



MR/DD WAIVER FREQUENTLY ASKED QUESTIONS



Volume 2-November 16, 2006

1. **If the team has reported the annual IPP date to APS as first day of the month, will the IPP be considered out of date if the date on the last IPP is October 23, 2006, and the date of the annual IPP reported to APS is November 1, 2006?**

The policy manual indicates that there is a 30 day window either before the due date of the IPP or after the due date of the IPP. The manual specifies the allowable number of cancellations of the IPP meeting by the provider and the member or family (one cancellation for each party within the 30 day limit). Services provided beyond 30 days will not be reimbursed.

2. **Will APS distribute 4 PA's at the time of the annual budget or will APS distribute PA's by the quarter?**

APS will distribute 4 PA's for the entire year at the time of the annual purchase of services. Each PA will have dates of service specific to the quarter.

3. **Providers previously billed QMRP for psychiatric medication visits ("med checks"); will this be included in the annual budget?**

No. These services are no longer available under Waiver. For members with co-existing mental health disorders, the member may be referred to a mental health provider. (i.e. Private Psychiatrist, Community Mental Health Center, etc.) These services are not included in the Waiver budget.

4. **Will EAA be included in the budget?**

Yes. When the member purchases EAA services, it will be included in the budget.

5. **When information is requested or clarified, how will providers be consistently informed?**

Training Material: APS training information or power point presentations will be posted on the APS website.

FAQ's: FAQ's will be emailed to providers. Check BMS, BHHF, and APS websites for other information.

Crosswalk: Procedure Code Crosswalk will be distributed with dates of implementation at the top of the form. Any new Crosswalk will be re-dated with the current date at the top.

Rates: Rates will be posted on the BMS website and distributed by mail and email. Bureau for Medical Services will issue formal policy clarification, billing, or procedural notices by letters or memos from the Bureau.



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Contacts:

For specific questions, contact the following:

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Changes in Manuals:

Providers will be notified of any changes or updates. The change log located at the front of the manual will reflect the change and the date of implementation.

6. Will the recent FAQ's released by BHHF be considered formal notification regarding policy?

Yes. FAQ's are an official clarification of policy.

7. Are providers required to complete the Care Connection for MR/DD Waiver recipients?

The Care Connection is not required by BMS or BHHF for MR/DD Waiver services. Members who need Behavioral Health Clinic or Rehabilitation will need to have the Care Connection completed.

8. In the previous manual, when the QMRP "ran out of units" in QMRP Level II, the QMRP could "bill-down" to QMRP Level I for additional units. Is this appropriate with Therapeutic Consultation (TC) codes in the new manual?

No. The TC must bill the specific service that the member needs and service to which the staff is qualified to bill. It is not appropriate to "bill-down" to a lower level of service.

9. If a member has only one Therapeutic Consultant, how will the Therapeutic Consultant bill when the Therapeutic Consultant provides both Residential and Day Habilitation services?

The residential TC is always the lead TC. It is only necessary to bill residential TC. The TC does not need to bill the day TC.

10. Does Medicaid limit the provider's administrative charges for contracted services?

No. MR/DD Waiver policy and BMS general policy does not specify a limit for administrative charges by a provider agency for a contracted entity. Historically, it was the intent for administrative charges to cover the cost of processing and the provider tax.



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11. Is it necessary to request approval for services exceeding the \$6,400 monthly ICF-MR cost?

No. The new policy manual does not require approval to exceed the monthly ICF-MR cost. Prior authorization is required for other services.

12. If I need a PA during the month of November, where do I send my request?

Send requests to Steve Brady at BHHF for the months of November and December. Beginning January 1, 2006, providers should request PA's from APS for services requiring a PA...

13. If a member needs counseling or therapy and this was previously provided under QMRP Level II billing, how will the member access counseling or therapy now?

Any member who needs counseling or therapy due to a mental health need may be referred to a mental health provider. APS PA's those services as well and they are based on medical necessity. Please develop a "back-up plan" for those individuals.

14. My Waiver agency contracts with a psychologist for annual psychological evaluations. I was told that Waiver provider agencies can no longer contract with a psychologist. Is this true? Will the Waiver agency be able to continue to bill for the psychological evaluations with a contracted psychologist?

Yes. The MR/DD Waiver provider agency may continue to contract with a psychologist and bill for the evaluation. Only a psychologist or psychologist under supervision may perform the service.

15. Can respite be a planned scheduled event?

Yes. Respite may be used to allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members (Chap 500, pg 43). Respite, however is not intended for everyday provision of care for a child or adult in the absence of parent(s) or primary caregiver(s) when the parent(s) or caretaker(s) goes to work.