeted Resolution Date: _____ Other: _____
- 3) Does the person have adequate crisis prevention, intervention and response plans? **__ YES __ NO**
 3a) If no, then specify plans for improvement: _____
 3b) Targeted Resolution Date: _____ Other: _____
- 4) Are there effective evacuation and disaster response plans in place? **__ YES __ NO**
 4a) If no, then specify plans for improvement: _____
 4b) Targeted Resolution Date: _____ Other: _____

VII. SERVICE TIME

Travel TO Start Time: _____ : _____ Travel TO End Time: _____ : _____
 Visit START Time: _____ : _____ Visit END Time: _____ : _____
 Travel FROM Start Time: _____ : _____ Travel FROM End Time: _____ : _____
 TOTAL Number of Miles: _____ TOTAL Number of Minutes: _____

VIII. SIGNATURE SECTION

Participant Signature	Date:	Habilitation Provider Signature	Date:
		(Check One) <input type="checkbox"/> Witness or <input type="checkbox"/> Guardian	
Service Coordinator Signature	Date:	Signature	Date:

MR/DD Waiver Service Coordination Visit
Day Habilitation (Every Other Month)

Check One

- Day Program Community Day Habilitation
 Pre-Vocational Training Supported Employment

Today's Visit Date: ___/___/___
Next Planned Visit Date: ___/___/___
Last IPP Team Review: ___/___/___
Date of Next IPP Review: ___/___/___
Service Code: _____

I. WAIVER PARTICIPANT INTERVIEW

NAME OF WAIVER PARTICIPANT: _____ age _____

LOCATION: _____

- 1) Is the participant safe, neat and clean? __ YES __ NO
1a) If no, list intervention: _____
- 2) Do you have any concerns or recommendations about your services? __ YES __ NO
2a) If yes, list: _____
- 3) What has improved over the last month for you? _____

II. HABILITATION PROVIDER INTERVIEW

- 1) Describe the overall status report of the participant given by the provider: _____

- 1a) List any concerns with attendance: _____
1b) List any concerns with behaviors: _____
- 2) List dates and outcomes of past months medical and/or other therapy appointments.
(Include any hospitalizations, diagnostic changes, needs for referral for prior authorization, side effect monitoring, illnesses....)
2a) _____
2b) _____
- 3) Were there any medication changes over the month? __ YES __ NO
3a) List if yes: _____
3b) If yes, was the Waiver RN and IDT team notified? __ YES __ NO
- 4) List Dates/Purposes of Upcoming Appointments: _____
- 5) Has the participant progressed in any areas? __ YES __ NO *Specify:* _____
- 6) Has the participant regressed in any areas? __ YES __ NO *Specify:* _____
- 7) Is there a current, complete, and signed copy of the IPP on site? __ YES __ NO
- 8) Is liaison work requested between the day and residential habilitation settings? __ YES __ NO
7a) If yes, state purpose: _____
- 9) Do you have the necessary equipment/ materials to provide active treatment services? __ YES __ NO
9a) If no, list needed items: _____
- 10) Is all adaptive equipment in working condition? __ YES __ NO *Specify:* _____
10a) If no, targeted resolution date: _____

III. OVERSIGHT AND ACCOUNTABILITY OBSERVATION

- 1) List any concerns with staffing/services: _____

 1a) Specify plans for resolution of any concerns: _____
- 2) Is there a back up plan in the event of habilitation provider and/or participant illness? YES NO
 2a) If no, specify plans for resolution: _____

IV. STATUS OF PAST MONTHS REQUESTS FOR SC FOLLOW-UP

- SC Task #1: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task #2: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task #3: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____
- SC Task # 4: _____ Completed Ongoing Pending
 Plans for resolution of any identified barriers: _____

V. ADDITIONAL REQUESTS FOR SC FOLLOW UP

- 1) _____ 2) _____
- 3) _____ 4) _____

VI. ENVIRONMENTAL ASSESSMENT

- 1) Is the site sanitary and safe? YES NO
 1a) Specify any needed improvements: _____
 1b) Targeted Resolution Date: _____ Other: _____
- 2) Is the site accessible for the participant? YES NO
 2a) If yes, then specify: _____
 2b) Targeted Resolution Date: _____ Other: _____
- 3) Does the person have adequate crisis prevention, intervention and response plans? YES NO
 3a) If no, then specify plans for improvement: _____
 3b) Targeted Resolution Date: _____ Other: _____
- 4) Are there effective evacuation and disaster response plans in place? YES NO
 4a) If no, then specify plans for improvement: _____
 4b) Targeted Resolution Date: _____ Other: _____

VII. SERVICE TIME

Travel TO Start Time: _____ : _____	Travel TO End Time: _____ : _____
Visit START Time: _____ : _____	Visit END Time: _____ : _____
Travel FROM Start Time: _____ : _____	Travel FROM End Time: _____ : _____
TOTAL Number of Miles: _____	TOTAL Number of Minutes: _____

VIII. SIGNATURE SECTION

Participant Signature _____ Date: _____

Habilitation Provider Signature _____ Date: _____
(Check ONE): WITNESS or GUARDIAN

Service Coordinator Signature _____ Date: _____

Signature _____ Date: _____

Community Residential Habilitation, Respite or Adult Companion Documentation Form

Participant Name/Client Number _____

Service Coordinator _____

Provider Name _____

Month/Year _____

Check One: Community Residential Habilitation Adult Companion I Adult Companion II Respite I Respite II

Date:	Code:	Start Time: Start Time:	Stop Time: Stop Time:	Total Time: Total Time:	Training/Objectives # __N/A	Transportation: yes__ no__ Total Miles:
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Summary: _____

Signature/Title of Provider: _____

Date:	Code:	Start Time: Start Time:	Stop Time: Stop Time:	Total Time: Total Time:	Training/Objectives # __N/A (No Training)	Transportation: yes__ no__ Total Miles:
-------	-------	----------------------------	--------------------------	----------------------------	--	--

Summary: _____

Signature/Title of Provider: _____

Date:	Code:	Start Time: Start Time:	Stop Time: Stop Time:	Total Time: Total Time:	Training/Objectives # __N/A (No Training)	Transportation: yes__ no__ Total Miles:
-------	-------	----------------------------	--------------------------	----------------------------	--	--

Summary: _____

Signature/Title of Provider: _____

Date:	Code:	Start Time: Start Time:	Stop Time: Stop Time:	Total Time: Total Time:	Training/Objectives # __N/A (No Training)	Transportation: yes__ no__ Total Miles:
-------	-------	----------------------------	--------------------------	----------------------------	--	--

Summary: _____

Signature/Title of Provider: _____

Date:	Code:	Start Time: Start Time:	Stop Time: Stop Time:	Total Time: Total Time:	Training/Objectives # __N/A (No Training)	Transportation: yes__ no__ Total Miles:
-------	-------	----------------------------	--------------------------	----------------------------	--	--

Summary: _____

Signature/Title of Provider: _____

Date:	Code:	Start Time: Start Time:	Stop Time: Stop Time:	Total Time: Total Time:	Training/Objectives # __N/A (No Training)	Transportation: yes__ no__ Total Miles:
-------	-------	----------------------------	--------------------------	----------------------------	--	--

Summary: _____

Signature/Title of Provider: _____

Date:	Code:	Start Time: Start Time:	Stop Time: Stop Time:	Total Time: Total Time:	Training/Objectives # __N/A (No Training)	Transportation: yes__ no__ Total Miles:
-------	-------	----------------------------	--------------------------	----------------------------	--	--

Summary: _____

Signature/Title of Provider: _____

Instructions for Completing Community Residential Habilitation, Respite or Adult Companion Documentation Form

1. Complete top portion of the form.

Participant Name/Client Number

Service Coordinator

Provider Name

Month/Year

2. Check type of service being provided. **Only one type of service may be entered/recorded on a form.*

Check One: Community Residential Habilitation Adult Companion I Adult Companion II Respite I Respite II

3. Enter the date of the service.

Date:							
1/1/06							

4. Enter the code of the service.

Code:							
T2017UA							

SERVICE CODES: Residential Habilitation

Transportation

T2017-UA= Community Residential Habilitation

A0160=Transportation I A0120=Transportation II

Adult Companion

Respite

S5135-UAU4= Adult Companion Level I, 1:1 ratio
 S5135-UAU3= Adult Companion Level I, 1:2 ratio
 S5135-UAU2= Adult Companion Level I, 1:3 ratio
 S5135-UBU4= Adult Companion Level II,1:1 ratio
 S5135-UAU3= Adult Companion Level II,1:2 ratio
 S5135-UBU2= Adult Companion Level II,1:3 ratio

T1005-UAU4= Respite Care Level I, 1:1 ratio
 T1005-UAU3= Respite Care Level I, 1:2 ratio
 T1005-UAU2= Respite Care Level I, 1:3 ratio
 T1005-UBU4= Respite Care Level II, 1:1 ratio
 T1005-UBU3= Respite Care Level II, 1:2 ratio
 T1005-UBU2= Respite Care Level II, 1:3 ratio

5. Enter the time service session begins (Start Time). ** If two (2) sessions are done in one day, there are to be two (2) Start Times.*

		Start Time: 9:30 am					
		Start Time:					

6. Enter the time service session ends (Stop Time). **If two (2) sessions are done in one day, there are to be two (2) Stop Times.*

		Stop Time: 11:00 am					
		Stop Time:					

7. Enter the full time it takes to complete the session (Total Time). **If two (2) sessions are done in one day, there are to be two (2) Total Times.*

				Total Time: 1:30			
				Total Time:			

8. Enter the number(s) of the training objective(s) worked on during the service session. If no training is done, mark "N/A".

				Training/Objectives # 1,5,6			
				__N/A (No Training)			

9. Mark "yes" if transportation was provided to the participant and the total miles used. Mark "no" if no transportation was provided.

						Transportation: yes <input checked="" type="checkbox"/> no <input type="checkbox"/>	
						Total Miles: 10	

10. Write a brief note describing the service session.

Summary: **Josh completed his shopping, purchasing, and choice training programs this morning at the local grocery. He was attentive and did well except with making change. Completed all programs.** Signature/Title of Provider: **Joe Staff, Res Hab**

MR/DD WAIVER PROGRAM

CERTIFICATION OF TRAINING FOR HABILITATION PROVIDERS

Name of Participant: _____ Date: _____

Service Coordination Agency: _____

Name of Subcontracting Agency (If applicable): _____

Name of Location: GH ISS/Semi-I/Apt Day Pro SFCH NF Home

Period for Which Training is Valid: From _____ To _____

Trained on the Following Program Objectives:

- | | |
|----------|-----------|
| 1. _____ | 9. _____ |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | 16. _____ |

* Note: Specific procedure/techniques/methods may be found attached to the program plan.
Amount of time spent training is documented in the QMRP case notes.

I certify that I have received training on the program objectives listed above. I will contact the service coordinator or QMRP if additional training is needed.

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature of Person Trained/Title

Signature and Credentials of Trainer

Date

DD-13

Revised July 2004

Name of QMRP _____

Date _____

Service Coordination Agency _____

Name of Subcontracting Agency (If applicable) _____

* Highest level of QMRP approved to bill: QMRP I QMRP II QMRP III

* QMRP is: An employee of the service coordination agency
 Subcontracting with the service coordination agency through another licensed
B
 Privately subcontracting with the service coordination agency (community
provider)

* Bachelor's degree obtained: Yes N/A In what area? _____
 Is a copy on file: Yes N/A

* Master's degree obtained: Yes N/A In what area? _____
 Is a copy on file: Yes N/A

* Doctoral degree obtained: Yes N/A In what area? _____
 Is a copy on file: Yes N/A

* Current license/certification verifying registration as a medical therapist: Yes N/A
 In what area? _____ Is a copy on file: Yes N/A

* Outline the years/months of experience with MR/DD individuals (previous employment, training, paid internship etc.). Include dates, names of agencies/institutions and any other specific details of the experiences (***This section is not applicable for licensed QMRP III's***):

Has the Participant utilized this service in the current calendar year? YES NO

If yes, what is the total amount of funding utilized in the current calendar year? \$_____

ATTACH THE FOLLOWING DOCUMENTATION:

- IPP recommendations**
- Documentation of denials or exhaustion of non-Medical and non-family resources**
- Purchase order detailing costs and description for the Environmental Accessibility Adaptations.**

Service Coordinator Signature/Date_____

Agency Contact Person Signature/Date_____

****All Original Documentation (form and attachments) must be maintained in the participant's file. A copy of this form must be maintained in a single file by the Agency Contact Person.****

DD-19

Revised July 2004

MR/DD WAIVER NOTIFICATION OF PARTICIPANT DEATH

(This form is only used to report deaths of participants who reside in a 24 hour staffed setting.)

TO: Office of Behavioral Health Services
MR/DD Waiver Program
350 Capitol Street, Room 350
Charleston, West Virginia 25301-3702

FROM: _____

INFORMATION ON THE DECEASED:

Name _____ Gender _____ Age _____

Date of Birth ____/____/____ Address _____

City _____ Medicaid Number _____

DIAGNOSIS AND MEDICAL CONDITION:

Axis
I _____

Axis
II _____

Axis
III _____

Medications: (Use additional paper if necessary)

List all current medications prescribed and non-prescribed.

--	--	--

<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Purpose of Medication</u>

Date of Death _____/_____/_____ Time of Death _____ a.m. / p.m. (Circle One)

Location of Death _____

ATTACHMENTS

**TITLE XIX MR/DD HOME & COMMUNITY BASED WAIVER
 ASSESSMENT TO DETERMINE EXTRAORDINARY CARE**

Red indicates suggestions made by work group – Changes would have to be approved by CMS

MOTOR SKILLS	Not-Applicable not – applicable is not included in the average	Independent Completes without assistance	Semi-Independent May require assistance of a device without personal assistance	Minimal Assistance Intermittent physical assistance of another person	Moderate Assistance Requires physical assistance of another person to accomplish	Total Assistance Unable to complete without constant physical assistance of another person	AVERAGE SCORE
	N/A	0	1	2	3	4	
Ambulation and mobility (n/a 0-20 months of age)							
Transfers (example from bed to chair) (n/a 0- 30 24 months of age)							
Positioning (bed mobility) (n/a 0-9 months of age)							
TOTAL MOTOR SKILLS Average of 3.0 and above is “extraordinary”							

PERSONAL CARE SKILLS	Not-Applicable not – applicable is not included in the average N/A	Independent Completes without assistance 0	Semi-Independent Sometimes needs verbal prompt to complete task 1	Minimal Assistance Verbal prompt required to complete task 2	Moderate Assistance Physical prompt and/or repeated instructions required to complete task 3	Total Assistance Unable to complete without constant physical assistance of another person 4	AVERAGE SCORE
Dressing (n/a 0-48 months of age)							
Grooming (hair) (n/a 0- 60 48 months of age)							
Bathing (n/a 0- 60 48 months of age)							
Oral hygiene (n/a 0- 60 48 months of age)							
Eating with utensils (n/a 0- 60 36 months of age)							
Simple Meal Preparation (n/a 0 -120 months of age)							
Household Skills (adult only)							
Toileting (n/a 0-48 months of age)							
TOTAL PERSONAL CARE SKILLS Average of 3.0 and above is “extraordinary”							

DAILY LIVING SKILLS	Not-Applicable not – applicable is not included in the average N/A	Independent Completes without assistance 0	Semi-Independent Sometimes needs verbal prompt to complete task 1	Minimal Assistance Verbal prompt required to complete task 2	Moderate Assistance Physical prompt and/or repeated instructions required to complete task 3	Total Assistance Unable to complete without constant physical assistance of another person 4	AVERAGE SCORE
Ability to engage in and complete age appropriate routine tasks (task in the home that would be age appropriate i.e. make bed)							
Ability to cross nearby residential street in own neighborhood (n/a 0 -84 month)							
Ability to ride public transportation (n/a 0-16 years)							
Ability to make simple purchases in own neighborhood (n/a 0 - 84 months)							
Age appropriate ability to recognize dangers (i.e. hot stove, traffic)							
TOTAL DAILY LIVING SKILLS Average of 3.0 and above is “extraordinary”							

COMMUNICATION SKILLS	Not-Applicable not – applicable is not included in the average N/A	Independent Completes without assistance 0	Semi-independent Sometimes needs verbal prompt or assistance to complete 1	Minimal Assistance Verbal prompt or assistance required to complete task 2	Moderate Assistance Physical prompt and/or repeated instructions required to complete task 3	Total Assistance Unable to complete without constant physical assistance of another 4	AVERAGE SCORE
Ability to communicate basic wants and needs (n/a 0-36 months)							
Ability to understand simple directives, instructions (n/a 0-48 months)							
Ability to initiate age appropriate social contacts with peers in own neighbor (n/a 0-84 months)							
Ability to understand very basic reading and writing (i.e. ability to recognize basic signs and written communication) (n/a 0-84 months)							
TOTAL COMMUNICATION SKILLS Average of 3.0 and above is “extraordinary”							

MALADAPTIVE ISSUES (will require a formal guideline, protocol or plan)	not – applicable is not included in the average N/A	This is not a problem – 0	Mild 1	Moderate 2	Serious 3	Extreme 4	AVERAGE SCORE
Participates in Self – Injurious Behaviors							
Participates in destruction of property							
Participates in behavior physically hurtful to others							
Participates in behaviors that interferes with activities of others							
Demonstrates unusual or repetitive habits							
Participates in behavior that is offensive to others							
Demonstrates verbal aggression							
TOTAL MALADAPTIVE ISSUES 2.0 or above on any item would be reason to evaluate for a guideline or protocol or plan – Has to be linked to ICAP assessment.							

SPECIALIZED PHYSICAL, MEDICAL AND THERAPEUTIC NEEDS	Not-Applicable not – applicable is not included in the average	Independent Completes without assistance	Semi- independent Sometimes needs verbal prompt to complete task	Minimal Assistance Verbal prompt required to complete task	Moderate Assistance Physical prompt and/or repeated instructions required to complete task	Total Assistance Unable to complete without constant physical and/or verbal assistance of another	AVERAGE SCORE
	N/A	0	1	2	3	4	
Ability to carry out specific therapeutic exercises (i.e. Physical, Occupational, Speech- Hearing –Language Plans)							
Ability to manage own medication (adults only 18 years of age and above)							
TOTAL SPECIALIZED Score of 3.0 on either item							

Payments will not be made for the routine care and supervision which would be expected to be provided by the care taker, or for activities or supervision for which payment is made by source other than Medicaid. Medicaid does not cover these components.

Services that are provided by legally responsible relatives will not cost more than equivalent services from customary providers.

COMMUNITY RESIDENTIAL HABILITATION PROVIDED BY A LEGALLY RESPONSIBLE RELATIVE

MR/DD Waiver Program providers must adhere to the following provisions as a condition of participation in the MR/DD Waiver Program and as a condition of reimbursement for habilitation services:

- The legally responsible adult may only provide services that have been identified as necessary in the Extraordinary Care Assessment.
- The legally responsible adult may only deliver the service of Community Residential Habilitation **to the individual in which they have legal responsibility.**
- Community Residential Habilitation cannot replace routine parenting activities.

The Service Coordination provider agency is responsible for the arrangement of residential habilitation services either through a legally responsible adult or other qualified residential providers.

Provider Qualifications:

- The individual is at least 18 years of age. Proof of age must be kept on file
- The individual has current certification in Cardio Pulmonary Resuscitation (CPR) and First Aide. Current certifications must be kept on file.
- The individual has received training. (It is necessary for providers of community residential habilitation services to receive training by a professional QMRP in instructional techniques necessary to achieve the objective specific to the member's IPP and issues related to health and welfare prior to the implementation of services). Following QMRP Instruction/training and documentation of the specific training goals must be included on the Certification of Training for Habilitation Providers form (DD-13).

The Service Coordination provider agency monitors the Residential Habilitation services provided by the legally responsible relative, as it does all services, through monthly home visits and other contacts. The agency which is responsible for providing Residential Habilitation services arranges for or provides a Qualified Mental Retardation Specialist who is responsible for training and monitoring to ensure the delivery of services in accordance with the IPP.

MR/DD WAIVER NURSING ACUITY GRID

8 HOURS PER DAY OR MORE NURSING SERVICES

Member _____

Agency _____

Medicaid Number _____

	Pt	Sc		Pt	Sc		Pt	Sc
Weight < 100 lbs	2		Weight < 125 lbs	3.0		Weight 125 lbs or greater	4.5	
Minimal on-going assessments (less than daily)	2		Moderate on-going assessments (Hands on every 4 - 6 hours)	4.0		Frequent visual monitoring (both technical and patient assessment)	9.0	
			VS/GLU/NEURO/RESP assess < q4 hr*	1.5		Continual assessments	6.0	
						VS/GLU/NEURO/RESP assessments > q 4 hr	1.0	
Routine meds > q 4 hrs	2		Complicated med schedule > q 2 hrs	5.0		VS/GLU/NEURO/RESP assessments > q 2 hr	3.0	
			Central line	2.5		Regular blood draws/IV Peripheral site **	4.5	
			Occasional transfusion/IV < month	2.5		Regular blood draws/IV central line **	6.0	
						IV Rx < q 4 hr	4.5	
Uncomplicated tube feeding	2		Tube feeding with minimal problem	2.5		IV Rx q 4 hr or more often	6.0	
Difficult/prolonged oral feeding	2		Occasional reflux	0.5		Central line with TPN	6.0	
			Gastrostomy tube	0.5		Chemotherapy	6.0	
O2 via cannula low flow rate	2		Tracheostomy (routine care)	1.5		IV pain control	6.0	
Suctioning < q 2 hrs	2		Suctioning > q 2 hrs	2.5		Ventilator	9.0	
Aspiration precautions	2		Humidification	1.5		No respiratory effort	12.0	
						C PAP or IMV < 12 hours/day	6.0	
						C PAP or IMV > 12 hours/day	9.0	
			CPT or Neb Tx < q 4 hours	1.5		Standby	3.0	
Requires all personal care/hygiene	2					Rehab transition (from ventilator)	9.0	

		Mild-mod seizures (Req min intervention)	2.5	CPT or Neb Rx > q 4 hr * (enter #_____)	3.0
		Frequency < 4 x day	1.5	CPT or Neb Rx > q 2 hr * (enter # _____)	3.0
		Frequency 4 - 6 x day	2.0	Severe seizures (reg IM or IV intervention)	4.5
Uncontrolled incontinence	2	Intermittent straight catheter	3.5	Frequency > 6 x day	1.5
Awake no more than 3 hr a night	2	Moderate sleep disturbance (Awake/turned q > 2 hr a night)	3.5	Uncontrolled incontinence (Frequent linen change)	6.0
Communication deficit (cognitive or verbal)	2	Disorientation/combativeness (Strikes out, attempts to hurt self)	5.0	Severe sleep disturbance (Awake > q 2 hr)	6.0
Developmental deficit	2	< 80 lbs	1.5		
		< 110 lbs	2.0	Disoriented/combativeness > 140 lbs	6.0
		< 140 lbs	2.5		
Developmentally delayed mobility	2			Requires isolation	6.0
Basic ROM (No PT or OT program)	2	Full OT (Set program q 4 hr)	5.5	Acute mobility problems (Potential for skin breakdown)	6.0
Play therapy	2	Full PT (Set program q 4 hr)	5.0		
Fracture or casted limb	2			Attends therapy with nurse	6.0
Body cast	2	RN case management < 4 hrs week ***	2.5	Peritoneal dialysis	6.0
		RN case management > 4 hrs week ***	5.0		
TOTAL		TOTAL		TOTAL	

Pt - Point Sc - Score * Give points for each type of assessment and each Neb or CPT Rx

** Give points for each IV Rx or blood draw ordered to a maximum of 10 points

***** Documentation must support item selected**

Nurse: _____

Date: _____

Signature: _____

Total Points: _____

MR/DD WAIVER

MR/DD WAIVER NURSING PSYCHOSOCIAL GRID

8 HOURS PER DAY OR MORE NURSING SERVICES

Member _____

Agency _____

Medicaid Number _____

	Minimal	Pt	Sc	Moderate	Pt	Sc	Extensive	Pt	Sc
Medical Management	Managed by primary care provider or one specialist.	1		Requires periodic medical specialty consultation.	2		Requires multidisciplinary team approach	3	
Primary Caregivers	Other caregivers present in home to provide care.	1		Other caregivers available outside of home by arrangement.	2		No other caregivers available	3	
Wage Earner	At least 2 responsible adults in home. Primary caregiver is not primary wage earner.	1		At least 2 responsible adults in the home. Primary caregiver contributes to wage earnings or is primary wage earner.	2		Primary caregiver may or may not be primary wage earner. Only one responsible adult in home.	3	
Family Constellation	No other dependents/or dependents have minimal needs.	1		1 to 3 dependents with moderate medical or emotional needs.	2		Greater than 3 dependents in the home with intense medical or emotional needs.	3	
Problem Solving Skills	Family exhibits problem identification and problem solving skills.	1		Family requires assistance in identifying problems/problem solving.	2		Family requires extensive assistance to recognize problems and identify solutions.	3	
Coping	Family follows through with recommendations, keeps appointments.	1		Family needs encouragement to follow through on recommendations. Inconsistent in keeping appointments.	2		Family follows through on recommendations only with extensive support and assistance.	3	
Support Systems	Support systems present and utilized.	1		Support system present but family needs encouragement to utilize.	2		Support systems absent.	3	
Other Stressors	No history of mental illness, and/or behavior problems.	1		History of mental illness or behavior problems among family members.	2		Current diagnosis of mental illness and/or behavior problems among family members.	3	
Resource Utilization and/or Private Insurance	Family's physical survival and security needs are met. Community resources and/or private insurance utilized.	2		Family resources are inadequate, barely meets its needs for security and physical survival. Able to buy only necessities. Requires assistance in identification/utilization of resources.	4		Family does not meet its needs for security and physical survival. Unable to buy the necessities. Requires intensive assistance to identify and utilize resources.	6	
Safety/Shelter	No safety or health hazards identified in home environment.	1		Needs assistance to correct safety and health hazards.	2		Home inadequate to meet minimum safety and health standards.	3	

ADL's (age appropriate)	ADL's met consistently.	1		Inconsistent in meeting ADL's.	2		ADL's not met.	3	
	TOTAL			TOTAL			TOTAL		

Pt - Point Sc - Score

Nurse: _____

Date _____

Signature: _____

Total Points _____

MR/DD WAIVER