

## **WEST VIRGINIA MEDICAID MR/DD HOME AND COMMUNITY BASED WAIVER MANUAL PUBLIC COMMENT PERIOD**

The Bureau for Medical Services (BMS), commonly known as West Virginia 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 for Medicare and Medicaid Services (CMS), the federal agency who has oversight over this program.

Over the last several weeks a workgroup of stakeholders from the Quality Assurance and Improvement Advisory Council, along with MR/DD Waiver staff, APS Healthcare, and BMS staff have been working on a draft of the manual. Public meetings were also held around the state with stakeholders to gather additional input.

We are again seeking additional comments from the public before the manual is finalized. All comments must be submitted by May 4, 2006. You may submit your comments in writing to Regina Wilson, Bureau for Medical Services, 350 Capitol Street, room 251, Charleston, West Virginia 25301, by fax to (304)558-1509, by email to [reginawilson@wvdhhr.org](mailto:reginawilson@wvdhhr.org) or you contact Regina Wilson via telephone, (304) 558-1708.

We very much appreciate your time and consideration. If you have any questions concerning this advisement, please call Pat Winston at (304) 558-1709.



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## CHAPTER 500—COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS, FOR 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).

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

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

**Activities of daily living (ADL's)** are activities usually performed in the course of a normal day in an individual's life, such as eating, dressing, bathing and personal hygiene, mobility, and bowel and bladder control.

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

**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



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guide the service delivery process. The development of the IPP is a joint effort between the member and other individuals such as professionals and natural supports involved in the member's life. The content of the IPP is guided by the member's needs, wishes, desires, and goals.

**Interdisciplinary Team (IDT)** is the member and 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. The IDT meetings are guided by the member's needs, wishes, desires, and goals.

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

**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:

- Is a 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

**Therapeutic Consultant:** A professional who provides services ~~either directly or~~ indirectly to the member to meet the behavioral, therapeutic, and person-specific needs. Therapeutic Consultant services may be provided by agency personnel or through contracted providers of this service. Therapeutic Consultant Services is a required component for the oversight of any training program or direct care services. Additional qualifications may be necessary dependent upon the specific service.

**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. It is administered by BMS in collaboration with BHHF pursuant to a Medicaid waiver option approved by the Centers 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 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

The Bureau for Medical Services (BMS) contracts with an Administrative Services Organization (ASO), APS Health Care, Inc., and the Bureau for Behavioral Health and Health Facilities (BHHF). They both act as an agent of BMS. BHHF administers the operation of the MR/DD Waiver Program. The Administrative Service Organization will conduct training for providers, consumers, advocacy groups, and DHHR. The ASO will provide a framework and a



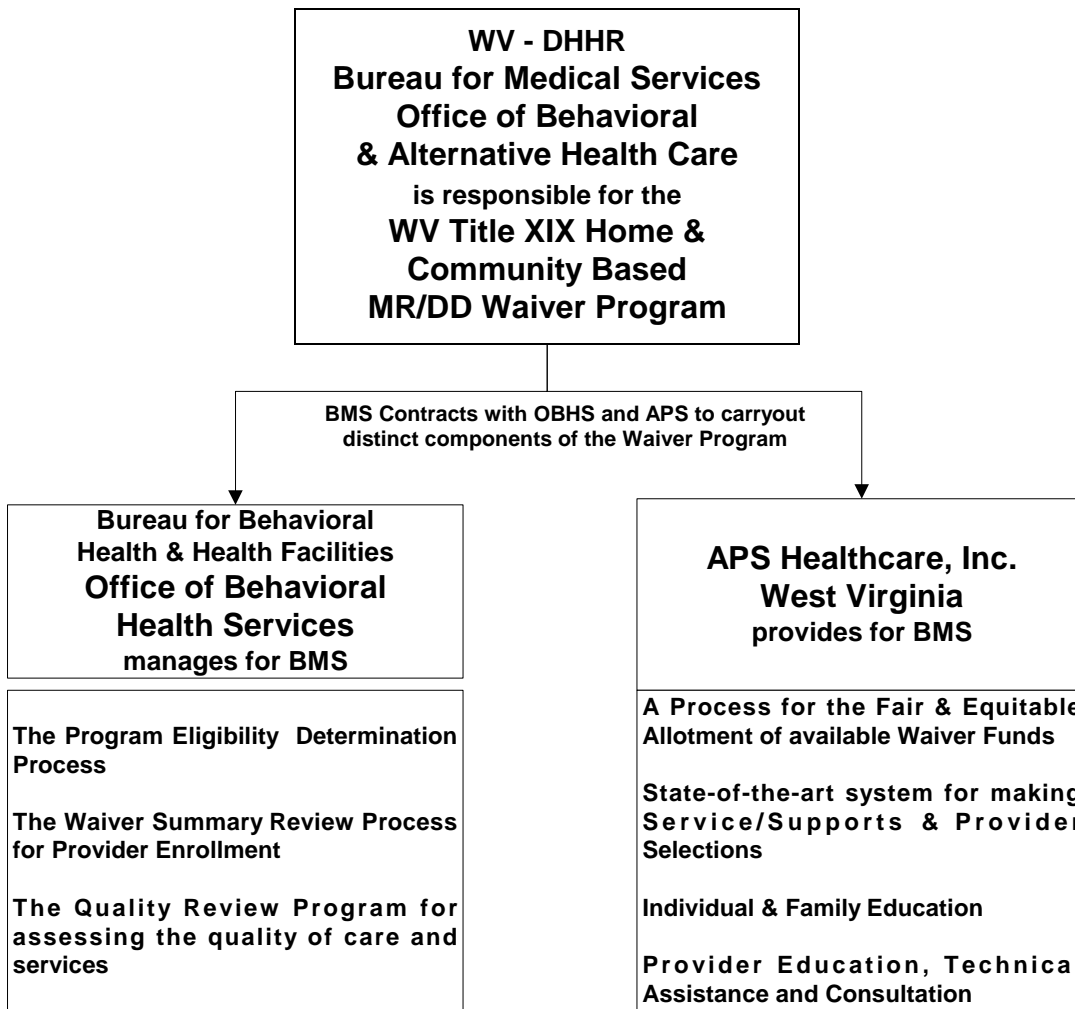
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process for the purchase of waiver services based on assessed needs and will provide service registration information to claims payer. BMS contracts with community behavioral health provider agencies for the provision of services for program members.



## 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



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

## 502.2 SPECIFIC REQUIREMENTS

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

- Meet and maintain the standards established by the Secretary of the U. S. Department of Health and Human Services (DHHS), and all applicable state and federal laws governing the provision of these services. Providers must receive Health Care Authority approval to provide behavioral health services via the Certificate of Need process (CON). In addition, they must have a full behavioral health license issued by the Office of Health Facility Licensure and Certification (OHFLAC). Prevocational services and supported employment entities acknowledged by a Division of Rehabilitation Services vendor, and a MR/DD Waiver provider 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 THERAPEUTIC CONSULTANT providers as referenced in Section 513.8



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### 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.

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

- Member Exit/Transfer Form (DD-16). The DD-16 must include the last date of service provided.
- Mortality Notification (DD-20) is due to the State MR/DD Waiver Office within seven days from the date of death.
- The Service Coordination Agency must notify the state MR/DD Waiver Office in writing, if they are exceeding the maximum case load cap. The Service Coordination Agency must address the following in writing within 48 hours:
  - The number of members per each Service Coordinator whose case load exceeds twenty members (e.g., Service Coordinator Name, # of members).
  - The agency plan, including time lines for hiring and training new Service Coordinators
  - The agency must include a back-up plan to cover emergencies.
- Changes in status (change of address, telephone number, service coordination provider, habilitation provider, etc)
  - The service coordinator is required to notify the state waiver office of the transfer of a member to another service coordination agency within ten (10) working days
  - The transferring agency is responsible for the notification
  - Lack of notification of the transfer will affect the prior authorization for service or registration of services to the correct service provider(s) and subsequent payment of claims for services

### 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 at the BMS Web Site ([www.wvdhhr.org/bms](http://www.wvdhhr.org/bms)).
- MR/DD Waiver Program provider agencies must comply with all other documentation requirements of this chapter.



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- All required documentation must be maintained for at least five (5) years in the provider's file subject to review by authorized BMS personnel or contracted agents. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute or five (5) years whichever is greater.
- All required documentation and records must be available upon request by BMS or federal monitors, or contracted agents for auditing and/or medical review purposes. Record retention must be in accordance with the MR/DD Waiver Record Retention Guidelines as found in Attachment 1 (verify content of 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.
- Agencies that wish to computerize any of the forms, DD-1 through DD-13, may do so. However, all basic components must be included and the name/number indicated on the form (refer to Chapter 300 for a description of general requirements for Medicaid record retention and documentation). This can be found on the BMS web site ([www.wvdhhr.org/bms](http://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.



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- MR/DD Waiver services may be provided out-of-state to participants residing in border counties of the state of West Virginia. The out-of-state services provided must be located within thirty (30) miles of the West Virginia border. The service is made available with the following limitations:
  - 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:

- The MR/DD Waiver Program must not substitute for entitled programs funded under other Federal public laws such as Special Education under P.L. 99-457 or 101-476 and rehabilitation services as stipulated under Section 110 of the Rehabilitation Act of 1973. (Public schools can currently bill for specific medical services under their own Medicaid provider numbers).
- Residential Habilitation payments may not be made for room and board or the cost of facility maintenance and upkeep
- Birth to Three services paid for by Medicaid for children enrolled in the MR/DD Waiver program
- MR/DD Waiver services may not be provided concurrently unless otherwise indicated in the service definition. For example Residential Habilitation services may not be provided concurrently with the individual's Day Habilitation Program, School services or Respite Care services.
- Personal care is not a habilitation service and may not be billed as such.

### **503 MEMBER ELIGIBILITY AND ENROLLMENT PROCESS**

The determination of the member’s eligibility is as follows:

#### **MEMBER ELIGIBILITY**

The member must have a determination of Medical Eligibility

The member must have a determination of Financial Eligibility

The member enrollment process is as follows:

#### **MEMBER ENROLLMENT**

The member is enrolled in the MR/DD Waiver Program at the time the member is granted a Waiver allocation (slot).



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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 (DHHR) office for assessment of financial eligibility.

### 503.1 APPLICATION

- A member may obtain an application information packet from: Local Behavioral Health Centers, local/county DHHR Offices 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.
- 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 if the member chooses over 90 days on the application (statement of interest). The Planning Registry is maintained by the State MR/DD Waiver office.
- The application process includes the preparation of the application packet and determination of medical eligibility and should occur within 90 days (45 days to complete the packet and 45 days to determine eligibility).
- Once the applicant completes the DD-14, he/she will submit the DD-14 to the selected MR/DD Waiver provider agency or the State MR/DD Waiver Office.
- Upon receipt of the DD-14, the Waiver provider agency will sign and date the DD-14.

The Waiver provider agency will forward a copy of the DD-14 to the State Waiver office. Applications should be addressed to the Bureau for Behavioral Health and Health Facilities (BHFF), Waiver Department, 350 Capitol Street, Room 350, Charleston, WV 25301

- 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. The Service Coordinator is then 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



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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 Comprehensive Psychological Evaluation (DD-3)
  - Completed psychological evaluation that includes clinical verification that the mental retardation and/or related condition with associated concurrent adaptive deficits were manifested prior to the age of 22, and are likely to continue indefinitely.
  - Any other documentation or information the provider agency or the applicant indicates as pertinent to determine eligibility such as:
    - A completed Social History (DD-4) (if applicable and available)
    - IEP, for school-age children (if applicable and available)
    - Birth to Three assessments (if applicable and available)

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

### Medical Eligibility Criteria

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

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



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- MR/DD State Waiver Office determines the level of care (eligibility) based on the Annual Medical Evaluation (DD-2A), the Psychological Evaluation (DD-3) and 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. Other documents that include the Social History, IEP for school age children and Birth to Three assessments if applicable and available may also be utilized.

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**

- 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.
  - Examples of related conditions which may, if severe and chronic in nature, make an individual eligible for the MR/DD Waiver Program include but are not limited to, the following:
    - Any condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires services similar to those required for persons with mental retardation.
    - Autism
    - Traumatic brain injury
    - Cerebral Palsy
    - Spina Bifida
    - Tuberous Sclerosis
  - Additionally, 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.
- Must have 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, any individual 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.



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#### Functionality

- Substantially limited functioning in (3) three or more of the following major life areas; (substantial limits is defined on standardized measures of adaptive behavior scores as (3) three standard deviations below the mean or less than (1) one 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 the documentation submitted for review, i.e., psychological, 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.
  - 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, engage in leisure activities and 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, 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).



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## 503.2 FINANCIAL

- The applicant or legal representative must make an application. However, it is the responsibility of the Service Coordinator to assist the member and ensure that the application is made. Written notification of medical eligibility for the MR/DD Waiver Program must be presented to the local/county DHHR to ensure accurate Medicaid coding for the appropriate Waiver program.
- An Economic Service (ES) Worker will take the application for financial eligibility (on a DHHR form labeled the ES-2 form) and the local/county DHHR office will determine financial eligibility for the MR/DD Waiver Program. If a person is Medicaid eligible and already has a medical card, the applicant, applicant's legal guardian or the service coordinator must contact the local/county DHHR office once eligibility is established to ensure he/she is properly coded.
- Individuals who are eligible for both Supplemental Security Income (SSI) and the MR/DD Waiver Program will not have to re-establish their financial eligibility every 6 months. Annual re-determination of financial eligibility for SSI benefits is used to re-establish financial eligibility for the MR/DD Waiver Program.

### Financial Eligibility Criteria

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 assets are 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).



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#### 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 the state's 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 (provided the member has a Waiver allocation):

- The date of medical eligibility (Psychological Evaluation, DD-3) which is established by the psychological evaluation or addendum (if the psychological is more than 90 days old) in an initial application packet
- The date on which the applicant made the application for financial eligibility at the local/county DHHR office

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

## **504 RE-DETERMINATION**

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

#### Annual Re-certification Application Packet



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At minimum, the Annual Medical Evaluation (DD-2), and the most current Psychological Evaluation (DD-3) must be submitted (see frequency requirements for psychological evaluation of adult or child). Any other documents/information the agency/applicant deems pertinent for re-determination may be submitted.

#### Frequency Requirement for Psychological Evaluation

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

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

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

- The required evaluations (DD-2, DD-3, etc) are reviewed by the State Waiver Office. If indicated, additional information may be requested provided the information is applicable and available as needed in order to determine recertification.
- The State Waiver Office sends a memorandum to the member's local DHHR 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.
- 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 State MR/DD Waiver office within 30 days of the expiration date of the member's eligibility may result in any of the following:

- Request to hold the submission of claims for reimbursement
- Loss of reimbursement for services provided
- Loss of Medical Card through the West Virginia DHHR (Medicaid coverage)
- Loss of reimbursement for services provided

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

## 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.



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- 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. Any change of provider will require a meeting of the Interdisciplinary Team.

#### **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 503.2 of this chapter. The county DHHR office must be contacted, in addition to the state MR/DD Waiver Program Coordinator's office, any time an individual's income or assets exceed the limits. The county DHHR office will close the Medicaid file upon notification of the increase in income or assets and notify the individual and the MR/DD Waiver Program office of termination of the medical card.
- The evaluations, which are used by the MR/DD Waiver Program to determine an individual's level of care (medical eligibility), demonstrate that he/she no longer requires an ICF/MR level of care and therefore, is not medically eligible for the MR/DD Waiver Program. The State MR/DD Waiver office will notify the individual of termination of services and of his/her right to appeal.
- 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 review and sign the Informed Consent (DD-7) indicating the choice to obtain other services and the Service Coordination provider agency must convene or participate in developing the IPP to transition the 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 representative.
- Any time an individual loses eligibility or chooses to leave the MR/DD Waiver Program, both the local DHHR office and the State MR/DD Waiver Program office must be informed of the date of the individual's discharge from MR/DD Waiver services. The termination of MR/DD Waiver services may be appealed through the appeals process outlined in Section 507 of this chapter.

#### **507 RIGHT TO APPEAL**

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



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#### 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, it 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 his/her legal representative 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 of written notification of the decision from the local agency. The MR/DD Waiver Program Coordinator will review the IPP, the relevant evaluations and the written decision from the local agency to determine the appropriateness of the services and implementation as described in the IPP.
- If the appeal is not resolved satisfactorily by the State MR/DD Waiver Program Coordinator, the person may then appeal to BMS. The appeal should be forwarded 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. If services being appealed are part of an initial IPP and have not been previously been offered, the service being appealed cannot be offered to the member.

#### 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 the 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.
- If MR/DD Waiver services are terminated or reduced by the State, 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.
- **90 Days to Request a Hearing:** The member has ninety (90) days to request a hearing after a Notice of Decision regarding eligibility has been received. Any member or authorized legal representative may request a hearing and must do so either by a written request or by using the "Request for Hearing" form. Refer to Request for Fair Hearing form.
- **13 Days to Request to Continue Services When Requesting a Hearing:** If services are terminated by the State and a hearing is requested, services will continue until a hearing decision is rendered. If an applicant/member wishes to appeal a decision they must submit the request for a hearing or pre-hearing



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conference within 13 days of receipt of the “Notice of Decision” to continue to receive services in the interim. Services are not continued while petitioning the appellate court. Refer to Appendix L of the General Medicaid Policy Manual.

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

#### **Appeal of a Budget Allocation by the Administrative Service Organization**

- If the appeal is not resolved by the Administrative Service Organization, APS Healthcare, Inc. 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.

#### **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:



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- 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 member's current IPP, along with authorizations granted by the BHHF Waiver Department, will be valid until the individual's annual IPP or there is a major juncture of treatment that requires a service to be modified or added. On or after July 1, 2006, the ASO will be responsible for the granting of prior authorizations at major junctions of treatment and at the time of the IPP.

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 to 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 Prior Authorization (for services would continue until such time that the next 90 day quarterly IDT meeting is conducted (Example: IDT team may meet at the next 90 day quarterly meeting if the member is hospitalized).

The Individual Waiver Budget Process is as follows:

- Administrative Service Organization (ASO) provides member education on the process, the available services under the waiver program, available provider agencies in the area, general information on the program and the Individualized Waiver Budget
- ASO conducts an independent assessment in collaboration with the member (and member's legal representative, if applicable). The logistics of scheduling the assessment will be done in collaboration with the member and his/her legal representative if applicable, and the service coordinator
- Individualized Waiver Budget is developed by the ASO which is based on the objective assessed needs of the member
- ASO recommends the Individualized Waiver Budget to the Service Coordinator
- 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.



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#### **509.1 PRIOR AUTHORIZATION**

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

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

#### **509.2 SERVICES REQUIRING PRIOR AUTHORIZATION**

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

- Exceeding the individual budget by the ASO
- Waiver Nursing services exceeding the minimum limits
- 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
- Exceed Transportation limit of 700 miles per month
- Respite in a general medical hospital.

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

#### **509.3 PRIOR AUTHORIZATION PROCESS**

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

- Submit prior authorization requests to the ASO
- Prior authorization requests for treatment junctures are to be submitted no less than 10 working days prior to the provision of services. If further clarification of a request is needed, 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 with the exception of crisis services (refer to Crisis Services).

The service coordinator is responsible for ensuring that all prior authorizations for the various providers are forwarded to the ASO. This process should be addressed during the Interdisciplinary Team Meeting.



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## 510 BILLING PROCEDURES

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

- MR/DD Waiver Program provider agencies must bill all third party liabilities such as a member's private insurance for those services that are covered by both private insurance and the Medicaid waiver program prior to billing Medicaid. Medicaid is considered a secondary insurance to an individual's private insurance.
- Claims will not be honored for services (inclusive of service code definitions) provided outside of the scope of Chapter 500 of the MR/DD Waiver policy manual or outside of the scope of federal regulations.

### 510.1 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.

#### PAYMENT LIMITATIONS

- Medicaid is the payer of last resort. Therefore, private insurance must be billed first for those services covered by both private insurance and Medicaid. The Service Coordinator must inform the member, his/her family and/or his/her legal representative of this requirement.
- MR/DD Waiver services may not be charged while an individual is receiving services as an inpatient in a hospital, nursing facility or ICF/MR. As an exception, while a member is inpatient in a non-state operated hospital, the member may receive respite services when the member requires a support staff that 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 Therapeutic Consultant, which may be billed starting 30 days prior to discharge. Allowable activities for the Therapeutic Consultant are assessment, evaluation, habilitation plan development, or behavioral support plan development, and training of direct support staff assigned to provide services at the time of discharge. The State MR/DD Waiver Coordinator must be notified of the actual date on which an applicant is discharged from an ICF/MR or state institution and begins to receive MR/DD Waiver services.
- Services provided during the initial evaluation process for completion of the application packet, such as Evaluations and Service Coordination, may be billed when the following criteria is present:
  - An allocation (*slot*) is available to the member
  - The psychological evaluation is within 90 days



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- The IPP is current and includes the services
- The member is both medically and financially eligible
- The date of service is not before the initial date of eligibility on the Medical card
- Ongoing services such as residential habilitation or day habilitation may be billed when the following criteria is in place:
  - An allocation (*slot*) is available to the member
  - Medical and financial eligibility 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.

#### **511 INTERDISCIPLINARY TEAM (IDT) COMPOSITION**

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

At a minimum, the annual IDT consists of:

- The member;
- His/her family and/or legal guardian as applicable;
- A service coordinator;
- At least one member of the team must be either the member's Skills Specialist or a Behavioral Specialist/Analyst;
- Representatives of all agencies/providers who provide services to the individual;
- Other members of the IDT must be included, as necessary, to develop a comprehensive IPP and assist the individual. Such members may include:
  - 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 as determined by the team;
  - A psychologist is required when the member has the need for specialized psychological evaluation and intervention due to co-existing mental health disorders or behavioral needs;
  - Professionals, such as a Physical Therapist, Occupational Therapist, Speech Therapist, Registered Dietician, Social Worker, etc.;
  - Paraprofessionals;
  - Direct service providers, such as Day Habilitation Program providers, Residential Habilitation providers and counselor;



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- 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. 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. IDT's **must** be rescheduled within 30 days of the expiration date. A total of two (2) requests to re-schedule the IDT may occur when extenuating circumstances exist. The following conditions exist:

- The Provider agencies may request to reschedule the IDT only once for an IPP.
- The member or member's legal representative (guardian) may request to re-schedule the IDT meeting only once for an IPP.
- The service coordinator is responsible for the coordination of the IDT meeting for the IDT team members.
- In extenuating circumstances, family members or guardians may participate by teleconferencing or video conferencing if the family member or guardian does not bill for the time spent in the IDT. The member and the service coordinator must be physically present during the IDT.

**NOTE: Delay of an IPP can result in a disallowance for the service beyond the 30 day expiration date.**

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. (Example: a change in where the member lives, when a new service is being added or deleted or a change is being requested for a service provider).



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- **Crisis IDT Meeting** – This type of IDT Meeting occurs when a member is experiencing a crisis (example: behavioral, medical, housing and service provision). In the event that all team members cannot be present (for a crisis IDT meeting only), a written report of the crisis IPP must be disseminated to all members within 5 working days.
- **Discharge Planning IDT Meeting** – This type of meeting must be held when a member is being discharged from MR/DD Waiver Services. This must also occur if the member is transferring to services outside of the Waiver program. Example: discharge from MR/DD Waiver services into an ICF-MR facility.

## 512 PROVIDER TRAINING

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

- Overview of Developmental disabilities
- People First Language
- Normalization
- Sensitivity to Individual/Family Needs/Concerns
- Participant Rights and Confidentiality
- Recognition of and reporting of neglect and abuse
- Positive Behavior Support
- Non-violent Crisis Intervention
- 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, Skills Specialist and Behavioral Specialist/Analyst must have training in:

- Development of task analysis and/or methodology



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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 providers training prior to the delivery of services.

**Provider agencies must maintain record of the training verification.**

## 512.1 INDEX OF COVERED SERVICES

Procedure Description	Procedure Code	Section
<b>Individual Program Development</b> Social Worker, Service Coordinator, Skills Specialist, Behavioral Support Specialist	T2024 U7	513.1
<b>Individual Program Development</b> Behavioral Analyst, Registered Nurse	T2024 U8	
<b>Individual Program Development</b> Physical Therapist, Occupational Therapist, Speech Language Therapist, Psychologist	T2024 U9	
<b>Service Coordination</b>	T1016 HI	513.2
<b>Transportation</b> per mile	A0160 HI	513.3
<b>Transportation</b> per trip	A0120 HI	
<b>Respite Care</b> Contracted Level 1 1:1 ratio	T1005 UA U4	513.4
<b>Respite Care</b> Contracted Level 1 1:2 ratio	T1005 UA U3	
<b>Respite Care</b> Contracted Level 1 1:3 ratio	T1005 UA U2	
<b>Respite Care</b> Agency Level 2 1:1 ratio	T1005 UB U4	
<b>Respite Care</b> Agency Level 2 1:2 ratio	T1005 UB U3	
<b>Respite Care</b> Agency Level 2 1:3 ratio	T1005 UB U2	
<b>Residential Habilitation</b> Community	T2017 UA	513.5.1
<b>Residential Habilitation</b> Agency 1:1 ratio	T2017 U4	513.5.2
<b>Residential Habilitation</b> Agency 1:2 ratio	T2017 U3	
<b>Residential Habilitation</b> Agency 1:3 ratio	T2017 U2	
<b>Residential Habilitation</b> Agency 1:4 ratio	T2017 U1	
<b>Adult Companion</b> Contracted Level 1 1:1 ratio	S5135 UA U4	513.6



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<b>Procedure Description</b>	<b>Procedure Code</b>	<b>Section</b>
<b>Adult Companion</b> Contracted Level 1 1:2 ratio	S5135 UA U3	
<b>Adult Companion</b> Contracted Level 1 1:3 ratio	S5135 UA U2	
<b>Adult Companion</b> Agency Level 2 1:1 ratio	S5135 UB U4	
<b>Adult Companion</b> Agency Level 2 1:2 ratio	S5135 UB U3	
<b>Adult Companion</b> Agency Level 2 1:3 ratio	S5135 UB U2	
<b>Day Habilitation</b> 1:1 ratio	T2021 U4	513.7
<b>Day Habilitation</b> 1:2 ratio	T2021 U3	
<b>Day Habilitation</b> 1:3 ratio	T2021 U2	
<b>Day Habilitation</b> 1:4 ratio	T2021 U1	
<b>Pre Vocational Training</b> Individual	T2015	513.7.1
<b>Pre Vocational Training</b> Group	T2015 HQ	
<b>Supported Employment</b> Individual	T2019	513.7.2
<b>Supported Employment</b> Group	T2019 HQ	
<b>Therapeutic Consultative Services</b> Skills Specialist	T2021 U7	513.8
<b>Therapeutic Consultative Services</b> Behavioral Specialist	T2021 U8	
<b>Therapeutic Consultative Services</b> Behavioral Analyst	T2021 U9	
<b>Extended Professional Services</b> Registered Dietician	S9470 HI	513.9
<b>Extended Professional Services</b> Physical Therapist	G0151 HI	
<b>Extended Professional Services</b> Occupational Therapist	G0152 HI	
<b>Extended Professional Services</b> Speech Therapist	G0153 HI	
<b>Skilled Nursing Services</b> LPN 1:1 ratio	T1003 HI U4	513.10.1
<b>Skilled Nursing Services</b> LPN 1:2 ratio	T1003 HI U3	
<b>Skilled Nursing Services</b> LPN 1:3 ratio	T1003 HI U2	
<b>Nursing Services</b> RN 1:1 ratio (restricted to skilled nursing services that can only be performed by a registered nurse)	T1002 HI	513.10.2
<b>Crisis Services</b>	T2034	513.11
<b>Environmental Accessibility Adaptations</b> home	S5165	513.12



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<b>Procedure Description</b>	<b>Procedure Code</b>	<b>Section</b>
<b>Environmental Accessibility Adaptations</b> vehicle	T2039	
<b>Extended Physician Services</b> Annual Medical Evaluation	99381HI to 99387 HI and 99391HI to 99397 HI	513.13
<b>Psychiatric Diagnostic Interview Examination</b>	90801 HI	513.14.1
<b>Psychological Testing with Interpretation and report</b>	96101 HI	513.14.2
<b>Psychological Testing – Developmental Testing with Interpretation and Report</b>	96111 HI	513.14.3
<b>Psychological Testing Developmental Testing – Limited with Interpretation and Report</b>	96110 HI	513.14.4
<b>Social History</b>	H0031 HI	513.15
<b>Social History</b> Update	H0031 HI U8	

**513 DESCRIPTION OF COVERED SERVICES**

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

**513.1 INDIVIDUAL PROGRAM PLAN DEVELOPMENT (IPP)**

**PROCEDURE CODE:** T2024U7= Service Coordinator, Skills Specialist, Behavior Specialist, Social Worker  
T2024U8= Behavioral Analyst, Registered Nurse  
T2024U9= Physical Therapist, Occupational Therapist, Speech Language Pathologist, Physician, Psychologist

**SERVICE UNITS:** 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.

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



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#### **PRIOR AUTHORIZATION:**

Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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:**

Individual Program Planning is the process by which the member and his/her IDT develops a person centered plan. The team should be comprised of the member and his or her “Circle of Support”. A “Circle of Support” is defined as; “a group of people with either a professional or personal vested interest in the member who offer either evaluation, planning, advocacy, or support to the member on an ongoing basis”. The circle of support may include the service coordinator, professionals, direct care providers, family members, guardian, and significant individuals in the member’s life with a vested interest in the member. Section 511 specifically addresses minimum composition requirements of the IDT. The content of the IPP must be guided by the member’s needs, wishes, desires, and goals.

This group that is inclusive of the member, participates in the IPP meeting for the purpose of review of assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, 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 Individual Program Planning includes the development of the initial IPP, annual IPP and subsequent reviews or revisions of the IPP (to include quarterly reviews as warranted).

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

#### **SITE OF SERVICE:**

Individual Program Planning development may be provided at the office of a provider agency, the member’s home, a residential or day program site, clinic or physician office or any other community setting available to the member.



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#### 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 and 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 can result in disallowance for IPP Development Services.

#### SERVICE RESTRICTIONS

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

#### PROVIDER QUALIFICATIONS

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

#### FREQUENCY OF REVIEW OF IPP

The annual IPP is to be reviewed annually and once quarterly unless specified by the Interdisciplinary Team. Minimally, it has to be reviewed at least every six months and at significant treatment junctures.

### 513.2 SERVICE COORDINATION

<b>PROCEDURE CODE:</b>	T1016-HI
<b>SERVICE UNITS:</b>	15 minutes
<b>SERVICE LIMITS:</b>	70 units per month up to a maximum of 840 units per year.
<b>PAYMENT LIMITS:</b>	Service units shall be rounded on a monthly (not daily) basis
<b>PRIOR AUTHORIZATION:</b>	Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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, along with the member a life-long, person-centered, goal-oriented process for coordinating the range of services, supports, 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



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disabilities in making 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 supervision involves review of clinical activities, review of case notes, and review of treatment plans for six (6) months. This must be verified by supervisory documentation once per month).
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

#### **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



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

#### **SERVICE COORDINATOR RESPONSIBILITIES**

The Service Coordinator shall perform the following activities:

##### **Service Coordination Assignment:**

- Each member will be assigned a single Service Coordinator.

##### **Application and Eligibility Process:**

- Accept referrals and provide the applicant and his/her family with the information necessary to choose between an institutional level of care in an ICF-MR facility or home and community-based services under the MR/DD Waiver Program. The Service Coordinator will conduct an interview with the applicant, his/her family, and/or legal representative to explain the choice between ICF/MR institutional and Waiver services and obtain a written informed consent for the applicant to receive Waiver services.
- Coordinate the initial medical evaluation (DD2), psychological evaluation (DD3), Social History (DD4) {if applicable and available}, IEP- psycho-educational assessment for school-age children {if applicable and available}, Birth to Three assessments {if applicable and available} as well as arrange/collect other necessary evaluations and information to establish eligibility.
- Submit the Annual Medical Evaluation (DD-2A) and psychological evaluation (DD3) {if applicable}, for re-certification to the State office no later than 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.
- 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.
- 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.



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- Service Coordination providers must begin the discharge process and provide linkage to services appropriate to level of need when a member is initially found to be ineligible for MR/DD Waiver Services.

#### **Linkage/Referral and Rights:**

- Provide oral and written information 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 and 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 program. 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 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 513.1 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.



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#### **Evaluation of the Implementation of the IPP and Services:**

- Ensure health and safety of the member.
- Ensure the implementation of services as indicated on the IPP.
- Visit the individual monthly at his/her residence to personally meet with the individual and service providers to verify that services are being delivered in accordance with the IPP in a safe environment, and check that documentation of services is occurring. Visits with the individual, his/her family and/or legal representative will be utilized by the Service Coordinator to update progress towards obtaining services and resources and discuss progress towards achieving objectives contained in the IPP. The Service Coordinator will also elicit information from the 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 activity every other month to verify that services are being delivered in accordance with the IPP, in a safe environment, and check that documentation of services is occurring. The Service Coordinator is encouraged to visit the supported employment setting if the visit will not be disruptive to the setting or member.
- 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.



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- The service coordinator must not provide Therapeutic Consultant services for members to whom they provide service coordination.

### 513. 3 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  
700 miles per month. Transportation exceeding 700 miles per month must receive prior approval by the ASO -A0160
- PAYMENT LIMITS:** Transportation can be billed concurrently only with Residential Habilitation, Day Habilitation, Respite, Pre-Vocational, Supported Employment, Service Coordination and Adult Companion.
- PRIOR AUTHORIZATION:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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

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 in this section.

One way trip (A0120 HI) Example for Community Based Programming: Member starts from his/her home, goes to site A to implement program, goes to site B to implement program, goes to site C to implement program and returns to his/her home. This is a one way trip. Example for Facility Based Programming: Member starts from his/her home, goes to site A and stays for an extended period of time. This is a one way trip. Member after spending an extended period of time leaves site A and returns to his/her home. This is a one way trip.

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



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#### SITE OF SERVICE

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

#### DOCUMENTATION

- Community Residential Habilitation, Adult Companion and Respite providers must complete the Progress Report (DD-12)
- Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.
- 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).

#### SERVICE RESTRICTIONS

- Transportation may not be billed in place of school-age entitlement services.
- Transportation may not be billed out-of-state with the exclusion of transportation billed on behalf of the member, who resides in a WV state border county and allows for access to community-based habilitation and vocational needs, and is general practice for any other state citizen to cross the state borders and is directly related to the IPP (e.g., Supported employment job site or store located within 30 miles of WV's state border). If destination is beyond 30 miles out of state for members living in a bordering county, the member must access "non-emergency" medical transportation services and must not access Waiver transportation for this type of trip.
- **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 IPP must also address the specific provider(s) responsible for providing the transportation.**
- The implementation of goals or objectives must be carried out in close proximity to the member's residence. If a setting is available for a reimbursable activity (i.e. habilitation, adult companion, respite) close to where the member resides, this setting must be utilized. Settings may include, but are not limited to stores, banks, libraries, work site, etc. Transportation must occur where the rest of the community typically does their local shopping or conducts local business utilizing the resources available in the member's neighborhood, town, city or county.
- Transportation must be for the member's specific needs that are addressed in the IPP and is not intended for the personal or work activities of a staff member or family members. This includes activities such as socialization, shopping, transporting or delivery needs of the staff member or family member.
- Transportation cannot be billed when the member is **NOT** in the vehicle.



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#### 513. 4 RESPITE CARE

<b>PROCEDURE CODE:</b>	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

**SERVICE LIMITS:** A Maximum combined limit of 6,912 units per year for Respite Level I and Respite Level II

**PAYMENT LIMITS:** Specialized Family Care Providers who provide respite services may not provide respite at a 1:3 ratio.

**PRIOR AUTHORIZATION:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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 an individual whose primary care is normally provided by the family or other primary care-giver of a member. The services are to be used on a short-term basis due to the absence of or need for relief of the primary care-giver.

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

Respite Care Services may be billed concurrently with transportation.

#### RESPITE SERVICES

Respite Care may be used to:

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



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

Up to 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 Therapeutic Consultant, either the Skills Specialist or Behavior Specialist/Analyst.

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**

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

#### **DOCUMENTATION**

- Documentation shall include 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). Transportation mileage must be included on the DD-12. Travel destinations to and from must be listed on the form.



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#### 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 cannot be utilized for the every day provision of care for a child or adult in the absence of a parent(s) or primary care-giver(s) when the parent(s) or caretaker(s) goes to work.

#### PROVIDER QUALIFICATIONS

All Respite Care services must be assessed and monitored by a Therapeutic Consultant, Skills Development Specialist, and Behavior Support Specialist for "respite relevant" training goals only.

**Respite Care Level I** Providers may be SFCP and/or biological or adoptive family members or relatives who do not reside with the member. Respite Care Level 1 providers are contracted by an agency. Respite Care Level I is an optional service for Waiver providers.

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

- 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). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

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

- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- 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. CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.



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#### 513.5 RESIDENTIAL HABILITATION

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

#### DEFINITION

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



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

#### SERVICE RESTRICTION

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

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

#### 513.5.1

#### 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 must be approved by the local waiver contact person prior to July 1, 2006 and by the ASO July 1, 2005 and beyond. The local Waiver contact person cannot authorize units in excess of four (4) hours after July 1, 2006.

**PRIOR AUTHORIZATION.** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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:** Community Residential Habilitation services are support services delivered in a participant's residence and in the community which provide instruction and assistance to enable him/her to acquire and maintain skills which will allow him/her to live and socialize more independently. Residential Habilitation services may also include behavioral support to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. Training must be age appropriate, functional and natural in terms of materials, location and times.

#### 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



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- Certification of CPR and First Aid

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 Therapeutic Consultants, either the Skills Specialist or Behavior Specialist/Analyst may provide training to Residential Habilitation providers.

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

#### **SITE OF SERVICE**

Community Residential Habilitation is provided in the following settings:

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

#### **DOCUMENTATION**

- Residential Habilitation providers must maintain detailed documentation (e.g., progress notes, daily activity logs) 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.
- Community Residential Habilitation providers must complete the Community Residential Habilitation Documentation from (DD 12).

#### **SERVICE RESTRICTIONS**

- It is not the member's or the member's legal representative's responsibility to provide or arrange for Residential Habilitation services. It is the responsibility of the Service Coordination provider agency to provide or arrange for Residential Habilitation services with trained and qualified Medicaid providers.
- Routine monitoring or support is not considered assistance in community residential habilitation services. This service includes activities that are considered "active treatment". Members may receive Community Residential Habilitation in the form of assistance as they participate in activities at home or in the local community. This assistance provides the individualized support necessary for participation in the activity during brief episodes between training steps.
- Providers for community residential habilitation can only be reimbursed for services that are considered extraordinary via the extraordinary care assessment.

### **513.5.2**

### **AGENCY RESIDENTIAL HABILITATION**



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**PROCEDURE CODE:** T2017-U4, T2017-U3, T2017-U2, T2017-U1  
**SERVICE UNITS:** 15 minutes  
**SERVICE LIMITS:** 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)  
 Staff / Member Ratio 1:1, 1:2, 1:3, and 1:4 Residential

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

**PRIOR AUTHORIZATION:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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 member’s community which provide instruction and assistance to enable him/her to acquire and maintain skills which will allow him/her to live and socialize more independently. Residential Habilitation services may also include behavioral support to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. Training must be age appropriate, functional and natural in terms of materials, location and times.

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

Up to 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 such as Therapeutic Consultant, Skills Specialist or Behavioral Specialist/Analyst may provide training to Residential Habilitation providers.

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

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).



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## PROVIDER QUALIFICATIONS

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

- Be at least 18 years old with proof of age on file;
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.) to deliver services;
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member;
- Certification in CPR and First Aid.

## SITE OF SERVICE

Residential Habilitation is provided in the following settings:

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

## 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



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- It is not the member’s or the member’s legal representative’s responsibility to provide or arrange for residential habilitation services. It is the responsibility of the Service Coordination provider agency to provide or arrange for residential habilitation services with trained and qualified Medicaid providers.
- Members may receive Residential Habilitation in the form of assistance by staff as they participate in activities at home or in the local community. This assistance provides the individualized support necessary for participation in the activity. Unlike residential habilitation training, this assistance is not presented in a training format with formal training objectives. Based upon evaluations, the IDT (1) determines if the individual requires assistance to participate in non-training residential activities; (2) identifies on the ISP those activities for which this support would be provided; and (3) specifies the amount of support (units per month). Residential Habilitation assistance is to be provided in combination with daily Residential Habilitation training. A member must have a current residential training program to qualify for the Residential Habilitation assistance and is to be maintained as described in the documentation section of Residential Habilitation.
- A maximum of 8 hours per day (32 units) of monitoring and supervision may be provided to a member. The need for monitoring and supervision must be supported by evaluations and included in the IPP. Justification for such services may include such factors as severe challenging behaviors or life-endangering medical conditions. Residential Habilitation monitoring and supervision in a family home or a Specialized Family Care Home (SFCH) may not be provided by a family member or the SFCP and requires an explanation of why the family supports are not available to the member for the purpose of night-time monitoring.
- Providers for residential habilitation can only be reimbursed for services that are considered extraordinary via the extraordinary care assessment

### 513.6 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
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:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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

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

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

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

#### ADULT COMPANION SERVICES

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

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

#### Conditions of Contracting:

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

- The contractor is a minimum of 18 years of age;
- Current certification in CPR and first aid. A copy of the certification card must be on file at the contracting provider agency;
- The contractor has training in health related issues (medication interactions, seizures, gastrostomy tubes, etc.) as needed per individual Waiver member;
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. **CIB is required for Level I and Level II.**

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

- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- Be at least 18 years old with proof of age on file at the provider agency



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- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member. **CIB is required for Level I and Level II.**

#### SITE OF SERVICE

Adult Companion services are provided in the following locations:

- Locations in the member's local community 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.
- Individualized Support Setting (ISS) (ISS = 3 or less members in one home)
- BHHF Development Disability (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 documentation form (DD-12) by the provider and monitored and reviewed by the Service Coordinator. Documentation shall include name of MR/DD Waiver member, the content of the activity, the relationship of that activity to an objective on the IPP, the actual time spent, including start and stop times, date of service, the staff to member ratio and the signature and credentials of the staff providing the service on the Adult Companion Services Documentation form (DD-12).

#### 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 or agency-staffed residential home such as an ISS or a group home.

### 513.7 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:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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 that are guided by the member's needs wishes, desires, and goals.

#### DAY HABILITATION SERVICES

Day Habilitation services consist of programs of instruction/training, supervision and assistance, specialist services and evaluations provided by or under the direct supervision of a therapeutic consultant, as described in Section 513.8 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 (volunteer work cannot take the place of a paid employment position)

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

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

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

Up to 4 units of day habilitation service may be charged by the Day Habilitation service provider to actively participate in the development of the annual IPP and 4 units may be charged to actively participate in the 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 can be delivered in staff/member ratio of 1:1, 1:2, 1:3 and 1:4. No other ratio combinations can be granted. There must be sufficient numbers of competent, trained staff to provide active habilitation and to protect the individual's health and safety.



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## PROVIDER QUALIFICATIONS

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

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

- Be at least 18 years old with proof of age on file
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)
- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

## 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 ASO and the following conditions must be met:
  - The services are overseen by a Therapeutic Consultant
  - All service providers meet the qualifications for delivering Day Habilitation services
  - Day Habilitation and Residential Habilitation services are not delivered concurrently
  - The Therapeutic Consultant must ensure the training of staff on appropriate training program goals and that activities occur in a normal, community setting.



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– Ordered by a physician

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

### 513.7.1 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:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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.

### PROVIDERS QUALIFICATIONS

- Must be at least 18 years old with proof of age on file.
- Have a high school diploma or Graduate Equivalency Degree (G.E.D.)



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- Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

### PREVOCATIONAL TRAINING SERVICES

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

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

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

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

### SITE OF SERVICE

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

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

### 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



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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 not provided through DRS, a program funded under the Rehabilitation Act of 1973, the MR/DD Waiver Program provider agency must make a referral to DRS. A copy of the referral must be maintained by the provider agency in the individual's record of service. MR/DD waiver pre-vocational services must not be utilized concurrently with any DRS pre-vocational services.

#### 513. 7. 2 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 Supported Employment 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:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

#### SUPPORTED EMPLOYMENT SERVICES



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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
- Supervision and monitoring by a job coach
- Intervention to replace inappropriate work behaviors with adaptive work skills and behaviors
- Retraining as jobs change or job tasks change
- Training in skills essential to obtain and retain employment, such as the effective use of community resources
- Transportation to and from job sites when other forms of transportation are unavailable or inaccessible.

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

Supported Employment Services must be supervised by a THERAPEUTIC CONSULTANT. In addition to the primary training requirements as outlined in 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 supported employment services under the MR/DD Waiver Program one must determine if services are currently provided through DRS. If services are not provided through DRS, a program funded under the Rehabilitation Act of 1973, the MR/DD Waiver Program provider agency must make a referral to DRS. A



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copy of the referral must be maintained by the provider agency in the individual's record of service. MR/DD waiver supported employment services must not be utilized concurrently with any DRS pre-vocational services.

**513.8 THERAPEUTIC CONSULTATIVE SERVICES**

<b>PROCEDURE CODE:</b>	Skills Specialist	T2021 U7
	Behavioral Specialist	T2021 U8
	Behavioral Analyst	T2021 U9

**SERVICE UNITS:** 15 minute units of service

**SERVICE LIMITS:** Skills Specialist – 20 hours per month; up to 35 hours per month with ASO approval

Behavioral Specialist - 30 hours per month; up to 50 hours per month with ASO approval (combined with Behavioral Specialist and Behavioral Analyst)

Behavioral Analyst – 30 hours per month; up to 50 hours per month with ASO approval (combined with Behavioral Specialist and Behavioral Analyst)

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

The Residential setting consultant and the day setting consultant may collaborate no more than 8 units per calendar year for the purpose of plan development

**PRIOR AUTHORIZATION:** Refer to Section 509, 509.1, 509.2 and 509.3. Effective 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.

Eligibility for Behavior Specialist or Behavior Analyst services require a rating of moderate, severe or critical on the annual ICAP rating of “maladaptive” behaviors.

Exception: When a member is in crisis, a functional analysis may be utilized to assess the member’s maladaptive behaviors. The ASO must have verification.

During the transition to the ASO, a functional analysis must be utilized to assess the need for Behavioral Support Services. Following the establishment of the member’s individual budget, the annual ICAP assessment as completed by the ASO will be required for all routine use of the Behavioral Support Services (with the exception of members in crisis).



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## GENERAL REQUIREMENTS FOR THERAPEUTIC CONSULTANTS

### PHILOSOPHY OF POSITIVE BEHAVIORAL SUPPORT

The MR/DD Waiver Program endorses the practice of Positive Behavioral Support. The practice offers a proactive approach to teaching adaptive skills and improving quality of life. All Therapeutic Consultants must utilize this clinical practice.

### ROLE OF THERAPEUTIC CONSULTANT

Although not mandated, each member may have up to two Therapeutic Consultants, a Therapeutic Consultant for the residential component of services and a second Therapeutic Consultant for the day setting.

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

A Skills Development Specialist will act as the consultant if there are no significant maladaptive issues present. The residential setting may have one consultant for the member and the day setting may have one consultant for the member. The day setting includes day habilitation, prevocational, and supported employment Services.

An individual with Behavioral Specialist/Analyst credentials who provide therapeutic consultant services to a member without indicated maladaptive behaviors will need to bill as a Skills Specialist.

In the event that there is more than one Consultant, the Residential Consultant will act as the primary Consultant. A secondary Consultant may be necessary if the individual is also receiving services in a day setting such as day habilitation, prevocational, or supported employment services. The Residential Therapeutic Consultant will be the primary Consultant responsible for coordinating the collaboration of the total habilitation plans and behavioral support plans, protocols, or guidelines. All habilitation plans (residential, day, prevocational/supported employment) must be developed in collaboration. The point of collaboration is the IDT. All Consultant's involved with the member's habilitation plans must sign each part of the plan (residential, day, prevocational/supported employment) indicating the plans are consistent with adaptive training methodologies, strategies, areas of skill improvement and maladaptive issues or interventions. Plans must be correlated with the results found in both the adaptive and maladaptive findings of the ICAP assessment. Consultants are responsible for the writing and collection of the habilitation plans, and training of the individuals who will be implementing the direct training with the member.

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

## DEFINITION

**Skills Specialist:** T2021 U7



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#### **Core Job Functions:**

- Development of task analysis and person specific strategy or methodology for implementation of intervention or instruction plans for an individual (habilitation plans or staff/caretaker directions/guidelines). Example: How may the staff/caretaker create a successful environment of the person?
- Train primary care providers (i.e., family, residential habilitation providers, day habilitation providers, and respite providers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans or guidelines).
- Assessment, evaluation and monitoring of the effectiveness of intervention or instruction plans (habilitation plans or behavioral guidelines) for habilitation training.
- Pre-vocational and supported employment training.

#### **DEFINITION OF PERSON SPECIFIC STRATEGIES (BEHAVIORAL GUIDELINES)**

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

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

#### **Service Restrictions:**

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

#### **Provider Qualifications:**

- Minimum of a Bachelor’s degree in human service field such as psychology, social work, education, or counseling
- Professional work experience providing services to individuals with mental retardation and/or developmental disabilities.
- Demonstrated competencies to perform duties of a skills development specialist

#### **Behavioral Specialist/Analyst:**

#### **Core Job Functions:**

- Responsible for all aspects of positive behavior support services
- Behavioral assessment or evaluation consisting of activities such as functional analysis of targeted behavior or analysis of behavioral data
- Behavioral support plan or protocol development



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- Training of providers to implement behavioral plan development of behavioral protocols and behavioral guidelines for direct care staff or families.
- Development of task analysis and/or methodology for implementation of intervention or instruction to an individual.
- Train primary care providers (i.e., family, residential habilitation providers, day habilitation providers and respite providers) in person-specific aspects and methods of intervention or instruction plans (habilitation plans, behavior plans or protocols).
- Training in the person-specific aspects and methods of a plan of intervention or instruction provided to the individual and/or primary care providers (i.e., family, residential habilitation providers, day habilitation providers and respite providers).
- Pre-vocational and supported employment training
- Assessment, evaluation and monitoring of the effectiveness of intervention and instruction plans (habilitation plans, behavior plans, protocols)

## PROVIDER QUALIFICATIONS

### BEHAVIORAL SPECIALIST (T2021U8):

- Minimum of Bachelor's Degree in Human Service field.
- Minimum of two years professional work experience working with individuals with mental retardation and/or developmental disabilities.
- Demonstrated competencies (course work, training) in the area of positive behavior support and skills development.
- Providers must have a Criminal Investigation Background Check. CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

### BEHAVIORAL ANALYST (T2021U9):

- Minimum of Master's Degree in human service field with a graduate level course work in applied behavioral analysis or positive behavioral support or;
- Minimum of Bachelor's Degree in human service field with a graduate level course work in applied behavioral analysis or positive behavioral support and;
- Minimum of three years professional work experience working with individuals with mental retardation and/or developmental disabilities and;



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- Demonstrated competencies (course work, training) in the area of positive behavior support and skills development.
- Providers must have a Criminal Investigation Background Check. CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

#### **DEFINITION OF A POSITIVE BEHAVIOR SUPPORT PLAN OR PROTOCOL:**

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

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

#### **Service Restrictions:**

- Therapeutic Consultation must not be provided as direct training of the member. (cannot provide direct services)

#### **Provider Qualifications:**

##### **Behavioral Specialist (T2021U8):**

THERAPEUTIC CONSULTANT with a minimum of a Bachelors degree in a Human Service field and a minimum of one year professional 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.

##### **Behavioral Analyst (T2021U9):**

A Therapeutic Consultant must have a minimum of a Master's degree in a Human Service field or graduate level coursework in applied behavioral analysis or positive behavioral support, and a minimum of three 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.



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Providers must have a Criminal Investigation Background Check. CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

**SITE OF SERVICE (INCLUSIVE FOR ALL Therapeutic Consultant Services)**

The Therapeutic Consultant’s office, the individual's home or other community locations which provide the proper equipment and physical facilities to deliver the specific THERAPEUTIC CONSULTANT services.

**DOCUMENTATION FOR ALL THERAPEUTIC CONSULTATION 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 Therapeutic Consultant. All data obtained for a functional analysis must be maintained in the member’s record. Service units are to be rounded on a monthly basis, not daily or weekly.

**513.9 EXTENDED PROFESSIONAL SERVICES**

<b>PROCEDURE CODE:</b>	Occupational Therapist G0152 HI
	Physical Therapist G0151 HI
	Speech Therapist G0153 HI
	Registered Dietician S9470 HI

**SERVICE UNITS:** 15 minute units of service except for Registered Dietician which is a per visit unit.

**SERVICE LIMITS:** Occupational Therapist, Physical Therapist, Speech Therapist, Registered Dietician. 40 units per month up to a maximum of 480 units annually. (Combined units with Occupational Therapist, Physical Therapist, Speech, and Registered Dietician)

**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, 509.1, 509.2 and 509.3 (Prior Authorization process). Effective 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**

**Professional Services:**

**Core Job Functions:**

Must be performed by a fully licensed, certified and/or registered (e.g., physical therapist, speech/language, occupational therapist, registered dietician).



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- Professional services must have a 1:1 ratio and consist of:
  - Physical therapy
  - Occupational therapy
  - Speech and language therapy
  - Dietary services by registered dietician.

#### **SITE OF SERVICE FOR ALL EXTENDED PROFESSIONAL SERVICES**

This service may be provided in the Extended Professional's office, the member's home or other community locations which provide the proper equipment and physical facilities to deliver the specific Extended Professional Services.

#### **DOCUMENTATION FOR ALL EXTENDED PROFESSIONAL SERVICES**

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

#### **513.10 SKILLED NURSING SERVICES**

##### **DEFINITION**

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

##### **SITE OF SERVICE**

Skilled Nursing Services can be provided in the following settings:

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



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

- Adequate electrical power including back-up power system (generator and/or battery);
- Adequate space for equipment and supplies;
- Adequate fire safety and adequate exits for medical and other emergencies;
- Clean environment to the extent that the individual’s life and health is not at risk;
- Working telephone available 24 hrs/day;
- 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.

#### DOCUMENTATION

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

#### SERVICE RESTRICTIONS

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

#### 513.10.1 NURSING SERVICES BY RN

<b>PROCEDURE CODE:</b>	T1002- HI U4 RN 1:1
<b>SERVICE UNITS:</b>	15 minutes
<b>SERVICE LIMITS:</b>	40 units per month without authorization
<b>PRIOR AUTHORIZATION:</b>	Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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. Nursing services must be physician ordered.

#### DEFINITION



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

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

- 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, if applicable (all member’s living in residential settings must have an annual nursing assessment; all member’s receiving nursing services through the MR/DD Waiver program must have an annual nursing assessment);
- Self-medication administration assessment);
- Completing forms necessary for prior authorization for nursing services;
- Nursing plan of care, including measurable goals/objectives
- Monthly nursing summaries
- Assist in obtaining informed consent for medication and/or treatments
- Direct supervision of AMAPs, LPNs
- working directly with physicians and specialists to plan medical treatment.

**PROVIDER QUALIFICATIONS:**

- Current WV registered nursing license
- CIB check

**513.10.2 SKILLED NURSING SERVICES LPN AND/OR RN**

**PROCEDURE CODE:**            T1003 HI U4        LPN 1: 1  
    T1003 HI U3        LPN 1: 2  
    T1003 HI U2        LPN 1: 3

**SERVICE UNITS:**                15 minutes

**SERVICE LIMITS:**            2 hours per day without authorization. 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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**PRIOR AUTHORIZATION:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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.

**Nursing service must be ordered and implemented under the supervision of a physician.**

### DEFINITION

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

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



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#### PROVIDER QUALIFICATIONS:

- Current WV License
- CIB check

#### 513.11 CRISIS SERVICES (service becomes effective 07-01-2006)

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

**SERVICE UNITS:** Unit = 1 hour

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

May not be provided in a mental health crisis stabilization unit, psychiatric hospital. MR/DD Crisis Sites, ICF-MR facility, general medical hospital, natural family home or specialized family care home

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

**PRIOR AUTHORIZATION:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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 this service is to respond to a crisis immediately, assess the situation, and stabilize as quickly as possible. Crisis service is an extraordinary circumstance requiring a short-term, acute service that utilizes positive behavioral support planning, interventions, strategies and direct care. This service requires medical necessity (Refer to Behavioral Needs Criteria below). This service is a 2:1 ratio (staff to member ratio). The additional staff person is available for assurance of health and safety in the respective setting.

#### AUTHORIZATION:

- The behavior support specialist may initiate the service by providing a written clinical justification within 48 hours or the next working day of the onset of crisis services.
- A prior authorization request must be submitted within 72 hours of implementation of the service. The service coordinator must request the authorization from the ASO. If the crisis occurs on a Friday, the request may be submitted on a Monday.



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- The service coordinator must maintain a record of the authorization for service and clinical justification by the behavior support specialist

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

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

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

Crisis Services staff will implement the plan(s) that are directed at reducing the maladaptive behavior(s). This service may include behavioral interventions to reduce challenging behaviors and replace them with socially valuable, adaptive behaviors and skills. All Crisis Services are provided under the supervision of a Behavioral Specialist/Analyst as described in Section 513.8 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.

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

#### **Eligible ICAP Criteria for Crisis Services:**

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



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

#### **Requirement:**

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

#### **PROVIDER QUALIFICATIONS**

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

Be at least 18 years old with proof of age on file

Have a high school diploma or Graduate Equivalency Degree (G.E.D.)

Criminal Investigation Background Check (CIB). CIB results which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse must be considered by the provider agency before placing an individual in a position to provide services to the member.

Refer to Section 512; 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 (group home is defined as a home setting where four (4) or more members reside).
- Individualized Support Settings (ISS) operated by a licensed behavioral health center serving people with mental retardation and/or developmental disabilities (ISS setting is defined as a home setting where one (1) to three (3) members reside).
- Crisis services may also be carried over into the necessary local public community environments, as specified in the IPP.
- This service may not be provided in settings such as a natural family, specialized family care and an adoptive family home.

#### **DOCUMENTATION:**

Following any use of crisis services, the individual's IPP will be reviewed and updated to reflect a plan for the prevention and interventions to ameliorate subsequent occurrences. The IPP must identify crisis early warning



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signals, triggers and the necessary services and supports to insure the health and safety of the individual. Any plan that involves the use of restrictive intervention will be approved by a behavior specialist or a behavior analyst and approved by the Human Rights Committee.

- Crisis Service providers must maintain detailed documentation (e.g., progress notes, daily activity logs, or behavioral data tracking forms) for residential sites in the center's chosen format. Documentation must include the name of MR/DD Waiver member, specific activity provided, its relationship to an IPP objective or targeted behavior, the actual time spent, including start and stop times, signatures and credentials of staff providing the service and the date of service.
- A written order is required by a behavioral specialist or behavioral analyst for this service.
- 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, nursing (less than 2 hours per day), respite, prevocational services or supported employment services during the 24 hour day when the member is receiving crisis services. A member may only receive service coordination, Therapeutic Consultant, or transportation services during the daily 24 hour time-frame that crisis services are received.
- Crisis services include informal 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 for the use as an emergency response for routine and on-going behavioral challenges.**
- The provision of staff as the only support to the member may not be the only intervention provided under crisis services. Clinical interventions must be present in addition to the staffing support.
- This service may not be provided in a hospital or a facility setting.

## 513.12 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:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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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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),
- 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**



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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 Attachment 1 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.

### 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



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

### 513.13 EXTENDED PHYSICIAN SERVICES (Annual Medical Evaluation)

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

**SERVICE UNITS:** Event

**SERVICE LIMITS:** One evaluation annually

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

**PRIOR AUTHORIZATION:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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.



**TITLE XIX MR/DD WAIVER MANUAL**  
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This service is used when submitting an initial application packet and to re-establish medical eligibility for re-certification on an annual basis.

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. 14.1                    Psychiatric Diagnostic Interview Examination**

**PROCEDURE CODE:**                    90801 HI  
**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:**            Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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.

**513.14.2                    Psychological Testing with interpretation and report**

**PROCEDURE CODE:**                    96101 HI  
**SERVICE UNITS:**                      1 hour (maximum of 4 hours)  
**SERVICE LIMITS:**                    One evaluation every three years for all members (adult and child). (Cannot be utilized within three year period with 96111)  
**PAYMENT LIMITS:**                    No one with credentials other than those specified for a psychologist or a psychologist under supervision may perform or submit a claim.

**PRIOR AUTHORIZATION:**            Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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.



**TITLE XIX MR/DD WAIVER MANUAL**  
**Draft for Public Comment Period**  
**April, 2006**



**513. 14.3 PSYCHOLOGICAL TESTING – DEVELOPMENTAL TESTING WITH INTERPRETATION AND REPORT (Triennial Psychological Evaluation)**

- PROCEDURE CODE:** 96111 HI
- 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:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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 below 18 years of age. An annual psychological update is not required for adults 18 years of age and older.

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

**SITE OF SERVICE**

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

**DOCUMENTATION**

Completion of the Psychological Evaluation (DD-3)



# TITLE XIX MR/DD WAIVER MANUAL

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#### 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.

### **513.14.4 Psychological Testing Developmental Testing – Limited with Interpretation and Report (Annual Psychological Evaluation)**

<b>PROCEDURE CODE:</b>	96110 HI
<b>SERVICE UNITS:</b>	per hour, maximum of 4 hours
<b>SERVICE LIMITS:</b>	One evaluation annually for children under age 18. Adults are not required to have an annual psychological update unless the condition warrants an evaluation for treatment purposes. Annual psychological evaluations are not required for level of care determination for adults over 18 years of age. Children under the age of 18 are required to submit an annual psychological update for level of care determination
<b>PAYMENT LIMITS:</b>	No provider with credentials other than those specified for a psychologist or a psychologist under supervision may perform or submit a claim for this service.



# TITLE XIX MR/DD WAIVER MANUAL

## Draft for Public Comment Period

### April, 2006



**PRIOR AUTHORIZATION:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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 care 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 below 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

### DOCUMENTATION

Completion of the Psychological Evaluation (DD-3)

### 513.15 SOCIAL HISTORY

**PROCEDURE CODE:** Social History- H0031-HI



# TITLE XIX MR/DD WAIVER MANUAL

## Draft for Public Comment Period

### April, 2006



**SERVICE UNITS:** Social History Update H0031 HI U8  
Event

**SERVICE LIMITS:** H0031 HI- At the time of enrollment, one comprehensive evaluation per member per provider per lifetime.  
H0031 HI U8- Annually

**PAYMENT LIMITS:** The initial social history service must be provided by a Therapeutic Consultant with at least Bachelor's degree in social work from an accredited college and/or WV licensure in social work. The initial social history is required for all new enrollees of the program. An annual social history may be performed for evaluation and planning purposes but is not required for the annual determination of level of care (medical eligibility).

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

**PRIOR AUTHORIZATION:** Refer to Sections 509, 509.1, 509.2 and 509.3. Effective 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, 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 by the IPP team members.



# TITLE XIX MR/DD WAIVER MANUAL

## Draft for Public Comment Period

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#### **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.

#### **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
- DD-3 Comprehensive Psychological Evaluation
- DD-4 Social History
- DD-5 Individual Program Plan
- DD-7 Informed Consent (Choice of ICF/MR and MR/DD Waiver)
- DD-7A Informed Consent (Choice of Providers and Services)
- DD-9 Monthly Home Visit Report
- DD-9A Day Habilitation Visit Report
- DD-12 Documentation - Monthly Progress Report
- DD-13 Certification of Training for Habilitation Providers
- DD-14 Application
- DD-16 Member Exit/Transfer
- DD-17 Therapeutic Consultant Credentialing Form
- DD-19 Environmental Accessibility Adaptations Form
- DD-20 Mortality Notification

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

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

**Service Coordination Agency:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Service Coordinator:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**I. DEMOGRAPHIC INFORMATION** (MAY BE COMPLETED BY SERVICE COORDINATOR OR FAMILY MEMBER)

1. Individual's Full Name		2. Sex: <input type="checkbox"/> F <input type="checkbox"/> M		3. Medicaid # (Required)	
4. Address (including Street/Box, City, State & Zip) _____ _____					
Phone: (    )					
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"/> ISS – One person (Intensive support setting)			
<input type="checkbox"/> Specialized family care provider		<input type="checkbox"/> ISS – Two person (Intensive support setting)			
<input type="checkbox"/> Group Home (4 or more persons)		<input type="checkbox"/> ISS – Three person (Intensive support setting)			
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** (MUST BE COMPLETED BY PHYSICIAN) **NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

<b>16. Height</b>	<b>Weight</b>	<b>BP</b>	<b>P</b>	<b>R</b>	<b>T</b>
-------------------	---------------	-----------	----------	----------	----------

**17. Allergies:**

**CODE:** √ = NORMAL   N = NOT DONE (PLEASE EXPLAIN WHY)   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		
VISION		
DENTAL		
HEARING		

**NEUROLOGICAL**

ALERTNESS		
COHERENCE		
ATTENTION SPAN		
SPEECH		
SENSATION		
COORDINATION		
GAIT		
MUSCLE TONE		
REFLEXES		

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/Tardive Disconesia \_\_\_\_\_

Unable to communicate \_\_\_\_\_

Limited communication \_\_\_\_\_

**ADDITIONAL RECOMMENDATIONS**

VISION THERAPY \_\_\_\_\_

SPEECH THERAPY \_\_\_\_\_

OCCUPATIONAL THERAPY \_\_\_\_\_

PHYSICAL THERAPY \_\_\_\_\_

SOAKS, DRESSINGS \_\_\_\_\_

TRACTION, CASTS \_\_\_\_\_

OXYGEN THERAPY \_\_\_\_\_

SUCTIONING \_\_\_\_\_

TRACHEOSTOMY \_\_\_\_\_

VENTILATOR \_\_\_\_\_

DIAGNOSTIC SERVICES \_\_\_\_\_

IV FLUIDS \_\_\_\_\_

LABS ORDERED \_\_\_\_\_

**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 \_\_\_\_\_

PHYSICIAN'S 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

## INDIVIDUAL PLAN

### Demographics

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

**People who help me and support me:** *Include natural supports, friends, family members, or professionals providing evaluation or support.)*

**What I want to do in the next year and who I would like to 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.)*

**If I could change things in my life, what would I change?**

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

**What community activities will enable me to pursue interests in a positive way?** *(What are my interests? What do I like to do? Where do I like to go? What activities make me smile?)*

**WHAT ARE MY DREAMS/GOALS IN THESE AREAS?**



**COMMUNITY PARTICIPATION**



**HOME AND SUPPORTS**



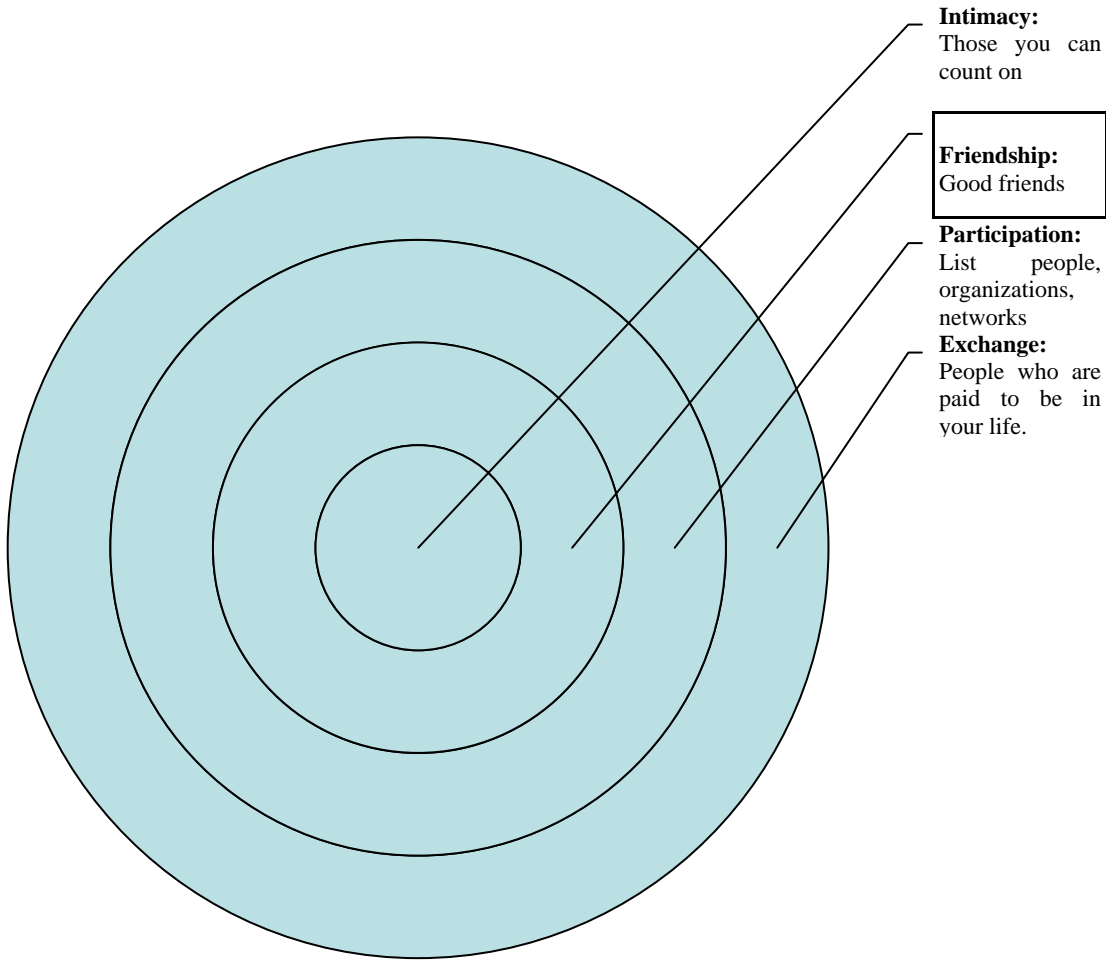
**MAKING MY OWN FRIENDS AND  
KEEPING FRIENDSHIPS**



**SUPPORT NETWORK (FAMILY, FRIENDS, ETC.)**

**Note: Use the findings from page 2 to assist in the identification of goals/dreams**

## CIRCLE OF SUPPORT



*Who can I count on?*

*Who is a good friend?*

*List people, organizations, or networks you are involved with:*

*People who are paid to be in my life (staff):*

*Who would you like to participate in developing your plan?*

**The Team will need to review above information with the person to determine how to develop support systems and increase participation in their communities.**

**Assessment and Evaluation Information Summary of Recommendations**

<b>Evaluation</b>	<b>Date of Evaluation</b>	<b>Summary of Priority Recommendations</b>
DD-2A		
DD-3		
DD-4		
PT		
OT		
ST		
Other Testing		
Extraordinary Care Assessment		
Nursing		
ICAP		
SIS		
Other		



## Individual Services Plan

May Utilize More Than One Page

Service	Availability/Accessibility	Provider				
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Yes</td> <td style="width: 15%;"></td> </tr> <tr> <td>No</td> <td></td> </tr> </table>	Yes		No		
Yes						
No						
Frequency of Service	Plan of Action	Start Date/End Date				
Service	Availability/Accessibility	Provider				
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Yes</td> <td style="width: 15%;"></td> </tr> <tr> <td>No</td> <td></td> </tr> </table>	Yes		No		
Yes						
No						
Frequency of Service	Plan of Action	Start Date/End Date				
Service	Availability/Accessibility	Provider				
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Yes</td> <td style="width: 15%;"></td> </tr> <tr> <td>No</td> <td></td> </tr> </table>	Yes		No		
Yes						
No						
Frequency of Service	Plan of Action	Start Date/End Date				
Service	Availability/Accessibility	Provider				
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Yes</td> <td style="width: 15%;"></td> </tr> <tr> <td>No</td> <td></td> </tr> </table>	Yes		No		
Yes						
No						
Frequency of Service	Plan of Action	Start Date/End Date				

## HABILITATION OBJECTIVE PAGE

Use as many of these sheets as necessary

Member Name		Provider	
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My goal is:

Start Date:

Target Date:

Goal Number	My Objective is	Method(s)
What is needed for me to meet my objective?		

My Goal is:

Start Date:

Target Date:

Goal Number	My Objective is	Method(s)
What is needed for me to meet my objective?		

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



**SIGNATURES**

<b>Relationship</b>	<b>Signature</b>	<b>Date Attended/Time</b>	<b>Agree</b>	<b>Disagree</b>
Consumer				
Parent/Guardian				
Service Coordinator				
RN/Physician				
Psychologist				
Other (Circle of Support, Advocate, PT, OT, ST, etc.)				

*\*IDT member has disagreed with the plan. The rationale is attached.*

**Rationale for Disagreement with the Plan**

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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:** \_\_\_\_\_

*(\*\*Indicate that information has been provided by initialing each area covered)*

- \_\_\_\_\_ 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
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Service Coordinator	Date	SC Supervisor	Date
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Witness	Date
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**WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES  
 NOTIFICATION OF CHOICE OF  
 MR/DD WAIVER PROVIDERS AND MR/DD WAIVER SERVICES**

**NAME:** \_\_\_\_\_

**AGENCY/FACILITY:** \_\_\_\_\_

*(\*\*Indicate that information has been provided by initialing each area covered)*

- \_\_\_\_\_ 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
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Witness	Date
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**DD 7-A**

**Revised December 2005**

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

PER CONTINUOUS BLOCK OF TIME:

Date:	Code:	Start Time:	Stop Time:	Total Time:	Training/Objective(s) # __N/A	Transportation: yes__ no__ Total Miles:
-------	-------	-------------	------------	-------------	----------------------------------	--

Summary: \_\_\_\_\_

Mileage: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Mileage: FROM: \_\_\_\_\_ - TO: \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_

PER CONTINUOUS BLOCK OF TIME:

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

Summary: \_\_\_\_\_

Mileage: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Mileage: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_

PER CONTINUOUS BLOCK OF TIME:

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

Summary: \_\_\_\_\_

Mileage: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Mileage: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_

PER CONTINUOUS BLOCK OF TIME:

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

Summary: \_\_\_\_\_

Mileage: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Mileage: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Signature/Title of Provider: \_\_\_\_\_

PER CONTINUOUS BLOCK OF TIME:

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

Summary: \_\_\_\_\_

Mileage: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Mileage: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

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 for each continuous block of time. (example date is 01-01-2006 - 6:00 a.m. to 9:00 a.m. is one continuous block of time - 10:00 a.m. to 12:30 p.m. is another continuous block of time - 6:30 p.m. to 9:30 p.m. is another continuous block of time)*

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

T1005-UAU4= Respite Care Level I, 1:1 ratio

S5135-UAU3= Adult Companion Level I, 1:2 ratio

T1005-UAU3= Respite Care Level I, 1:2 ratio

S5135-UAU2= Adult Companion Level I, 1:3 ratio

T1005-UAU2= Respite Care Level I, 1:3 ratio

S5135-UBU4= Adult Companion Level II, 1:1 ratio

T1005-UBU4= Respite Care Level II, 1:1 ratio

S5135-UAU3= Adult Companion Level II, 1:2 ratio

T1005-UBU3= Respite Care Level II, 1:2 ratio

S5135-UBU2= Adult Companion Level II, 1:3 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.* This refers to blocks of continuous time for each specific code – You may complete more than one objective during the “continuous” block of time.

		Start Time: 9:30 am					
		Start Time:					

6. Enter the time service session ends (Stop Time). *\*If two (2) sessions (time lapse between continuous blocks of time) 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 (give specific locations activity(ies) were implemented). He was attentive and did well except with making change. Completed all programs.**

Signature/Title of Provider: **Joe Staff, Res Hab**

11. Mileage (from) initial starting point (be specific – list “address” instead of “home” (to) specific destination where activity(ies) occurred – list specific site “Mercer County Public Library” instead “Library”, “Hometown Grocery Store – 10<sup>th</sup> Street” instead of “store”, Hometown Restaurant – 6<sup>th</sup> Street ” instead of restaurant.

**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.

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Signature of Person Trained/Title

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Signature of Person Trained/Title

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Signature of Person Trained/Title

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Signature of Person Trained/Title

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Signature of Person Trained/Title

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Signature of Person Trained/Title

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Signature of Person Trained/Title

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Signature of Person Trained/Title

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Signature of Person Trained/Title

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Signature of Person Trained/Title

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Signature and Credentials of Trainer

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Date

**DD-13**

**Revised July 2004**

**MR/DD WAIVER PROGRAM  
PARTICIPANT EXIT/TRANSFER FORM**

(This form should be completed and received at the MR/DD Waiver office **within seven (7) days** of the participant's exit/transfer from the agency)

NAME OF AGENCY: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME OF PARTICIPANT: \_\_\_\_\_

DATE OF EXIT OR TRANSFER FROM THE PROGRAM: \_\_\_\_\_

REASON FOR EXITING THE PROGRAM:

- OPTED OFF THE MR/DD WAIVER PROGRAM.

Reason: \_\_\_\_\_

Date of Transitional IPP Meeting: \_\_\_\_\_

Participant and/or Legal Representative \_\_\_\_\_ agreed or \_\_\_\_\_ refused to participate in the transitional IPP meeting.

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT OR LEGAL GUARDIAN      DATE

\_\_\_\_\_  
SIGNATURE OF WITNESS                                      DATE

- DECEASED

- PARTICIPANT IS NO LONGER MEDICALLY ELIGIBLE FOR AN ICF/MR LEVEL OF CARE

- PARTICIPANT IS NO LONGER FINANCIALLY ELIGIBLE FOR THE MR/DD WAIVER PROGRAM

- PARTICIPANT IS NO LONGER ELIGIBLE FOR AN ICF/MR LEVEL OF CARE

- STILL ON THE WAIVER PROGRAM; TRANSFERRED TO ANOTHER      AGENCY

Transferred to: \_\_\_\_\_

- OTHER \_\_\_\_\_

SIGNATURE OF PERSON COMPLETING FORM		DATE:	
SIGNATURE OF RECIPIENT		DATE:	
SIGNATURE OF GUARDIAN (if applicable)		DATE:	

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***):

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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.

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<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 \_\_\_\_\_

**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

<b>MOTOR SKILLS</b>	<b>Not-Applicable</b> not – applicable is not included in the average	<b>Independent</b> Completes without assistance	<b>Semi-Independent</b> May require assistance of a device without personal assistance	<b>Minimal Assistance</b> Intermittent physical assistance of another person	<b>Moderate Assistance</b> Requires physical assistance of another person to accomplish	<b>Total Assistance</b> Unable to complete without constant physical assistance of another person	<b>AVERAGE SCORE</b>
	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- <del>30</del> <b>24</b> months of age)							
Positioning (bed mobility) (n/a 0-9 months of age)							
<b>TOTAL MOTOR SKILLS</b> Average of 3.0 and above is “extraordinary”							

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

<b>DAILY LIVING SKILLS</b>	<b>Not-Applicable</b> not – applicable is not included in the average N/A	<b>Independent</b> Completes without assistance 0	<b>Semi-Independent</b> Sometimes needs verbal prompt to complete task 1	<b>Minimal Assistance</b> Verbal prompt required to complete task 2	<b>Moderate Assistance</b> Physical prompt and/or repeated instructions required to complete task 3	<b>Total Assistance</b> Unable to complete without constant physical assistance of another person 4	<b>AVERAGE SCORE</b>
Ability to engage in and complete age appropriate routine tasks or <b> routines of the day for a child below age 5 (task in the home that would be age appropriate i.e. make bed)</b>							
Ability to cross nearby residential street in own neighborhood <b> or recognize traffic safety</b> (n/a 0 -84 month)							
Ability to ride public transportation (n/a 0- <del>16</del> <b>14</b> years)							
Ability to make simple purchases in own neighborhood ( n/a 0 - 84 months)							
<b>Age appropriate ability to recognize dangers</b> such as “hot, electrical, falls, or sharp objects (i.e. hot stove, electrical outlets, stairs, etc.) n/a 0-36 months							
<b>TOTAL DAILY LIVING SKILLS</b> Average of 3.0 and above is “extraordinary”							

<b>COMMUNICATION SKILLS</b>	<b>Not-Applicable</b> not – applicable is not included in the average N/A	<b>Independent</b> Completes without assistance 0	<b>Semi-independent</b> Sometimes needs verbal prompt or assistance to complete 1	<b>Minimal Assistance</b> Verbal prompt or assistance required to complete task 2	<b>Moderate Assistance</b> Physical prompt and/or repeated instructions required to complete task 3	<b>Total Assistance</b> Unable to complete without constant physical assistance of another 4	<b>AVERAGE SCORE</b>
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)							
<b>TOTAL COMMUNICATION SKILLS</b> Average of 3.0 and above is “extraordinary”							

<b>MALADAPTIVE ISSUES</b> (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	<b>AVERAGE SCORE</b>
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							
<b>TOTAL MALADAPTIVE ISSUES</b> 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. (Follow the Protocol for ICAP for guidelines, protocols or BSP)							

<b>SPECIALIZED PHYSICAL, MEDICAL AND THERAPEUTIC NEEDS</b>	<b>Not-Applicable</b>  not – applicable is not included in the average	<b>Independent</b>  Completes without assistance	<b>Semi- independent</b>  Sometimes needs verbal prompt to complete task	<b>Minimal Assistance</b>  Verbal prompt required to complete task	<b>Moderate Assistance</b>  Physical prompt and/or repeated instructions required to complete task	<b>Total Assistance</b>  Unable to complete without constant physical and/or verbal assistance of another	<b>AVERAGE SCORE</b>
	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)							
<b>TOTAL SPECIALIZED Score of 3.0 on either item</b>							

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.

