CHAPTER 513 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES WAIVER (IDDW)

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BACKGROUND

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

Medicaid offers a comprehensive scope of medically necessary medical and mental health services. All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, using professionally accepted standards of care, and in accordance with all state and federal requirements. Enrolled providers are subject to review of services provided to Medicaid members by the BMS regardless of prior authorization requirements. All providers of service must keep current, accurate, legible, and completed documentation to justify medical necessity of services provided to each Medicaid member and this documentation must be made available to the BMS or its designee upon request.

This chapter sets forth the BMS requirements for payment of services provided to eligible West Virginia Medicaid members under the Intellectual and Developmental Disabilities Waiver (IDDW). These members may or may not be eligible for other Medicaid services.

This waiver is administered by the West Virginia DoHS under Title XIX of the Social Security Act and Chapter 9 of West Virginia Code.

PROGRAM DESCRIPTION

The IDDW program is West Virginia's home and community-based services program for individuals with intellectual and/or developmental disabilities (I/DD). It is administered by the BMS pursuant to a Medicaid waiver option approved by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for oversight of the IDDW program. The IDDW program reimburses the provision of services to instruct, train, support, supervise, and help individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible. The IDDW program authorizes and provides services based on the member's annual functional assessment and assigned individualized budget. The delivery of IDDW services occurs in community-based settings including the member's home and public locations in the member's community.

All services, except participant-directed goods and services, are available through the Traditional Service Option offered by IDDW providers statewide. Each member must receive case management services through the Traditional Option. For more information refer to Section 513.9.

Services are available through the Participant-Directed Option (*Personal Options*) to members who are eligible and who choose to direct some or all the services available through this option. These include person-centered support, respite (in-home and out-of-home), transportation, speech therapy, occupational therapy, physical therapy, dietary therapy, environmental accessibility adaptations home and vehicle, and goods and services. For more information refer to Section 513.9. Members may choose

all their services through the Traditional Option, or the member may choose to mix traditional option services and participant-directed option services.

All required documentation forms are available on the Bureau for Medical Services website.

HOME- AND COMMUNITY-BASED SERVICES

BACKGROUND

In January 2014, the Centers for Medicare and Medicaid Services (CMS) issued the Home and Community-Based Services (HCBS) Final Rule (CMS-2249-F and CMS-2296-F). The rule ensures individuals receiving long-term services and support through Medicaid HCBS programs under 1915(c) have:

- Full access to the greater community
- Opportunities for competitive, integrated employment
- Community engagement
- Control over personal finances
- Services in settings comparable to those not receiving Medicaid HCBS

West Virginia's Medicaid HCBS system includes four 1915(c) waiver programs affected by the Final Rule:

- Aged and Disabled Waiver (ADW)
- Intellectual and/or Developmental Disabilities Waiver (IDDW)
- Traumatic Brain Injury Waiver (TBIW)
- Children with Serious Emotional Disorders Waiver (CSEDW)

Each waiver provides services in different types of settings, which must meet specific federal requirements to ensure they do not isolate or institutionalize individuals.

As a result, West Virginia underwent the process of developing the West Virginia Home and Community Based Services Statewide Settings Transition Plan pursuant to 42 CFR 441.301(c)(6) that contained the actions the State took to bring all West Virginia waivers into compliance with requirements set forth in 42 CFR 441.301(c)(4-5). Specific details of all plan steps may be found at the West Virginia's Statewide Transition Plan webpage.

HEIGHTENED SCRUTINY OVERVIEW

During the development process of the West Virginia HBCS Statewide Settings Transition Plan, all distinct settings and addresses were reviewed and sorted into one of five categories:

- Fully compliant
- Not compliant but intends to become compliant
- Unable to reach compliance
- Presumed institutional and determined incompatible with compliance

- Non-HCBS settings such as intermediate care facilities (ICF), institutions for mental disease (IMD), nursing facilities, or hospitals not subject to the Final Rule

Settings presumed institutional were not immediately excluded. These settings have characteristics that are presumed to be incompatible with HCBS requirements as they have isolating qualities such as:

- Being found in a building that provides inpatient institutional support treatment
- Located in a building on the grounds of, or immediately next to, a public institution, or
- Any other setting having the effect of isolating individuals from the broader community including:
    - Settings where members have limited opportunity for interaction in and with the broader community, either by being physically removed from the broader community or does not facilitate access consistent with the member's Person-Centered Plan, or
    - Where the setting restricts member choice in receiving services or engaging in activities outside of the setting.

These settings may be determined by the state to have or will overcome the institutional presumption and meet settings criteria compliance by the end of the transition period. These cases are sent to CMS for heightened scrutiny review with evidence including review documents, stakeholder interviews and comments, and other evidence, as necessary.

During the transition period, the BMS did not identify any settings requiring the heightened scrutiny process and data analysis from these evaluations can be found on the West Virginia Statewide Transition Plan website. The heightened scrutiny process may be triggered in the future should any provider wish to enroll which meets the qualities of a presumed institutionalized setting.

All members and settings for the affected West Virginia Waiver programs will be reviewed annually using the following protocols.

ALL HCBS SETTINGS

Home and community-based settings must have all the following qualities, in addition to any member-specific needs as indicated on the member's person-centered plan regardless of who controls the setting per 42 CFR 441.301:

- Full integration into the community includes engaging in community life, opportunities for competitive employment, and having control over personal resources.
- Selected by the individual based on preference and needs from non-disability specific settings with options for private units.
- Supports privacy, respect, and freedom from coercion and restraint.
- Support for independence and personal choice
- Flexibility in service delivery and provider choice.

Case managers and direct-support professional staff must complete mandatory training on the Statewide Transition Plan. Members will receive educational information on the Statewide Transition Plan from their case managers.

MEMBER-CONTROLLED SETTINGS

Member-controlled settings are defined as homes or apartments owned or leased by an HCBS member or one of their family members related by birth, marriage, or adoption. 92% of the members on all three Waiver programs live in these settings, which are presumed compliant under federal rules, but must be verified.

Oversight

The member's qualified case manager must assess the setting annually, up to 90 days prior to the member's anchor date, to determine that the member continues to live in a compliant setting by assessing whether the setting provides:

- Full integration into the community includes engaging in community life, opportunities for competitive employment, and having control over personal resources.
- It is selected by the individual based on preference and needs from non-disability specific settings with options for private units.
- Privacy, respect, and freedom from coercion and restraint.
- Support for independence and personal choice.
- Flexibility in service delivery and provider choice.

The member-controlled setting assessment may be found on the Resources page of the West Virginia Statewide Transition Plan website.

Remediation

Any member living in a setting which does not meet the above standards must begin remediation by their case management agency to achieve compliance. Remediation attempts will be monitored by the BMS, and assistance provided if needed.

If a setting cannot be remediated, the member will be referred to transition to an approved setting. Members who cannot or refuse to transition and/or who cannot be remediated may, as a last resort, be discharged from the program.

Provider-Owned/Controlled Settings

Provider-controlled settings are owned or operated by an agency provider or where a member lives with a paid, unrelated caregiver:

- IDDW facility-based day habilitation settings
- Specialized family care homes
- 24 hours a day, seven days a week-supported settings (unlicensed residential homes)
- 24 hours a day, seven days a week group homes, four or more members (licensed group homes)
- CSEDW therapeutic foster homes

All waiver agencies will be contacted annually to verify the settings owned, leased, or run by the provider agency. The agency must notify the BMS within 15 days of any change in status, i.e., sites added and

removed. New settings must be assessed by the BMS or the utilization management contractor (UMC) for compliance before any HCBS services may be billed.

Oversight

All provider-controlled settings and members who receive services in these settings will be evaluated at least annually by the BMS or the UMC to ensure the setting continues to meet the requirements of the Final Rule:

Choice and personalization:

- The member chooses their setting from options that are not disability-specific and can opt for a private unit if desired and supported by assessed needs.
- Choices are based on the members' needs, preferences, and available resources for room and board.
- The member actively takes part in developing and updating their person-centered plan.

Community integration:

- Members take part in community activities, both planned and spontaneous.
- They have opportunities for employment in inclusive settings and to fully engage in community life.
- The setting does not isolate them from the broader community.

Privacy and living arrangements:

- Members have their own bedroom or share with a roommate of their choice.
- Their unit has a lockable door, with only appropriate staff having keys.
- Visitors are allowed at any time.
- Privacy and dignity are always respected.

Autonomy and daily life:

- Members control their daily schedules.
- They decide when, what, and with whom to eat, and have access to food at any time.
- They choose their providers and have input on the services and supports they receive.
- They can make private calls, texts, or emails at their convenience.

Rights and protections:

- Members are free from coercion or restraint.
- Staff communicate respectfully and support individual member comfort and preferences.
- Those needing help are dressed in their own clothing, appropriate to the time of day and their preferences.

Environment and accessibility:

- The setting supports independence and allows for unrestricted movement.

- The physical environment meets the needs of members requiring additional support.
- The setting complies with state laws and regulations without unnecessarily limiting personal choice.

The provider-controlled setting assessment may be found on the Resources page of the West Virginia Statewide Transition Plan website.

Remediation

Any provider-controlled setting which does not meet the above standards will be referred to BMS for remediation to achieve compliance.

If a setting cannot be remediated to meet all standards, the setting will be removed from approved providers listings, and the member(s) will be referred to transition to an approved setting. Members who cannot or refuse to transition and/or who cannot be remediated may, as a last resort, be discharged from the program.

Transitioning Members from Non-Compliant Settings

When a setting no longer meets federal standards, West Virginia follows a structured, person-centered transition process to support the members affected:

- Discovery:
  - Case managers or a BMS representative/UMC representative identified a setting that is out of compliance.
- Remediation Plan:
  - Member-Controlled Settings: Case managers develop a remediation plan to correct non-compliant requirements within 30 days.
  - Provider-Controlled Settings: Case managers collaborate with providers to develop a remediation plan to correct non-compliant requirements within 30 days.
- Implementation:
  - 30 additional days are given to implementing the remediation plan to bring the setting into compliance.
- Follow-up:
  - Member-Controlled Settings: Case managers conduct a follow-up visit within another 30 days to evaluate compliance.
  - Provider-Controlled Settings: The UMC conducts a follow-up visit within another 30 days to evaluate compliance.

If compliance is not achieved within 90 days, the setting is considered non-compliant with the federal HCBS settings rule and BMS is notified by the UMC (provider-controlled settings) or case manager (member-controlled settings). The BMS then starts a structured transition process to ensure the safety and continuity of care for affected members.

The provider is officially notified by the BMS via certified mail and email that the setting is non-compliant. At this time, the provider(s) must begin a 90-day transition phase to relocate the affected member(s) to a

compliant setting or initiate disenrolling the member from the program if relocation is not possible or refused. Members who choose to transition to a compliant setting will have 90 days to complete the transition process.

- Providers must notify affected members within 10 calendar days after receiving the notice from the BMS indicating the setting is non-compliant and explaining their options for disenrollment or transitioning.
- The BMS will additionally notify members five business days following the provider notification to ensure all parties.
- The provider is responsible for helping the member in locating a compliant setting within the current agency or a provider who has available compliant settings.
- Within 30 business days of the BMS non-compliance notice, the provider must submit an Agency Transition Plan to BMS which includes:
    - The address(es) of the non-compliant setting(s).
    - Names and Medicaid numbers of affected members.
    - HCBS services members are receiving.
    - Date of the Critical Juncture meeting for each member.
    - Outcome of each meeting, including the chosen compliant setting.
    - Planned transition date for each member.
- Providers must update the transition plan weekly until all transitions are finalized.
- Providers must copy the BMS on all communications with members and families regarding transitions.

During the 90-day transition phase, members may remain in the non-compliant setting, but HCBS services cannot be billed for that setting. The BMS will start disenrollment of the non-compliant setting at the end of 45 days or when all members have transitioned.

Members and families are encouraged to contact the BMS directly with any questions or to request transition assistance. These requests may be submitted via phone, email, or letter. Should a provider be unable to fully support the member in a transition, the BMS will intervene and assist directly to ensure prompt placement in a compliant setting. In some cases, the BMS may extend the 90-day transition period to ensure services are not further disrupted for the member(s).

PROVIDER ENROLLMENT AND PARTICIPATION REQUIREMENTS

513.1 BUREAU FOR MEDICAL SERVICES (BMS) CONTRACTUAL RELATIONSHIPS

The BMS contracts with a UMC. The UMC acts as an agent of the BMS and administers and supports the operations of the IDDW program. The UMC processes initial eligibility determination packets and conducts the annual functional assessment to establish re-determination of medical eligibility and to calculate individualized budgets. The UMC conducts education for IDDW providers, members, advocacy groups, and DoHS. The UMC provides a framework and a process for the purchase of waiver services based on individualized budgets. At times, the UMC, in collaboration with the BMS, will provide answers to policy questions which will serve as Policy Clarifications. These policy clarifications will be posted on

the IDDW website under Policy Clarifications. Policy Clarifications (frequently asked questions) serve as an extension of the IDDW policy manual and offer additional guidance regarding the application of program policies. Program providers are expected to review and adhere to Policy Clarifications.

The UMC provides authorization for services that are based on the member's assessed needs and provides authorization information to the claim payer. The BMS contracts with IDDW providers for the provision of services for members.

The BMS contracts with a medical eligibility contracted agent (MECA) to determine initial and re-determination medical eligibility of prospective and active members and to recruit and train licensed psychologists to take part in the Independent Psychologist Network (IPN). The UMC and the MECA work together to process initial applications and re-determination packets.

The BMS contracts with a fiscal/employer agent (F/EA) to administer the *Personal Options* Financial Management Services (FMS) program. The F/EA acts as a subagent of the BMS for the purpose of performing employer and payroll functions for members wishing to self-direct some of their services through the *Personal Options* FMS.

The BMS also contracts with licensed IDDW providers who wish to participate in the West Virginia Medicaid Program.

In addition, the BMS contracts with an Electronic Visit Verification (EVV) provider to support the documentation of services in compliance with requirements of the 21st Century Cures Act. While providers do not have to use the BMS contracted EVV vendor, it is the provider's responsibility to ensure that the EVV vendor of their choice complies with all requirements of the 21st Century Cures Act.

Please refer to the IDDW website for UMC, MECA, and *Personal Options* vendors for current contact information.

513.2 PROVIDER ENROLLMENT AND RESPONSIBILITIES

In addition to provider enrollment requirements in *Chapter 300, Provider Participation Requirements*, IDDW Program providers must meet all the requirements listed below:

Licensure and Certification Standards

- Receive a Certificate of Need (CON) approval from the West Virginia Health Care Authority through the full-length CON process or through the Summary Review process. NOTE: To contract with extended professionals to provide dietary therapy, occupational therapy, physical therapy, and/or speech therapy services, the applicable service(s) must be included on the provider agency's CON.
- Obtain and maintain a behavioral health license through the Office of Health Facility Licensure & Certification (OHFLAC). NOTE: This requirement does not apply to case management-only agencies.

- Obtain and maintain a provider certification through the UMC, as described in Section 513.2.4. NOTE: This requirement only applies to case management-only agencies.
- Meet and maintain all BMS enrollment requirements including a valid provider agreement on file that is signed by the IDDW provider and BMS, as well as a valid Medicaid enrollment agreement.
- Meet and maintain the standards established by U.S. Department of Health and Human Services (DHHS), and all applicable state and federal laws governing the provision of these services.
- Comply with all American with Disabilities Act (ADA) requirements if applicable.
- Comply with all Social Security Administration (SSA) requirements for serving as a representative payee, if applicable, including maintaining documentation for a minimum of two years.

Administrative Standards

- Hire and retain a qualified workforce.
- Maintain a record of the training verification or recertification for each agency staff.
- Subcontract with licensed individual or group practices of the behavioral health profession as defined by the OHFLAC, if contracting occurs.
- Ensure that services are delivered, and documentation meets regulatory and professional standards before the claims are submitted.
- Ensure that all required documentation is maintained at the agency on behalf of the State of West Virginia and accessible for state and federal audits.
- Maintain evidence of implementing a utilization review and quality improvement process which includes verification that services have been provided, and the quality of those services meets the standards of the IDDW program and all other applicable licensing and certification bodies.
- Provide an assigned agency IDDW contact person whose duties include:
    - Review of home and day service visits to assure compliance with waiver policy.
    - Oversight of agency staff implementing the Individual Program Plans (IPPs) for all members taking part in the IDDW program.
    - Communicate promptly with the BMS and the UMC.
    - Participate in quarterly training sessions and routine conference calls provided by the UMC.
- Maintain written policies and procedures to avoid conflicts of interest (if agency provides case management and other services).
- Implement the IDDW Quality Improvement System as further defined under Section 513.2.3.

Responsibilities to program members

- Provide each member with a maximum choice of IDDW services within their individualized budgets available in each of the service delivery models and a choice of service delivery models.
- Ensure that a member is not discharged, discriminated, or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted or who has participated in an investigation process that involves an IDDW provider.
- Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services the member needs to another provider(s) and is agreed upon by the member and/or their legal representative and the receiving provider(s). If a provider discharges a member without a viable discharge/transfer plan, agreed to by the member and/or

legal guardian (in writing), the provider may be subject to a targeted review, referral/enrollment hold, reduction in caseload and/or disenrollment as an IDDW provider.
- Help members receiving services in securing safe housing.
- Ensure that all residential sites (leased or rented by IDDW providers) provide a safe environment for members and agency staff.
- Ensure that specific goals, based on assessments and designed to keep the optional adaptive functioning of the individual, are implemented. Goals shall have related measurable objectives, have an expected achievement date, and, when appropriate, outcomes for discharge.
- Provide proper auxiliary aids and services when necessary to ensure effective communication with members and/or legal representatives when natural or other supports are not available. This includes, but is not limited to, the use of qualified sign language interpreters, documents in Braille or large print, and audio recordings.

Responsibilities to Agency Staff

- Ensure that all agency staff providing direct care services are fully trained in the proper care of the member to whom they will be providing services prior to being billed. A registered nurse (RN), behavioral support professional (BSP), or case manager must conduct health and safety training, however, the member (with the support of the interdisciplinary team (IDT)) decides who is best suited to provide health and safety training and may select another provider or individual to deliver this training. Fully trained agency staff must be available until newly hired agency staff or qualified support workers are trained.
- Employ or contract with extended professional agency staff who meet all the training and credentialing requirements listed under this section and its subparts, as well as the individual service definitions of this chapter.
- Ensure access to professional therapy services to all members, including the use of “pass-through” contracts with professional therapy service providers.
- Ensure that agency staff are not discharged, discriminated, or retaliated against in any way if they filed a complaint, filed a complaint on someone else’s behalf, or taken part in an investigation process that involves an IDDW provider.
- Ensure that all residential sites (leased or rented by the IDDW provider) provide a safe environment for the agency staff.
- Begin the mandatory IDDW program training for all agency staff on the first day of employment and document all mandatory training on the Certificate of Training form (WV-BMS-IDD-06). All evidence of training for all staff must be documented by the IDDW provider agency for all staff who deliver services. IDDW provider agencies may (but are not required to) accept documentation of completion of equivalent mandatory training from other certified IDDW provider agencies when it meets all content, documentation, and recency requirements described in Sections 513.2.3.5 and 513.3.3. All training documentation must be kept on file by the IDDW provider agency and made available upon request within seven calendar days.
- All agency staff, having direct contact with members must meet the following qualifications:
    - Approved criminal background checks as defined in Section 513.2.1 Criminal Background Checks. Refer to *Chapter 700 West Virginia, Clearance for Access: Registry & Employment Screening (WV CARES)* for criminal background check information. NOTE: This does not include contracted, licensed professional staff. OHFLAC and/or the

Office of the Inspector General (OIG) are responsible for conducting background checks on licensed professional staff.

- Are not listed on the list of excluded individuals kept by the Office of the Inspector General (OIG) as defined in Section 513.2.1 Criminal Background Checks. NOTE: This includes contracted professional staff.
- Though not a requirement, BMS strongly urges providers to obtain an Approved Protective Services Record Check and consider the results. The form can be found on the Bureau for Social Services (BSS) website.
- Be over the age of 18.
- Be able to perform required tasks.
- Agency staff who function as approved medication assistive personnel (AMAP) must have high school diplomas or the equivalent and be certified AMAPs. Additional information regarding the AMAP program can be found on the OHFLAC website.
- Any staff person who provides transportation services must have a valid driver's license, proof of current vehicle insurance and registration. In addition, any staff person who provides transportation services must abide by local, state, and federal laws about vehicle licensing, registration, and inspections upon hire and checked annually thereafter. As of August 1, 2025, an affidavit, completed by the staff providing transportation, attesting to the validity of their driver's license, current vehicle insurance, and registration may serve as evidence of compliance following State laws.
- Documented training on emergency procedures, such as crisis intervention and restraints upon hire and thereafter only if considered necessary by the IDT based on the assessed needs of the member.
- Documented training on the recognition and documentation of reporting suspected abuse, neglect, and exploitation, including injuries of unknown origin.
- Documented training on First Aid by a certified trainer from an approved agency listed on the IDDW website to include always having current First Aid certification upon hire and as shown by the expiration date on the card. NOTE: In-person or virtual skills demonstrations are acceptable with a valid certificate from an approved vendor. Licensed registered nurses (RNs) and licensed practical nurses (LPNs) are excluded from the First Aid certification requirement.
- Documented training in Cardiopulmonary Resuscitation (CPR) by an approved agency listed on the IDDW website to include always having current CPR certification upon hire and as indicated per expiration date on the card (this training and refresher trainings must include manual demonstration and be specific to the ages of the members supported by the agency staff). NOTE: In-person or virtual skills demonstrations are acceptable with a valid certificate from an approved vendor. Licensed RNs and LPNs are excluded from CPR training and certification requirements.
- Completion of the West Virginia Association for Positive Behavior Support (WV APBS) Overview of Positive Behavior Support or the West Virginia University's Center for Excellence in Disabilities (WVU CED) Positive Behavior Support Direct-Care Overview, provided upon hire. While not a requirement, The BMS urges providers to provide ongoing training and support to all applicable staff related to positive behavior support either through annual retraining or targeted trainings, as needed.

- Case managers hired after October 1, 2022, must complete the conflict free-case management (CFCM) training in the State of West Virginia Public Learning Center System.
- All staff must be trained to provide IDDW services in a culturally and linguistically appropriate manner upon hire. At a minimum, being culturally and linguistically proper means being respectful of and responsive to individual beliefs, practices, and diverse needs. While not a requirement, the BMS also strongly urges providers to retrain all applicable staff based upon individual member needs, as necessary.
- Provide and keep documentation of competency-based training initially and annually as mandated by OHFLAC and the IDDW policy manual. A score of 80% or higher on the training post-test is needed to prove competence. For all trainings, annually is defined as within the month the training expires. These trainings include:
    - Treatment policies and procedures, including confidentiality training.
    - Rights of members.
    - Infectious disease control.
    - Direct-care ethics for direct-support professionals providing person-centered supports, day supports, and respite that minimally addresses:
        - A focus on the member, including commitment to person-centered supports as best practice.
        - Promoting the physical and emotional well-being of the member.
        - Integrity and responsibility.
        - Confidentiality.
        - Justice, fairness, and equity.
        - Respect.
        - Relationships.
        - Self-determination; and
        - Advocacy.
    - Recognition of documentation of and reporting of suspected abuse, neglect and exploitation, including injuries of unknown origin.
- Prior to providing services to individual members, all direct-support professionals providing person-centered supports, day supports, respite, and LPNs providing person-centered supports (when applicable) must receive initial training, and at least annual training thereafter. For all trainings, annually is defined as within the month the training expires. These trainings include:
    - Emergency care to include member-specific crisis plans and emergency disaster plans.
    - Member-specific needs (including behavioral, habilitation, and other needs).
    - Member-specific health and welfare needs (including medical diagnosis, medication, and side effects).

  Documentation for each training must include training topic, date, the beginning time of the training, the ending time of the training, the location of the training, the signature or the electronic signature of the instructor, and the signature or the electronic signature of the trainee. Internet training must include the person's name, the name of the internet provider, and a certificate of completion or other documentation showing successful completion. All documented evidence of training for all staff who deliver IDDW services must be kept on file and available upon request. Qualifications must be verified initially as current and updated as required.
- Each agency is responsible for keeping documentation of training completion for their own staff on the members' crisis plan, as needed, and for health and safety training, as applicable. The

individual named by the IDT as the person(s) best suited to complete the training must make these records available to the staff person's employer. If an agency is unable to obtain this documentation, then it is recommended that the provider keeps a record of attempts to obtain the training records to show compliance with training record retention requirements. Note: Electronic signatures must comply with the documentation and record retention requirements described in *Chapter 100, General Information* of the BMS policy manual.

- Prior to using an internet provider for training purposes, the name, web address, and course names must be sent to the UMC for review. The UMC will respond in writing whether the training meets training criteria.

Electronic Visit Verification

As required by the Cures Act, BMS implemented the Electronic Visit Verification (EVV) system to verify In-Home visits for *Personal Care* Services (participant-directed support) providers on March 1, 2021, and Home Health Care Services (HHCS) providers by January 1, 2023. The EVV system verifies:

- Type of service performed.
- Individual receiving the service.
- Date of the service.
- Location of service delivery.
- Individual providing the service; and
- Time the service begins and ends.

Providers of home-based agency person-centered support, in-home respite and out-of-home respite must use the EVV system to document the delivery of these services. Direct-care staff use the system to check in at the beginning of the visit. After the visit, the member or authorized representative use the system to verify the correct visit has been provided and documented. BMS ensures that the EVV solution is secure, minimally burdensome, and does not constrain member choice of a caregiver or the manner of care delivery. The BMS provides training and an EVV guide. The EVV vendor is also responsible for training members and their staff to use the EVV system correctly, as well as providing ongoing support and oversight of the EVV system.

Conflicts of Interest

- The CMS requires that services be free of conflicts of interest. The BMS has implemented a system that allows members to receive services in a conflict-free manner. Agencies that provide case management services to a member cannot provide any other IDDW or HCBS (NOTE: behavioral health, applied behavioral analysis, and other non-IDD covered therapies are not considered a conflict of interest) to that member if provision of those services would result in financial gain, potential financial gain, or job security, whether those services be funded by Medicaid or an alternative funding source. It is considered a conflict of interest for payee services to be provided by a member's case management agency; however, exceptions may be granted on a case-by-case basis if no other payee services are available.
- Conflicts of interest are prohibited. A conflict of interest is when the case manager who represents the member who receives services has competing interests due to affiliation with a provider agency, combined with some other action. "Affiliated" means has either an employment,

contractual or other relationship with a provider agency such that the case manager receives financial gain or potential financial gain or job security when the provider agency receives business serving IDDW members.

- At no time shall an agency or person affiliated with an agency provide services to a member while serving as their landlord, except in the case in which the home in which the tenant resides and rents from their agency or person affiliated with the agency has been licensed by OHFLAC. Conflicts of interest are prohibited for members accessing IDDW services, regardless of the service and funding source involved.
- If a case manager influences the Freedom of Choice of the member, a conflict of interest occurs. To ensure complete impartiality, the case manager and other agency personnel, except for the legal representative of the member being assessed or the specialized family care provider, will be excused when the Freedom of Choice form is completed during the annual functional assessment. If the member has a legal representative who is not in attendance, the legal representative must sign the Freedom of Choice within 10 days, however, if it is not possible, the Freedom of Choice Form should be completed at or before the person's Annual IPP meeting. The case manager should document the circumstance that prohibited completion within 10 calendar days.
- Case managers must always ensure any affiliation with a provider agency does not influence their actions about seeking services for the member they represent. Failure to abide by this Conflict of Interest policy will result in the loss of provider IDDW certification for the provider involved in the conflict of interest for a period of one year and all current members being served by the suspended provider will be transferred to other case management agencies. Additionally, any case manager who takes improper action as described above will be referred to their professional licensing board, if applicable, for a potential violation of ethics. (BMS notes that whether any action is taken would be within the sole discretion of the individual licensing boards and depend upon its specific ethical rules). Reports of failure to abide by this Conflict of Interest policy will be investigated by the UMC and the results of this investigation will be reported to the BMS for review and possible action.
- The following safeguards must be in place to ensure that service plan development is conducted in the best interests of the member when an IDDW agency has been approved to provide both case management and other HCBS to a member:
    - The agency must have separate files for case management and other HCBS. It is the responsibility of the agency director to ensure separate file maintenance.
    - The case management offices are in a separate location from the other HCBS services (if they are in the same building they must be physically separated).
    - There shall be no sharing of supervisory staff between the case management and HCBS services.
    - The case manager may not provide any other HCBS services to the member.
    - The case manager must have documentation from the BMS or their designee for the approved request due to 25-mile radius, language, or cultural background.
    - West Virginia will monitor the conflict free services through quality reviews conducted by the UMC.
    - Case managers must remain neutral during the development of the IPP, including the requirement that the IDDW agency separate HCBS from case management services into distinct functions, with separate oversight.

  - IDDW agencies must have a policy to show how the agency ensures that the case manager is free from influence of other HCBS service providers regarding member Plans of Care.
  - Any case manager working for an agency that will also be providing other HCBS services will sign a Conflict of Interest Assurance form, and the completed form must be placed in the case manager's personnel file.
  - Evidence of administrative separation on an organizational chart that includes position titles and names of staff must be available to the BMS or their designee during quality reviews or upon request.
- The agency owner/administrator must also sign an Attestation/Conflict of Interest application for home and community-based waiver services that includes, at a minimum, the following:
  - The agency has administrative separation of supervision of case management and HCBS.
  - Members are offered choice for HCBS between and among available service providers. Members are not limited to HCBS provided only by this agency.
  - Members are free to choose or deny HCBS without influence from case management or HCBS staff.
  - Members choose how, when, and where to receive their approved HCBS per the person-centered service planning process and plan.
  - Members are free to communicate grievance(s) about case management or HCBS delivered by the agency.
  - The grievance/complaint procedure is available, clear and understood by members and legal representatives.
  - Grievances/complaints are resolved promptly by giving the member the opportunity to file a grievance/complaint with the agency. If the grievance/complaint is not resolved, then the member is given the opportunity to present their case to the UMC for resolution.

513.2.1 Criminal Background Checks

Refer to *Chapter 700 West Virginia Clearance for Access: Registry & Employment Screening (WV CARES)* for criminal background check information.

513.2.2 Office Criteria

IDDW service providers must designate and staff at least one physical office within West Virginia. A post office box or commercial mailbox will not suffice. Each designated office must meet the following criteria:

- Must be physically located in West Virginia.
- Meet ADA requirements for physical accessibility (refer to 28 CFR 36) including, but not limited to:
  - Maintaining an unobstructed pedestrian passage in the hallways, offices, lobbies, bathrooms, entrance and exits
  - The entrance and exit have accessible handicapped curbs, sidewalks and/or ramps
  - The restrooms have grab bars for convenience
  - A telephone is accessible

  - Drinking fountains and/or water made available as needed
- Be readily identifiable to the public.
- Maintain a primary telephone number that is listed with the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine is not a primary business telephone.)
- When transmitting sensitive information, keep and use an agency secure Health Insurance Portability and Accountability Act (HIPAA) compliant e-mail address for communication with the BMS and the UMC for all staff.
- Any written communication having protected health information or personally identifiable information, must be sent in a secure manner that protects the member's information.
- Do not use personally identifiable information in the subject line of a secure email.
- Personal electronic devices are prohibited when using personally identifiable information.
- Referencing people receiving IDDW services on social media in any manner is strictly prohibited, unless the individual(s) sign a HIPAA compliant written release.
- Must have access to a computer, fax, email address, scanner, and internet, at a minimum.
- Use any database system, software, etc., compatible with/approved and/or mandated by the BMS.
- Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.
- Have space for securely maintaining program and personnel records. (Refer to *Chapter 100, General Information*, and *Chapter 300, Provider Participation Requirements*, for more information on maintenance of records).
- Maintain a 24-hour contact method.
- Any authentication method for electronic and stamped signatures must meet the following basic requirements:
  - Unique to the person using it
  - Capable of verification
  - Under the sole control of the person using it, and
  - Linked to the data in such a manner that if the data is changed, the signature is invalidated.

513.2.3 Quality Improvement System (QIS)

The BMS is responsible for building and supporting the QIS. The IDDW provider and the *Personal Options* vendor are responsible for taking part in all activities related to the QIS. The QIS is used by the BMS and the UMC as a continuous system that measures system performance, tracks remediation activities, and finds opportunities for system improvement.

Achieving and maintaining program quality is an ongoing process that includes collecting and examining information about program operations and outcomes for members receiving services and then using the information to find strengths and weaknesses in program performance. This information is used to form the basis of remediation and improvement strategies.

The QIS is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are routinely met; and ensure the active involvement of interested parties in the quality improvement process.

513.2.3.1 Centers for Medicare and Medicaid Services (CMS) Quality Assurances

The CMS mandates the IDDW program guarantee the following quality assurances:

- **IDDW Administration and Oversight:** The BMS is the State Medicaid agency actively involved in the oversight of the IDDW and is ultimately responsible for all facets of the IDDW program.
- **Level of Care:** Members enrolled in the IDDW program have needs consistent with an institutional level of care.
- **Provider Qualifications:** IDDW providers are qualified to deliver services/supports.
- **Service Plan:** Members have a service plan that is appropriate to their needs and preference and receive the services/supports specified in the service plan.
- **Health and Welfare:** Members' health and welfare are safeguarded; and
- **Financial Accountability:** Claims for IDDW services are paid according to state payment methodologies specified in the approved waiver.

Data is collected and analyzed for all quality assurances and sub-assurances based on West Virginia's quality performance indicators, as approved by the CMS. The primary sources of discovery include IDDW provider reviews, incident management reports, complaints and/or grievances of members or their legal representatives, OHFLAC reviews, abuse and neglect reports, administrative reports, oversight of delegated administrative functions and interested party input from interested parties.

513.2.3.2 Quality Improvement Advisory (QIA)

The QIA Council is the focal point of stakeholder input for the IDDW program and plays an integral role in data analysis, trend identification, and the development and implementation of remediation strategies.

The role of the QIA Council is to advise and assist the BMS and the UMC staff in program planning, development and evaluation consistent with its stated purpose. In this role, the QIA Council uses the IDDW Performance Indicators as a guide to:

- Recommend policy changes.
- Recommend program priorities and quality initiatives.
- Monitor and evaluate policy changes.
- Monitor and evaluate the implementation of IDDW priorities and quality initiatives.
- Serve as a liaison between the IDDW and interested parties; and
- Establish committees and work groups consistent with their purpose and guidelines.

The QIA Council membership is made up of persons who formerly utilized IDDW services of the IDDW program, members who currently utilize IDDW services (or their legal representatives), service providers, and advocates and other allies of people with intellectual and/or developmental disabilities.

513.2.3.3 IDDW Provider Reviews

The primary means of monitoring the quality of the IDDW services is through provider reviews conducted on a defined cycle by OHFLAC and the UMC, as determined by the BMS.

The UMC performs on-site and desk documentation provider reviews, staff interviews, telephone satisfaction surveys with members/legal representatives, and day service visits to confirm certification documentation and address the CMS quality assurance standards. Targeted on-site IDDW provider reviews and/or desk reviews may by conducted by OHFLAC and/or the UMC in follow-up to incident management reports, complaint data, Plan of Correction (POC), or any other areas of concern call for more comprehensive investigations.

Upon completion of each provider review, the UMC conducts an exit summation, either face-to-face or via teleconference if review conducted via desk audit, with staff chosen by the provider to attend. Within 120 days of the exit summation, the UMC will make available to the provider a draft exit report and a POC to be completed by the IDDW provider. If citations resulting in potential monetary disallowances are found, the IDDW provider will have 30 days from receipt of the draft exit report to send comments to address citations, along with any necessary, supporting information and documentation as well as the completed POC back to the UMC. If a POC is not submitted within the 30-day comment period, the BMS may place a hold on payments for services. After the 30-day comment period has ended, the BMS will review the draft report, and any comments submitted by the IDDW provider and issue a final report to the IDDW provider's executive director and designated waiver contact. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of IDDW services. A Cover Letter to the IDDW provider's executive director and designated waiver contact will outline the following options to effectuate repayment:

- Payment to the BMS within 60 days after the BMS notifies the provider of the overpayment/disallowance: or
- Placement of a lien by the BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment/disallowance: or
- A recovery schedule of up to a 12-month period, via monthly payments or the placement of a lien against future payments.

If the IDDW provider disagrees with the final report, the IDDW provider may request a document/desk review (DDR) within 30 days of receipt of the final report pursuant to the procedures in *Chapter 100, General Information* of the West Virginia Medicaid policy manual. The IDDW provider must still complete the written repayment arrangement within 30 days of receipt of the final report, but scheduled repayments will not begin until after the DDR decision. The request for a DDR must be in writing, signed, and set forth in detail the items in contention. The letter must be addressed to:

Commissioner Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301-3706

If no potential disallowances are found during the UMC review, then the IDDW provider will receive a final letter and a final report from the BMS.

Reviews of Participant-Directed services are included in Section 513.9, Description of Services for *Personal Options*.

For information relating to additional audits that may be conducted for services please see *Chapter 800, Program Integrity* of the BMS Policy Manual that identifies other State/Federal auditing bodies and related procedures.

513.2.3.4 Plan of Correction

In addition to the draft review report sent to the IDDW providers, the UMC will also send a draft POC electronically. IDDW providers must complete and electronically submit the POC to the UMC for approval within 30 calendar days of receipt of the draft POC from the UMC. The BMS may place a hold on claims if an approvable POC is not received by the UMC within the specified time frame. The POC must include:

- How the deficient practice for the persons cited in the deficiency will be corrected.
- What system will be put into place to prevent recurrence of the deficient practice.
- How the provider will monitor to assure future compliance and who will be responsible for the monitoring.
- The date the POC will be completed; and
- Any provider-specific training requests related to the deficiencies.

513.2.3.5 Training and Technical Assistance

The UMC develops and conducts training for IDDW providers and other interested parties as necessary to improve systemic and provider-specific quality of care and regulatory compliance. Training is available through both face-to-face and web-based venues.

513.2.3.6 Self-Reviews

IDDW agencies must submit evidence to the UMC every calendar year to document continuing compliance with all certification requirements as specified in this manual. Evidence reports must include a signed attestation from an appropriate official of the provider agency (e.g., executive director, Board Chair, etc.). Reports may be sent from a provider's human resources (HR) system. For example, providers may send an Excel spreadsheet or any other format that includes all applicable fields and documents training dates of employees. This form must be sent electronically to the UMC. This self-review tool allows providers to incorporate into their quality assurance and improvement processes a method to ensure quality services occur and CMS Quality Assurances are met.

Each provider will be required to submit a self-review per their agency's review schedule, as approved by BMS or its designee. The exact due date will be communicated to the provider at least 45 calendar days prior to the due date.

513.2.3.7 Utilization Guidelines for IDDW

Each agency must put into place a set of Utilization Guidelines to ensure that each member who receives IDDW services receives the authorized services and supports at the right time, in the right amount, and for as long as the services are needed. Utilization Guidelines are a person-centered process that starts with person-centered planning. The purpose of Utilization Guidelines is to monitor claims submission and ensure that services provided are in compliance with the IDDW Manual and existing authorizations, and to ensure that the services requested and utilized for the member are within the annual individualized budget, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2, Service Authorization Process.

Agencies providing services must have Utilization Guidelines in place that tracks units of services utilized and billed. It is the expectation that each provider agency be able to report units used and units still available at the IDT meetings (if not earlier). This is not only necessary for transfer/authorization purposes but is also necessary for IDTs to make good decisions about purchasing services. Each agency is to have and adhere to a Utilization Guidelines policy. Except for Crisis Services, agencies must receive prior authorization for each service provided, as outlined under Section 513.22, Prior Authorizations and specified in each service definition under “Prior Authorization.”

The internal policy of each agency must minimally address the following:

- Staff training
- Education of staff on how services will be delivered throughout the service year. This education should minimally include the following:
- Tentative schedule of the member (daily, weekly, monthly)
- Units of service authorized
- Averages of usage (daily/monthly)
- Individualized training (as needed)
- Requirements and limitations of the service provided
- Empowering and educating members and families so that they can make informed choices about their services and supports.
- Assessing needs of the member
- Service requests are based on identified need for the coming service year; therefore, additional units may not be requested for contingency purposes.
- Choosing services based on the members’ assessed needs and within the individual annual budget.
- Monitoring service utilization throughout the service year.
- Monitoring the needs of the member and updating services as needed.
- Delivering services based on:
    - Assessed need within the individualized budget.
    - Agreement by the IDT.
    - IDDW service caps and limitations.
    - Documentation on the IPP; and
    - The individualized waiver budget.

513.2.4 Provider Agency Certification (Case Management-Only)

IDDW provider agencies that only provide case management services must be certified by the UMC. A certification application must be completed and submitted to the UMC.

To be certified as an IDDW case management-only agency, applicants must meet and maintain the following requirements:

- A business license issued by the state of West Virginia.
- A Federal Tax Identification Number (FEIN).
- An organizational chart (Note: Providers must submit an updated organizational chart to the UMC upon any changes in the organizational structure).
- A list of the Board of Directors (if applicable).
- A list of all agency staff including their qualifications.
- A Quality Management Plan for the agency.
- Written policies and procedures for processing complaints and grievances, from staff or members, that:
    - Addresses the process for submitting a complaint.
    - Provides steps for remediation of the complaint including who will be involved in the process.
    - Includes steps for notifying the member/staff of the findings and recommendations.
    - Provides steps for advancing the complaint if the member/staff does not feel the complaint has been resolved.
    - Ensures that a member or agency staff are not discharged, discriminated against, or retaliated against in any way if they have been a complainant, on whose behalf a complaint has been submitted, or who has taken part in an investigation process that involves an IDDW provider.
- Written policies and procedures for the use of personally and agency owned electronic devices which include, but are not limited to:
    - Prohibiting using personally identifiable information in text messages and subject lines of emails.
    - Prohibit the use of personally identifiable information in the body of emails unless the email is sent securely through a HIPAA-compliant connection.
    - Prohibit the use of personally identifiable information from being posted on social media sites.
    - Prohibiting use of public Wi-Fi connections.
    - Informing agency employees that, during an investigation, related information on their personal cell phone may be discoverable and;
    - Requiring all electronic devices to be encrypted.
- Written policies and procedures for members who wish to transfer services to another agency.
- Written policies and procedures for the discontinuation of a member's service.
- Written policies and procedures to avoid conflict of interest, including education of case managers on general conflict of interest/professional ethics with verification:
    - Annual signed Conflict of Interest Statement for all case managers and the agency director.

  - Process for investigating reports on conflict of interest complaints.
  - Process for reporting to the BMS.
  - Process for reporting complaints to professional licensing boards for ethics violations.
- Office space that allows for confidentiality of the member.
- An Agency Emergency Plan for members and office operations that includes:
  - Office Emergency Back-up Plan ensuring office staffing and facilities are in place during emergencies such as floods, fires, etc. NOTE: Temporary facilities must meet all requirements and the UMC must be notified within 48 hours of the emergency relocation.
  - Process for notification of members of the Emergency Back-up Plan.
- Accept referrals in the UMC's portal within five business days or forfeit the referral.
- Develop and implement policies and procedures for people with limited English ability and/or accessible format needs that culturally and linguistically appropriate to ensure meaningful access to services.
- Provide computer(s) for staff with HIPAA secure email accounts, the UMC's portal access, internet access, and current (within the last five years) software for spreadsheets.
- Hire and retain a qualified workforce.
- Ensure that a member is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services that the member needs to another provider(s) and is agreed upon by the member and/or their legal representative and the receiving provider(s).
- Ensure that services are delivered, and that documentation meets regulatory and professional standards before claims are submitted.
- Participate in all mandatory training sessions.

Agencies will be reviewed by the UMC within six months of initial agency certification, and annually thereafter. (See *Chapter 300, Provider Participation Requirements*).

Providers will be held accountable for information contained in all Medicaid common chapters. Providers are encouraged to contact the UMC for training needs and technical assistance at any time.

513.3 STAFF QUALIFICATIONS AND TRAINING REQUIREMENTS

All staff must be trained to provide IDDW services in a culturally and linguistically proper manner. At a minimum, being culturally and linguistically proper means being respectful of and responsive to individual beliefs, practices, and diverse needs.

513.3.1 Behavior Support Professional (BSP) Agency Staff Qualifications

513.3.1.1 Behavior Support Professional I (BSP I) Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, BSP I agency staff providing BSP services must meet the standard listed below.

- At a minimum, have a Bachelor of Arts (BA) or Bachelor of Science (BS) degree in a human services field or a Board of Regents degree, one-year of documented professional experience in

the IDD field, completion of the West Virginia Association for Positive Behavior Support (WV APBS) facilitated three-hour "Overview of Positive Behavior Support' or the West Virginia University Center for Excellence in Disabilities (WVU CED) "Positive Behavior Support Direct Care Overview", and completion of an approved WV APBS curriculum, or,

- Agency staff employed as therapeutic consultants prior to December 1, 2015, with a degree in a non-human service field, one-year professional experience in the IDD field, completion of the WV APBS facilitated three-hour Overview of Positive Behavior Support or the WVU CED Positive Behavior Support Direct Care Overview and the completion of an approved WV APBS curriculum.

Exception: Those meeting all the above requirements except the one-year experience will be considered qualified only if clinical supervision is provided by a BSP. Clinical supervision must involve review of clinical activities, review of case notes, and review of habilitation program for a minimum of six months. Monthly verification of supervisory activities is needed.

Note: New hires of individual agencies and existing agency staff who transition into a BSP role that has not completed an approved WV APBS curriculum must successfully do so within the first six months of employment and be undergoing clinical supervision by a BSP.

513.3.1.2 Behavior Support Professional II (BSP II) Agency Staff Qualifications

In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, BSP II agency staff providing BSP services must meet at least one of the standards listed below:

- Be a Board-Certified Behavior Analyst (BCBA) - Master's degree or Board-Certified Behavior Analyst Doctoral Level (BCBA-D) – Doctoral degree and completion of either the WVAPBS facilitated Overview of Positive Behavior Support or the WVUCED Positive Behavior Support Direct Care Overview, three years of documented professional experience working with individuals with IDD; or
- Have a Master of Arts (MA) or Master of Science (MS) degree, three years professional experience working with individuals with IDD, and have a Positive Behavior Support endorsement by a recognized APBS Network or Positive Behavior Support Board of Review; or
- Have a Bachelor of Arts (BA), Bachelor of Science (BS) degree, Board of Regents degree or Board-Certified Assistant Behavior Analyst (BCaBA) credential, three years professional experience working with individuals with IDD, and have a Positive Behavior Support endorsement by a recognized APBS Network or a Positive Behavior Support Board of Review.

For IPP services, the BSP I and II must also meet those requirements listed in Section 513.8.

To qualify to train others using an approved curriculum, an individual must meet one of the following four criteria:

- Be the developer of an approved training as indicated on the submitted application; or
- Be able to provide documentation that certifies completion of an approved training course (though not necessarily the course for which they are the trainer); or

- Be a Board-Certified Behavior Analyst and have documentation certifying completion of the facilitated Overview of Positive Behavior Support; or
- Be an endorsed positive behavior support professional through a recognized APBS Network or Board of Review.

513.3.2 Crisis Services Agency Staff Qualifications

Must meet all IDDW staff requirements in Sections 513.2 - 513.2.1.

513.3.3 Dietary Therapist Agency Staff Qualifications

In addition to meeting all IDDW staff requirements in Sections 513.2 - 513.2.1, agency staff providing dietary care services must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

If the dietitian is not agency staff but is contracted by the IDDW provider to provide services in their specialty, then the dietician must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

513.3.4 Facility-Based Day Habilitation Agency Staff Qualifications

Must meet all IDDW staff requirements in Sections 513.2 - 513.2.1.

513.3.5 Job Development Agency Staff Qualifications

Must meet all IDDW staff requirements in Sections 513.2 - 513.2.1.

513.3.6 Occupational Therapist Agency Staff Qualifications

In addition to meeting all IDDW staff requirements in Sections 513.2 - 513.2.1, agency staff providing occupational therapy services must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

If the occupational therapist is contracted by the IDDW provider to provide services in their specialty, then the occupational therapist must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

513.3.7 Person-Centered Support Agency Staff Qualifications

Person-centered support agency staff must meet all requirements for IDDW agency staff listed in Sections 513.2 - 513.2.1.

513.3.8 Physical Therapist Agency Staff Qualifications

In addition to meeting all IDDW staff requirements in Sections 513.2 - 513.2.1, agency staff providing physical therapy services must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

If the physical therapist is contracted by the IDDW provider to provide services in their specialty, then the physical therapist must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

513.3.9 Pre-Vocational Agency Staff Qualifications

Must meet all IDDW staff requirements in Sections 513.2 - 513.2.1.

513.3.10 Qualified Support Workers (QSW) Qualifications (*Personal Options* Only)

All qualified support workers must meet the qualifications listed in this section and its subparts. For all training listed below (except for CPR/First Aid which expires as indicated by the date on the card), "annually" is defined as within the month the training expires.

- Must be 18 years of age or over.
- Be able to perform the participant-specific required tasks.
- Have documentation of initial and renewal of training requirements.
- Documented training on Emergency Procedures, such as crisis intervention and restraints upon hire and annually thereafter.
- Documented training on emergency care such as training on the individual's Crisis Plan, Emergency Worker Back-up Plan, and Emergency Disaster Plan upon hire and on an as needed basis thereafter.
- Documented training on Infectious Disease Control upon hire and annually thereafter.
- Documented training on First Aid by a certified trainer from an approved agency listed on the IDDW website to include a current First Aid Certification upon hire and renewal as indicated per expiration date on the card.
- Documented training in CPR by an approved agency listed on the IDDW website to include a current CPR certification upon hire and renewed as indicated per expiration date on the card (This training, including refresher trainings, must include manual demonstration and be specific to the ages of the members supported by the QSW).
- Documented training on member-specific needs (including special needs, physical and behavioral health needs) upon hire and as needed thereafter.
- Documented training in recognition of documentation of and reporting of suspected abuse, neglect and exploitation upon hire and annually thereafter.

Qualifications must be verified initially upon hire as current and updated, as necessary. The QSW may be responsible for certain costs, i.e. CPR and First Aid certifications and criminal background checks through WV CARES.

Any qualified support worker who provides transportation services must have a valid driver's license in addition to abiding by local, state, and federal laws regarding vehicle licensing, registration and inspections upon hire and checked annually thereafter. Providers may screen workers' driving records through the WV CARES automated West Virginia Department of Motor Vehicles Registry.

NOTE: All direct-access personnel employed by the individual receiving services through the *Personal Options* program must adhere to all the standards and requirements in Section 513.2.1 Criminal Background Checks and its subparts.

513.3.11 Respite Agency Staff Qualifications

Must meet all IDDW staff requirements in Sections 513.2 - 513.2.1.

513.3.12 Case Management Agency Staff Qualifications

In addition to meeting all IDDW staff requirements in Sections 513.2 - 513.2.1, each person employed by agencies providing case management services must complete and pass Conflict Free Case Management (CFCM) training and certification. All case managers must meet one of the following requirements listed below:

1. Four-year degree in the human service field and one or more years of experience in IDD.
2. Four-year degree in the human service field and less than one year of experience* in IDD.
3. Four-year degree in a non-human service field and one year experience* in IDD.
4. No degree or two-year degree and is a licensed social worker (LSW) grandfathered in by the West Virginia Board of Social Worker Examiners due to experience in IDD.
5. RN with a two-year RN degree employed prior to December 1, 2015.
6. Two-year degree and three years of documented experience* in IDD.
7. Five years of experience* in IDD in lieu of a degree.

All case managers, except licensed social workers, counselors, and/or registered nurses, must also complete and obtain certification in the online case management training developed by BMS.

*Must be under the supervision of the case manager supervisor. Clinical supervision involves review of clinical activities, review of case notes, and review of treatment plans for six months. This must be verified by supervisory documentation once per month.

513.3.13 Skilled Nursing Agency Staff Qualifications

In addition to meeting all IDDW staff requirements in Sections 513.2 - 513.2.1, agency staff providing skilled nursing services must be an LPN or a licensed RN in the State of West Virginia. The nursing license must include a CPR component, or the nurse must have a separate and current CPR card.

For IPP services the RN must also meet those requirements listed in Section 513.8.

513.3.14 Speech Therapist Agency Staff Qualifications

In addition to meeting all IDDW staff requirements in Sections 513.2 - 513.2.1, agency staff providing speech therapy services must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

If the speech therapist is contracted by the IDDW provider to provide services in their specialty, then the speech therapist must be individually enrolled as a West Virginia Medicaid provider and licensed to practice in the State of West Virginia.

513.3.15 Stand-By Intervention Agency Staff Qualifications

Must meet all IDDW staff requirements in Sections 513.2 - 513.2.1.

513.3.16 Supported Employment Agency Staff Qualifications

Must meet all IDDW staff requirements in Sections 513.2 - 513.2.1.

513.3.17 Transportation Services Agency Staff Qualifications

In addition to meeting all IDDW staff requirements in Sections 513.2 - 513.2.1, the provider is required to maintain documentation at all times verifying that agency staff providing transportation services have a valid driver's license, proof of current vehicle insurance, inspection and registration.

Staff must also abide by local, state, and federal laws regarding vehicle licensing, registration, and inspections upon hire and checked annually thereafter.

513.4 REPORTING REQUIREMENTS

Anyone providing IDDW services who suspects an incidence of abuse or neglect is mandated by Behavioral Health Centers Licensure Legislative Rules (Title 71 Series 25), West Virginia State Code§ 9-6-1, § 9-6-9, and § 49-6A-2 to report the incident. Reports of abuse, neglect, and/or exploitation may be made anonymously by calling 1-800-352-6513, seven days a week, 24 hours a day.

The IDDW provider must also report suspected incidence of abuse, neglect, and/or exploitation to OHFLAC. OHFLAC may be contacted by calling (304) 558-0050 or reports may be faxed to (304) 558-2515. The OHFLAC may help with referring the report to the proper authorities.

If the member is also a Medley class member, the member's advocate must also be notified.

IDDW providers must use the West Virginia Incident Management System (WV IMS) to report and track the types of incidents listed below for anyone the agency provides services to.

- Simple Incidents – Any unusual event occurring to a member that needs to be recorded and investigated for risk management or quality improvement purposes but does not require treatment

beyond basic first aid provided at the location of the injury. Examples would be a minor assault by another member with injury resulting; seizures in an individual not prone to seizures; injuries of unknown origin; high rates of uncharacteristic self-injurious behavior with no significant negative outcome; suicidal threats or gestures without significant injury; medication error with minimal or no negative outcome; etc. Examples of basic first aid include application of an antiseptic, topical cream/ointment, or a bandage.

- Critical Incidents – Those incidents with a high likelihood of producing real or potential harm to the health and well-being of the member or members served but not involving abuse or neglect.
- Abuse, Neglect and Exploitation Incidents – Those incidents which meet the following definitions of abuse, neglect, or exploitation:
    - Abuse means any physical motion or action (hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs. It includes use of corporal punishment as well as the use of any restrictive intrusive procedure to control inappropriate behavior for purposes of punishment.
    - Abuse also includes psychological abuse which means humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma.
    - Abuse also includes verbal abuse which means use of oral, written, or gestured language by which abuse occurs. This includes demeaning and derogatory terms to describe persons with disabilities. Verbal abuse includes, but is not limited to yelling or using demeaning, derogatory, vulgar, profane or threatening language; threatening tones in speaking; teasing, pestering, molesting, deriding, harassing, mimicking or humiliating a person in any way; and making sexual innuendo.
    - Neglect means a negligent act or pattern of actions or events that caused or may have caused injury or death to person or may have placed a person at risk of injury or death that was committed by an individual responsible for providing services. Neglect includes, but is not limited to, a pattern of failure to establish or carry out a member's individualized program plan or treatment plan that placed or may have placed a member at risk of injury or death; a pattern of failure to provide adequate nutrition, clothing or health care; failure to provide a safe environment; and failure to maintain sufficient, appropriately trained staff.
    - Exploitation means the unlawful expenditure or willful dissipation of the funds or assets owned or paid to or for the benefit of an incapacitated individual.

Any incident involving a person utilizing IDDW services must be reported to the UMC by entering the incident into the WV IMS within 24 hours of learning of the incident. The IDDW provider's director or designated staff will immediately review each Incident Report and decide whether the incident calls for a thorough investigation. Investigations must be started within 24 hours of learning about the incident.

A completed Incident Report must be entered into the WV IMS (when available) within 14 calendar days of the incident. At any time during an investigation should an allegation or concern of abuse or neglect arise, the provider shall immediately notify Adult Protective Services (APS) or Child Protective Services (CPS) as mandated by State Code. Providers are responsible for investigating all incidents, including those reported to APS or CPS. The provider will inform the person and/or their legal representative (if applicable) of the results of an investigation.

The agency whose staff observe, are involved in, or are informed of the incident should report it in the WV IMS. In the event the individual receives case management from another agency, or self-directs via the *Personal Options* Service Delivery model, the residential/day service agency or resource consultant, as applicable, is responsible for notifying the case manager of the incident, as well as for completing follow-up in the IMS. That agency or resource consultant, as applicable, must also provide the case manager with copies of all related documentation. If the incident occurs in a residential or day setting where the individual also receives case management services, the observer can notify the case manager, who can then enter the incident.

All members of the IDT must work together to ensure that all documentation, as it relates to the accurate recordkeeping of incident reporting, is made available to all applicable IDT members.

The IDDW provider must also follow any other reporting required for mandatory reporters or as part of their behavioral health license.

Incidents pertaining to members who direct services through the *Personal Options* FMS Model are also required to be reported through the WV IMS and the appropriate Protective Services entity.

As of November 7, 2024, the DD-11 form (Notification of Death) has been discontinued. Providers no longer complete a DD-11 form or attach completed forms in The UMC's web-based portal. The DD-11 has been replaced by the Notification of Death in the Atrezzo IMS. When a member passes away, providers must complete an incident report, the Notification of Death in the Atrezzo IMS, and start the discharge process in the UMC's portal.

The case manager is responsible for submitting and maintaining accurate and current data in the UMC's portal including name, address, telephone numbers, case management provider, legal representative name, and contact information, etc. of all individuals served.

The case manager must notify the UMC of a member's transfer to another case management provider or if the member chooses another service delivery system within two working days. The case manager must transfer the member in the UMC's portal by the effective date of the transfer. The effective date must fall on the first of a month.

- The transferring agency is responsible for the notification by submitting the Member Transfer/Discharge form (WV-BMS-IDD-10). This form must include the last date of service provided.
- Lack of notification of the transfer will affect the prior authorization for service or registration of services to the correct service provider(s) and subsequent payment of claims for services.

513.5 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

General Requirements

- IDDW Program provider agencies must follow the documentation and maintenance of records requirements described in *Chapter 100, General Information*; and *Chapter 300, Provider Participation Requirements* of the BMS policy manual.
- Program provider agencies must comply with all other documentation requirements of this chapter.
- All required documentation must be maintained by the IDDW provider for at least five years in the member's file subject to review by authorized BMS personnel or contracted agents. If there is a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years, whichever is greater.
- When a staff member joins an agency after previous employment at another certified IDDW agency, prior training records may be obtained and recognized by the receiving agency. If the receiving agency chooses to recognize prior training records, the receiving agency must verify that all training documentation follows policy requirements. All IDDW agencies must maintain training documentation and records per the retention timeline outlined in *Chapter 300, Provider Participation Requirements*.
- All required documentation and records must be available upon request by the BMS or federal monitors, or contracted agents for auditing and/or medical review purposes. Provider agencies may be subject to a payment hold for failure to provide requested documentation.
- Failure to maintain all required documentation and in the manner required by the BMS, may result in the disallowance and recovery by the BMS of any amounts paid to the provider for which the required documentation is not maintained and not provided to the BMS upon request.

Specific Requirements

The IDDW provider agencies must maintain a specific record for all services received by the member, including but not limited to:

- Each IDDW provider must maintain all required IDDW documentation on behalf of the State of West Virginia and for state and federal monitors, including all IDDW forms as applicable to the policy requirement or service code requirement.
- Agencies that wish to computerize any of the forms may do so. All basic components must be included, and the name/number indicated on the form (refer to *Chapter 300, Provider Participation Requirements*, for a description of general requirements for Medicaid record retention and documentation).
- All Waiver services providers must maintain service progress notes, Case Management Logs, behavioral data collection, and/or attendance records to substantiate that services billed by the IDDW 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 under Section 513.9 Description of Service Options and their subparts as well as each service definition in this Chapter.
- Day-to-day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for services. Monitoring and review of services as related to the IPP or monthly summary contact form are to be maintained in the case management provider record. While monitoring the IPP and services, the case manager 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.

- The original physical copy of the annual assessment performed by the UMC with the member, their guardian, and/or his/her IDT. Once the annual assessment is completed, and the member or their guardian has signed the document attesting to its accuracy and completeness, it will be the duty of the primary service provider to ensure that the document is not altered, copied, or distributed in any manner. However, the primary service provider must make the original physical copy annual assessment available to the member, their guardian and their IDT at the service provider's offices, upon request, to review only. The case manager provider agency may store the document electronically but must be able to make the document available upon request of the member or their legal representative.
- Required on-site documentation may be maintained in an electronic format if the documentation is accessible to individuals who may need to access it. Electronic health record and electronic signature requirements described in *Chapter 100, General Information* of the BMS policy manual. In addition to all documentation required by other state agencies, the IDDW provider must give this information to the member when they reside in their natural family home. The IDDW provider must ensure that the following is maintained in the member's home when the member lives in an unlicensed residential or licensed group home setting:
    - Personal demographic/emergency contact information. If community activities are planned, a copy will be taken in a sealed envelope for emergency use only.
    - Current complete IPP include current psychological, social, and physical evaluations (if applicable), current Behavior Support Plan, activity schedule, Crisis Plan, Individual Habilitation Plan (IHP), and Individual Education Plan (IEP). The IPP must be attached in the UMC's portal prior to the UMC making decisions on requests for prior authorization for IDDW services.
    - Current doctor's orders for every medication administered at that site, even if the member self-administers.
    - Current daily direct support documentation, task analysis and/or staff notes.
    - Current Medication Administration Records.
    - Copies of other pertinent medical or evaluative information relevant to treatment.

ELIGIBILITY AND ENROLLMENT

513.6 APPLICANT ELIGIBILITY AND ENROLLMENT PROCESS

For an applicant to be found eligible for the IDDW program, they must:

- Meet medical eligibility.
- Meet financial eligibility.
- Be at least three years of age.
- Be a resident of West Virginia, and be able to provide proof of residency upon application; and
- Have chosen Home and Community-Based Services over services in an institutional setting (Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Enrollment in the IDDW program is dependent upon the availability of a funded IDDW slot.

The applicant must have a written determination that they meet medical eligibility criteria. Initial medical eligibility is determined by the MECA through review of an Independent Psychological Evaluation (IPE) report completed by a member of the Independent Psychologist Network (IPN); which may include background information, mental status examination, a measure of intelligence, adaptive behavior, achievement and any other documentation deemed appropriate.

If an IDDW slot is available, then the applicant must establish financial eligibility before being enrolled in the IDDW program. If a slot is not available, the applicant is placed on a managed enrollment list. When a slot becomes available, then the applicant is informed and must establish financial eligibility before being enrolled on the IDDW Program.

513.6.1 Application Process

Each new applicant must follow the eligibility process listed below for medical and financial eligibility. An applicant first has medical eligibility determined and then has financial when a funded slot is available.

513.6.1.1 Initial Eligibility Determination Process

An applicant may obtain an application form (WV-BMS-IDD-1) from licensed behavioral health centers, IDDW providers, West Virginia DoHS local county offices, aging and disability resource centers (ADRC), the appropriate UMC, and on the IDDW website. Completed applications must be sent to the UMC. Information explaining the process to submit to the UMC can be found in the application).

Upon receipt of the WV-BMS-IDD-1, the UMC time and date stamps the application.

The UMC contacts the applicant within three business days upon receipt of the WV-BMS-IDD-1 and provides a list of Independent Psychologists (IP) in the Independent Psychologist Network (IPN) trained by the MECA who are available within the applicant's geographical area. The applicant chooses a psychologist in the IPN and contacts the IP to schedule the appointment within 14 calendar days.

Psychologists in the IPN are identified and placed on a list following documented training by the MECA. The IP is responsible for completing an Independent IPE and uploading it to the required internet site within 60 calendar days of the receipt date of the IPN Response form. The evaluation includes assessments which support the diagnostic considerations offered and relevant measures of adaptive behavior.

To be a member of the IPN, the individual performing the assessment must be a West Virginia licensed psychologist, a West Virginia Medicaid provider who performs comprehensive psychological evaluations independent of IDDW providers and is a member of the IPN trained by the MECA.

The IPE is used by the MECA to make a medical eligibility determination.

The MECA makes a medical eligibility determination within 30 calendar days of receipt of the completed IPE that uses the current approved diagnostic system. A written decision is mailed to the applicant and/or

their legal representative by the UMC. The BMS retains final decision-making authority regarding all eligibility determinations.

If an applicant is approved for medical eligibility by the MECA, a funded IDDW slot is available, and financial eligibility is established, then the applicant is enrolled into the Waiver program. If a slot is not available, then the applicant will be placed on a managed enrollment list until a funded slot allocation is available and financial eligibility is established.

If an applicant is determined not to be medically eligible by the MECA, a written Notice of Decision, a Request for Medicaid Fair Hearing form, and a copy of the IPE is mailed via certified mail by the UMC to the applicant or their legal representative. The denial of medical eligibility may be appealed by the applicant or their legal representative through the Medicaid Fair Hearing process by sending the Request for Medicaid Fair Hearing form to the Board of Review within 90 calendar days of receipt of the Notice of Decision. The Notice of Decision letter also allows the applicant or their legal representative to request a second medical evaluation.

If a second medical evaluation is requested, then it must be completed within 60 calendar days by a different member of the IPN at the expense of the BMS. If an applicant is determined to be medically eligible, a slot is available, and financial eligibility is met, then the applicant is enrolled into the Waiver program. If a slot is not available, then the applicant will be placed on a managed enrollment list until a funded slot is available and financial eligibility is established.

If the applicant is again determined not to be medically eligible based on the second medical evaluation, then the applicant or their legal guardian will receive a written Notice of Decision, a Request for Medicaid Fair Hearing form, and a copy of the second IPE by certified mail by the UMC. This second denial of medical eligibility may be appealed through the Medicaid Fair Hearing process by submitting the Request for Medicaid Fair Hearing form to the Board of Review within 90 calendar days of receipt of the Notice of Decision and a Medicaid Fair Hearing will be scheduled.

The applicant or legal representative may request a pre-hearing conference at any time prior to the Medicaid Fair Hearing. At the pre-hearing conference, the applicant and/or their legal representative and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the denial.

The applicant shall have the right to access their IPE used by the MECA in making the eligibility decision and copies shall be provided free of charge by the BMS.

If the denial of initial medical eligibility is reversed by the hearing officer, the applicant will be placed on the managed enrollment list based on the date of the hearing officer's decision. When a slot is available, the applicant will be enrolled on the program once financial eligibility is established.

Any applicant denied medical eligibility may re-apply to the IDDW program at any time.

The applicant's right to a medical eligibility determination within 90 calendar days may be forfeited if the applicant fails to schedule and keep a timely appointment or does not submit follow up information

needed to complete the IPE to the IP within a reasonable time specified by the IP. Examples of follow-up documentation requested by the IP may include, but may not be limited to:

- IEP for school-aged children.
- Birth-to-Three assessments.
- Medical records to support the presence of a severe related condition; and
- Any other documentation deemed necessary by the IP to complete the IPE.

513.6.2 Initial Medical Eligibility

To be medically eligible, the applicant must need the level of care and services provided in an ICF/IID as evidenced by required evaluations and other information requested by the IP or the MECA and corroborated by narrative descriptions of functioning and reported history. An ICF/IID provides services in an institutional setting for persons with intellectual disability or a related condition. An ICF/IID provides monitoring, supervision, training, and supports.

Evaluations of the applicant must demonstrate:

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

The MECA determines the qualification for an ICF/IID level of care (medical eligibility) based on the IPE that verifies that the applicant has an intellectual or developmental disability with concurrent substantial deficits that manifested prior to age 22 or a related condition which constitutes a severe and chronic disability with concurrent substantial deficits that manifested prior to age 22. For the IDDW program, individuals must meet criteria for medical eligibility not only by test scores, but also narrative descriptions contained in the documentation.

To be eligible to receive IDDW services, an applicant must meet the medical eligibility criteria in each of the following categories:

- Diagnosis.
- Functionality
- Need for active treatment; and
- Requirement of ICF/IID Level of Care.

513.6.2.1 Diagnosis

To be eligible to receive IDDW services, the following medical eligibility criteria questions must be addressed by the MECA:

- Does the person have a diagnosis of IDD or resource consultant?
- Does the person need the level of care and services provided by an intermediate care facility for individuals with intellectual disability (ICF/IDD)? This is evidenced by required evaluations and

corroborated by narrative descriptions of functioning and reported history. An ICF/IDD facility provides monitoring, supervision, training and supports.

- Does the person have substantial adaptive deficits in three of the six major life areas (functionality) due to an IDD or related condition that manifested prior to the age of 22?
- Does the person have a related developmental condition which constitutes a severe and chronic disability with concurrent substantial deficits that are not primarily due to a mental illness? Related conditions, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior like that of intellectually disabled persons and requires services like those required for persons with intellectual disabilities can include but are not limited to the following:
    - Autism Level 3 (per current DSM and/or ICD codes)
    - Traumatic brain injury
    - Cerebral Palsy
    - Spina Bifida
    - Tuberous Sclerosis
- Any condition, other than mental illness, found to be closely related to intellectual disabilities because this condition results in impairment of general intellectual functioning or adaptive behavior like that of intellectually disabled persons, and requires services like those needed for persons with intellectual disabilities.
- Additionally, the applicant who has a diagnosis of intellectual disability or a severe-related condition with associated concurrent adaptive deficits must meet the following requirements:
    - Likely to continue indefinitely; and,
    - Must have the presence of at least three substantial deficits out of the six identified major life areas listed under Section 513.6.2.2.

513.6.2.2 Functionality

A deficiency in functionality must be met for IDDW eligibility. Functionality is defined as substantially limited functioning in three or more of the six major life areas as evidenced by standardized measures of adaptive behavior scores that are three standard deviations below the mean or less than one percentile when derived from non-ID normative populations or in the average range or equal to or below the 75th percentile rank when derived from ID normative populations. The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological evaluations, the IEP, occupational therapy evaluations, etc.

The six major life areas include:

- Self-care
- Receptive or expressive language (communication)
- Learning (functional academics)
- Mobility
- Self-direction

- Capacity for independent living. This major life area is determined to be met by substantial limitations in at least three of the following subdomains: home living, social skills, employment, health and safety, community, and leisure activities.

Functionality scores must be obtained from using an appropriate standardized test for measuring adaptive behavior that is administered and scored by an individual professionally trained and credentialed to administer the test.

The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological report, the IEP, occupational therapy evaluation, etc., if requested by the independent psychologist for review.

513.6.3.2 Active Treatment

To be eligible for the IDDW program, the individual must meet the ICF/IDD level of care. The eligibility evaluation of the applicant must demonstrate:

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

The applicant or legal representative will be informed of the right to choose between ICF/IID services and home and community-based services under the IDDW and informed of their right to a fair hearing in the event of an adverse decision.

513.6.3 Initial Financial Eligibility

Upon notification that an IDDW slot is available, the applicant, or legal representative must make an application for financial eligibility at a West Virginia DoHS local county office. See the West Virginia Income Maintenance Manual for further details.

The individual will receive a letter informing them that an IDDW slot has been awarded. The IDDW applicant will then be contacted by their assigned service support facilitator to complete the initial functional assessment and Freedom of Choice. The slot allocation must be presented to the West Virginia DoHS to begin the financial eligibility determination process.

An applicant for IDDW services who does not currently participate in a full-coverage Medicaid group and receive a Medicaid card completes the application form, DFA-1, with an economic services worker (ESW) who processes the application, makes a financial eligibility decision, and notifies the applicant through written form (Economic Services Notification Letter – ESNL-A). **The Slot Allocation Letter for medical eligibility for the IDDW Program must be presented to the ESW before financial eligibility can be determined.**

An applicant for IDDW services, who participates in a full-coverage Medicaid group such as an SSI or Deemed SSI, completes an abbreviated application form, the DFA-LTC-5 which evaluates annuities,

trusts, and/or potential transfers of resources in relation to financial eligibility for the additional IDDW services. The ESW also provides written verification (ESNL-A) of financial application to the member and/or their legal representative.

When approved financially by the ESW, the ESW will process the assistance group in the data system, which will facilitate triggers to the BMS for payment for eligible medical services to occur to eligible Medicaid providers.

513.6.3.1 Determination of Initial Financial Eligibility

The applicant must meet the following financial eligibility criteria:

Income

The applicant's monthly income may not exceed 300% of the current maximum monthly Supplemental Security Income (SSI) payment for a single individual. Applicants who are found to be financially eligible will receive a letter (ESNL-A) from the West Virginia DoHS. The maximum monthly SSI payment may be found by contacting the local county DoHS office or local Social Security Administration office.

- Only the applicant's personal income is considered for determination.
- The parent's or spouse's income is not considered for determining financial eligibility.
- An applicant does not have to be SSI eligible to become eligible for the IDDW program.

Assets

- An individual's assets, excluding residence, furnishings, and personal vehicle (owned and registered in person's name) may not exceed $2,000.
- The parent and/or legal guardian's assets are not considered for determining financial eligibility.

513.6.4 Slot Allocation Referral and Selection Process

Provided a funded IDDW slot is available, the allocation process is based on:

- The chronological order by date of the UMC's receipt of the fully completed initial application (WV-BMS I/DD-1) which includes approval of eligibility from the MECA or
- The date of a fair hearing decision if medical eligibility is established because of a Medicaid Fair Hearing.

Once an IDDW slot is available, the enrollee will receive an informational packet up to 90 calendar days prior to the slot being awarded. A Freedom of Choice form (WV-BMS-I/DD-2) on which the enrollee must indicate the wish to receive HBCS as opposed to services in an ICF/IID, their chosen Service Delivery Model (Traditional or Traditional and Participant-Directed) as well as the chosen case management provider will be included and must be returned to the UMC within 30 calendar days of receipt of the informational packet.

The enrollee must access case management and at least one IDDW direct care service within 180 calendar days when the funded slot becomes available or the enrollee will be discharged from the program.

Upon receipt of the complete and signed Freedom of Choice form, the UMC will refer the member to his/her chosen case management provider and if indicated, *Personal Options* FMS. The case manager provider may reject the referral only if:

- It appears to have been received in error.
- The CM provider is unable to meet the referred member's medical and/or behavioral needs.

Case management providers that reject referrals due to internal service capacity policies may not receive future referrals until the capacity/service issues are resolved.
Before an allocated slot can be accessed by the applicant and their chosen IDDW provider, proof of medical and financial eligibility (ESNL-A) obtained from the West Virginia DoHS during the financial eligibility determination must be presented to the IDDW provider.

513.6.5 Eligibility Effective Date

The initial effective date of a Medicaid card for an applicant who has not previously gotten one is the latest of the following two dates (provided the person has a slot allocation):

- The date of initial medical eligibility which is established by the MECA or
- The date on which the applicant was approved for financial eligibility at a local/county DoHS office. The applicant will receive a letter from the West Virginia DoHS (ESNL-A) stating the date the applicant is financially eligible for the program.

513.7 ANNUAL REDETERMINATION OF ELIGIBILITY PROCESS

For a member to be redetermined eligible, the member must continue to meet all eligibility criteria (both medical and financial) and continue to have deficits in at least three of the six identified major life areas, as previously defined.

513.7.1 Annual Re-Determination of Medical Eligibility

Per federal law, redetermination of medical eligibility must be completed at least annually. The anchor date of the member's medical redetermination is the anniversary date of the first month after the initial medical eligibility was established by the MECA.

The anchor date of the person's annual redetermination is the first day of the month after the initial medical eligibility was established by the MECA. The UMC employs service support facilitators to conduct reevaluations for program members. Service support facilitators qualifications include a bachelor's degree in a human service field and at least one year experience with the disability population. Service support facilitator staff go through a rigorous training protocol which includes trainer-led instruction, shadowing seasoned staff and periodic evaluation of their work.

At a minimum, annual redetermination of eligibility will include one annual functional assessment which includes a structured interview as well as standardized measures of adaptive behavior in the six major life areas completed by a service support facilitator employed by the UMC, and the results provided to the MECA. The MECA will determine medical eligibility annually based on this assessment of functioning as defined in Section 513.6.2.2.

If a member is found not to be medically eligible, a written Notice of Decision, a Request for Hearing form, and the results of the functional assessment are sent via certified mail by the UMC to the member or their legal representative. The member's case manager is also notified by the UMC. The denial of medical eligibility may be appealed through the Medicaid Fair Hearing process if the Request for Hearing form is submitted by the member or their legal representative to the Board of Review within 90 calendar days of receipt of the Notice of Decision. The Notice of Decision letter also allows the member or their legal representative to request a second medical evaluation.

If the member's medical eligibility is terminated and the member or legal representative wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted within 13 calendar days of the member or their legal representative's receipt of the Notice of Decision.

If the member chooses to have a second medical evaluation, they must begin the process by selecting a member of the IPN within 15 business days of the Notice of Decision from the BMS. Further, the member must have an evaluation completed within 60 calendar days of selection of an IPN member.

If the member does not meet the timeframes, the Bureau will go ahead with scheduling a hearing on the Notice of Decision which prompted the request for a second medical evaluation. If the member is determined to be medically eligible because of a Medicaid Fair Hearing, then services will continue if the member or their legal representative requests this within 13 calendar days of receipt of the Notice of Decision letter. If services were terminated due to the member or their legal representative not requesting their continuance within 13 calendar days of the receipt of the Notice of Decision letter, then services will begin again on the date of the hearing officer's decision of reversal.

At any time prior to the Medicaid Fair Hearing, the member, or legal representative may request a pre-hearing conference. At the pre-hearing conference, the member and/or their legal representative, the UMC and a representative from the MECA will review the information submitted for the medical eligibility determination and the basis for the termination. For additional information on appealing medical eligibility refer to Section 513.25.4.

513.7.2 Annual Redetermination of Financial Eligibility

All members utilizing IDDW services must have financial eligibility redetermined annually by their local or county West Virginia DoHS. Members who are found financially eligible will receive documentation from the West Virginia DoHS (ESNL-A) The documentation of financial eligibility must be shared with the individual's case management provider. The member must provide their Notice of Decision letter re-establishing their medical eligibility to the West Virginia DoHS before financial eligibility can be established.

A member's income and assets are evaluated using the same criteria used during the initial financial eligibility determination.

513.8 INDIVIDUAL PROGRAM PLAN (IPP)

Central to the services that a member receives through the IDDW program is the member's IPP. Developing the IPP is the process by which the member is assisted by the IDT which consists of their legal representative (when applicable), their advocate (when applicable), and other natural supports the member chooses to invite, as well as attendees required by the IDDW program policy manual. This team meets to decide what needs to be done, when and how it needs to be done and by whom. The IDT also determines how to document the decisions made by this planning team.

The IDT must include, at a minimum, the member's legal representative (if applicable), the case manager, the IDDW provider representative, the Medley advocate (if applicable), medical power of attorney, and/or healthcare surrogate (if applicable).

The content of the IPP must be guided by the members' assessed needs, wishes, desires, and goals. However, the requested services cannot exceed the member's individualized budget. If the member and/or the team believe that the member requires services more than the individualized budget, the team may list those additional services in the separate section of the IPP set aside for this purpose. However, for the member to begin receiving any services under the IPP, the case manager must submit a list of services that can be purchased within the member's individualized budget, making sure all direct-care service needs are purchased first, after purchasing case management services. Only services that can be purchased within the budget may be authorized and all other service needs must be covered by natural or unpaid supports or from programs other than IDDW. Services more than the individualized budget may be approved per the procedures and standards described in Section 513.25.4.2.

If a member has had a documented change in need since the annual functional assessment was conducted, then a Critical Juncture should occur immediately to discuss the need for additional services.

All IPP meetings should be scheduled at a time and location that takes into consideration the schedule and availability of the member, their legal representative (when applicable), and the other members of the team.

The member must attend the IPP meeting. If the member is a legal adult without a legal representative, the member must attend the entire meeting to provide informed consent and sign the IPP developed by the IDT during the meeting. If the member has a legal representative, the legal representative must attend the IPP in person. The legal representative may participate via teleconference in extenuating circumstances. If the legal representative attends via teleconference, the IPP must be signed electronically, and the signature must include a date and time stamp.

Note: Electronic signatures must follow the documentation and record retention requirements described in *Chapter 100, General Information* of the BMS policy manual.

If the member has a Medley Advocate, the Medley Advocate must also attend the entire meeting. Pursuant to 42 CFR 441.301(c)(2), the IPP must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation and present at the IDT, at the close of the IPP meeting. The IPP must be uploaded to the UMC portal within ten business days.

IPP includes the Initial IPP which must be developed within seven calendar days of intake/admission to a new provider agency, the annual IPP, and subsequent reviews or revisions of the IPP, Critical Juncture, Transfer, and Discharge IPPs. Activities conducted before or after the meeting may meet the criteria for case management activities.

All IPPs must be uploaded into the UMC's portal and given to all team members within 14 business days and must include:

- All components in the WV-BMS-IDD-05
- Cover/demographics
- Meeting minutes
- Circle of support/goals and dreams
- Summary of assessment and evaluation results
- Medications
- Individual Service Plan
  - IDDW Services*
  - Non-IDDW Services and Natural Supports
- Individual Habilitation Plan and Task Analysis if the member receives formal training
- Tentative Weekly Schedule (including both paid and unpaid supports and any other programs providing any type of service, i.e. personal care, private duty nursing, etc.)
- Signature Sheet (and rationale for disagreement if necessary). The Signature Sheet must be signed by all members of the IDT present at the IPP meeting.
  - In case of a member's refusal to sign the IPP, the reason for refusal must be documented in the IPP. Members have the right to refuse to sign and/or disagree with the IPP and it may be appropriate to support the member to engage with an advocacy organization or other trusted person to resolve any disagreements about service provision.
- Behavior Support Plan or Protocol, if applicable, with signatures of developer and member/legal representative (must indicate consent by member/legal representative)
  - Dates that plan was approved and initiated will be reviewed. If the plan includes restrictive measures, then approval by the IDDW provider's Human Rights Committee (HRC)must be attached. The HRC must monitor plans with adverse procedures at least annually.
  - The member or their legal representative must sign off on their agreement prior to the development of the plan.
- Crisis Plan to include Emergency Disaster Plans
- HCBS Integrated Settings Rule Questionnaire
- Individual Spending Plan (when available) if a member is self-directing any of the participant-directed services
  - The names of individuals providing participant-directed, person-centered support, in-home respite and out of home respite services

Note: Contents of the IPP are subject to change. Providers are responsible for adhering to all program changes, including changes in required documentation, as posted on the IDDW website and described in the UMC's frequently asked questions.

IDDW services must be purchased in the following order so that the health and safety of the member receiving services is ensured:

- Case management services must be purchased first, followed by direct-care services in the following order: person-centered support services, crisis services, day services, electronic monitoring, direct-licensed practical nurse services and respite services.
- Professional services may be purchased in any order that meets the individual's unique support needs.

If a finalized IPP needs changes, the team must complete an IPP Addendum form before service requests will be considered.

The Crisis Plan is incorporated into the IPP and must be completed for each member. A Crisis Plan must be personalized and address any foreseeable issues which might put the member's health, safety, or well-being in jeopardy. A Crisis Plan should incorporate the level of supports which would likely be needed for unforeseen circumstances. A Crisis Plan must cover the following events:

- No call/no show of support staff.
- Primary caregiver becomes unavailable or unable to provide continued support.
- Weather-related/environmental issues (transportation, inability to get to scheduled location, etc.).
- Disaster-related issues (flood, fire, etc.).
- Health/medical issues (medication administration, serious allergies, seizure protocol, etc.).
- Termination from or reduction of IDDW services.
- Bed bug infestations, including relocation plan and financially responsible party.
- Any other member-specific needs, including, but not limited to the following:
    - Restrictions/restrictive measures in place
    - Fall/choking protocol
    - Suicidal ideation or self-harm protocol
    - Pica/ingesting inedible items
    - Non-verbal or alternative communication that may affect ability to communicate/understand the emergency or emergency responders/act accordingly
    - Deaf/hard of hearing members
    - Elopement
    - Emergency geo-tracking device – how to use, company administrating the service, etc.
    - Comfort items or necessary/important items to ensure member has access to them
    - Internet/phone safety (dialing 911 in non-emergencies, talking to underage people online, etc.)

The IPP serves as documentation of the IDT meeting. A team member's signature on the IPP constitutes participation in the team meeting; however, the Signature Sheet must be updated to document the team member's participation in the meeting. Team meeting minutes must be kept with the IPP to document

discussion in the meeting, record critical issues from the meeting, and convey the active participation of each IDT member.

The IPP must be signed in real time, by all IDT members who attended the meeting prior to the conclusion of the IPP meeting. In addition, the IDT must write down their agreement/disagreement with the IPP, date of the meeting, and the total time spent in the meeting for each team member. The member, or their legal representative, a representative from each provider agency, and the Medley Advocate (if applicable) must agree with the plan and sign the IPP for it to be considered a valid IPP, per 42 CFR 441.301(c)(2). A copy of the IPP is kept in all participating provider agency records and distributed, via secure electronic means, to all team members by the case manager within seven calendar days of the date of the IDT team meeting. The IPP must be uploaded into the UMC's portal within 14 calendar days of the IDT meeting to ensure timely authorization of services.

In extenuating circumstances (i.e. legal representative living out of state or inclement weather), IDT members may take part by teleconferencing. Team members who attend by teleconference may not bill for the time spent in the IDT and the case manager must note on the signature sheet that they attended by phone. If the legal representative attends via teleconference the case manager must obtain their signature within seven calendar days.

An IPP includes the completed IPP (WV-BMS-IDD-5) and the following attachments: Crisis Response Plan, Behavior Support Plan/Protocols (if applicable), tentative weekly schedule, budgeted cost of planned services, spending plans (if the member self-directs eligible services), and meeting minutes. The IPP must be developed on an annual basis. The IPP must be reviewed and approved by the IDT at least every 90 calendar days unless otherwise specified in the plan; however, the time between reviews shall not exceed 180 calendar days. The IPP must be updated at Critical Juncture meetings to include IDT recommendations.

The IPP must reflect all services, programs and supports, both unpaid and paid. If the member also accesses personal care, private duty nursing, home health or hospice, for example, the IPP must reflect how and when these programs are used and attach a daily/weekly schedule to reflect all services. At no time can programs duplicate times or services.

All Medley class members must have IDT meetings every quarter, but the Medley advocate may choose to only attend the six-month and the annual IDT.

Medicaid cannot reimburse services delivered when the IPP has expired, has not been reviewed within required timelines, and/or does not include required signatures or services.

513.8.1 The Interdisciplinary Team (IDT)

The IDT participates in the IDT meeting for the purpose of reviewing assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outline of service options and training goals, and preparation of interventions or strategies necessary to implement a person-centered plan within the member's individualized budget. The IDT must make every effort to purchase IDDW services within the individualized assessed budget. The IDT must consider all

supports available, both paid and unpaid, formal and informal, and both IDDW services and supports and non-IDDW services and supports (such as Medicaid state plan, school-based services, etc.).

In circumstances when individuals wish to live in 24-hour supported settings (intensively support setting (ISS) and group home), the individualized budget must be considered before signing leases, renting apartments, living in family-owned homes or homes left in trust to the member. The member and the legal representative may want the member to live in a certain setting or even live alone, but if the individualized assessed budget does not provide enough supports for these settings, then the member or the legal representative need to look at alternatives – roommates, more natural support, supplemental funding from family or trusts, etc.

Any services that cannot be purchased within budget must be supported from unpaid or natural supports or services from another program other than the IDDW, except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2. IDT meetings should be held in a manner that is convenient for the member and ensures the confidentiality of the member. Restaurants or other public locations are not appropriate sites to conduct IDT meetings. If the member, their legal representative, and members of the IDT agree, meetings (other than annual IDT meetings) may be held virtually through a secure platform.

All direct support and case management services must be purchased first before professional services. This is to ensure the health and safety of the member. The direct-care support services must be purchased in any order necessary to meet the individual's unique support needs: all types of person-centered supports, facility-based day habilitation, pre-vocational, job development, supported employment, electronic monitoring, LPN services and respite services.

At a minimum, the IDT consists of:

- The member
- Their legal representative as applicable
    - Guardian
    - Healthcare surrogate
    - Medical Power of Attorney (only required if needed for medical decisions)
- The member's case manager
- Representatives of all IDDW providers that provide services to the individual; and,
- A Medley advocate if the member is a Medley class member.

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

- Natural supports the member chooses to invite
- Professionals such as BSP, RN or LPN, physical therapist, occupational therapist, speech therapist, registered dietician, etc.
- Direct-service workers, such as day services providers, person-centered support workers and respite workers

- Service providers from other systems such as the local education agency/public schools, Division of Rehabilitation Services (DRS), or Birth-to-Three (provided that no duplication of service exists)
- Family-based care specialist (when member resides in a specialized family care home); and,
- Advocate (when applicable).

All members of the IDT must sign the IPP signature sheet and indicate their participation in the meeting and must sign indicating agreement or disagreement with the IPP. All members of the IDT who attend the IPP meeting must sign the IPP in real time, prior to the conclusion of the IPP meeting.

If the member or their legal representative disagrees with the IPP, the IPP is not valid.

The case manager assumes the role of facilitator and coordinator for the meeting; however, the team is directed by the member or their legal representative using a person-centered approach to planning.

513.8.1.1 Initial and Seven-Day IDT Meeting

Initial IDT Meeting

This meeting is mandatory when a member receives an IDDW slot.

The initial meeting occurs within the first seven calendar days of admission/intake by a provider/case management agency and must include IDDW services as well as other support services a member needs to live successfully in the community. This IPP document must reflect a full range of planned services, Medicaid, non-Medicaid and natural supports.

This meeting must be documented on the Initial IPP (WV-BMS-IDD-4) by the member's case manager. If the team does not have enough information to agree on a full array of services the Initial IPP will allow for up to 30 calendar days of service while the team explores options for long-term services. The team must then reconvene within 30 calendar days of admission/intake to finalize services and document the IPP (WV-BMS-IDD-5). If services can be finalized at this initial meeting and a full range of planned services are documented, then the 30-day IDT meeting will not be necessary, and the meeting should be documented on the IPP (WV-BMS-IDD-5) with all required components.

Seven-Day IDT

When a member transfers from one residential provider to another or from one day setting to another, the IDT must conduct a seven-day IPP meeting. This meeting is required to outline the services and supports the member needs to successfully access the new setting.

If the IDT cannot finalize the services needed at the seven-day IPP meeting, a 30-day IPP meeting is required. If the IDT can finalize services, the 30-day IPP meeting is not required. The case manager is responsible for:

- Coordinating and documenting the meeting
- Requesting purchases/modifications in the UMC's portal within 14 calendar days; and
- Disseminating the completed IPP within 14 calendar days

513.8.1.2 30-Day IDT Meeting

This meeting is only required if a full range of planned services were not finalized at the seven-day IPP meeting for the Initial IPP and the IPP for members who've transferred residential providers. If this meeting is necessary, the resulting IPP (WV-BMS-IDD-5) must be completed by the case manager and will serve as the annual IPP and must be reviewed every six months.

513.8.1.3 Transfer/Discharge IDT Meeting

This meeting is held when a member transfers from one IDDW provider to another, chooses a different service delivery model, or when the member no longer meets medical or financial eligibility.

Service Provider Transfer

When the member or their legal representative wish to transfer residential, day services, and/or case management services from one provider to another, the IDT must conduct a transfer IPP meeting. The member or their legal representative, as well as the transfer to agency, must agree to the transfer.

The case manager is responsible for:

- Coordinating the meeting
- Documenting the transfer
- Sending the completed IPP to the transfer to agency within 14 calendar days
- Making purchases and modifications in the UMC's portal prior to the effective transfer date; and,
- Submitting the transfer via the UMC's portal and attaching the Transfer/Discharge form (WV-BMS-IDD-10) within five business days

If the resulting IPP is found to be not valid because necessary team members did not attend, or necessary services were not addressed during the transfer, then the authorizations may be rolled back to the transfer from agency until a valid IPP is held.

The effective date of transfer for Case Management services must be the first day of the selected month.

Service Delivery Model Transfer

When the member or their legal representative wish to direct the available Participant-Directed services through the *Personal Options* model or chooses to stop directing services through *Personal Options* and return to the Traditional model, the IDT must conduct a transfer meeting. Members transferring services to the *Personal Options* model will be contacted by the *Personal Options* vender and a participant-directed budget will be developed for participant-directed services. All Traditional services will remain with the IDDW provider(s) in amounts agreed upon by the IDT.

The case manager is responsible for:

- Coordinating the meeting
- Documenting the transfer

- Disseminating the completed IPP within 14 calendar days
- Completing modifications and purchases for any Traditional and/or participant-directed services in the UMC's portal
- Uploading the completed Freedom of Choice form (WV-BMS-IDD-2) within two business days of receipt; and,
- Referring the member to the *Personal Options* vendor in the UMC's portal when transferring from the Traditional to *Personal Options* Model

Discharge From the IDD Waiver Program

When a member is no longer financially or medically eligible for IDDW services, voluntarily chooses to no longer receive services through the IDDW program, or meets criteria outlined in Section 513.26, the IDT must conduct a discharge IPP meeting. The team must discuss discharge options at the meeting which could include, but are not limited to, accessing other Medicaid or privately funded programs, natural supports, or relocation to another state.

In addition to conducting and documenting the discharge, the case manager is responsible for:

- Completing and submitting the Member Transfer/Discharge Form (WV-BMS-IDD-10) to the UMC's portal within seven calendar days; and,
- Discharge the member in the UMC's portal by the effective date of the valid discharge.

513.8.1.4 Critical Juncture IDT Meeting

This meeting is held as soon as possible when there is a significant change in the members' assessed needs and/or planned services. A critical juncture may be the result of a change in the member's medical/physical status, behavioral status, or availability of natural supports. The IPP must be updated to include IDT recommendations, minutes, and signatures of all IDT members indicating their attendance and agreement or disagreement.

A face-to-face meeting may be held under any of the following circumstances:

- All team members do not agree with services or service mix.
- If the individual and/or members of the IDT do not have a reliable internet connection and/or audio capability.
- A new goal will be implemented for the member.
- The team is discussing implementation of a Positive Behavior Support Plan, where one was not previously required.
- The member changes residential setting (example: moving from natural family to a licensed group home or an unlicensed residential home).
- The member who lives in an unlicensed residential home, licensed group home or specialized family care home moves to a different location.
- The member goes into crisis placement.
- The member has a change in legal representative status.
- The primary caregiver changes or passes away.
- The member elects to change Service Delivery Model.

- The member receives a new service not previously received.
- The member receiving services has had a documented change in need between the time the annual functional assessment was conducted, and the budget letter was received.

The case manager, in consultation with the member or their legal representative and the IDT, should conduct a Critical Juncture meeting whenever the need is identified. For more information on service authorizations refer to Section 513.25.4 Appeals and Service Authorizations.

513.8.1.5 Annual, Quarterly, and Six-Month IDT Meetings

To develop the IPP, the IDT must meet during the calendar month preceding the member's annual anchor date. If the anchor date does not fall on the first of the month, the meeting may take place up to 30 calendar days before that date. The anchor date sets the clock for scheduling all subsequent IPPs. The IPP must be reviewed and approved by the IDT at least every three months unless otherwise specified in the plan, however the time between reviews shall not exceed six months. The IPP must be reviewed at Critical Juncture meetings.

Medley Class members are required to have IDT meetings every quarter; however, the Medley Advocate may choose to only attend the annual and six-month IDT meetings.

513.9 DESCRIPTION OF SERVICE OPTIONS

Two service options are offered in the IDDW:

1. Traditional Service option
2. Participant-Directed Service option (as provided by the *Personal Options* FMS)

A member may choose either service option at any time by completing a Freedom of Choice Form (WV-BMS-IDD-2). When a member chooses a new Service Delivery Model, (ex., opts to add participant-directed services or change from Participant-Directed to Traditional Service option), the case manager will enter the information into the UMC's portal within two business days of receipt and schedule a Critical Juncture IDT meeting. If the member chooses a new Service Delivery Model at or near the time of a regularly scheduled IPP meeting, a critical juncture meeting may not be needed as the change of Service Delivery Model can be addressed during the regularly scheduled IPP.

At this meeting, the IDT will discuss the transition from one Service Delivery Model to the other, including timelines and services. If the member is transitioning from the Traditional Service Delivery Model to the Participant-Directed Service Delivery Model, a participant-directed budget will be developed while all other services will remain with the IDDW provider(s). If the member is transitioning from the Participant-Directed Service Delivery Model to the Traditional Service Delivery Model, services that were participant-directed will be referred to the chosen Traditional service agency.

513.9.1 Traditional Service Delivery Model

The Traditional Service Delivery Model is available to every member who receives IDDW services.

If the member chooses this Service Delivery Model, all services will be accessed through an IDDW provider after being determined necessary, appropriate, and within the assessed budget. The IDDW provider has employer authority as well as fiscal responsibility for the services listed on the service plan of the member. These services are provided in home and community-based settings where the member lives and participates in community activities.

It is required that case management be accessed through the Traditional Service Delivery Model by all members who receive services.

The following services are available via the Traditional Service Delivery Model:

- Behavior support professional
- Crisis services
- Electronic monitoring
- Environmental accessibility adaptations
- Extended professional services
- Dietary therapy
- Occupational therapy
- Physical therapy
- Speech therapy
- Facility-based day habilitation
- Job development
- Person-centered support
- Pre-vocational services
- Respite
- Case management
- Skilled nursing
- Rn services
- LPN services
- Supported employment
- Transportation

When a member accesses all services via the Traditional Service Delivery Model, the assessed budget is used to access services that can be purchased within the assessed budget. Based on assessments, the IDT identifies needed services and addresses those on the IPP. Service limits based on the age and residential setting of the member may not be exceeded.

Once the team determines the array of services that may be purchased within the individualized budget, the case manager documents on the IPP (WV-BMS-IDD-5) and requests the units agreed upon in the UMC's portal.

The hourly wage of agency staff employed by an IDDW provider is determined solely by the agency that employs the staff person. Agency providers must always comply with all local, state, and federal wage and hour employment laws and regulations, including, but not limited to, the West Virginia Wage and

Hour Act, Fair Labor Standards Act (FLSA), and Internal Revenue Service (IRS) laws and regulations. IDDW providers are solely responsible for making their own determination as to whether an individual performing work for the agency is an employee or independent contractor under applicable state and federal laws and regulations. Provider agencies should not interpret this as an opportunity to misclassify workers as independent contractors. Provider agencies are solely responsible for any liability resulting from misclassification of workers. BMS reserves the right to disenroll any IDDW provider which is found to have misclassified employees by the U.S. Department of Labor, IRS, or any other applicable state or federal agency. All agency staff hired by an IDDW provider must meet the requirements listed in the applicable Agency Staff Qualifications in Section 513.3.

Regarding the provision of Traditional Service Delivery Model services, the UMC is responsible to:

- Conduct agency satisfaction surveys with a sample of members and their representatives (when applicable), and receive and analyze the survey results and report them to BMS annually; and
- Conduct provider reviews on a defined cycle using an approved review protocol based on IDDW requirements.

513.9.2 Participant-Directed Service Delivery Model

The Participant-Directed Service Delivery Model is available to every member except for those living in OHFLAC licensed residential settings. Based on assessments, the IDT identifies needed services and addresses those on the IPP.

If the member chooses this Service Delivery Model, they can exercise choice and control over the participant-directed services they choose and the individuals and organizations who provide them (employer authority); and/or how the portion of their individualized budget associated with participant-directed services (i.e., their participant-directed budget) is spent (budget authority).

The participant-directed services over which members can exercise choice and control are family/home-based person-centered support, unlicensed residential person-centered support, physical therapy, occupational therapy, speech therapy, dietary therapy, environmental accessibility adaptation, in-home respite, out-of-home respite, participant directed goods and services, and transportation. (Note that participant-directed goods and services and transportation can only be participant-directed if at least one of either a person-centered support and/or a respite service is also participant-directed.)

The maximum amount of a participant-directed budget is the equivalent monetary value of person-centered support service units, respite service units, participant-directed goods and services, and transportation service units available, based on the age, residential setting, needs of the member, and units available. When a member is accessing person-centered support, respite, participant-directed goods and services, and/or transportation services, whether via the Traditional or Participant-Directed Service Option, the total dollar amount of the services must be added together and may not exceed the service limits in both Service Options combined.

All services purchased must be within the individualized budget. While the total cost of IDDW services must remain within budget, members are provided with the opportunity to re-direct portions of their budget

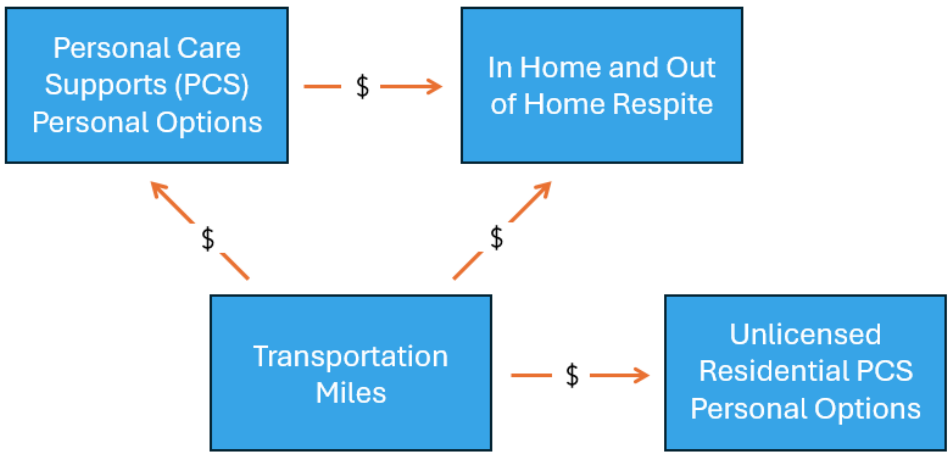
to meet their individual needs and preferences. Both Person-Centered Support: *Personal Options* and Transportation Miles: *Personal Options* monies may be transferred into Respite: *Personal Options* to increase this service. Transportation Miles: *Personal Options* monies may also be transferred to Person-Centered Supports: *Personal Options* to increase this service. Transportation Miles: *Personal Options* monies may also be transferred to Unlicensed-Residential Person-Centered Support: *Personal Options* to increase this service.

However, Respite: *Personal Options* monies may not be transferred into the following:

- Person-Centered Support: *Personal Options* or Transportation Miles: *Personal Options*.
- Participant-Directed Goods and Services into Respite: *Personal Options.*
- Family Person-Centered Supports: *Personal Options* or Transportation Miles: *Personal Options*.
- Participant-Directed Goods and Services.

The graphic below depicts permissible exchanges between the Traditional Service Option and the Participant-Directed Service Option.

I/DDW Allowable Financial Authority Exchanges



Only those $$ exchanges indicated with an arrow are allowed.
All others are prohibited.

Once all the equivalent monies are transferred into the participant-directed budget, the member and/or their legal/non-legal representative, along with their *Personal Options* resource consultant, create a spending plan. The member and/or their legal/non-legal representative then chooses the types of services, the amount of services, and the wages of the member's employees within the parameters of the entire participant-directed budget.

The *Personal Options* vendor assigns a *Personal Options* Resource Consultant to assist and support each self-directing member to develop and monitor monthly spending plans. The resource consultant will ensure the member/representative is aware of service utilization so that the member/representative can adjust the spending plan if the budget amount allows for modifications.

The hourly wage of the QSW employed by a member may not exceed the Medicaid rate minus all mandatory deductions. All QSW hired by the member must meet the requirements listed under Section 513.3.10.

Members who choose to self-direct their IDDW services will do so with the support of an FMS called Personal Options. If utilizing *Personal Options*, the member is the common law employer, or employer of record, of the QSW(s) hired.

To assist with functions related to being the common law employer, the member may appoint a representative. A representative may not be a paid employee providing *Personal Options* IDDW services to the member. As the common law employer, the member is responsible to:

- Elect the participant-directed option.
- Work with their resource consultant to become oriented and enrolled in the Participant-Directed Service Delivery Model, enroll QSWs, develop a spending plan for the participant-directed budget, and create an emergency QSW's back-up plan to ensure staffing, as needed.
- Recruit and hire their QSWs.
- Provide required training to QSWs, including training on needs specific to the member.
- Determine QSWs' work schedule and how and when the QSWs should perform the required tasks.
- Determine the QSWs' daily activities.
- Evaluate the QSWs' performance.
- Review, sign, and submit QSWs' timesheets to the *Personal Options* FMS.
- Maintain documentation in a secure location and ensure employee confidentiality.
- Discharge QSWs, when necessary; and
- Notify the service coordinator of any changes in service need.

The *Personal Options* FMS acts as the fiscal/employer agent to the member, and is therefore responsible to:

- Assist common law employers exercising budget authority.
- Act as a neutral bank, receiving and disbursing public funds, tracking and reporting on the budget funds (received, disbursed and any balances) of the member.
- Monitor spending of budget funds following approved spending plans.
- Make available a monthly utilization report to identify the members' use of budget funds.
- Submit claims to the state's claim processing agent on behalf of the member/employer.
- Process and pay invoices for transportation in the member's approved participant-directed spending plan.
- Assist members in exercising employer authority.

- Assist the member in verifying workers' citizenship or legal alien status (e.g., completing and keeping a copy of the USCIS Form I-9 for each support service worker the member employs).
- Assist in submitting criminal background checks of prospective QSW(s).
- Collect and process QSW timesheets.
- Operate a payroll service, (including withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, FICA and FUTA), state (e.g., income tax withholding and SUTA), and, when applicable, local employment taxes and insurance premiums).
- Distribute payroll checks on behalf of the member.
- Execute simplified Medicaid provider agreements on behalf of the Medicaid agency.
- Provide orientation/skills training to members who receive services about their responsibilities when they function as the employer of record of their QSWs.
- Provide ongoing information and help to common law employers; and
- Monitor and report data about quality and utilization of the *Personal Options* FMS as required to the BMS.

The *Personal Options* FMS is not the common law employer of the QSW(s) who provide services to the members. Rather, the *Personal Options* FMS assists the member common law employer in performing all that is needed from an employer for wages paid on their behalf and all that is required of the payer for requirements of back-up withholding, as applicable. The *Personal Options* FMS operates under §3504 of the IRS code, Revenue Procedure 80-4 and Proposed Notice 2003-70, applicable state and local labor, employment tax and Medicaid program rules, as required.

Personal Options makes available Information and Assistance (I&A) services to common law employers to support their use of participant-directed services and to perform effectively as the common law employer of their Qualified Support Workers. I&A provided by the *Personal Options* FMS include:

- Common law employer orientation sessions once the member chooses to use participant-directed services and enrolls with *Personal Options*.
- Skills training to help common law employers to effectively use participant-directed services and the FMS and perform the required tasks of an employer of record of QSW. Common law employer orientation provides information on:
    - Roles, responsibilities of, and potential liabilities for each of the interested parties related to the delivery and receipt of participant-directed services (i.e., common law employer, *Personal Options*, UMC, case management, BMS),
    - How to use *Personal Options*,
    - How to effectively perform as a common law employer of their QSW,
    - How to ensure that the common law employer is meeting Medicaid and *Personal Options* requirements, and,
    - How a member would stop using participant-directed services and begin to receive traditional services, if they so desire.

The *Personal Options* FMS provides I&A supports to members who receive services and their representatives (when applicable) who wish to function as common law employers. Educational materials are provided to interested parties on the roles and responsibilities of the Personal Options FMS, as well as the roles and responsibilities of others, such as members, their representative, QSW(s), and the BMS.

The materials also address what is needed from the member to be a common law employer and provide a venue through which a member may enroll in the Participant-Directed Service Delivery Model. The *Personal Options* FMS also makes available materials to members who receive services and their representatives (when applicable), to implement and support their use of participant-directed services and perform as employer of record.

If the Participant-Directed Service Delivery Model is selected by the member, the *Personal Options* FMS, rather than the case manager, provides I&A service that includes:

- Providing or linking common law employers with program materials in a format that they can use and understand.
- Providing and helping with the completion of enrollment packets for common law employers.
- Providing and helping the common law employer with employment packets.
- Discussing and/or helping determine the participant-directed budget with the common law employer.
- Presenting the common law employer with the *Personal Options* FMS role regarding payment for services.
- Assisting common law employers with determining participant-directed budget expenditures (hiring).
- Assisting with the development of an individualized spending plan based upon the annual participant-directed budget.
- Making available to the member/representative a process for voicing complaints/grievances pertaining to the *Personal Options* FMS performance.
- Providing additional oversight to the common law employer as requested or needed.
- Monitoring and reporting information about the utilization of the participant-directed budget to the member, representative, case manager, and the BMS; and
- Explaining all costs/fees associated with participant-directing to the member. The costs/fees are for the criminal investigation background check, CPR, and First Aid for QSWs. The cost for the FMS does not come out of the individual's budget.

Regarding the provision of participant-directed services, the UMC is responsible for:

- Distributing the *Personal Options* FMS satisfaction survey, developed by BMS, to members who participant-direct their services or their representatives (when applicable) and receive and analyze the survey results and report them to BMS annually; and
- Conducting *Personal Options* FMS performance reviews on a defined cycle using a review protocol based on the *Personal Options* FMS requirements.

513.10 BEHAVIOR SUPPORT PROFESSIONAL SERVICES

513.10.1 Behavior Support Professional I and II (Traditional Option)

Behavior Support Professional (BSP) services are provided to members with assessed need, as identified on the annual functional assessment, for adaptive skills training. For members who require adaptive skills training, the BSP performs the following activities:

- Develops training plans that include member-specific aspects and methods of intervention or instruction.
- Provides training to staff members who will implement the training plans on aspects and methods of intervention (i.e., family, person-centered support, facility-based day habilitation, supported employment, and crisis direct-support professionals).
- Provides training for direct-support professionals who provide respite services if applicable for respite-relevant training objectives or health/safety training objectives only.
- Evaluates/monitors the effectiveness of the training plans through analysis of programming results that occur at least monthly.
- Follows-up once training plans have been implemented to observe progress/regression.
- Revises training plans as needed.
- In addition, this service may also be used to address assessed and identified maladaptive behaviors that require informal or formal intervention. For members who require Positive Behavior Support to manage maladaptive behaviors, the BSP performs the following activities:
    - Completes a Functional Behavior Assessment (FBA) to identify targeted maladaptive behaviors.
    - The FBA is a part of the Positive Behavior Support Plan process and documented team agreement is required after discussing the implementation of all areas of the Positive Behavior Support Plan process.
    - Creates Positive Behavior Support Plans, as necessary, to meet “Association for Positive Behavior Support” standards of practice.
    - Provides training to staff members who will implement the Plan (i.e. family, person-centered support, facility-based day habilitation, supported employment, crisis, and respite direct-support professionals).
    - Evaluates/monitors the effectiveness of the Positive Behavior Support plan through analysis of programming results that occur at least monthly.
    - Follows-up once the Plan has been implemented to observe progress/regression; and
    - Revises the Plan as needed.
- Develop the task analysis portion of the Individual Habilitation Plan (IHP)/Individual Service Plan (ISP) and member-specific strategy or methodology for development of habilitation plans, including tentative schedule.
- Develop Interactive Guidelines or Behavior Protocols for individuals who do not require a formal PBS Plan.
- Collaborate with BSP(s) from other agency(s) to ensure that PBS strategies are consistently applied across all environments.
- Facilitate person-centered planning as a part of the PBS Plan.
- Present proposed restrictive measures to the IDDW provider’s Human Rights Committee (HRC) if no other professional is presenting the same information regarding the member.
- Attend and participate in IDT meetings and the annual assessment of functioning for eligibility conducted by UMC, if requested by the member or their legal representative.
- Evaluate environment(s) for implementation of the ISP to help ensure the optimal environment for habilitation plans, when clinically indicated and beneficial to the member.
- Assist members who receive services in selecting the most suitable environment for their habilitation needs.

- Provide on-site training to the support staff in behavioral/crisis situations.
- Consult via telephone during behavioral crisis situations only.
- Develop/update the behavioral crisis section of the crisis plan.
- Verify data compiled by direct-support professionals for accuracy; and
- Attend and contribute to Futures Planning sessions, including Planning Alternative Tomorrows with Hope (PATHs) and Making Action Plans (MAPs).

Procedure Code	T2021-HN Level I
	T2025-HO Level II
Service Units	Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, any unlicensed residential home, a licensed IDDW provider agency office, a licensed day program facility, a licensed pre-vocational site, licensed crisis sites, public community locations, and a member's supported work site.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include all the items listed below:

- Member's name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Analysis of the data collected, or problem identified
- Clinical outcome of the service provided
- Plan of intervention as the result of the analysis
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The amount of service must be identified on the IPP.
- The maximum annual units of BSP services cannot exceed 768 units/192 hours per IPP year.

- Staff members providing BSP services may not live in the members' home.
- If the assigned BSP is unavailable due to an emergency or illness, another BSP may provide services in their absence.
- BSP Level I services may only be provided by a staff person who meets the criteria in Sections 513.2 - 513.2.1, and Section 513.3.1.1.
- BSP Level II services may only be provided by a staff person who meets the criteria in Sections 513.2 - 513.2.1, and Section 513.3.1.2.
- Direct-care services provided by the BSP must be billed utilizing the appropriate direct care service code.
- BSP services may not be billed for traveling to complete BSP activities.
- BSP services cannot be billed for completing administrative activities which includes:
    - HR activities such as staff supervision, monitoring, and scheduling.
    - Routine review of a member's file for quality assurance purposes.
    - Staff meetings for groups or individuals.
    - Monitoring of a licensed group home (fire drills, hot water heater temperature checks, etc.).
    - Filing, collating, and writing notes to staff.
    - Phone calls to staff.
    - Observing staff while training individuals without a clinical reason.
    - Administering assessments not warranted or requested by the member or their legal representative.
    - Making plans for a parent for a weekend visit.
    - Working in the home while providing direct care staff coverage.
    - Sitting in the waiting room for a doctor or medical appointment.
    - Conducting routine home visits without justification, only case managers are required to make routine home visits.

513.10.2 Behavior Support Professional I and II, Individual Program Planning (Traditional Option)

This is a service that allows the BSP to attend a member's IDT meeting to present assessments or evaluations completed for the purpose of integrating recommendations, training goals, and intervention strategies into the member's IPP.

Individual Program Planning is the process by which the member and their IDT develop a plan based on a person-centered philosophy. The BSP participates in the IDT meeting for the purpose of reviewing assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and the preparation of interventions or strategies necessary to implement a person-centered plan.

Procedure Code: T2024-HI Level I

T2025-HI Level II

Service Units: Unit = Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, any Unlicensed Residential Home, a licensed IDDW provider agency office, a licensed day program facility or licensed pre-vocational center, licensed crisis sites, and public community locations. The meeting cannot begin at one location and then continue at another location.

Documentation: Documentation must include signature, date of service, the total time spent at the meeting on the members' IPP, and a separate progress note must also be completed.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual combined units of BSP IPP Planning (both BSP I and BSP II) cannot exceed four events per member's annual IPP year.
- BSP may attend all planning meetings, either face-to-face or by teleconference, but to bill the IPP code, the professional must be present for the duration of the IPP meeting.
- IPP cannot be billed for preparation prior to or for follow-up performed after the IPP meeting.
- Staff providing BSP services may not be an individual who lives in the member's residence.

513.11 CRISIS SERVICES

513.11.1 Crisis Services (Traditional Option)

The goal of this service is to respond to a crisis immediately, and to assess and stabilize the situation as quickly as possible. Crisis services provided by awake and alert staff are to be used if there is an extraordinary circumstance requiring a short-term, acute service that uses PBS planning, interventions, strategies, and direct care. Crisis services may be utilized in both a behavioral health and medical health crisis (ex., member requires a 2-person lift, acute medical needs following hospital discharge, etc.) This service requires prior authorization. Crisis services may be authorized for the IPP year and utilized intermittently, as needed. This service has a 2:1 ratio (agency staff to member ratio). The additional agency staff person is available for assurance of health and safety in the respective setting. Crisis services include formal training, informal training, and Positive Behavior Support.

Procedure Code: T2017 2:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Crisis Services may be authorized for the IPP year and used intermittently, as needed, to meet the members' individual needs. Prior authorizations are based on specific assessed needs as identified on the annual functional assessment, and services must be within the member's individualized budget. Crisis services utilization must be reviewed by the IDT every three months, at a minimum, to monitor service utilization and ensure that the member's Behavior Support Plan is followed.

The purpose of authorizing crisis services for up to six months at a time is to ensure that individuals have access to necessary services and supports to minimize use of emergency department services and in-patient psychiatric hospitalization. Individuals may access crisis support services intermittently, as needed, without the need to seek repeated authorizations which could impact timely access to care, however, the IDT must closely monitor the use of intermittent crisis-site person-centered support to ensure that services are provided following the person-centered plan and behavior support plan. Under emergent circumstances which place the member's or others' health and safety at risk, Crisis Services may be immediately implemented without prior authorization up to a maximum of 72 hours.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, and public community locations.

Documentation: A detailed progress note is required. If the Direct-Support Service Log (WV-BMS-IDD-07) is used, the service log and progress note must both be completed by all agency staff providing this service. Documentation must include the following:

- Member's name
- Service code
- Date
- Start time
- Stop time
- Summary of the crisis service interventions
- Total time spent
- Signature of agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of Crisis Services cannot exceed 17,280 units or 4,320 hours per IPP year.
- This service may be billed concurrently with case management, BSP, and Transportation.
- This service may not be billed concurrently with person-centered support, facility-based day habilitation, LPN, respite, pre-vocational, job development, and supported employment.
- The ratio of agency staff to member receiving services is 2:1 for this service.

- Direct-support professionals providing crisis services may not live in the members' home.
- This service is not intended for routine use as emergency response for ongoing behavioral challenges.

513.12 EXTENDED PROFESSIONAL SERVICES

513.12.1 Dietary Therapy (Traditional Option)

Dietary Services may be provided directly to members 21 years of age and older by a registered dietary therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Nutritional assessment and therapy for diseases that have a nutritional component.
- Preventive health and diet assessment.
- Weight management therapy.
- Design of menus.
- Screening.
- Assessments.
- Planning and reporting.
- Reporting use of services to the IDT.
- Direct therapeutic intervention.
- Consultation or demonstration of techniques with other service providers and family members.
- Attending and taking part in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or legal representative.

Direct-care services provided by the dietary therapist must be billed using the appropriate direct-care service code.

The scope and nature of these services differ from dietary therapy services offered under the State Plan. Dietary Therapy services provided under the Waiver are for chronic conditions and maintenance, while the dietary therapy services offered under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT), but consistent with waiver goals of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met.

Procedure Code: 97802AE 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre-vocational center, the therapist's office or location of practice and crisis sites.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include the following:

- Member's name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of dietary therapy services may not exceed 416 units or 104 hours per IPP year. This is in combination with physical therapy and occupational therapy.
- The ratio of agency staff to member receiving services is 1:1 for this service.
- Agency staff providing dietary therapy services may live in the member's home.
- Agency staff may not bill for dietary therapy for completing administrative activities.

513.12.2 Occupational Therapy (Traditional Option)

Occupational Therapy is provided directly to members 21 years or older by an occupational therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Evaluation and training services in the areas of gross and fine motor function.
- Self-care.
- Sensory and perceptual motor function.
- Screening and assessments.
- Planning and reporting.
- Direct therapeutic intervention.
- Design, fabrication, training and assistance with adaptive aids and devices.
- Consultation or demonstration of techniques with other service providers and family members.
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or legal representative.

The scope and nature of these services differ from occupational therapy services offered under the State Plan. Occupational therapy services provided under the Waiver are for chronic conditions and maintenance, while the occupational therapy services offered under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver goals of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met.

Procedure Code: 97530GO 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, except to the extent services more than the individualized budget are approved per the procedures and standards in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, any unlicensed residential home, a licensed day program facility or pre-vocational center, and crisis sites.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include the following:

- Member's name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- This service is limited to members 21 years old and older. Members under 21 may access this service through the EPSDT program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of occupational therapy may not exceed 416 units or 104 hours per IPP year. This is in combination with physical and dietary therapy.

- The ratio of agency staff to member receiving services is 1:1 for this service.
- Agency staff providing occupational therapy services may not live in the members' home.
- Agency staff providing occupational therapy services may not bill for administrative activities.

513.12.3 Physical Therapy (Traditional Option)

Physical therapy is provided directly to members 21 years old and older by a physical therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Screening and assessments.
- Treatment and training programs that are designed to preserve and improve abilities for independent functioning (e.g. gross and fine motor skills, range of motion, strength, muscle tone).
- Activities of daily living.
- Planning and reporting.
- Direct therapeutic intervention.
- Training and assistance with adaptive aids and devices.
- Consultation or demonstration of techniques with other service providers and family members.
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or their legal representative.

The scope and nature of these services differ from physical therapy services offered under the State Plan. Physical therapy services provided under the Waiver are for chronic conditions and maintenance, while the physical therapy services offered under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver goals of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met.

Procedure Code: 97530GP 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre-vocational center and crisis sites.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include the following items:

- Member's name
- Service code

- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- This service is limited to members 21 years old and older. Members under 21 may access this service through the EPSDT program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of physical therapy may not exceed 416 units or 104 hours per IPP year. This is in combination with occupational and dietary therapy.
- The ratio of agency staff to member receiving services is 1:1 for this service.
- Agency staff providing physical therapy services may not live in the member's home.
- Agency staff providing physical therapy services may not bill for administrative activities.

513.12.4 Speech Therapy (Traditional Option)

Speech therapy is provided directly to members 21 years old and older by a speech pathologist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Screening and assessments.
- Direct-therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids.
- Language stimulation and correction of defects in voice, articulation, rate and rhythm.
- Design, fabrication, training and assistance with adaptive aids and devices.
- Consultation or demonstration of techniques with other service providers and family members.
- Attending and participating in IDT meetings and the annual assessment of functioning and eligibility conducted by the UMC if requested by the member or their legal representative.

The scope and nature of these services differ from speech therapy services offered under the State Plan. Speech Therapy services provided under the Waiver are for chronic conditions and maintenance, while the speech therapy services offered under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver goals of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met.

Procedure Code: 92507GN 1:1 ratio

Service Units: Unit = 1 Event

Prior Authorization: All units must be prior authorized before being provided. Prior authorizations are based on assessed need as identified on the annual functional assessment and services must be within the member's individualized budget, unless an exception is approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre-vocational site, and crisis sites.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include all the following items:

- Member's name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- This service is limited to members 21 years old and older. Members under 21 may access this service through the EPSDT program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 96 units or 96 events per member's annual IPP year for members below age 24.
- 48 units or 48 events per member's annual IPP year for members age 24 and over.
- The ratio of agency staff to member is 1:1 for this service.
- Agency staff providing speech therapy services may not live in the member's home.
- Agency staff may not bill speech therapy services for completing administrative activities.

513.12.5 Dietary Therapy (Participant-Directed Option, Personal Options Model)

Dietary therapy is provided directly to members 21 years and over by a dietary therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Nutritional assessment and therapy for diseases that have a nutritional component.
- Preventive health and diet assessment.
- Weight management therapy.
- Design of menus.
- Screening.
- Assessments.
- Planning and reporting.
- Direct therapeutic intervention.
- Consultation or demonstration of techniques with other service providers and family members.
- Attending and taking part in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or legal representative.

The scope and nature of these services differ from dietary therapy services offered under the State Plan. Dietary therapy services provided under the Waiver are for chronic conditions and maintenance, while the dietary therapy services offered under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver goals of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met. Direct-care services provided by the dietary therapist must be billed using the appropriate direct care service code.

Procedure Code: 97802AEUG 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre-vocational center and crisis sites.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include the following:

- Member's name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent

- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of dietary therapy services may not exceed 416 units or 104 hours per IPP year. This is in combination with physical and occupational therapy.
- The ratio of staff to member receiving services is 1:1 for this service.
- Staff providing physical therapy services may not live in the members' home.
- Staff providing physical therapy services may not bill for administrative activities.

513.12.6 Occupational Therapy (Participant-Directed Option, Personal Options Model)

Occupational Therapy is provided directly to members 21 years old and over by an occupational therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Evaluation and training services in the areas of gross and fine motor function.
- Self-care.
- Sensory and perceptual motor function.
- Screening and assessments.
- Planning and reporting.
- Direct therapeutic intervention.
- Design, fabrication, training and assistance with adaptive aids and devices.
- Consultation or demonstration of techniques with other service providers and family members.
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or legal representative.

The scope and nature of these services differ from occupational therapy services offered under the State Plan. Occupational therapy services provided under the Waiver are for chronic conditions and maintenance, while the occupational therapy services offered under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver goals of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met. Direct-care services provided by the occupational therapist must be billed using the appropriate direct care service code.

Procedure Code: 97530GOUG 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, any unlicensed residential home, a licensed day program facility or pre-vocational center and crisis sites.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include the following:

- Member's name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- This service is limited to members 21 years old and over. Members under 21 may access this service through the EPSDT program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of occupational therapy may not exceed 416 units or 104 hours per IPP year. This is in combination with physical and dietary therapy.
- The ratio of staff to member receiving services is 1:1 for this service.
- Staff providing physical therapy services may not live in the members' home.
- Staff providing physical therapy services may not bill for administrative activities.

513.12.7 Physical Therapy (Participant-Directed Option, Personal Options Model)

Physical therapy is provided directly to members 21 years and over by a physical therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Screening and assessments.
- Treatment and training programs that are designed to preserve and improve abilities for independent functioning (e.g. gross and fine motor skills, range of motion, strength, muscle tone).
- Activities of daily living.
- Planning and reporting.
- Direct therapeutic intervention.
- Training and assistance with adaptive aids and devices.
- Consultation or demonstration of techniques with other service providers and family members.
- Attending and participating in IDT meetings and the annual assessment of functioning for eligibility conducted by the UMC if requested by the member or their legal representative.

The scope and nature of these services differ from physical therapy services offered under the State Plan. Physical therapy services provided under the Waiver are for chronic conditions and maintenance, while the physical therapy services offered under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver goals of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met. Direct-care services provided by the physical therapist must be billed utilizing the appropriate direct care service code.

Procedure Code: 97530GPUG 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre- vocational center, and crisis sites.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include the following:

- Member's name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- This service is limited to members 21 years and over. Members under 21 may access this service through the EPSDT program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of physical therapy may not exceed 416 units or 104 hours per IPP year. This is in combination with occupational and dietary therapy.
- The ratio of staff to member receiving services is 1:1 for this service.
- Staff providing physical therapy services may not live in the member's home.
- Staff providing physical therapy services may not bill for administrative activities.

513.12.8 Speech Therapy (Participant-Directed Option, Personal Options Model)

Speech therapy is provided directly to members 21 years old and older by a speech therapist that is licensed in West Virginia and an enrolled Medicaid provider. Services may include:

- Screening and assessments.
- Direct therapeutic intervention and treatment for speech and hearing disabilities such as delayed speech, stuttering, spastic speech, aphasic disorders, injuries, lip reading or signing, or the use of hearing aids.
- Language stimulation and correction of defects in voice, articulation, rate and rhythm.
- Design, fabrication, training and assistance with adaptive aids and devices.
- Consultation or demonstration of techniques with other service providers and family members.
- Attending and participating in IDT meetings and the annual assessment of functioning and eligibility conducted by the UMC if requested by the member or their legal representative.

The scope and nature of these services differ from speech therapy services offered under the State Plan. Speech Therapy services provided under the Waiver are for chronic conditions and maintenance, while the speech therapy services offered under the State Plan are short term and restorative in nature. These services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver goals of avoiding institutionalization. Any similar services provided in a school setting may also be eligible for reimbursement under the waiver when Medicaid program requirements are met. Direct-care services provided by the speech therapist must be billed utilizing the appropriate direct care service code.

Procedure Code: 92507GNUG 1:1 ratio

Service Units: Unit = 1 Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre-vocational site and crisis sites.

Documentation: A detailed progress note or evaluation report for each service is required. Documentation must include the following:

- Member's name
- Service code
- Date of service
- Start time
- Stop time
- Total time spent
- Description of the service provided
- Assessment of progress or lack of progress
- Signature and credentials of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- This service is limited to members 21 years and over. Members under 21 may access this service through the EPSDT program.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 96 units or 96 events per member's annual IPP year for members below age 22.
- 48 units or 48 events per member's annual IPP year for members age 22 and over.
- The ratio of staff to member receiving services is 1:1 for this service.
- Staff providing physical therapy services may not live in the members' home.
- Staff providing physical therapy services may not bill for administrative activities.

513.13 ELECTRONIC MONITORING

513.13.1 Electronic Monitoring (Traditional Option)

Electronic monitoring services include the provision of oversight and monitoring within the residential setting through off-site electronic surveillance. Also included is the provision of designated IDDW agency stand-by intervention staff prepared for prompt engagement with the member(s) and/or immediate deployment to the residential setting. The use of this service must be designed and implemented to

ensure the need for independence and privacy of the member in their own home/apartment. The following requirements must be met:

- This service is only to be used when there is no paid staff in the members' home.
- This service may be installed in residential settings in which adult members, their legal representatives (if applicable) and their IDT teams request such surveillance and monitoring in place of paid staff.
- All electronic monitoring systems or companies used or contracted by the IDDW provider meet the standards set by the BMS and must be pre-approved by the BMS before providing any services and approved annually thereafter.
- The IDDW provider must have written policies and procedures approved by the BMS that define emergency situations and details how remote and stand-by staff will respond to each (for example: fire, prolonged power outage, medical crisis, stranger in the home, violence between members, any situation that appears to threaten the health and welfare of the member).
- The electronic monitoring system or company must receive notification of smoke/heat activation at each member's home.
- The electronic monitoring system or company must have two-way (at minimum, full duplex) audio communication capabilities to allow monitoring base staff to effectively interact with and address the needs of the members in each home, including emergency situations when the participant may not be able to use the telephone.
- The electronic monitoring system or company must allow the monitoring base staff to have visual (video) oversight of areas in the member's home considered necessary by the IDT.
- At the time of monitoring, the monitoring base staff may not have duties other than the oversight and support of members at the remote living site.
- The monitoring base staff will assess any urgent situation at a member's living site and call 911 emergency personnel first if that is considered necessary, then call the stand-by staff.
- The monitoring base staff will stay engaged with the participant(s) at the living site during an urgent situation until the stand-by staff or emergency personnel arrive.
- Any member wishing to access this service must first be assessed using the identified Risk Assessment and approved by the IDDW provider's Human Rights Committee (HRC) to ensure that the member's health and welfare will not be harmed by accessing this service. The approval of the HRC must be documented and attached to the members' IPP.
- After the HRC's approval is obtained, the member and their legal representative (if applicable) and the IDT must give informed consent and document the approval of such support in place of on-site staff or natural supports on the member's IPP.
- The member is allowed to turn the remote monitoring system on and off and is instructed by the provider regarding this functionality.
- The member, their legal representative, and all IDT members are made aware of both the benefits and the risks of the operating parameters and limitations. Benefits may include increased independence and privacy, and risks may include not having on-site staff in case of an emergency.
- The residential agency conducts a programmatic review of the system as well as a drill at seven calendar days of implementation, again at 14 calendar days and at least quarterly thereafter. The drill will consist of evaluating the equipment and response time.

- The case manager reviews the continued usage of this service at every home visit and during every IPP and makes the IDT aware of any problems or concerns met with the use of this system, all of which is documented on the IPP.
- The number of members served by one stand-by intervention staff for on-site response is determined by the IDT and based upon the assessed needs of the members being served in specifically identified locations.
- The IDDW provider has stand-by intervention staff who meet the following standards:
    - Responds by being at the member's residential living site within 20 minutes or less from the time an incident is identified by the remote staff, and the stand-by staff acknowledges receipt of the notification by the remote staff. The IDT has the authority to set a shorter response time based on the individual member's need.
    - Helps the member in the home as needed to ensure the urgent need/issue that generated a response has been resolved.
- Each time an emergency response is generated, an incident report must be sent to the WV IMS by the IDDW provider.

Procedure Code: S5161U1 1:1 ratio
S5161U2 1:2 ratio
S5161U3 1:3 ratio
S5161U4 1:4 ratio

Service Units: Unit = 1 Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the adult member's family residence, a licensed Group Home and in an unlicensed residential home.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to members over the age of 18.
- The maximum units of electronic monitoring service available for members living in unlicensed residential settings cannot exceed 23,360 units or 5,840 hours (average 16 hours per day) per member's IPP year. This service is in combination with all other person-centered support, crisis intervention, LPN, facility-based day habilitation, pre-vocational, job development and supported employment services.

- The maximum units of electronic monitoring service available for members living in natural family/specialized family care homes is 11,680 units or 2920 hours (eight hours per day). This service is in combination with all other person-centered support, crisis intervention, LPN, facility-based day habilitation, pre-vocational, job development and supported employment services.
- The maximum annual units of electronic monitoring for members who live in licensed group home or unlicensed residential home is 23,360 units or 5,840 hours per IPP year and is in combination with person-centered support, facility-based day habilitation, pre-vocational, supported employment, job development, crisis and LPN services.
- Only electronic monitoring/surveillance systems approved by the BMS may be used.
- The member will not be charged for installation costs related to video and/or audio equipment.
- The electronic monitoring/surveillance system may not be used in specialized family care homes.
- The electronic monitoring/surveillance system may not be used to monitor direct-care staff.
- The electronic monitoring/surveillance system serves as a replacement for direct-care staff, thus no other direct-care service may be billed at the same time for the member receiving services or for any other people receiving IDDW services living in the home.

513.14 ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

513.14.1 Environmental Accessibility Adaptations Home (Traditional Option)

Environmental Accessibility Adaptations-Home (EAA-Home) are physical adaptations to the private residence of the member or the member's family home which maximize the member's physical accessibility to the home and within the home. EAA-Home must be documented in the member's IPP and must include the specific item requested. Additionally, these adaptations enable the member to function with greater independence in the home. This service is used only after all other funding sources have been exhausted.

All EAA-Home requests must be submitted by the case management provider to the UMC for approval. If approved, the case management provider is responsible for ensuring the adaptation to the home is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation including dated and itemized receipts of the completed adaptation must be kept by the case management provider.

Procedure Code: S5165

Service Units: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home or an unlicensed residential home.

Documentation: IDDW provider must keep the following documentation in the member's file.

- The original Request for Environmental Accessibility Adaptations form (WV-BMS-IDD-08).
- Any assessments detailing the need for the EAA.
- The member's IPP which details the need for the EAA, and IDT approval.
- Proof of purchase including any receipts or invoices pertinent to the EAA.
- Verification by the IDDW provider that the approved EAA was completed as approved.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- EAA-Home is not intended to replace the members', member's family, or landlord's responsibility for routine maintenance and upkeep of the home. These include but are not limited to cleaning, painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and heating, plumbing, electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the member's need. Appliances compliant with the American Disabilities Act (ADA) are sufficient to meet this requirement.
- The specific item(s) must be documented on the IPP.
- Computers, communication devices, palm pilots, and other technologies are not considered eligible for this service.
- Adaptations made to rental residences or to specialized family care homes must be portable.
- $1,000 available per member's annual IPP year in combination with Traditional and *Personal Options* EAA, Vehicle and/or Participant-Directed Goods and Services.
- The case management agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.14.2 Environmental Accessibility Adaptations Vehicle (Traditional Option)

Environmental Accessibility Adaptations-Vehicle (EAA-Vehicle) are physical adaptations to the vehicle including paying for accessibility adaptations to a vehicle that is the member's primary mode of transportation. EAA-Vehicle is documented on the member's IPP and must include the specific item requested. The purpose of this service is to maximize the member's accessibility to the vehicle only. All EAA-Vehicle requests must be sent by the case management provider to the UMC for approval. If approved, the case management provider is responsible for ensuring the adaptation to the vehicle is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation

including dated and itemized receipts of the completed adaptation must be kept by the case management provider.

Procedure Code: T2039

Service Units: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided to a vehicle owned or leased by the member or the member's family. The vehicle must be the member's primary means of transportation and the adaptations are to maximize the member's accessibility to the vehicle.

Documentation: IDDW provider must maintain the following documentation in the member's file.

- The original Request for Environmental Accessibility Adaptations form (WV-BMS-IDD-08).
- Any assessments detailing the need for the EAA.
- The member's IPP which details the need for the EAA, and the IDT approval.
- Proof of purchase, including any receipts or invoices pertinent to the EAA.
- Verification by the IDDW provider that the approved EAA was completed as approved.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- $1,000 available per member's annual IPP year in combination with Traditional and *Personal Options* EAA – Home and/or Vehicle and/or participant-directed goods and services.
- The specific item(s) must be documented on the IPP.
- This service may not be used for adaptations or improvements to the vehicle that are of general utility (such as running boards) and are not of direct medical or remedial benefit to the individual.
- This service may not be used to buy or lease a vehicle.
- This service may not be used to adapt a vehicle owned or leased by an IDDW provider agency.
- This service may not be used for regularly scheduled upkeep, maintenance, and repairs of a vehicle except upkeep and maintenance of the modifications.
- Car seats unless specifically adapted/modified for the person.
- The case management agency must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.14.3 Environmental Accessibility Adaptations Home (Participant-Directed Option, Personal Options Model

EAA-Home are physical adaptations to the private residence of the member or the member's family home which maximize the member's physical accessibility to the home and within the home. EAA-Home must be documented in the member's IPP and must include the specific item requested. Additionally, these adaptations enable the member to function with greater independence in the home. This service is used only after all other funding sources have been exhausted.

All EAA requests must be sent by the case management provider to the UMC for approval. If approved, the *Personal Options* vendor is responsible for ensuring the adaptation to the home is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation including dated and itemized receipts of the completed adaptation must be maintained by the case management provider and the *Personal Options* vendor.

Procedure Code: S5165UG

Service Units: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home or an unlicensed residential home.

Documentation: IDDW provider must keep the following documentation in the members' file, and the Case Manager informed when service is completed:

- The original Request for EAA form (WV-BMS-IDD-08).
- Any assessments detailing the need for the EAA.
- The member's IPP which details the need for the EAA, and the IDT approval.
- Proof of purchase including any receipts or invoices pertinent to the EAA.
- Verification by the *Personal Options* vendor that the approved EAA was completed as approved.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- EAA-Home is not intended to replace the members', member's family, or landlord's responsibility for routine maintenance and upkeep of the home. These include but are not limited to cleaning, painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and

heating, plumbing, electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair)

- Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the member's need. Appliances compliant with the ADA are not sufficient to meet this requirement.
- The specific item(s) must be documented on the IPP.
- Computers, communication devices, tablets, and other technologies, landline telephones or cell phones, swimming pools, hot tubs or spas or any accessories, repairs or supplies for these items, railing for decks or porches, appliances that are not adapted/modified, yard work, household cleaning supplies, utility payments, household furnishings such as comforters, linens, drapes, etc. Furniture unless it is a lift chair for someone with documented mobility issues, outdoor recreational equipment unless specifically adapted for the person's needs, driveway or walkway repairs or supplies unless specifically to exit or enter home to and from vehicle, covered awnings.
- Adaptations made to rental residences must be portable.
- Adaptations made to rental residences or to specialized family care homes must be portable.
- $1000 available per member's annual IPP year in combination with Traditional and/or *Personal Options* Environmental Accessibility Adaptations – Home and/or Vehicle and/or participant-directed goods and services.
- The *Personal Options* vendor must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.14.4 Environmental Accessibility Adaptations Vehicle (Participant-Directed Option, Personal Options Model)

EAA-Vehicle are physical adaptations to the vehicle including paying for accessibility adaptations to a vehicle that is the member's primary mode of transportation. EAA-Vehicle is documented on the member's IPP and must include the specific item requested. The purpose of this service is to maximize the member's accessibility to the vehicle only.

All EAA requests must be sent by the case management provider to the UMC for approval. If approved, the *Personal Options* vendor is responsible for ensuring the adaptation to the vehicle is completed as specified prior to receiving payment and/or paying contracted vendor(s). Documentation including dated and itemized receipts of the completed adaptation must be kept by the case management provider and the *Personal Options* vendor.

Procedure Code: T2039UG

Service Units: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided to a vehicle owned or leased by the member or the member's family. The vehicle must be the member's primary means of transportation and the adaptations are to maximize the member's accessibility to the vehicle.

Documentation: IDDW provider must keep the following documentation in the member's file.

- The original Request for EAA form (WV-BMS-IDD-08).
- Any assessments detailing the need for the EAA.
- The member's IPP which details the need for the EAA, and the IDT approval.
- Proof of purchase, including any receipts or invoices pertinent to the EAA.
- Verification by the IDDW provider that the approved EAA was completed as approved.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- $1,000 available per member's annual IPP year in combination with Traditional and *Personal Options* EAA - Home and/or participant-directed goods and services.
- The specific item(s) must be documented on the IPP.
- This service may not be used to buy or lease a vehicle.
- This service may not be used for regularly scheduled upkeep, maintenance, or repairs of a vehicle except upkeep and maintenance of the modifications.
- This service may not be used for running boards, insurance or gas money.
- Car seats unless specifically adapted/modified for the person.
- The *Personal Options* vendor must not pay EAA funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the EAA service.

513.15 DAY SERVICES

513.15.1 Facility-Based Day Habilitation (Traditional Option)

Facility-based day habilitation is a structured program that uses meaningful and productive activities designed to promote the acquisition of skills or maintenance of skills for the member outside the residential home. The services must be provided by awake and alert staff and based on assessment, be person-centered/goal oriented, and be meaningful/productive activities that are guided by the member's strengths, needs, wishes, desires, and goals.

Facility-based day habilitation activities in the plan must be developed exclusively to address the habilitation and support needs of the person who receives services. Activities must consist of programs of instruction/training, supervision and assistance, specialist services, and evaluations provided by or under the direct supervision of qualified staff (training programs must be developed by a BSP).

Facility-based day habilitation activities must be based at the licensed site, but the member may access community services and activities from the licensed site.

Meals provided as part of this service shall not constitute a full nutritional regimen of three meals per day. Facility-Based Day Habilitation program services include, but are not limited to:

- Development of self-care skills.
- Use of community services and businesses.
- Emergency skills training.
- Mobility skills training.
- Nutritional skills training.
- Social skills training.
- Communication and speech instruction (prescribed by a speech language pathologist).
- Therapy objectives (prescribed by physical therapist, occupational therapist, etc.).
- Interpersonal skills instruction.
- Functional academic training such as recognizing emergency and other public signs, independent money management skills, etc.
- Citizenship, rights and responsibilities, self-advocacy, voting training.
- Self-administration of medication training.
- Independent living skills training.
- Training the individual to follow directions and conduct assigned duties.

Facility-based day habilitation direct-support professionals may attend and take part in IDT meetings and the annual functional assessment for eligibility which is conducted by the UMC and IDT if requested by the member or their legal representative.

Procedure Code: T2021U5 1:1-2 ratio
T2021U6 1:3-4 ratio
T2021U7 1:5-6 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the community or in a licensed IDD Facility-Based Day Program facility.

Documentation: Documentation must be completed on a Direct-Support Service Log (WV-BMS-IDD-7) to include the information listed below. If additional information is called for due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues the agency staff should

complete the accompanying Direct-Care Progress Note to detail the issue. As training is always provided in this setting, the agency staff must also complete the task analysis.

- Member's name
- Service code including modifier to indicate staff to member ratio
- Date of service
- Start time
- Stop time
- Total time spent
- Task analysis
- Transportation log (if applicable)
- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of facility-based day habilitation cannot exceed 6,240 units or 1560 hours (average six hours/day) per member's IPP year. When the member accesses other direct care services, these units are counted toward the daily cap of all direct care services (all other types of person-centered support, other day services, LPN, crisis intervention, and electronic monitoring).
- This service may not be billed concurrently with any other direct care services.
- Agency staff members to member ratios for this service are 1:1-2, 1:3-4, and 1:5-6.
- Agency staff providing facility-based day habilitation services may not live in the members' home.
- Only members 18 years of age and over may access this service.

513.15.2 Pre-Vocational (Traditional Option)

Pre-vocational services are designed to create a path to integrated community-based employment for which an individual is compensated at or above the minimum wage, but no less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. These services should enable each member to reach the highest level of work in a setting matched to the individual's strengths, interests, priorities, and abilities.

Pre-vocational activities in the plan must be developed exclusively to address the habilitation and support needs of the member. Activities must consist of programs of instruction/training developed and evaluated by a Behavior Support Professional. Supervision, assistance, and specialist services are provided under the direct supervision of a pre-vocational program supervisor.

Tasks of benefit to a provider are those tasks performed by a member, for which the provider would otherwise have to pay an employee to complete. A member taking out trash generated by the whole room

or setting (not just the member's personal trash) would be an example of a task benefiting the provider. A member being trained to clean up after him/herself would not fall in this category.

Meals provided as part of this service shall not constitute a full nutritional regimen of three meals per day. Pre-vocational Services include, but are not limited to, such concepts as:

- Attendance.
- Task completion.
- Problem solving.
- Interpersonal relations.
- Safety.
- Appropriate attitudes and work habits, such as socially appropriate behaviors on the worksite.
- Adjusting to production and performance standards of the workplace.
- Following directions.
- Compliance in workplace rules or procedures.
- Appropriate use of work facilities, such as restrooms, cafeterias/lunchrooms, and break areas.
- Accessing and managing any personal funds.

Members receiving pre-vocational services must have employment-related goals on the IPP and general habilitation activities must be designed to support such employment goals. Members may receive minimum wage. If the IDDW provider benefits from the member's labor, then the member must be paid.

Pre-vocational direct-support professionals may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the member or their legal representative.

Procedure Code: T2021U1 1:1-2 ratio
T2021U2 1:3-4 ratio
T2021U3 1:5-6 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service must be provided in a licensed IDD Facility-Based Day program facility. Pre-vocational services are not delivered in an integrated work setting through Supported Employment.

Documentation: Documentation must be completed on a Direct-Support Service Log (WV-BMS-IDD-7) to include the information listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation, or other issues, the staff member should

complete the accompanying Direct-Support Progress Note to detail the issue. As training is always provided in this setting, the staff member must also complete the task analysis.

- Name of the member
- Service code including modifier to indicate ratio of staff member to member
- Date of service
- Start time
- Stop time
- Total time spent
- Task Analysis
- Transportation log (if applicable)
- Signature of the staff member

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- The maximum annual units of pre-vocational services cannot exceed 6,240 units or 1,560 hours (average six hours/weekday) in combination with all other direct care services such as participant-directed support, other day services, LPN, Crisis Intervention, and electronic monitoring.
- This service may not be billed concurrently with any other direct support services.
- If an agency does not have the Department of Labor certificate, they must pay the individual at least minimum wage. Gift cards are not allowed. If the agency sells the product being made, then the member must be reimbursed for their services either by using the "piece rate" or minimum wage standard.
- The ratios of staff members to member are 1:1-2, 1:3-4, and 1:5-6 for this service.
- Direct-support professionals providing pre-vocational services may not live in the member's home.
- The amount of pre-vocational services must be identified on the IPP.
- Only members 18 years of age and over may access this service.
- Only BSPs or RN may bill for providing training to pre-vocational staff.

513.15.3 Job Development (Traditional Option)

Job development services are designed for analysis, situational assessments, and supports in either getting or keeping competitive employment. These services should enable each member to attain and maintain employment at the highest level of work in a setting matched to the individual's strengths, interests, priorities, and abilities.

Job development services must be supervised by a supported employment services supervisor or a BSP. In addition to the standard training requirements, paraprofessionals providing job development must have documented training or experience in implementation of Supported Employment Plans of Instruction.

Meals provided as part of this service shall not constitute a full nutritional regimen of three meals per day.

Job development services include, but are not limited to, such concepts as:

- Planned visits and meetings with prospective employers to facilitate job acquisition.
- Negotiating job duties and employer expectations.
- Analyzing work duties expected by the employer.
- Creating, changing, or customizing a community-based job so that it may be successfully performed by the member.
- Assessment in integrated employment settings to evaluate task management and job skill requirements.
- Assessment of personal interactions with co-workers and the public.
- Supports to help a member in developing a business plan and obtaining funding to start his/her own business.

Volunteering at integrated work sites to practice the above skills with a time limit not to exceed one year.

Members receiving job development services must have employment-related goals on the IPP and general habilitation activities must be designed to support such employment goals.

Job development direct-support professionals may attend and take part in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the member or their legal representative.

Procedure Code: T1019HB 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in community settings, and/or integrated employment setting. The provider's office is not considered a community setting.

Documentation: Documentation must be completed on a Direct-Support Service Log (WV-BMS-IDD-7) to include the information listed below. If additional information is warranted due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation, or other issues, the staff member should complete the accompanying Direct-Support Progress Note to detail the issue. As training is always provided in this setting, the staff member must also complete the task analysis.

- Name of the member
- Service code (including modifier to indicate ratio of staff member to member)
- Date of service
- Start time
- Stop time
- Total time spent

- Task Analysis
- Transportation log (if applicable)
- Signature of the staff member

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of job development services cannot exceed 6,240 units or 1,560 hours (average six hours/weekday) in combination with all other direct care services including participant-directed support, other day services, LPN, crisis intervention, and electronic monitoring.
- This service may not be billed concurrently with any other direct-support services.
- The ratios of staff members to member are 1:1
- Direct-support professionals providing Job Development services may not live in the home of the member.
- The amount of job development services must be identified on the IPP.
- Only members 18 years of age and over may access this service.
- Only BSPs or RN may bill for providing training to Job Development staff.

513.15.4 Supported Employment (Traditional Option)

Supported employment services provided by awake and alert staff 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. The services are designed to help individuals for whom competitive employment at or above the minimum wage is unlikely without such support and services and need ongoing support based upon the member's level of need. Supported employment services include, but are not limited to:

- Vocational counseling (example: discussion of the members' on-the-job work activities).
- 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 that are essential to obtain and keep 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 use of supported employment. Supported employment services must be supervised by a supported employment services supervisor or a BSP. In

addition to the standard training requirements, paraprofessionals providing supported employment must have documented training or experience in implementation of Supported Employment Plans of Instruction.

Providers of supported employment services may attend and take part in IDT meetings and the annual assessment of functioning for eligibility conducted by UMC if requested by the member or their legal representative.

Documentation is kept in the file of each member receiving this service that a referral was made to a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) before this service was provided.

Procedure Code: T2019 1:1 ratio

T2019HQ 1:2-4 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service must be provided in an integrated community work setting unless the member is self-employed and may not be provided in any setting owned or leased by an IDDW provider agency. An integrated setting requires that most of the member's co-workers in the setting do not have disabilities.

Documentation: Documentation must include the following:

- Member's name
- Service code (including modifier to indicate staff to member ratio)
- Date of service
- Start time
- Stop time
- Total time spent
- Task Analysis
- Transportation log (if applicable)
- Signature of the agency staff

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.

- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- Supported Employment may not be billed without documentation of a referral to the Division of Rehabilitation Services (DRS).
- Agency staff providing supported employment services may not be an individual who lives in the members' home.
- The maximum annual units of supported employment cannot exceed 8,320 units or 2080 hours in combination with all other direct-care services including Participant-Directed Support, other day services, LPN, crisis intervention, and electronic monitoring.
- This service may not be billed concurrently with any other direct care services.
- Group services for this service have an agency staff to member ratio of 1:2-4.

513.16 GOODS AND SERVICES

513.16.1 Participant-Directed Goods and Services (Participant-Directed Option, Personal Options Model

Participant-directed goods and services are services, equipment, or supplies not otherwise provided through this Waiver program or through the Medicaid State Plan that addresses an identified need in the IPP and meet the following requirements:

- An item or service that would decrease the need for other Medicaid services and/or promote full inclusion in the community and/or increase member's safety in the home environment.
- The member does not have the funds to purchase the item or service, or the item or service is not available through another source.
- This service cannot be accessed as a means of reimbursement for items or services that have already been obtained and not been pre-approved by the *Personal Options* F/EA
- Participant-directed goods and services are purchased from the participant-directed budget.
- Participant-directed goods and services item(s) requested must be supported by an assessed need identified on the annual functional assessment and the item(s) requested must be specifically documented in the IPP.
- Participant-directed goods and services item(s) must be pre-approved by the UMC, and purchase must be documented by receipts or other documentation of the goods or services from the established business or otherwise qualified entity or individual.
- The need must be documented on the annual IPP unless it is a new need which must be documented on a critical juncture IPP.

NOTE: All services must be based on assessed need and within a member's individualized budget. If the need was documented on the Annual IPP but not incorporated into the budget at that time and the member is over budget, then modifications of the services already purchased must occur before this authorization will be approved. If this is a new need, then it should be presented as a need to exceed the budget based on a new need.

Procedure Code: T2028SC

Service Units: Unit = $1.00

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: The goods or services are routinely provided at the member's residence or to the member as they take part in community activities.

Documentation:

- The specific item(s) must be documented in the IPP.
- Goods and services must be purchased from an established business or otherwise qualified entity or individual and must be documented by a dated and itemized receipt or other documentation.

Limitations/Caps:

- The amount of service is limited by the member's individualized participant-directed budget and spending plan. If a member is self-directing this service, then the amount of services that can be self-directed is limited by the participant-directed budget of the member.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 1000 units ($1,000) per member's IPP year in combination with Traditional and *Personal Options* EAA – Vehicle and Home.
- The *Personal Options* vendor must not pay PDGS funds to the member, staff, or family/legal representative. Payment for cost of services must be issued to the vendor of the participant-directed goods and services service.
- To access participant-directed goods and services, the member must also access at least one other type of participant-directed service during the budget year, i.e. participant-directed support or respite.
- Participant-directed goods and services monies may not be transferred into Family Person-Centered Supports: *Personal Options*, Respite; *Personal Options* or Transportation Miles; *Personal Options*

The following represents non-permissible goods and services:

- Goods, services and supports that are available through another source.
- Goods, services or supports provided to or benefiting persons other than the member.
- Room and board.
- Personal items and services not related to the qualifying disability.
- Gifts for workers/family/friends, payments to someone to serve as a representative.

- Clothing, (unless it is designed for a specific special need related to a member's qualifying diagnosis), food and beverages.
- Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the member's need. Appliances compliant with the American Disabilities Act (ADA) are not sufficient to meet this requirement.
- Air purifiers, humidifiers or air conditioners unless individual has a documented respiratory/allergy condition or diagnosis.
- Electronic entertainment equipment.
- Utility payments.
- Generators unless used for medical equipment only and cannot be for the entire house.
- Swimming pools, hot tubs and spas or any accessories, repairs or supplies for these items.
- Railings for decks and porches.
- Outdoor recreational equipment unless specifically adapted for the individual's needs.
- Costs associated with travel.
- Household furnishings such as comforters, linens, drapes and furniture.
- Furniture, unless it is designed to assist with a specific special need and related to the individual's diagnosis, such as a lift chair for someone with mobility issues.
- Vehicle expenses including running boards, routine maintenance and repairs, insurance and gas.
- Medications, vitamins, and herbal supplements.
- Illegal drugs or alcohol.
- Experimental or investigational treatments.
- Computers or monitors.
- Communication devices/tablets for children under the age of 21.
- Communication devices/tablets for adults over the age of 21 unless specifically recommended by a licensed speech therapist.
- Computer software.
- Fax machines.
- Copiers.
- Scanners.
- Printers or ink cartridges.
- Landline telephones or cell phones.
- Car seats and strollers which do not require modifications.
- Monthly internet subscriptions.
- Yard work.
- Household cleaning supplies.
- Home maintenance including paint and replacement of flooring, appliances, doors, furnaces, hot water tank, roof and windows (unless the item needs modified such as a window that is large enough for an adult to use to exit in case of a fire).
- Fences, gates, half-doors.
- Driveway or walkway repairs or supplies unless specifically to exit or enter home to and from vehicle.
- Covered awnings.
- Pet/pet care including service animals, veterinary bills, food and training.

- Respite and/or direct-care services (person-centered support, LPN, supported employment, facility-based day habilitation, etc.).
- Spa services.
- Public education or items needed for public educational purposes.
- Personal hygiene items.
- Summer camps.
- Day care.
- Discretionary cash.

Participant-directed goods and services is not intended to replace the responsibility of a parent or family member for goods and services typically or routinely purchased for individuals during their lifetime, regardless of disability. Additionally, participant-directed goods and services cannot replace the responsibility of the member, their family, or their landlord for routine maintenance and upkeep of the home. These include but are not limited to cleaning, painting, repair/replacement of roof, windows or flooring, structural repairs, air conditioning and heating, plumbing and electrical maintenance, fences, security systems, adaptations that add to the square footage of the home except when necessary to complete an approved adaptation, (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

513.17 PERSON-CENTERED SUPPORT

There are five types of Person-Centered Support services available under the Traditional Option and three types of Person-Centered Support services available under the *Personal Options* model. Each is described in detail in its specific section.

- Family Person-Centered Support - Traditional
- Home-Based Person-Centered Support - Traditional
- Licensed Group Home Person-Centered Support - Traditional
- Unlicensed Residential Person-Centered Support - Traditional
- Crisis Site Person-Centered Support – Traditional
- Person-Centered Support – *Personal Options*
- Provided by staff that do not live in the member's home
- Provided by staff that do live in the member's home
- Unlicensed Residential Person-Centered Support – *Personal Options*

513.17.1 Family Person-Centered Support

513.17.1.1 Family Person-Centered Support

Family person-centered support services can only be provided by family members or specialized family care providers living in the home with the person who receives services. For the purposes of providing services, family members include biological/adoptive parents or stepparents, biological/adoptive adult siblings or stepsiblings, biological/adoptive grandparents or step-grandparents, biological/adoptive aunts/uncles or step-aunts/uncles, and specialized family care providers only. Other relationships may be

considered with prior approval by the BMS; for example, a non-family member who lives in the home, such as a domestic partner of a member's parent.

Family Person-Centered Support is provided by awake and alert direct-support professionals and consists of individually tailored training and/or support activities that enable the member to live and participate in their community inclusively. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence and personal choice, and to allow for maximum inclusion in their community of choice.

Family person-centered support may be used to assist with the acquisition, retention, and/or improvement of the following areas of functionality:

- Self-care.
- Receptive or expressive language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for Independent Living.

Family person-centered support services must be assessment based and outlined on the IPP. Activities must allow the member to live and participate in the most integrated setting appropriate to their needs.

Family person-centered support services may include training specific to the member, attendance, and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC.

Procedure Code: S5125U5 1:1 ratio

S5125U6 1:2 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the family residence of the member, a specialized family care home, and/or in the local public community.

Documentation: Documentation must be completed on the Direct-Support Service Log (WV-BMS-IDD 07) to include the items listed below. If additional information is called for due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff member should complete the accompanying Direct-Support Progress Note to detail the issue. If training was provided, the staff must also complete the task analysis. The Direct-Support Service Log must include the following:

- Name of the member
- Direct care service provider name

- Month/Day/Year of service
- Service code (including modifier to indicate staff to member ratio)
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff member

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of family person-centered support services cannot exceed 7,320 units or 1,830 hours (based upon average of five hours per day) per IPP year for natural family/specialized family care home settings for members under age 18. This is in combination with all other types of person-centered support and crisis intervention. The maximum annual units of family person-centered support services cannot exceed 11,680 units or 2,920 hours (based upon average of eight hours per day) per IPP year for natural family/specialized family care home settings for members aged 18 and older. This is in combination with all other types of person-centered support, LPN, crisis intervention, and electronic monitoring. All direct-support services cannot exceed an average of 12 hours per day on days when facility-based day-habilitation, job development, pre-vocational, and/or supported employment services are provided.
- If the person is aged 18 or older and still attending public school, then the limits of 7,320 15-minute units per IPP year will apply.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff members to members who receive services are 1:1 and 1:2 for this service.
- The amount of family person-centered support provided must be identified on the IPP.
- Family person-centered support is not available while the member is hospitalized in a Medicaid certified hospital except for members who live in a specialized family care home when behavioral needs of the member arise due to the temporary change in environment.
- Family person-centered support is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities found either within or outside of a medical hospital.
- Family person-centered support cannot replace the routine care, and supervision which is expected to be provided to biological, adoptive or foster children or adults by a parent or a specialized family care provider.
- Family person-centered support may not substitute for federally mandated educational services.
- Spouses are excluded from providing family person-centered support services.

513.17.1.2 Person-Centered Support (Personal Options Model)

Person-Centered Support: *Personal Options* is provided by awake and alert staff and consist of individually tailored training and/or support activities that enable the member to live and inclusively take part in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence and personal choice, and to allow for maximum inclusion in their community of choice.

Person-Centered Support: *Personal Options* services are available to members living in the family home of the member and specialized family care homes.

Person-Centered Support: *Personal Options* may be used to help with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care.
- Receptive or expressive language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

Person-Centered Support: *Personal Options* services must be assessment based and outlined on the members' spending plan. Activities must allow the member to live and participate in the most integrated setting appropriate to their needs.

Person-Centered Support: *Personal Options* services may include training specific to the member. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is permitted, if requested by the member or their legal representative.

Procedure Code: S5125UA 1:1 ratio (provided by staff that do not live in the member's home)
S5125UAUK 1:1 ratio (provided by staff that live in the member's home)

Service Units: Unit = 15 minutes

Prior Authorization: All units of Person-Centered Support – *Personal Options* are purchased and authorized under the S5125UA service code. The F/EA vendor will be responsible for claiming services provided by staff that live in the members' home by including the UK modifier on service claims.
All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the family residence of the member, a specialized family care home, and/or in the local public community.

Documentation: The staff member must document the hours provided per day to the member. The documentation must be specific to the service and must include:

- Name of the member
- Month of service
- Year of service
- Day of service
- Total time spent
- Transportation Log including beginning location (from), end location (to) and total number of miles for the trip
- Signature of the staff member and the member and representative (when applicable)

If a BSP is involved in training plans conducted by the staff member, documentation is completed through those training plans per the IPP. This documentation must be kept by the member/employer and provided to the BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units Person-Centered Support: *Personal Options* services are limited to the equivalent monetary value of 7,320 units or 1,830 hours (based upon average of five hours per day) of traditional family person-centered support per IPP year for members under age 18 when transferring funds from the annual budget allocation to the participant-directed budget. This is in combination with all other types of person-centered support and crisis intervention.
- The maximum annual units of Person-Centered Support: *Personal Options* services are limited to the equivalent monetary value of 11,680 units or 2,920 hours (based upon average of eight hours per day) of traditional family person-centered support per IPP year for members aged 18 and older when transferring funds from the annual budget allocation to the participant-directed budget. This is in combination with all other types of person-centered support, LPN, crisis intervention, and electronic monitoring.
- If the person is still attending public school, then the limits of 7,320 15-minute units per IPP year will apply.
- Units/funds of authorized person-centered support: *Personal Options* may not be used to access additional extended professional therapies: *Personal Options*, EAA- Vehicle and Home: *Personal Options* or participant-directed goods and services.
- All direct-support services cannot exceed the equivalent monetary value of an average of 12 hours per day on days when facility-based day habilitation, job development, pre-vocational, and/or supported employment services are provided.
- The equivalent monetary value for respite services cannot be used to access additional person-centered support: *Personal Options* services; however, if additional respite units are needed, the equivalent monetary value of person-centered support: *Personal Options* services may be used to access additional respite services.
- The equivalent monetary value for person-centered support: *Personal Options* services may be used to increase respite: *Personal Options* but cannot be used to increase transportation:

Personal Options, EAA: *Personal Options*, dietary therapy: *Personal Options*, occupational therapy: *Personal Options*, speech therapy: *Personal Options*, physical therapy: *Personal Options* or participant-directed goods and services.

- This service may not be billed concurrently with any other direct support service.
- The ratio of staff member to member is 1:1 for this service.
- Person-centered support: *Personal Options* is not available while the member is hospitalized in a Medicaid certified hospital except for members who live in a specialized family care home when the behavioral needs of the member arise due to the temporary change in environment.
- Person-centered support: *Personal Options* is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities found either within or outside of a medical hospital.
- Person-centered support: *Personal Options* cannot replace routine care and supervision, which is expected to be provided to biological, adoptive or foster children or adults by a parent or a specialized family care provider.
- Person-centered support: *Personal Options* may not substitute for federally mandated educational services.
- A member's representative may not be a paid employee providing *Personal Options* IDDW services to the member.
- Spouses are excluded from providing person centered support: *Personal Options* services.

513.17.2 Home-Based Agency Person-Centered Support

513.17.2.1 Home-Based Agency Person-Centered Support (Traditional Option

Home-based agency person-centered support is provided in the home of the member, in a specialized family care home, and/or in the local public community by agency direct-support professionals who **do not live in the members' home**. Home-based agency person-centered support is provided by awake and alert direct-support professionals and consists of individually tailored training and/or support activities that enable the member to live and inclusively participate in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Home-based agency person-centered support services may be used to help with the acquisition, retention, and/or improvement of the following areas of functionality:

- Self-care.
- Receptive or expressive language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent General Education Development (GED). Information about the AMAP program requirements may be found in WV Code Ch.16B-10 and on the OHFLAC website.

Home-based agency person-centered support services must be assessment based and outlined on the IPP. Activities must allow the member to live and participate in the most integrated setting appropriate to their needs and within their individualized budget.

Home-based agency person-centered support services may include training specific to the member. Home-based agency person-centered support direct-support professionals may compile data collected in daily documentation during their shift for later review by the BSP, if safety/health and oversight of the member are not compromised.

Home-based agency person-centered support direct-support professionals may attend and take part in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the member or their legal representative.

Procedure Code: S5125U7 1:1 ratio
S5125U8 1:2 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the family residence of the member, a specialized family care home, and/or in the local public community. This service may not be provided in a direct-support professional's home. This service may not be billed while a member is working or volunteering at a provider-owned/controlled site.

Documentation: Documentation must be completed on the Direct-Support Service Log (WV-BMS-IDD 07) to include the items listed below. If additional information is called for due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff member should complete the accompanying Direct-Support Progress Note to detail the issue. If training was provided, the staff must also complete the task analysis. The Direct-Support Service Log must include the following:

- Name of the member
- Month of service
- Year of service
- Day of service
- Service code (including modifier to indicate staff to member ratio)
- Start time

- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff member

Home-based agency Person-Centered Support Direct-Support Professionals will be subject to usage of EVV and all corresponding requirements.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of home-based agency person-centered support services cannot exceed 7,320 units or 1,830 hours (based upon average of five hours per day) per IPP year for natural family/specialized family care home settings for members under age 18. If the person is still attending public school, then the limits of 7,320 15-minute units per IPP year will apply. This is in combination with all other types of person-centered support and crisis intervention.
- The maximum annual units of home-based agency person-centered support services cannot exceed 11,680 units or 2,920 hours (based upon average of eight hours per day) per IPP year for natural family/specialized family care home settings for members aged 18 and older. This is in combination with all other types of person-centered support, LPN, crisis intervention, and electronic monitoring. Direct support services cannot exceed an average of 12 hours per day on days when facility-based day habilitation, job development, pre-vocational, and/or supported employment services are provided.
- This service may not be billed concurrently with any other direct support service.
- The ratios of staff members to member are 1:1 and 1:2 for this service.
- The amount of home-based agency person-centered support provided must be identified on the IPP.
- Direct-support professionals providing home-based agency person-centered support services may not live in the home of the member.
- Home-based agency person-centered support is not available while the member is hospitalized in a Medicaid-certified hospital, except for members who live in an unlicensed residential home, licensed group home or specialized family care home when behavioral needs of the member arise due to the temporary change in environment.
- Home-Based Agency Person-Centered Support is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities found either within or outside of a medical hospital.
- Home-Based Agency Person-Centered Support services cannot replace the routine care, and supervision which is expected to be provided to biological, adoptive or foster children or adults by a parent or specialized family care provider. The IDT must make every effort to meet the

assessed needs as identified on the annual functional assessment, of the member through natural supports.
- Home-based agency person-centered support may not substitute for federally mandated educational services.
- Spouses are excluded from providing home-based agency person-centered support services.

513.17.3 Licensed Group Home Person-Centered Support (Traditional Option)

Licensed group home person-centered support is provided to adults aged 18 and older who live in a site licensed by the Office of Health and Health Facility Licensure and Certification (OHFLAC) by awake and alert direct-support professionals and consists of individually tailored training and/or support activities that enable the person who receives services to live and inclusively participate in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the person who receives services to have greater independence and personal choice, and to allow for maximum inclusion into their community.

This service is limited to not more than four individuals per setting. Eight licensed group homes have been grandfathered in under the new Integrated Settings Rule, and these eight sites may continue to serve more than four individuals. Contact the BMS for a list of those specific sites.

Licensed group home, person-centered support may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care.
- Receptive or expressive language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED. Information about the AMAP program requirements may be found in WV Code Ch.16B-10 and on the OHFLAC website. Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED. licensed group, person-centered support services must be assessment based and outlined on the IPP. Activities must allow the member to reside and participate in the most integrated setting appropriate to their needs.

Licensed group home, person-centered support services may include on-site training specific to the member. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is allowed if requested by the member or their legal representative.

Licensed group home person-centered Support direct-support professionals may compile data collected in daily documentation during their shift for later review by the BSP, if safety/health and oversight of the member are not compromised.

Staff providing licensed group home, person-centered support cannot be a family member of the member. For the purposes of providing licensed group home, person-centered support services, family members include biological/adoptive parents or stepparents, biological/adoptive adult siblings or stepsiblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/uncles only. Spouses of members are also excluded from providing services.

Procedure Code:	S5125U1 1:1 ratio
	S5125U2 1:2 ratio
	S5125U3 1:3 ratio
	S5125U4 1:4 ratio
	S5125U1 AMAP 1:1 ratio
	S5125U2 AMAP 1:2 ratio
	S5125U3 AMAP 1:3 ratio
	S5125U4 AMAP 1:4 ratio
Service Units:	Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in a group home licensed by OHFLAC and/or in the local public community.

Documentation: Documentation must be completed on the Direct-Support Service Log (WV-BMS-IDD 07) to include the items listed below. If additional information is called for due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff member should complete the accompanying Direct-Support Progress Note to detail the issue. If training was provided, the staff member must also complete the task analysis.

The Direct-Support Service Log must include the following items:

- Name of the member
- Case management provider name
- Month/Day/Year of service
- Service Code (including modifier to indicate staff to member ratio)
- Start time

- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff member

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to adults aged 18 and older.
- The maximum annual units of licensed group home person-centered support services cannot exceed 35,040 units or 8,760 hours (based upon average of 24 hours per day) per IPP year. This is in combination with all other types of person-centered support, LPN, crisis intervention, facility-based day habilitation, pre-vocational, job development, supported employment, and electronic monitoring.
- All requests for more than an average of 12 hours per day of 1:1 service require the BMS approval. Approval of this level of service will be based on demonstration of assessed need not a particular residential placement.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff members to members are 1:1, 1:2, 1:3, and 1:4 for this service.
- The amount of licensed group home and person-centered support provided must be identified on the IPP.
- Licensed group home person-centered support is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities found either within or outside of a medical hospital.
- All people living together in one of these settings must be served by the same IDDW residential provider.

513.17.4 Unlicensed Residential Person-Centered Support

513.17.4.1 Unlicensed Residential Person-Centered Support

Unlicensed residential person-centered support is provided to adults aged 18 and older in an unlicensed residential home (formerly known as intensively supported setting or ISS) and/or in the local public community. Unlicensed residential person-centered support is provided by awake and alert direct-support professionals who do not live in the home with the member and consists of individually tailored training and/or support activities that enable the member to live and inclusively take part in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence and personal choice, and to allow for maximum inclusion into their community.

This service occurs in Intensively Supported Settings which are typically apartments or homes that are rented or leased by 1, 2 or 3 unrelated individuals (exceptions may be made for siblings). If the setting is owned or leased by an IDDW provider, then the person living there does not qualify for this code.

Unlicensed residential person-centered support may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care.
- Receptive or expressive language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

Staff members administering medications per the AMAP program must meet all requirements for that program which include having a high school diploma or the equivalent GED. Information about the AMAP program requirements may be found in WV Code Ch.16B-10 and on the OHFLAC website.

Unlicensed residential person-centered support services must be assessment based and outlined on the IPP. Activities must allow the member to live and participate in the most integrated setting appropriate to their needs and within their individualized budget.

Unlicensed residential person-centered support services may include on-site training specific to the member.

Unlicensed residential person-centered support direct-support professionals may compile data collected in daily documentation during their shift for later review by the BSP, if safety/health and oversight of the member is not compromised.

Unlicensed residential person-centered support direct-support professionals may attend and take part in IDT meetings and the annual functional assessment for eligibility conducted by the UMC if requested by the member or their legal representative.

Direct-support professionals providing unlicensed residential person-centered support cannot be a family member of the member. For the purposes of providing unlicensed residential person-centered support services, family members include biological/adoptive parents or stepparents, biological/adoptive adult siblings or stepsiblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step aunts/uncles only. Spouses of members are excluded from providing services.

Procedure Code: S5125HI 1:1 ratio

S5125UN 1:2 ratio

S5125UP 1:3 ratio

S5125U4 1:4 ratio

S5125HI AMAP: 1:1 ratio

S5125UN AMAP: 1:2 ratio

S5125UP AMAP 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in an Unlicensed Residential Home and/or in the local public community.

Documentation: Documentation must be completed on the Direct-Support Service Log (WV-BMS-IDD 07) to include the items listed below. If additional information is called for due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff member should complete the accompanying Direct-Support Progress Note to detail the issue. If training was provided, the staff member must also complete the task analysis. The Direct-Support Service Log must include the following:

- Name of the member
- Month/Day/Year of service
- Service Code (including modifier to indicate staff to member ratio)
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff member

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to adults aged 18 and older.
- The maximum annual units of unlicensed residential person-centered support services cannot exceed 35,040 units or 8,760 hours (based upon average of 24 hours per day) per IPP year. This is in combination with all other types of person-centered support, LPN, crisis intervention, facility-

based day habilitation, pre-vocational, job development, supported employment, and electronic monitoring.

- All requests for more than an average of 12 hours per day of 1:1 service requires BMS approval. Approval of this level of service will be based on demonstration of assessed need not on a particular residential setting.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff members to members are 1:1, 1:2, and 1:3 for this service.
- The amount of unlicensed residential person-centered support provided must be identified on the IPP.
- Unlicensed residential person-centered support is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities found either within or outside of a medical hospital.
- This service is limited to no more than three individuals per setting; note that, other than siblings, individuals must not be related.
- Unlicensed residential person-centered support cannot be provided in a setting owned or leased by an IDDW provider.
- All people residing together in one of these settings must be served by the same IDDW residential provider.

513.17.4.2 Unlicensed Residential Person-Centered Support (Personal Options Model)

Unlicensed residential person-centered support: *Personal Options* Model is provided to adults aged 18 and older in an unlicensed residential home and/or in the local public community. Unlicensed residential person-centered support: *Personal Options* is provided by awake and alert staff who **do not live in the home with the member** and consists of individually tailored training and/or support activities that enable the member to live and inclusively take part in their community. The activities and environments are designed to increase the acquisition of skills and appropriate behavior that are necessary for the member to have greater independence and personal choice, and to allow for maximum inclusion into their community.

Unlicensed residential person-centered support: *Personal Options* may be used to assist with the acquisition, retention and/or improvement of the following areas of functionality:

- Self-care.
- Receptive or expressive language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

Unlicensed residential person-centered support: *Personal Options* services must be assessment based and outlined on the IPP. Activities must allow the member to live and participate in the most integrated setting appropriate to their needs.

Unlicensed residential person-centered support: *Personal Options* services may include training specific to the member. Attendance and participation in IDT meetings and the annual functional assessment for eligibility conducted by the UMC is allowed if requested by the member or their legal representative.

Unlicensed residential person-centered support: *Personal Options* staff may compile data collected in daily documentation during their shift for later review by the BSP, if safety/health and oversight of the member are not compromised.

Staff providing unlicensed residential person-centered support: *Personal Options* cannot be a family member of the member. For the purposes of providing unlicensed residential participant-directed support services, family members include biological/adoptive parents or stepparents, biological/adoptive adult siblings or stepsiblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step aunts/uncles only. Spouses of members are excluded from providing services.

Procedure Code: S5125UD 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in an unlicensed residential home and/or in the local public community.

Documentation: The staff member must document the hours provided per day to the member. The documentation must be specific to the service and must include:

- Name of the member
- Month/Day/Year of service
- Total time spent
- Transportation Log including beginning location (from), end location (to) and total number of miles for the trip
- Signature of the staff member and the member and representative (when applicable)

If a BSP is involved in training plans conducted by the staff member, documentation is completed through those training plans per the IPP. This documentation must be kept by the member/employer and provided to the BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.

- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is limited to adults aged 18 and older.
- The maximum annual units of unlicensed residential person-centered support: *Personal Options* services cannot exceed 35,040 units or 8,760 hours (based upon an average of 24 hours per day) per IPP year. This is in combination with all other types of person-centered support, LPN, crisis intervention, facility-based day habilitation, pre-vocational, job development, supported employment, and electronic monitoring.
- All direct support services cannot exceed the equivalent monetary value of an average of 12 hours per day on days when facility-based day habilitation, job development, pre-vocational, and/or supported employment services are provided.
- All requests for more than an average of 12 hours per day of 1:1 service requires the BMS approval. Approval of this level of service will be based on demonstration of assessed need.
- This service may not be billed concurrently with any other direct care service.
- The ratio of staff member to member is 1:1 for this service.
- The amount of unlicensed residential person-centered support: *Personal Options* provided must be identified on the IPP.
- Units/funds of authorized unlicensed residential person-centered support: *Personal Options* may not be used to access additional extended therapies: *Personal Options*, EAA- Vehicle and Home: *Personal Options* or participant-directed goods and services.
- Unlicensed residential person-centered support: *Personal Options* is not available in nursing homes, psychiatric hospitals, correctional facilities, or rehabilitative facilities found either within or outside of a medical hospital.
- This service is limited to no more than three individuals per setting; note that, other than siblings, individuals must not be related.
- Unlicensed residential person-centered support: *Personal Options* cannot be provided in a setting owned or leased by an IDDW provider.

513.17.5 Crisis Site Person-Centered Support (Traditional Option)

Crisis site person-centered support services provided by awake and alert direct-support professionals specifically designed to provide temporary substitute care for an individual who need an alternative residential setting due to behavioral needs or lack of supports. Crisis site person-centered support is provided in a site licensed by the OHFLAC by awake and alert direct-support professionals. Sites must be either adult or child (no combination) and must serve only persons approved for IDDW. Training programs on the IPP may be implemented by direct-support professionals while the member is at the crisis site.

The services are to be utilized only in licensed crisis sites and used on a short-term basis not to exceed a maximum stay of 30 calendar days per admission without prior authorization from the UMC. During the service year, the duration of a crisis site stay may not exceed a total of 180 calendar days, and prior authorization may be provided for up to six months at a time. If crisis services are authorized beyond 30 calendar days, the IDT must meet to review and monitor the utilization of crisis services monthly to ensure that the individual's needs are being met. The IDT must also review the individual's behavior support plan

and evaluate whether additional services and supports are necessary to meet the individual's behavioral needs.

The purpose of authorizing crisis services for up to six months at a time is to ensure that individuals have access to necessary services and supports to minimize use of emergency department services and in-patient psychiatric hospitalization. Individuals may access crisis support services intermittently, as needed, without the need to seek repeated authorizations which could affect timely access to care. However, the IDT must closely monitor the use of intermittent crisis-site person-centered support to ensure that services are provided per the person-centered plan and behavior support plan.

Crisis site services usually occur after a Critical Juncture in treatment and must be approved by the IDT. If crisis site services are utilized due to an emergent need there must be a plan to transition the member back into the community developed at the time of admission by the case manager and the length of stay in the crisis site may not exceed 30 calendar days per admission.

Crisis site facilities are listed on the IDDW Provider Reference Guide. Case managers must contact individual sites to determine availability for admission.

The referral packet to the crisis site must include the IPP that identifies the services to be provided and assessments as appropriate. The case manager must send form WV-BMS-IDD-12 to the UMC within 72 hours.

Direct-support professionals may compile data collected in daily documentation during their shift for later review by the BSP, if safety/health and oversight of the member are not compromised.

Procedure Code: T1005U7 1:1 ratio
T1005U8 1:2 ratio
T1005U9 1:3 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Under emergent circumstances that place the health and safety of the member at risk, this service may be immediately implemented without prior authorization up to a maximum of 72 hours.

Site of Service: This service may only be provided in sites that are licensed by the OHFALC as crisis sites.

Documentation: Documentation must be completed on the Direct-Support Service Log (WV-BMS-IDD-07) to include the items listed below. If additional information is called for due to unusual or unforeseen

circumstances related to behavioral, medical, social, habilitation or other issues the staff member should complete the accompanying Direct-Support Progress Note to detail the issue. The Direct-Support Service Log must include the following items.

- Name of the member
- Month/Day/Year of service
- Service code (including modifier to indicate staff to member ratio)
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff member

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- Prior authorization may be provided for up to 17,520 units or 4380 hours (based upon an average of 24 hours per day for 180 calendar days) at a time.
- The maximum annual units of crisis site services may not exceed 17,280 units or 4,320 hours (based upon an average of 24 hours per day for 180 calendar days) per IPP year. This is in combination with person-centered support, day services, LPN, crisis intervention and electronic monitoring.
- An equivalent reduction in other authorized direct-support professional services must be made in the UMC's portal to offset the number of units of crisis site services requested.
- Form WV-BMS-IDD-12 must be sent by the case manager to the UMC within 72 hours of admission.
- The ratios of staff members to member are 1:1, 1:2, and 1:3 for this service.
- This service may not be billed concurrently with any other direct support service.
- Crisis site services must be prior authorized by the UMC. Under emergent circumstances which place the health and safety of the member or others at risk, Crisis site services may be immediately implemented without prior authorization up to a maximum of 72 hours.

513.18 RESPITE

There are two types of respite services available under the Traditional Option, each of which is described in detail in its specific section. Not all forms of respite are paid services. The two types are:

1. In-home respite*
2. Out-of-home respite*

*Denotes that this service may be participant-directed through the *Personal Options* Model.

513.18.1 In-Home Respite

513.18.1.1 In-Home Respite (Traditional Option)

In-Home Respite services provided by awake and alert direct-support professionals are specifically designed to provide temporary substitute care normally provided by a family member or a specialized family care provider. The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the member, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the member is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver.

In-Home Respite services may be used to:

- Allow the primary caregiver to have planned time from the caretaker role.
- Help the primary caregiver in crisis and emergency situations.
- Ensure the physical and/or emotional well-being of the primary caregiver by temporarily relieving them of the responsibility of providing care.
- Support the member while the primary caregiver works outside the home.

Direct-support professionals providing In-Home Respite services may attend and take part in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the member or their legal representative.

In-home respite direct-support professionals are subject to usage of EVV and all corresponding requirements.

Procedure Code: T1005UA 1:1 ratio
T1005UB 1:2 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the family residence of the member, a specialized family care home where the member lives, and public community locations.

Documentation: Documentation must be completed on the Direct-Support Service Log (WV-BMS-IDD-07) to include the items listed below. If additional information is called for due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff member should complete the accompanying Direct-Support Progress Note to detail the issue. The Direct-Support Service Log must include the following:

- Name of the member
- Month/Day/Year of service
- Service code (including modifier to indicate ratio of staff to member)
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff member

If a BSP is involved in training plans conducted by the Respite staff member, documentation is completed through those training plans per the IPP. This documentation must be kept by the member/employer and provided to the BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of In-Home Respite service may not exceed 3,650 units or 912 hours (based upon average of 2.5 hours/ day) per IPP year. This is in combination with out-of-home respite, in-home respite: *Personal Options*, and out-of-home respite: *Personal Options*.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff member to member are 1:1 and 1:2 for this service.
- The amount of in-home respite must be identified on the IPP.
- In-home respite is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities found either within or outside of a medical hospital.
- In-home respite services are not available to members living in unlicensed residential home or licensed GH settings.
- In-home respite services may not be provided by a spouse of a member or any other individual living in the member's home.
- In-home respite services are not to replace natural supports and cannot be provided by biological or adoptive parents or stepparents.
- In-home respite services may not be provided in an ICF/IID facility.
- The primary caregiver may not provide respite for any other member while the member the primary caregiver is responsible for is also receiving services. For example: Primary Caregiver A

is responsible for Member B. Primary Caregiver C is responsible for Member D. Primary Caregiver A cannot provider respite to Member D while Primary Caregiver C provides respite for Member B.

513.18.1.2 In-Home Respite (Personal Option Model)

In-home respite: *Personal Options* services provided by awake and alert staff are specifically designed to provide temporary substitute care normally provided by a family member or a specialized family care provider. Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the member, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the member is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver. Not all forms of respite are paid services.

Anytime the primary caregiver can get a break from providing care, then this is a form of respite. The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. In-home respite: *Personal Options* services consist of temporary care services for an individual who cannot provide for all their own needs. Members providing in-home respite: *Personal Options* services may take part in person-centered planning.

In-home respite: *Personal Options* services may be used to:

- Allow the primary caregiver to have planned time from the caretaker role.
- Help the primary caregiver in crisis and emergency situations.
- Ensure the physical and/or emotional well-being of the primary caregiver by temporarily relieving them of the responsibility of providing care.
- Support the member while the primary caregiver works outside the home.

Staff providing in-home respite: *Personal Options* services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the member or their legal representative.

In-home respite direct support professionals are subject to usage of EVV and NPI number use and all corresponding requirements.

Procedure Code: T1005UD 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the members' individualized budget unless an exception has been approved as described in Section 513.25.4.2. The annual budget for participant-directed services is determined following the purchase of Traditional services.

Site of Service: This service may be provided in the family residence of the member, a specialized family care home where the member lives, and/or public community locations.

Documentation: The staff member must document the hours provided per day to the member. The documentation must be specific to the service and must include:

- Name of the member
- Month/Day/Year of service
- Total time spent
- Transportation Log (when applicable) includes beginning location (from), end location (to) and total number of miles for the trip
- Signature of the staff member and the member and representative (when applicable)

If a BSP is involved in training plans conducted by the respite staff member, documentation is completed through those training plans per the IPP. This documentation must be kept by the member/employer and provided to the BSP as needed for oversight of training programs.

Limitations/Caps:

- The amount of service is limited by the individualized participant-directed budget and spending plan.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of in-home respite: *Personal Options* services are limited to the equivalent monetary value of 3,650 units or 912 hours (based upon average of 2.5 hour per day) per IPP year. This is in combination with out-of-home respite, in-home respite, and out-of-home respite: *Personal Options*.
- This service may not be billed concurrently with any other direct-support service.
- The ratio of staff member to member is 1:1 for this service.
- The amount of in-home respite: *Personal Options* must be identified on the IPP.
- In-home respite service units/funds may not be transferred to access additional units of any other *Personal Options* service except out-of-home respite: *Personal Options*.
- Staff providing in-home respite: *Personal Options* may not live in the home of the member or within the specialized family care home where the member lives.
- In-home respite: *Personal Options* is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities found either within or outside of a medical hospital.
- In-home respite: *Personal Options* services are not available to members living in unlicensed residential home or licensed group settings.
- In-home respite: *Personal Options* services are not to replace natural supports and cannot be provided by biological, adoptive or stepparents.
- In-home respite: *Personal Options* services may not be provided in an ICF/IID facility.
- The primary caregiver may not provide respite for any other member receiving services while the member the primary caregiver is responsible for is also receiving services. For example: Primary

Caregiver A is responsible for Member B. Primary Caregiver C is responsible for Member D. Primary Caregiver A cannot provider respite to Member D while Primary Caregiver C provides respite for Member B.

- The equivalent monetary value for in-home respite: *Personal Options* services cannot be used to access additional units of any other *Personal Options* service except for out-of-home respite: *Personal Options*.

513.18.2 Out-of-Home Respite

513.18.2.1 Out-of-Home Respite (Traditional Option)

Out-of-home respite services are provided out of the home where the individual lives and are provided by awake and alert direct-support professionals who are specifically designed to provide temporary substitute care normally provided by a family member or a specialized family care provider. Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the member, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the member is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver. Not all forms of respite are paid services. Anytime the primary caregiver can get a break from providing care, then this is a form of respite.

The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Out-of-home respite services consist of temporary care services for an individual who cannot provide for all their own needs. Persons providing out-of-home respite services may participate in person-centered planning.

Out-of-home respite services may be used to:

- Allow the primary caregiver to have planned time from the caretaker role.
- Help the primary caregiver in crisis and emergency situations.
- Ensure the physical and/or emotional well-being of the primary caregiver by temporarily relieving them of the responsibility of providing care.
- Support the member while the primary caregiver works outside the home.

Direct-support professionals providing out-of-home respite services may attend and participate in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the member or their legal representative.

Procedure Code:	T1005U1 1:1 ratio
	T1005U5 1:2 ratio
	T1005U6 1:3 ratio
Service Units:	Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service must be provided in a specialized family care home in which the member does not reside, licensed facility-based day programs, licensed pre-vocational centers, and/or public community locations.

Documentation: Documentation must be completed on the Direct-Support Service Log (WV-BMS-IDD-07) to include the items listed below. If additional information is called for due to unusual or unforeseen circumstances related to behavioral, medical, social, habilitation or other issues, the staff member should complete the accompanying Direct-Support Progress Note to detail the issue. The Direct-Support Service Log must include the following:

- Name of the member
- Month/Day/Year of service
- Service code (including modifier to indicate ratio of staff to member)
- Start time
- Stop time
- Total time spent
- Indication (Y/N) of whether training was provided
- Transportation Log including beginning location (from) and end location (to) and total number of miles for the trip
- Signature of the staff member
- Out-of-home respite direct-support professionals are subject to usage of EVV and NPI number use and all corresponding requirements.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of out-of-home respite service may not exceed 3,650 units or 912 hours (based upon average of 2.5 hours/ day). This is in combination with in-home respite, in-home respite: *Personal Options*, and out-of-home respite: *Personal Options*.
- This service may not be billed concurrently with any other direct care service.
- The ratios of staff member to member are 1:1, 1:2, and 1:3 for this service.
- The amount of out-of-home respite must be identified on the IPP.
- Out-of-home respite is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities found either within or outside of a medical hospital.
- Out-of-home respite services are not available to members living in an unlicensed residential home or licensed group home settings.

- Out-of-home respite services may not be provided by a spouse of a member or any other individual living in the home of the member.
- Out-of-home respite services are not to replace natural supports and cannot be provided by biological or adoptive parents or stepparents.
- Out-of-home respite services may not be provided in an ICF/IID facility.
- Out-of-home respite services may not be provided to individuals under 18 years of age in a Facility-Based Day Habilitation program or a pre-vocational center.
- The primary caregiver may not provide respite for any other member receiving services while the member the primary caregiver is responsible for is also receiving services. For example: Primary Caregiver A is responsible for Member B. Primary Caregiver C is responsible for Member D. Primary Caregiver A cannot provider respite to Member D while Primary Caregiver C provides respite for Member B.

513.18.2.2 Out-of-Home Respite (Personal Options Model)

Out-of-home respite: *Personal Options* services provided outside the home where the member lives by awake and alert staff is specifically designed to provide temporary substitute care normally provided by a family member or a specialized family care provider. Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the member, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the member is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver. Not all forms of respite are paid services. Anytime the primary caregiver can get a break from providing care, then this is a form of respite.

The services are to be used for relief of the primary caregiver(s) to help prevent the breakdown of the primary caregiver(s) due to the physical burden and emotional stress of providing continuous support and care to the dependent member. Out-of-home respite: *Personal Options* services consist of temporary care services for an individual who cannot provide for all their own needs. Persons providing out-of-home respite: *Personal Options* services may take part in person-centered planning.

Out-of-home respite: *Personal Options* services may be used to:

- Allow the primary caregiver to have planned time from the caretaker role.
- Help the primary caregiver in crisis and emergency situations.
- Ensure the physical and/or emotional well-being of the primary caregiver by temporarily relieving them of the responsibility of providing care.
- Support the member while the primary caregiver works outside the home.

Staff providing out-of-home respite: *Personal Options* services may attend and take part in IDT meetings and the annual functional assessment for eligibility conducted by UMC if requested by the member or their legal representative.

Procedure Code: T1005UC 1:1 ratio

Service Units: Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2. The annual budget for participant-directed services is determined following the purchase of Traditional services.

Site of Service: This service must be provided in a specialized family care home in which the member does not reside and/or public community locations.

Documentation: The staff member must document the hours provided per day to the member. The documentation must be specific to the service and must include:

- Name of the member
- Month/Day/Year of service
- Total time spent
- Transportation Log (when applicable) including beginning location (from), end location
- (to) and total number of miles for the trip
- Signature of the staff member and the member and representative (when applicable)

If a BSP is involved in training plans conducted by the respite staff member, documentation is completed through those training plans per the IPP. This documentation must be kept by the member/employer and provided to the BSP as needed for oversight of training programs.

Out-of-home respite Direct-Support Professionals will be subject to usage of the EVV and National Provider Identifier (NPI) number use and all corresponding requirements.

Limitations/Caps:

- The amount of service is limited by the individualized participant-directed budget and spending plan.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of out-of-home respite: *Personal Options* services are limited to the equivalent monetary value of Traditional Respite of 3,650 units or 912 hours (based upon average of 2.5 hour per day) per IPP year when transferring funds from the annual budget allocation to the participant-directed budget. This is in combination with out-of-home respite, in-home respite, and in-home respite: *Personal Options*.
- This service may not be billed concurrently with any other direct support service.
- The ratio of staff member to member is 1:1 for this service.
- The amount of out-of-home respite: *Personal Options* must be identified on the IPP.
- Out-of-home respite service units/funds may not be transferred to access additional units of any other Personal Options service except in-home respite: *Personal Options*.

- Out-of-home respite: *Personal Options* is not available in medical hospitals, nursing homes, psychiatric hospitals, correctional facilities or rehabilitative facilities found either within or outside of a medical hospital.
- Out-of-home respite: *Personal Options* services are not available to members living in an unlicensed residential home or licensed group home settings.
- Out-of-home respite: *Personal Options* services may not be provided by a spouse of a member or any other individual living in the home of the member.
- Out-of-home respite: *Personal Options* services are not to replace natural supports and cannot be provided by biological, adoptive or stepparents.
- Out-of-home respite: *Personal Options* services may not be provided in an ICF/IID facility.
- Out-of-home respite: *Personal Options* services may not be provided to individuals under 18 years of age in a Facility-Based Day Habilitation program or a Pre-Vocational Center.
- The primary caregiver may not provide respite for any other member while the member the primary caregiver is responsible for is also receiving services. For example: Primary Caregiver A is responsible for Member B. Primary Caregiver C is responsible for Member D. Primary Caregiver A cannot provider respite to Member D while Primary Caregiver C provides respite for Member B.

513.19 CASE MANAGEMENT

513.19.1 Case Management (Traditional Option)

Case management services establish, along with the member, a life-long, person-centered, goal-oriented process for coordinating the supports (both natural and paid), range of services, instruction and assistance needed by persons with developmental disabilities. It is designed to ensure accessibility, accountability and continuity of support and services. This service also ensures that the maximum potential and productivity of a member is used in making meaningful choices regarding their life and their inclusion in the community. All IDDW services purchased, however, must be within their annual individualized budget.

Once the member/legal representative has chosen a case management provider from the available IDDW providers, the agency assigns a case manager to the member. The member/legal representative may request the assignment of a specific case manager and when possible, the agency honors the request.

The member/legal representative may choose to transfer to a different case management provider for any reason, and the transfer will be effective on the first of the following month. The member will have choice of case management agency and choice of provider agency(s). Unless prior approval is granted, no case management agency may provide other HCBS for a member, whether those services are funded by Medicaid or another funding source. A case management agency may be approved to provide other HCBS services only when there is no other willing and qualified case management providers with capacity within a 25-mile radius of the member's home or there are no other willing and qualified case management providers who have a common language or cultural background with the member. Religion is not considered a reason for approval of a cultural background exception.

The case manager must inform the member or their legal representative of all licensed IDDW agency providers who serve the region where the member lives. This is to ensure the member, or their legal representative, have a free choice of providers. At the annual functional assessment, the UMC will inform the member and their legal representative of case management agencies that serve the county in which the member lives.

The following safeguards must be in place to ensure that service plan development is conducted in the best interests of the member when an IDDW agency has been approved to provide both case management and other HCBS to a member:

- The agency must have separate files for case management and other HCBS. It is the responsibility of the agency director to ensure separate file maintenance.
- The case management offices are in a separate location from the other HCBS (they may be in the same building but physically separated).
- There shall be no sharing of supervisory staff between the case management and HCBS.
- The case manager may not provide any other HCBS to the member.
- The case manager must have documentation from the BMS or their designee for the approved exemption request to provide other HCBS due to 25-mile radius, language or cultural background.
- West Virginia will monitor the conflict free services through quality reviews conducted by the Administrative Services Organization (ASO).
- Case managers must remain neutral during the development of the IPP and including the requirement that the IDD agency separate HCBS from case management services into distinct functions, with separate oversight.
- IDDW agencies must have a policy that includes how the agency ensures that the case manager is free from influence of other HCBS providers about member Plans of Care.
- Any case manager working for an agency that will also be providing other HCBS will sign a Conflict-of-Interest Assurance form, and the completed form must be placed in the case manager's personnel file. Failure to have the form in the file when reviewed will result in sanctions including disallowance of units billed.
- Evidence of administrative separation on an organizational chart that includes position titles and names of staff must be available to the BMS or their designee during quality reviews or request.
- The agency owner/administrator must also sign an Attestation/Conflict-of-Interest application for HCBS that includes, at a minimum, the following:
    - The agency has administrative separation of supervision of case management and HCBS.
    - Members are offered choice for HCBS between and among available service providers. Members are not limited to HCBS provided only by this agency.
    - Members are free to choose or deny HCBS without influence from case management or HCBS staff.
    - Members choose how, when, and where to receive their approved HCBS per the person-centered service planning process and plan.
    - Members are free to communicate grievance(s) about case management or HCBS delivered by the agency.

- The grievance/complaint procedure is available, clear and understood by members and legal representatives.
- Grievances/complaints are resolved promptly by giving the member the opportunity to file a grievance/complaint with the agency. If the grievance/complaint is not resolved, then the member is given the opportunity to present their case to the UMC for resolution.

Conflict-of-Interest standards and policy apply to all agents, individuals and agency entities, public or private. At a minimum, the agency case manager, and the agency owner cannot be related by blood or marriage to the member or to any paid caregiver of the member, cannot be financially responsible for the member, cannot be empowered to make financial or health decisions for the member, and cannot hold financial interest in any entity paid to provide services to the member. Failure to abide by Conflict-of-Interest policy and standards will result in the loss of case management certification for the provider involved in the conflict of interest for a period of one year and all current members being served by the suspended provider will be transferred to other case management agencies. Any case manager who knowingly violates Conflict of Interest policy or standards will be referred to their professional licensing board for a potential violation of ethics. (BMS notes that whether any action is taken would be within the sole discretion of the licensing board and depend upon its specific ethical rules). Reports of failure to abide by this Conflict-of-Interest policy will be investigated by the UMC, and the results of this investigation will be reported to the BMS for review and possible action. Additionally, cooperating agencies must have a Memo of Understanding (MOU) that addresses liability issues.

The case manager must, at a minimum, perform the following:

- Help the member and/or legal representative with re-determination of financial eligibility as required at the DoHS office in the county where the member lives.
- Begin the discharge process and provide linkage to services appropriate to the level of need when a member is found to be ineligible for IDDW services during annual eligibility or financial redetermination.
- Help with procurement of person-centered services that are appropriate and necessary for each member within and beyond the scope of the IDDW program including annual medical and other evaluations as applicable to the member.
- Function as an advocate for the member. The IDDW 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 case manager to advocate with these systems to obtain the required and appropriate services.
- Provide education, linkage and referral to community resources,
- Promote a valuable and meaningful social role for the member in the community while recognizing the member's unique cultural and personal value system.
- Interface with the UMC on behalf of the member about the assessment process, purchase of services and budget process. Activities may include linkage, negotiation of services, submission of information, coordination of choice of appropriate assessment respondents on behalf of the member, education and coordination of the most appropriate assessment setting that best meets the member's needs.

- Purchase services to obtain authorizations or change existing authorizations within seven days of the IDT meeting or team's approval of a service plan addendum.
- Communicate with other service providers on the IDT to allow for continuity of services and payment of services.
- Coordinate necessary evaluations to be used as a basis of need and recommendation for services in the development of the IPP.
- Coordinate with and notify IDT members at least one month in advance of meeting.
- Support the member as necessary to meet and conduct IDT meetings using person-centered thinking and planning strategies.
- Document all services, both paid and unpaid, from all programs on the IPP.
- Review schedules of all programs used by the member to ensure that times and tasks do not overlap or duplicate.
- Coordinate the development of IPPs at least annually. The IPP must be reviewed and approved by the IDT at least every three months unless otherwise specified in the plan but shall not exceed six months. NOTE: Services cannot be provided without a valid IPP. If an IDT cannot meet within required timeframes, an exception can be requested by submitting form WV-BMS-IDD-12 to the UMC. Exceptions will be approved for member-related reasons, such as hospitalization, illness, or other emergency. Without an approved exception, services may not be provided without an authorization.
- Access the necessary resources detailed in the IPP, make referrals to qualified service providers and resources, and monitor that service providers implement the instructional, behavioral and service objectives of the IPP.
- Disseminate copies of all IPPs, via secure electronic means, to the IDT members and Participant-Directed service Option providers (if applicable) within 14 calendar days of the IDT meeting.
- Upload any required documentation into the UMC's portal within 14 calendar days of the IDT meeting. NOTE: No services will be prior authorized until the current IPP is loaded into the portal.
- Upload into the UMC's portal any additional documentation requested by the BMS or the UMC.
- Disseminate copies of the budget sheet from the IDDW UMC's portal, once finalized.
- Monitor to ensure that the members' health and safety needs are addressed.
- Follow reporting requirements of the WV IMS for members on their caseload.
- Personally meet with members monthly who are living in a 24-hour setting and/or specialized family care setting. The members' paid or natural supports must be present with the member at the time of the visit. Verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented. The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identify unmet needs. Document the case manager Home/Day Visit using form WV-BMS-IDD-03.
- Meet quarterly in-person, and electronically other months with members living in a natural family setting, including their paid or natural supports, at the member's residence to verify that services are being delivered in a safe environment, in accordance with the IPP and appropriately documented. Case managers may meet more often with the individual due to changes in circumstances and/or the individual or family's needs and preferences. If there is a change in the individual member's needs, case managers must increase the frequency of contacts necessary to address and/or monitor until the area of concern is satisfactorily resolved.

- The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identify unmet needs. The visit is documented on the case manager Home/Day Visit Form (WV-BMS-IDD-03).
- Personally meet at least quarterly with the member and their support staff at the member's facility-based day program or vocational skills development center (if applicable). The purpose of these visits is to determine progress toward obtaining services and resources, assess achievement of training objectives, and identify unmet needs. The visit is documented on the case manager Home/Day Visit form (WV-BMS-IDD-03).
- The case manager is responsible for the development of the Crisis Plan which is to identify the entity/individual responsible for responding to each type of crisis reflected in the plan and notify all appropriate parties if a member is admitted to a crisis site or state institution.
- Process Freedom of Choice forms (WV-BMS-IDD-2) in the UMC's portal within two business days any time a member requests a change of case management agency, service provider agency, and/or service delivery models.
- Coordinate transfer/discharge meetings to ensure the linkage to a new case management agency, service provider agency, or service delivery Model and access to services when transferring services from one provider agency to another or to another type of service delivery model. Coordination efforts must continue by the current case management provider until the transfer of services is finalized.
- Travel as necessary to complete case management activities related to the IPP.
- Provide information and assistance regarding participant-directed services during annual IPP meetings and upon request by the member or legal representative.
- Inform the member, in writing, of their rights at least annually.
- Attend and take part in the annual functional assessment for eligibility conducted by UMC.
- Monitor any restrictive measures approved by the HRC to ensure the measures are implemented properly and reviewed at least annually by the HRC and by the IDT at every meeting.
- Attend and contribute to Futures Planning sessions, including, but not limited to, PATHs and MAPs.

Failure to carry out the required case management activities will result in sanctions against the agency including, but not limited to, a targeted review that may result in referral/admissions ban or reduction in case load size; and/or disenrollment as an IDDW provider.

Procedure Code: G9002U3 Case Management Natural Family & SFC

G9002U4 Case Management ISS & Group Home

Service Units: Unit = Per member/Per month

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in any setting that allows the case manager to complete all necessary duties for the member.

Documentation: A progress log for each service is required each month, including when any type of IDT meeting is held. Documentation must include all the following items.

- Case management agency
- Member name
- Date of service
- Start time
- Stop time
- Summary of the service provided
- Signature and credentials of the agency staff
- Service code

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 12 units or 12 events (one per month) per member's annual IPP year.
- A member may only have one case manager assigned at one time. In case of a transfer from one case management provider to another case management provider, the effective date of the transfer must fall on the 1st day of the month following the "transfer-to" agency's acceptance of the referral. The "transfer from" agency must finalize documentation related to member services but will not be able to bill during this time.
- Case management services can be billed while a member's status in The UMC's portal reflects "Member Hold - Extension" if needed. Appropriate documentation, either the IDD-3 and/or the Case Manager Log as applicable and must be kept.
- Agency staff providing case management services may not live in the member's home.
- Case management cannot be billed for the entire calendar month if a home visit does not occur within that calendar month unless an approved WV-BMS-IDD-12 is on file.
- The case management agency cannot provide any direct-care services for the member for whom they provide case management services.

513.20 SKILLED NURSING

513.20.1 Skilled Nursing Licensed Practical Nurse (Traditional Option)

LPN services listed in the service plan must be within the scope of West Virginia's Nurse Practice Act, ordered by a physician and are provided by an LPN under the supervision and monitoring of an RN actively licensed to practice in the State. LPN services are available to people who are aged 21 or older, as children with significant medical issues can access private duty nursing via the Medicaid State Plan.

This service can only be used for activities that require a nurse to complete according to the WV Nurse Practice Act, however, any medication administration and performance of health care maintenance tasks as described in W. Va. CSR §64-60-1 et seq. should be provided by a trained AMAP, when available. If the LPN performs these tasks, then the LPN must bill the appropriate direct care code for person-centered support or day services. Nursing services provided by an awake and alert LPN include but are not limited to:

- Verifying and documenting physician orders if only RNs or LPNs are administering medication (no AMAPS are administering medications);
- Ordering medications per physician orders;
- Reviewing and verifying physician orders are current, properly documented and communicated to direct-care staff and others per IDDW provider policy;
- Directing nursing care including medication/treatment administration unless the medications/treatments are described in W. Va. CSR § 64-60-1 et seq.;
- Reviewing Medication Administration Records (MARs), medication storage and documentation (when no AMAPs are administering medication);
- Reviewing scheduled medical appointments before occurrence and communicating this information to others per IDDW provider policy;
- Facilitating procurement and monitoring of medical equipment;
- Training members on individualized medical and health needs, such as wound care, medically necessary diets, etc.;
- Collecting medical data for RN assessment (seizure logs, sleep logs, food logs, etc.);
- Obtaining informed consent;
- Updating emergency sheets; and
- Consulting with the RN about member specific issues when a medical need arises.

Note: If these services are provided by an RN, then the LPN code must be billed for reimbursement unless it is a service that may be provided by an AMAP; then it must be billed at the person-centered support rate.

The Request for Nursing Service form (WV-BMS-IDD-09) must be sent to the UMC for prior authorization and must include a detailed list and schedule of all LPN activities that will be provided. Any activities that are not within the scope of LPN duties according to the Nurse Practice Act must be billed as person-centered support or respite.

The LPN may attend and take part in IDT meetings and the annual assessment of functioning for eligibility conducted by UMC at the request of the member or their legal representative.

Procedure Code:	T1003U4 1:1 ratio
	T1003U3 1:2 ratio
	T1003U2 1:3 ratio
Service Units:	Unit = 15 minutes

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the members' individualized budget unless an exception has been approved as described in Section 513.25.4.2. A complete and accurate DD-9 must be submitted to the UMC for all skilled nursing prior authorization requests. A checklist and instructions are provided on the IDDW website.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre-vocational center, crisis sites and public community locations.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- This service is only available for adults aged 21 and older. If an individual 18 years of age and older receives any type of Day Services or lives in an ISS or licensed group homes, then the service is available.
- This service can only be used for activities that require a nurse to complete according to the WV Nurse Practice Act.
- LPN services may not be billed if the service may be provided by an approved and available AMAP certified staff member.
- The maximum annual units of LPN services cannot exceed 2,920 units or 730 hours (based upon an average of two hours per day) per member's annual IPP year of which 240 units may be used to complete indirect tasks for individuals over the age of 18 and attending day services and/or residing in an ISS/group home setting. Indirect LPN services are those that are conducted that do not require direct contact with the person who receives services. These include, but are not limited to, scheduling doctor appointments, documenting physicians' orders, and completing Medication Administration Records. Under extraordinary circumstances documented on WV-BMS-IDD-09, the LPN units may be approved up to 11,680 units or 2920 hours (average eight hours/day) per member's annual IPP year or the monetary equivalent of eight hours of 1:1 LPN service when alternate LPN service ratios are used. This is in combination with person-centered support, day services, crisis intervention and electronic monitoring.
- All LPN services provided must be within the scope of practice for Licensed Practical Nurses. If an LPN provides a service that is not within the scope of the WV Nurse Practice Act (such as taking vital signs, providing personal hygiene, comfort, nutrition, ambulation and environmental safety and protection), it will be considered a person-centered support or respite service and must be billed as such.
- This service may not be billed concurrently with any other direct care services.
- Agency staff to member ratio codes are 1:1, 1:2 and 1:3.
- Staff members providing Skilled Nursing LPN services may not live in the member's home.
- LPN services may not be billed for completing administrative activities, including but not limited to:

- Attempting phone calls when the line is busy or leaving a message.
- Nursing assessments required by the IDDW provider but not the IDDW manual.
- Waiting at a physician's office.
- Conducting group training on general medical topics.
- Orientation training that is not member specific.
- Reviewing incident reports.
- Travel.

Documentation: A detailed progress note for each service is required. Documentation must include all the following items.

- Member's name
- Service code (including modifier to indicate staff to member ratio)
- Date of service
- Start time
- Stop time
- Total time spent
- Detailed summary of the service provided
- Signature and credentials of the agency staff

513.20.2 Skilled Nursing Licensed Registered Nurse (Traditional Nurse)

RN services listed in the service plan are within the scope of the West Virginia Nurse Practice Act, ordered by a physician and are provided by a licensed RN licensed to practice in the State. RN Skilled Nursing services are services which only a licensed RN can perform. The service must be provided by an RN under the direction of a physician. The RN may perform clinical supervision of LPN and AMAP staff. RN Skilled Nursing Services are restricted to those nursing services that are outside the scope and practice of an LPN. If the RN provides a Skilled Nursing service that is within the scope of practice for an LPN, the RN must use the LPN code.

The RN may also bill for training of unlicensed staff in the member's home, unlicensed residential home, licensed group home and Licensed Day program settings on the member's specific medical needs and related interventions as recommended by the member's treatment team. The RN may attend and take part in the IPP and the annual functional assessment for eligibility conducted by UMC based upon the member or their legal representative's request.

Direct-care services provided by the RN must be billed using the appropriate direct care service code. The RN may bill complete assessments if a member's medical need warrants an individualized assessment.

The RN must complete a summary of services provided, if needed by a change in the member's medical needs, such as Emergency Room visits, medication changes, diagnostic changes, new treatments recommended by physician, etc.

The RN may bill a consult with LPNs who are providing direct care when an urgent, member-specific medical need arises.

Skilled nursing medication administration is designed to support oversight of medication administration by unlicensed direct-support providers. Direct support staff are allowed to administer medications under West Virginia's AMAP program. AMAP staff are trained by OHFLAC approved registered professional nurses and must work under the supervision of an RN. The skilled nursing medication administration service is reimbursed at a flat, daily rate to help ensure RNs are reimbursed for providing supervision and training to AMAP staff, as needed. The skilled nursing medication administration service can also be billed when an RN must administer medications in the absence of certified, available AMAP staff.

Procedure Code:	T1002HI 1:1 ratio
Service Units:	Unit = 15 minutes
	Skilled Nursing
	Med Administration
Procedure Code:	T1003TE 1:1 ratio
Service Units:	Unit = Event (1x/day maximum)

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2. A complete and accurate WV-BMS-IDD-09 must be sent to the UMC for all skilled nursing prior authorization requests. A checklist and instructions are provided on the IDDW website.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre-vocational center, crisis sites and public community locations.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- 480 units or 120 hours per member's annual IPP year.
- The agency staff to member ratio for this service is 1:1.
- If the RN provides a skilled nursing service that is within the scope of practice for an LPN, the RN must use the LPN code/rate.
- Agency staff providing skilled nursing RN services may not live in the member's home.
- RN services may only be billed 30 calendar days prior to discharge for a member or applicant being discharged from a state institution, a medical hospital, rehabilitation hospital, a psychiatric facility, nursing home, ICF/IID or another West Virginia waiver program for planning purposes.

- Only RNs can bill for completing a WV-BMS-IDD-09.
- RN services may not be billed for completing administrative activities including but not limited to:
  - Attempting phone calls when the line is busy or leaving a message.
  - Nursing assessments required by the IDDW provider but not the IDDW manual.
  - Waiting at a physician's office.
  - Reading LPN notes.
  - Conducting group training on general medical topics.
  - Orientation training that is not member specific.
  - Reviewing incident reports.
  - Assessing LPN competency and providing support.
  - Travel

513.20.3 Skilled Nursing Licensed Registered Nurse, Individual Program Planning (Traditional Option)

This is a service that allows the RN to attend a member's IDT meeting in person or by video-conferencing to present assessments or evaluations completed for the purpose of integrating recommendations, training goals and intervention strategies into the member's IPP.

Individual program planning is the process by which the member and their IDT develop a plan based on a person-centered philosophy. The RN takes part in the IDT meeting for the purpose of reviewing assessments or evaluations, discussion of recommendations or individualized needs, identification of resources or methods of support, outlines of service options and training goals, and preparation of interventions or strategies necessary to implement a Person-Centered Plan.

Procedure Code: T2024TD 1:1 ratio

Service Units: Unit = Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be provided in the member's family residence, a specialized family care home, a licensed group home, an unlicensed residential home, a licensed day program facility or pre-vocational center, crisis sites and public community locations. The meeting cannot begin at one location and then be continued at another.

Documentation: Documentation must include signature, date of service and the total time spent at the meeting on the member's IPP and a separate progress note must also be completed.

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.

- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- Four events per member's annual IPP year.
- Professional must attend all planning meetings, either face-to-face or by teleconference, if billing the IPP code, the professional must be present for the entirety of IPP meeting. IPP cannot be billed for preparation prior, or follow-up performed after the IPP meeting.
- Staff providing Skilled Nursing RN IPP services may live in the member's home.
- Only one RN may bill for this service during an IDT meeting.

513.21 TRANSPORTATION

Members who receive IDDW services are required to access non-emergency medical transportation (NEMT) for non-IDDW Medicaid services, including doctor appointments. NEMT must be arranged through the state's contracted NEMT vendor. IDDW services, including mileage, cannot duplicate state plan services. As such, NEMT must be used when IDDW services are not being provided and for non-emergency visits that result in Medicaid transportation being used.

513.21.1 Transportation Miles (Traditional Option)

Transportation Miles: services are provided to the IDDW member for trips to and from the member's home, licensed IDD Facility-Based Day Habilitation program, pre-vocational centers, job development activities or supported employment activities, or to the site of a planned activity or service which is addressed on the IPP and based on assessed need identified on the annual functional assessment. This service may be billed concurrently with person-centered support services, respite, LPN, RN, supported employment and all day services.

Procedure Code: A0160U1

Service Units: Unit = 1 mile

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be billed to and from any activity or service outlined in the member's IPP and based on assessed need.

Documentation: Agency staff must complete the transportation log section of the Direct-Support Documentation form (WV-BMS-IDD-07) to include all the following items.

- Member's name
- Service code
- Date of service
- "From" location (Specific Site: example member's home)

- "To" location (Specific Site: example Beckley Walmart)
- Purpose of trip
- Total number of miles per trip

The members' IPP must specify the number of miles per service (ex. Up to 100 miles per month shall be used for transporting the member to and from his job location).

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum annual units of transportation: miles cannot exceed 9,600 miles per member's annual IPP year (based on average of 800 miles per month).
- Member must be present in vehicle if mileage is billed. If more than one member is present in the vehicle, then the total mileage will be divided between the number of members present in vehicle.
- Must be related to a specific activity or service based on an assessed need as identified on the annual function assessment and documented in the IPP.
- Transportation services (including non-emergency medical transportation) may be billed concurrently with direct support services, however, the IDT is responsible for identifying the level of support that an individual needs in the IPP, including the need for direct support when transported in an agency vehicle.
- May be used up to 30 miles beyond the West Virginia border by members living in a West Virginia county bordering another state.

513.21.2 Transportation Miles (Participant-Directed Option, Personal Options Model)

Transportation Miles: services are provided to the IDDW member for trips to and from the member's home, licensed IDD Facility-Based Day Habilitation program, pre-vocational, job development activities or supported employment activities, or to a community-based planned activity or service which is based on assessed need. This service may be billed concurrently with person-centered support services: *Personal Options* option or respite: *Personal Options* option. The number of miles per service must be included on the member's IPP.

Procedure Code: A0160U3

Service Units: Unit = 1 mile

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the members' individualized budget unless an exception has been approved as described

in Section 513.25.4.2. The annual budget for participant-directed services is determined following the purchase of Traditional Services.

Site of Service: This service may be billed to and from any activity or service outlined on the member's IPP and based on assessed need.

Documentation: The members' spending plan must specify the number of miles to be provided and Qualified Support Workers must document the provision of transportation on a transportation log that includes:

- Member's name
- Date of service
- "From" location (Specific Site: example member's home)
- "To" location (Specific Site: example Beckley Walmart)
- Purpose of trip
- Total number of miles for the trip

Limitations/Caps:

- The amount of service is limited by the member's Individualized Participant-Directed Budget and Spending Plan.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a critical juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The program representative may not bill for providing transportation services.
- The maximum annual units of transportation miles: *Personal Options* services are limited to the equivalent monetary value of Traditional Transportation Miles of 9,600 units (based upon average of 800 miles per month) per IPP year when transferring funds from the annual budget allocation to the participant-directed budget.
- The amount of transportation provided to a member directing their transportation services must be identified on the spending plan.
- The equivalent monetary value for transportation miles: *Personal Options* may be used to increase access to Person-Centered Support: *Personal Options* and Respite: *Personal Options*, but not participant-directed goods and services.
- Member must be present in vehicle if mileage is billed. If more than one member is present in the vehicle, then the total mileage will be divided between the number of members present in vehicle.
- Must be related to an assessed need identified on the annual functional assessment and documented in the IPP.
- May be used within 30 miles of the West Virginia border when the member is a resident of a county bordering the state of West Virginia.

513.21.3 Transportation Trips (Traditional Option)

Transportation services are provided to the IDDW member in the IDDW provider agency's owned or leased mini-van or mini-bus for trips to and from the member's home, licensed Facility-based Day

Habilitation program, pre-vocational center, job development activities or supported employment site or to the site of a planned activity or service which is addressed on the IPP and based on assessed need.

The agency mini-bus or mini-van must have proof of current vehicle insurance and registration inside the vehicle in addition to abiding by local, state and federal laws about vehicle licensing, registration and inspections.

Agency passenger mini-bus or mini-van must have had the original capacity to transport more than six passengers but less than 16 passengers.

Procedure Code: A0120HI

Service Units: Unit = 1 Event

Prior Authorization: All units of service must be prior authorized before being provided. Prior authorizations are based on assessed need identified on the annual functional assessment. Services must be within the member's individualized budget unless an exception has been approved as described in Section 513.25.4.2.

Site of Service: This service may be billed to and from any activity or service outlined on the member's IPP and based on assessed need as identified on the annual functional assessment.

Documentation: Agency staff must complete the transportation log section of the Direct-Support Documentation form (WV-BMS-IDD-07) and include the following:

- Member's name
- Service code
- Date of service
- "From" location (Specific Site: example member's home)
- "To" location (Specific Site: example Beckley Walmart)
- Purpose of trip

The members' IPP must specify the number of trips per service (ex. Up to 20 trips per month shall be used for transporting the member to and from his job location).

Limitations/Caps:

- The amount of service is limited by the member's individualized budget, unless approved through the exceptions process found in Section 513.25.4.2.
- If a member has a documented change in need after the annual functional assessment has been conducted, then a Critical Juncture IPP meeting must occur to discuss the need for additional services which may or may not be authorized.
- The maximum units of transportation trips cannot exceed two one-way trips per day or 520 trips annually.
- Member must be present in agency-owned mini-van or mini-bus if trips are billed.

- A trip must be related to a specific activity or service based on an assessed need identified on the annual functional assessment and documented in the IPP.
- A trip may be billed concurrently with person-centered support services, crisis services, respite and any day services. These services may not be provided by the driver of the vehicle.

513.22 PRIOR AUTHORIZATIONS

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the Provider Manual.

To receive payment from the BMS, a provider must follow prior authorization requirements. BMS in its sole discretion determines what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met. All services provided within the IDDW program must be authorized with the UMC. Services requiring prior authorization (refer to Section 513.5 Documentation and Record Retention Requirements as well as each service definition in this chapter) must be submitted to the UMC within 10 business days of the IDT meeting at which the services were chosen. The case manager is responsible for ensuring that all prior authorizations for all chosen IDDW providers are sent to the UMC.

513.22 BILLING PROCEDURES

Claims may be processed for less than a full unit of service. 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 must take place on the last date in the service range. Billing cannot be rounded more than once within a calendar month. **The billing period cannot overlap calendar months.**

- Medicaid is the payer of last resort. IDDW program providers 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. The case manager must inform the member, their family and/or legal representative of this requirement.
- Services may not be dated after the date of a member's death. Services must be provided and dated prior to the member's discharge date to be billed.
- Claims will not be honored for services regardless of the service code definition, provided outside of the scope of *Chapter 513, IDDW* policy manual or outside of the scope of federal regulations.

513.24 PAYMENTS AND PAYMENT LIMITATIONS

IDDW providers must comply with the payment and billing procedures and requirements described in *Chapter 600, Reimbursement Methodologies* of the Provider Manual.

Except for case management services, IDDW services may not be billed while an individual is inpatient at an ICF/IID facility, a state institution, nursing facility, rehabilitation facility, or psychiatric facility. Billing of case management, when a member is temporarily in a facility and/or has been placed on hold status to

facilitate returning to their home/community, is limited to three months unless additional case management units have been prior approved.

If a member is jailed or imprisoned, the service coordinator should submit an I/DD-12 to the UMC and request an eligibility extension. If the member has or will go a calendar month without accessing a direct-care service, the service coordinator must send an I/DD-12 to the UMC as soon as they become aware of the member's circumstances.

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

513.25 RIGHTS AND RESPONSIBILITIES OF MEMBERS/LEGAL REPRESENTATIVES

513.25.1 Rights

The member retains all rights afforded to them under the law and the following is a limited list of rights for a IDDW program member. Each member is informed of these rights by their IDDW provider case management agency upon enrollment and at least annually thereafter.

- Members and/or their legal representatives have the right to choose between home and community-based services as an alternative to institutional care and a choice of service delivery models by the UMC through the completion of a Freedom of Choice form (WV-BMS-IDD-2) upon enrollment in the program and at least annually thereafter.
- Members and/or their legal representatives have a choice of IDDW providers however, members must choose a case management agency that is separate from the agency(s) that provides other HCBS unless a geographic, cultural or language exception is granted.
- Members and/or their legal representatives have a choice of service delivery models.
- Members and/or their legal representatives have the right to address dissatisfaction with services through the IDDW provider's grievance procedure.
- Members directing their services through *Personal Options* will also have the right to address dissatisfaction with FMS. The *Personal Options* vendor must have a procedure for responding to and tracking member complaints.
- Members or their legal representatives have the right to access the Medicaid Fair Hearing process consistent with state and federal law.
- Members have the right to be free from abuse, neglect and financial exploitation.
- Members and/or their legal representatives have the right to be notified and attend all of their IDT meetings, including critical juncture meetings.
- Members and/or their legal representatives have the right to choose who they wish to attend their IDT meetings, in addition to those attendees required by regulations.
- Members and/or their legal representatives have the right to obtain advocacy.
- Members and/or their legal representatives have the right to file a complaint with the UMC about the results of their functional assessment.

- Members and/or their legal representatives have the right to have all assessments, evaluations, medical treatments, budgets and IPPs explained to them in a format they can understand, even if they have a legal representative making the final decisions about their health care.
- Members and/or their legal representative have the right to make decisions about their services.
- Members have the right to receive reasonable accommodations afforded to them under the ADA.

513.25.2 Responsibilities

The member and/or their legal representative, if applicable, have the following responsibilities:

- To be present during IDT meetings. In extremely extenuating circumstances, the legal representative or other team members may take part by teleconferencing if they do not bill for the time spent in the IDT. The member must be present and stay for the entire meeting if they do not have a legal representative.
- To understand that this is an optional program and that not all needs may be able to be met through the services available within this program and a member's annual individualized budget.
- To participate and supply correct information in the annual assessments for determination of medical eligibility and individualized budget.
- To purchase services within their annual individualized budget or use natural or unpaid supports for services unable to be purchased, except to the extent services more than the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.
- To take part in re-determination of financial eligibility at their local West Virginia DoHS as required.
- To follow all IDDW policies including routine home visits by the case manager.
- To implement the portions of the IPP for which they have accepted responsibility.
- To maintain a safe home environment for all service providers.
- To provide their case manager with income information so financial eligibility can be monitored.
- To notify their case manager immediately if the member's living arrangements change, the member's needs change, the member is hospitalized or if the member needs to have a critical juncture meeting.

Failure to follow these responsibilities may jeopardize the members' continuation of IDDW services.

513.25.3 Grievances/Complaints

A member receiving services has the right to obtain oral and written information on the provider agency's (or F/EA if self-directing) rights and grievance policies. If the member or their legal representative is dissatisfied with the quality of services or the provider of service, it is recommended that they follow the IDDW provider agency's grievance process. If the issue is not resolved at this level, the member or legal representative may file a formal complaint with the UMC. The UMC will complete an investigation and report the results to the BMS and to the member or their legal representative.

513.25.4 Appeals and Service Authorizations

If a member is determined not to be medically eligible, then the UMC sends by certified mail to the member or their legal representative which includes a written Notice of Decision (termination) and a Request for Hearing form that includes free legal resources and the results of the functional assessment. A notice is also sent to the member's case manager through the UMC's portal. The termination may be appealed through the Medicaid Fair Hearing process if the Request for Hearing form is sent to the Board of Review within 90 calendar days of receipt of the Notice of Decision. If the member or their legal representative wish to continue existing services throughout the appeal process, the Request for Hearing form must be given within 13 calendar days of the member or their legal representative's receipt of the Notice of Decision. If the Request for Hearing form is not sent within 13 calendar days of receipt of the Notice of Decision, reimbursement for all IDDW services will cease.

After filing a request for a Medicaid Fair Hearing, the member receiving services, or their legal representative may also request a second medical evaluation (IPE). The second medical evaluation must be completed within 60 calendar days by a member of the IPN. The case manager, upon notification of the eligibility decision, must begin the discharge process by arranging for a Transfer/Discharge IDT meeting to develop a "backup" plan for transition because reimbursement for IDDW services will cease on the 13th day after receipt of the written Notice of Decision letter if the member or their legal guardian does not submit a Request for Hearing form.

If the member is again denied medical eligibility based on the second medical evaluation, the member or their legal representative will receive a written Notice of Decision, a Request for a Fair Hearing form and a copy of the second medical evaluation by certified mail from the UMC. The member's case manager will also receive a notice through the UMC's portal. The member or their legal representative may appeal this decision through the Medicaid Fair Hearing process if the Request for Hearing form is sent to the Board of Review within 90 calendar days of receipt of the Notice of Decision.

A pre-hearing conference may be requested by the member or their legal representative any time prior to the Medicaid Fair Hearing and the UMC will schedule. If the member or their legal representative has obtained legal counsel, the BMS legal counsel will conduct the pre-hearing. At the pre-hearing conference, the member and/or their legal representative and a representative from the MECA will review the information sent for the medical eligibility determination and the basis for the termination.

If the denial of medical eligibility is upheld by the hearing officer, services that were continued during the appeal process must cease on the date of the hearing decision. If the member is eligible financially for Medicaid services without the IDDW program, other services may be available for the individual. If the termination based on medical eligibility is reversed by the hearing officer, the individual's services will continue with no interruption.

The member and/or their legal representative shall have the right to access their medical evaluation (IPE) used by the MECA in making the eligibility decision and copies shall be provided free of charge.

513.25.4.2 Service Authorization Process

The UMC will conduct the functional assessment up to 90 calendar days prior to each member's anchor date. At the time of the annual functional assessment by the UMC, each member or legal representative

must complete the Freedom of Choice form (WV-BMS-IDD-2) indicating their choice of level of care settings, case management agency, other providers of IDDW services and service delivery models. If the member has a legal representative that did not attend the Annual Functional Assessment and complete the Freedom of Choice form (WV-BMS-IDD-2), then it is the responsibility of the case manager to obtain the signature of the legal representative prior to or at the annual IPP.

If determined medically eligible, the member or their legal representative and case management provider will receive an individualized budget calculated pursuant to the methodology which is available on the BMS website

Once the member's budget has been calculated, the member will receive a notice each year that sets forth the member's individualized budget for the IPP year and an explanation for how the individualized budget was calculated.

The UMC, the member, the legal representative, the case manager, and any other members of the IDT that the member wishes to be present will attend the annual assessment. The UMC will work with the member and his or her team to complete the standardized functional assessment.

The member and/or their legal representative shall sign an acknowledgment that they took part in the assessment and were given the opportunity to review and concur with the answers recorded during the assessment. If the member or their legal representative declines to sign the acknowledgment for any reason (e.g., member/legal representative does not believe the answers were recorded accurately), the member or their legal representative shall notify the UMC through their case manager within five business days of the assessment date, and the UMC shall resolve the issue by conferring with the member and/or their legal representative to come to an agreement on the answers on the assessment. If the member or their legal representative still disputes the answers on the assessment, then the issue can be appealed through a Medicaid Fair Hearing. The Assessment Data Modification Request form (WV-BMS-IDD-13) must be fully completed and must cite the items in question.

The member will receive notice of their budget calculation, which will include an explanation for how the budget was calculated and instructions for seeking services that cost more than the budgeted amount. The budget calculation is not a decision about the services the member will be eligible to receive.

The IDT must initially make every effort to purchase services for the member within the budget allocated by the UMC. As part of this effort, the IDT should consider, among other things, substituting less expensive services for more expensive services; accessing Medicaid services offered outside of the IDDW program; and determining whether any services covered by private insurance may be helpful to the member.

Once the member receives their budget letter, the IDT team will meet with the member to develop the annual IPP. If the member and/or the IDT team develop an IPP that is within budget and otherwise compliant with West Virginia DoHS policies (e.g., all services are within the service-specific caps), the West Virginia DoHS or their designated UMC will approve the IPP and authorize services.

Redetermination Requests

Within 14 calendar days of receiving a budget, if the member or their legal representative believes that a technical error was made (e.g., a typographical error on the assessment); or there has been a change in circumstances since the assessment that is documented pursuant to a critical juncture meeting under Section 513.8.1.4, then the member or their legal representative will direct the case manager to notify the UMC. The UMC will review the redetermination request to determine if there has been a technical error in the assessment process or a change in circumstances calling for a critical juncture meeting. A decision will be made within 20 business days after a redetermination request. The UMC may communicate with the case manager and request additional information from the member, their legal representative, or case manager, if necessary. If the UMC determines there was a technical error in the assessment or in applying the budget methodology, or if a critical juncture meeting is called for the UMC may re-calculate the budget. If the UMC finds that a documented change pursuant to a critical juncture meeting has occurred, and results in the member's budget increasing, the UMC will send this finding to the BMS with a recommendation for the budget increase. The BMS will make the final determination as to whether the members' individualized budget should be increased.

The UMC does not have authority to change or increase the member's individualized budget during a redetermination, unless it finds that there was an error in the member's assessment or in the BMS application of its budget methodology. Otherwise, authorizing services more than the individualized budget can only be done by the BMS through the "exceptions process".

If the UMC determines there was no technical error and no change in circumstances, the first level redetermination will be closed. The UMC will inform the individual or their legal guardian in writing that the redetermination has been closed and explain the procedures for receiving services within the member's budget and for pursuing the "exceptions process" with the BMS.

If the IDT continues to believe that the UMC has made an error in the member's assessment or in applying the BMS budget methodology, the member may request a Medicaid Fair Hearing on this limited issue. The member may not, at this juncture, request a Medicaid Fair Hearing on any other issues, including the sufficiency of the individualized budget in meeting the members' needs. Before requesting a Fair Hearing on other issues, the member must first complete the "exceptions process" described below.

Exceptions Process

The IDT has an obligation to make every attempt to purchase services it considers necessary within the individualized budget. If the IDT determines after careful consideration that funds beyond the individualized budget are still necessary to avoid a risk of institutionalization, the member and/or the legal representative, or the case manager on their behalf, after consultation with the IDT, may submit a request for services in excess of the budget to BMS through the UMC's portal, at any time during the member's service year, along with any supporting documentation.

If the member or their legal representative believes services more than the budget are necessary, they will fill out an additional section of the IPP that reflects all the additional services that the member or their legal representative believes the member needs. Even if the IDT believes that services more than the budget are necessary, the IDT must complete the primary section of the IPP and specify services that can be purchased within the member's individualized budget. No services for the IPP year will be authorized

unless this primary section is completed. The member or their legal representative must sign off on the request for services more than the budget. Services requested above the budget amount, described in the additional section of the IPP, cannot be authorized unless and until an exception is approved through the exceptions process.

An “exceptions process” request for services exceeding the member’s individualized budget is clinically researched and reviewed by the BMS. Such request may also be negotiated between the member or their legal representative, the case manager/IDT and the BMS. A panel of three individuals employed by the West Virginia DoHS or its contractor will review the “exceptions” request to determine if any errors were made in the service authorization process, including if any technical errors were made in the assessment, and/or if funds more than the budget are needed to purchase clinically appropriate services necessary to prevent a risk of institutionalization. At least one individual on the panel will have medical training. A decision will be made by the Exceptions Panel within 20 business days after the Exceptions Panel has received submission explaining the basis for the exceptions request with any/all supporting documentation.

The individual seeking additional services through the “exceptions process” has the burden of showing that services more than the individualized budget are necessary to avoid a risk of institutionalization. To make this showing, the member or their legal representative must provide a clear explanation on the “exceptions process” request as to which additional services are requested and why they are necessary to prevent a risk of institutionalization and provide documentation to support their position. All documentation must be attached/enclosed/provided if the member would like the BMS to consider such documents in making its decision. Referring to documents on the “exceptions process” form is NOT sufficient; any documents the member would like the BMS to consider must be attached to the “exceptions process” form and specific sections highlighted for the BMS to review

In determining whether the member has shown their need to receive services more than the budget, the three-person panel shall consider:

- The members’ most recent standardized functional assessment, Structured Interview, and all IPPs from the current year.
- Any information provided by the member in their application for an exception.
- The feasibility of rearranging services within the member’s budget.
- The availability of less expensive services that can be substituted for more expensive services.
- Services covered outside the IDDW program by Medicaid or by private insurance.
- The natural supports available to the member and limitations on those supports.

If the BMS concludes that the member has demonstrated that funds in excess of the individualized budget are necessary to prevent a risk of institutionalization, the BMS will authorize funds to the budget to the extent necessary to keep the member safe and healthy and avoid a risk of institutionalization, and the IPP will be finalized. If the BMS decides that the member does not show that funds more than the individualized budget are necessary to avoid a risk of institutionalization, BMS will not authorize funds. If BMS decides that an error was made in the service authorization process, it will take steps necessary to correct the error.

If, during the "exceptions process", the BMS determines there was not an error, or that the requested additional services and funding are not warranted, a Letter of Denial will be sent to the member or their legal representative, which will include an explanation as to why the services(s) and funding were denied, how to file for a Medicaid Fair Hearing and free legal services available. All decisions during the "exceptions process" shall be reviewed and/or issued by the BMS.

A member will have the ability to appeal the decision made through the "exceptions process" by requesting a Medicaid Fair Hearing. The hearing officer will apply the same standard used by the BMS exceptions process panel, i.e., whether the member has proven the need for services more than the individualized budget and that the services are necessary to avoid a risk of institutionalization.

513.26 DISCHARGE

A member may be discharged from the IDDW Program for a reason outlined below. The case manager must complete and submit a copy of the Member Transfer/Discharge Form (WV-BMS-IDD- 10) to the UMC within seven calendar days.

- A member's income or assets exceed the limits specified in Section 513.6.3.1 of this chapter. The West Virginia DoHS county office must be contacted, in addition to the UMC, any time an individual's income or assets exceed the limits.
- The West Virginia DoHS county office closes the Medicaid file upon notification of the increase in income or assets and notifies the individual and the UMC of termination of the Medicaid card. The case manager is responsible for monitoring the members' assets and is also the party responsible for reporting when the member's income or assets exceed the limits specified in Section 513.6.3.1 of this chapter. The case manager may request information from the member, the member's payee or member's legal representative to ensure that financial eligibility is not "lost" throughout the year due to excessive assets or other reasons.
- The annual functional assessment which is used by the MECA to determine a member's medical eligibility proves that they are no longer medically eligible for the IDDW Program. The UMC notifies the member or their legal representative and the member's case manager of termination of services and of their right to appeal as outlined in Section 513.25.4.
- A member or their legal representative voluntarily terminates Waiver services by signing the Transfer/Discharge form (WV-BMS-IDD-10). The case manager must convene the IDT in the development of the IPP to transition the member to the new services when applicable.
- A member becomes deceased. Effective 11/27/2024, DD-11s (Notification of Death) have been discontinued. The DD-11 will be replaced by the Notification of Death in the UMC's portal. Providers must complete an incident report, the Notification of Death in the UMC's portal and initiate the discharge process in UMC's portal.
- A member or their legal representative does not comply with all IDDW policies including monthly contacts by case manager, participation in required assessments, IDT meetings and IPP development. The member may be discharged from the IDDW Program following consultation and approval from the UMC.
- A member does not access or use at least one IDDW Service each month (except for case management). Individuals who are hospitalized for medical reasons will be considered an

exception. If the member or their legal representative signed a Transfer/Discharge form (WV-BMS-IDD-10), then it is effective on the date of signature, and this rule does not apply.

The case manager must transfer/discharge the member in the UMC's web-based portal by the effective date of the valid transfer/discharge.

IDDW providers are prohibited from discharging, discriminating, or retaliating in any way against a member and/or their legal representative who has been a complainant, on whose behalf a complaint has been sent, or who has participated in an investigation process involving the IDDW provider.

IDDW case management providers may not discharge a member if the member chooses to self-direct part or all their services to the participant-directed service option.

513.27 TRANSFER

The member has the right to transfer case management and other services from the existing provider to another chosen provider at any time for any reason. Transfers must be addressed on the IPP and approved by the member or their legal representative and a representative from the receiving provider as shown by their signature on the IPP signature sheet. During the transition from one provider to another, the IPP must be developed and must specifically address the responsibilities and associated time frames of the "transfer-from" and the "transfer-to" providers. The case manager must complete and submit the Member Transfer/Discharge form (WV-BMS-IDD-10) within seven calendar days to the UMC. If a transfer IPP is found not to be valid, the authorizations for services may be rolled back to the transfer-from provider until a valid IPP is submitted.

An IDDW provider may not terminate services unless a viable IPP is in place that effectively transfers needed services from one IDDW provider to another provider and is agreed upon by the member and/or their legal representative and the receiving provider. If a provider discharges a member without a viable discharge/transfer is place, agreed to by the member and/or legal guardian (in writing), the provider may be subject to a targeted review, referral/enrollment hold, reduction in caseload and/or disenrollment as an IDDW provider. Providers are prohibited from discriminating in any way against a member or legal representative wishing to transfer services to another provider agency.

513.28 SERVICE LIMITATIONS

Services governing the provision of all West Virginia Medicaid services apply pursuant to *Chapter 300, Provider Participation Requirements* of the Provider Manual and Section 513.8 of this chapter. Reimbursement for services is made pursuant to *Chapter 600, Reimbursement Methodologies*, however, the following limitations also apply to the requirements for payment of services that are appropriate and necessary for IDDW program services.

- IDDW services are made available with the following limitations:
  - All members must live in West Virginia.
  - All IDDW regulations and policies must be followed in the provision of the services. This includes the requirement that all IDDW providers be licensed in the State of West Virginia and enrolled in the West Virginia Medicaid Program.

  - The services provided must conform with the stated goals and objectives on the member's IPP; and
  - Individual service and limitations described in this manual must be followed.
- IDDW services may be provided within 30 miles of the West Virginia border to members living in a county bordering another state.
- In addition to the non-covered services listed in *Chapter 100, General Information*, of the West Virginia Medicaid Provider Manual, BMS will not pay for the following services:
  - The IDDW 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 school services, including children who are home-schooled, receive home-bound instruction, and children who are eligible for public school services but are not enrolled.
  - Person-centered support services payments may not be made for room and board or the cost of facility maintenance and upkeep.
  - Birth-to-Three services paid for by Title C of Individuals with Disabilities Education Act (IDEA) for children enrolled in the IDDW Program; and
  - IDDW services may not be provided concurrently unless otherwise indicated in the service definition. For example, person-centered support services may not be provided concurrently with the member's Facility-Based Day Habilitation program, pre-vocational, school-based services, crisis services, supported employment services, job development, LPN services, or respite care services.
- Reimbursement for IDDW services cannot be made for service provided outside a valid IPP.
- To be considered valid, the IPP must be current (dated within the past year and reviewed with last six months by IDT), signed by all required IDT members and include all provided services. The following are considered reasons for an invalid IPP:
  - Services provided when eligibility has not been established.
  - Services provided when there is no IPP.
  - Services provided without supporting documentation.
  - Services provided by unqualified staff.
  - Services provided outside the scope of a defined service.

513.29 HOW TO OBTAIN INFORMATION

Please refer to the IDDW program website for its contact information.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

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

Agency Staff: Staff or contracted extended professional staff employed by an IDDW provider to provide services to members in the IDDW Program through the Traditional Option.

Aging and Disability Resource Centers (ADRCs): The state agency sponsored by the West Virginia Bureau of Senior Services who have a wide-ranging list of resources available for informational purposes. These services and supports can help the member remain at home and active in the community by providing a comprehensive assessment of the members' needs and empowering the member to make informed choices and decisions about long-term care.

Annual "Anchor" Date: The annual date by which the member's medical eligibility must be recertified and is determined by the anniversary date that is the first day of the month following the date when initial medical eligibility was established by the Medical Eligibility Contracted Agent (MECA). This date will also serve as the annual IPP date.

Approved Medication Assistive Personnel (AMAP): An unlicensed staff member who meets the eligibility requirements to become an AMAP, has successfully completed the required training and competency testing and has been deemed competent by the RN to administer medications to residents in the covered facilities in accordance with AMAP policy.

Board of Review: The agency under the West Virginia DoHS and the Office of Inspector General that provides impartial hearings to members who are aggrieved by an adverse action including denial of eligibility, eligibility terminations or denial of a covered benefit or service.

Circle of Support: A group of people with an interest in the member who offer either evaluation, planning, advocacy, or support to the member on an ongoing basis.

Common Law Employer: The entity that is viewed by the Internal Revenue Service (IRS), United States Customs and Immigration Service, state tax and labor departments as the employer. In the *Personal Options* FMS Model, the member is the common law employer.

Conflict of Interest: When the case manager who represents the member has competing interests due to affiliation with a service provider agency.

Critical Juncture: Any time that there is a significant event or change in the member's life that requires a meeting of the interdisciplinary team (IDT). This occurrence may require that a service needs to be decreased, increased or changed. A critical juncture constitutes a change in the member's needs such as behavioral, mental health or physical health, service/service units, support, setting, or a crisis.
Days: Calendar days unless otherwise specified.

Developmental Disability: Members with related conditions who have a severe, chronic disability that meets all of the following conditions: It is attributable to cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually or developmentally disabled persons, and requires treatment or services similar to those required for these persons. It is manifested before the person reaches age 22; it is likely to continue indefinitely; it results in substantial functional limitations in three or more of the following areas of major life activity:

1. Self-care,
2. Understanding and use of language,
3. Learning,
4. Mobility,
5. Self-direction, and,
6. Capacity for independent living. (Refer to the Code of Federal Regulations 42 CFR 435.1010).

Direct-Care Services: Person-centered support, respite, facility-based day habilitation, pre- vocational, job development, crisis intervention, supported employment, and LPN services available through the IDDW program.

Extended Professional Staff: West Virginia licensed dieticians, occupational therapists, physical therapists and speech therapists who are enrolled Medicaid providers who contract with an IDDW provider to provide services in their specialty.

Financial Management Service (FMS): A general term applied to a service/function that assists a member to:

- Manage and direct the distribution of funds contained in the participant-directed budget.
- Facilitate the employment of staff by the member by performing as the member's agent such employer responsibilities as verifying worker qualifications, processing payroll, withholding and filing federal, state, and local taxes, and making tax payments to appropriate tax authorities; and,
- Performing fiscal accounting and making expenditure reports to the participant and/or their legal representative. In the IDDW *Personal Options* is the Model of Financial Management Services.

Home and Community Based Services (HCBS): Services which enable individuals to remain in the community setting rather than being admitted to an institution.

Human Services Field Degree: Four-year degree from an accredited college or university in one of the following fields: Psychology; Criminal Justice; Board of Regents; Recreational Therapy; Political Science; Nursing; Sociology; Social Work; Counseling; Teacher Education; Behavioral Health; Liberal Arts or other degree approved by the West Virginia Board of Social Work Examiners.

Incident: Any unusual event occurring to a member that needs to be recorded and investigated for risk management or Quality Improvement purposes.

Independent Psychologist (IP): A West Virginia licensed psychologist who is a West Virginia Medicaid provider who performs comprehensive psychological evaluations independent of IDDW providers and who is a member of the Independent Psychologist Network trained by the MECA.

Independent Psychological Evaluation (IPE): An evaluation completed by a psychologist of the Independent Psychologist Network which includes background information, behavioral observations, documentation that addresses the six major life areas, developmental history, mental status examination, diagnosis and prognosis.

Independent Psychologist Network (IPN): West Virginia licensed psychologists who are enrolled West Virginia Medicaid Providers and have completed the required IPN Training provided by the MECA training and agreed to complete the IPE as defined.

Individual Education Program (IEP): The legal document that defines an individual's special education program and includes the disability under which the individual qualifies for special education services, the services the school will provide, the individual's yearly goals and objectives and any accommodations that must be made to assist in the individual's learning.

Individual Program Plan (IPP): The required document outlining activities that primarily focus on the establishment of a potentially life-long, person-centered, goal-oriented process for coordinating the range of services, instruction and help needed by members of the IDDW program. It is designed to ensure accessibility, accountability, and continuity of support and services. The content of the IPP must be guided by the member's needs, wishes, desires and goals but based on the member's assessed needs.

Individual Program Planning: The process by which the member is assisted by a team consisting of their legal representative (when applicable), their advocate (when applicable) other natural supports the member chooses to invite as well as attendees required by the IDDW program policy manual who meet to decide what needs to be done, by whom, when and how and to document the decisions made by this planning team. The purpose of IPP planning is to identify and address a member's assessed needs.

Integrated Work Setting Site: A site where an individual receiving IDDW job development or supported employment services is employed where not more than 75% of the people with the same job description are diagnosed with an intellectual or developmental disability.

Intellectual Disabilities and Developmental Disabilities Waiver (IDDW) Program: The program funded by the Center for Medicare and Medicaid and administered by the Bureau for Medical Services. This program offers a comprehensive scope of services and supports to eligible IDDW program members. Authorized services, if applicable, must be rendered by enrolled IDDW providers within the scope of their licenses and per all state and federal requirements. The BMS also contracts with a UMC to perform waiver operations including annual functional assessment for eligibility and budget determinations for active program members, prior authorization of services, and quality assurance/improvement functions. The BMS contracts with a MECA to assess and determine initial medical eligibility for program applicants as well as review and approve annual re-determination of eligibility for waiver services. The BMS contracts with a claims agent to process Medicaid claims. The BMS also contracts with one Fiscal Employer Agent (F/EA) known as *Personal Options* to provide Financial Management Services to waiver members who choose to direct their own services through the participant-directed service options. *Personal Options* also provides information and referral services to members choosing that Participant-Directed option. The Office of Health Facility Licensure and Certification (OHFLAC) provide monitoring and supervision of members' health and welfare through oversight of IDDW providers.

Intellectual Disabilities and Developmental Disabilities Waiver (IDDW) Provider: An agency that has been granted a Certificate of Need (CON) from the West Virginia Health Care Authority or an exemption from the CON Summary Review Committee and is licensed by OHFLAC to provide behavioral health services and is an enrolled West Virginia Medicaid provider.

Intellectual Disability: A condition which is usually permanent and originates prior to the age of 18. This condition results in significantly below average intellectual functioning as measured on standardized tests of intelligence (IQ of 70 or below) along with concurrent impairments in age-appropriate adaptive functioning. Causes of intellectual disabilities may vary and degree of intellectual impairment can range from mild to profound. (See current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for further explanation.)

Intensively Supported Setting (ISS): A residential home that is not licensed by the OHFLAC with one to three people receiving services who lease, own or rent the home.

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

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID): An institution for persons with intellectual disabilities that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability as defined in 42 CFR 435.1010.

Legal Representative: The parent of a minor child or a court appointed legal guardian for an adult or child or anyone with legal standing to make decisions for the member.

Licensed Group Home: A residential setting that is licensed by the OHFLAC with one to four people receiving services. The site is leased or owned by an IDDW agency provider.

Making Action Plans (MAPS): A person-centered planning tool that uses a graphic process to tell the story of a person's milestones, help others get to know them, and begin it build a plan to move in the direction of their dreams.

Medicaid Fair Hearing: The formal process by which a member or applicant may appeal a decision if the individual feels aggrieved by an adverse action that is consistent with state and federal law, including eligibility denials, eligibility terminations or when denied a covered benefit or service. This process is conducted by an impartial Board of Review hearing officer.

Medical Eligibility Contracted Agency (MECA): The contracted agent of BMS responsible for the determination of medical eligibility for IDDW applicants, annual redeterminations of continued eligibility for members and recruiting and training licensed psychologists for participation in the IPN.

Medication Administration Record (MAR): The report that serves as a legal record of the drugs administered to a member by a nurse or other healthcare professional, such as an AMAP.

Medley Advocate: Employees of the designated Medley Advocacy Agency that advocates for the inclusion of services appropriate to the individual and for services consistent with the principles of least restrictive alternative and the member's choice.

Medley Class Member: Individuals with a diagnosis of intellectual disabilities who were institutionalized prior to the age of 23 in a West Virginia state institution i.e. Weston State Hospital, William Sharpe Hospital, Huntington State Hospital, Mildred Bateman Hospital, Colin- Anderson Center, Greenbrier Center, Spencer State Hospital, Lakin State Hospital or Hopemont State Hospital for at least 30 days and whose birth date is on or after April 1, 1956.

Member: The individual Medicaid member receiving IDDW services.

Member's Family Residence: A residence where the member has a 911 address and lives with at least one biological, adoptive, natural, or other family member and/or a certified specialized family care provider.

Natural Supports: Family, friends, neighbors or anyone who provides a service to a member but is not reimbursed. Normal parenting activities such as but not limited to transporting a child to school, church or to visit relatives or caring for a child who is absent from school due to illness are considered natural supports.

Non-Legal Representative: A person freely appointed by the member or their legal representative to assist the member or their legal representative with the responsibilities of participant direction, including exercising budget authority and employer authority.

Office of Health Facility Licensure and Certification (OHFLAC): The state agency that inspects and licenses IDDW providers to assure the health and safety of IDDW members. Licensed entities include but are not limited to behavioral health providers, IDDW providers, facility-based day programs, group homes, supported employment facilities, and case management agencies.

Participant-Directed Services: Services that an IDDW member not living in a licensed setting may choose to self-direct. The member may decide what mix of personal assistance supports and services work best for them within their individualized budget.

Personal Options Financial Management Services Model: The fiscal/employer agent (F/EA) Financial Management Service that is a contracted subagent of the BMS that assists the member and/or their legal/non-legal representative with exercising employer and budget authority by assisting with the hiring of member's qualified support workers and completing payroll functions. The F/EA also provides information and assistance (I&A) to members choosing to direct the available services.

Planning Alternative Tomorrows with Hope (PATHS): Results oriented creative planning tool which starts in the future and works backwards to an outcome of first (beginning) steps that are possible and positive.

Pre-Hearing Conference: A meeting requested by the applicant or member and/or legal representative to review the information submitted for the medical eligibility determination and the basis for the denial/ termination. A Medicaid Fair Hearing pre-hearing conference may be requested any time prior to a Medicaid Fair Hearing.

Professional Experience: A position that requires a minimum of a bachelor's degree or a professional license, such as an LPN.

Public Community Location: Any community setting open to the public such as libraries, banks, stores, post offices, etc. facility-based day, pre-vocational sites and provider offices are not considered public community locations.

Public Education Services: School services for students through the end of the school year when the student turns 21 years of age or the student has met graduation requirements for a standard high school diploma as defined by the Individuals with Disabilities Education Act (IDEA) and WV policy 2419. qualified support worker (QSW): Direct-care workers employed by the self-directing member who provide person-centered support services, respite services or transportation services to the member through one of the participant-directed options.

Resource Consultant: A representative from the fiscal/employer agent's Financial Management Service who assists the member and/or their legal/non-legal representative who choose this Participant-Directed Option with the responsibilities of self-direction; developing a plan and budget to meet their needs; providing information and resources to help hire, train and manage employees; provides resources to assist the member with locating staff,; providing information and resources to help purchase goods and services; helping to complete required paperwork for this service option; and helping the member select a representative to assist them, as needed.

Safe Environment: A place where people feel secure; where they are not at risk of being subject to harm, abuse, neglect or exploitation; and where they have the freedom to make choices without fear of recourse.

Specialized Family Care Provider (SFCP): An individual who operates a foster-care home which has received certification through the West Virginia DoHS Specialized Family Care program. Both the home and the individual providing services are certified by a specialized family care family-based care specialist.

Stand-by Staff: Agency staff that are on stand-by status to replace electronic monitoring and on-site surveillance within 20 minutes or less of notification by base monitoring staff.

Traditional Services: Home and community-based services that help members of the IDDW program maintain their independence and decide for themselves what mix of personal assistance supports, and services that work best for them.

Unlicensed Residential Home: A residential home setting that is not licensed by the OHFLAC with one to three adults living in the home. The member's name is either on the lease, or the member pays rent.

No biological, adoptive, or other family members live in the home setting with the member or work in the home. An exception would be when siblings who are also IDDW members live in a setting without any other family members.

Utilization Management Contractor (UMC): The contracted agent of the BMS who is responsible for processing initial applications, investigating complaints, assessing waiver members' needs, functionality and supports and determining an individualized budget. The UMC also provides education for members, their families, their workers, and IDDW providers. The UMC may grant prior authorization for services provided to West Virginia Medicaid members. The UMC utilizes nationally recognized medical appropriateness criteria established and approved by the BMS for medical necessity reviews. The UMC interfaces with the claims management system to ensure that purchased services are properly reimbursed.

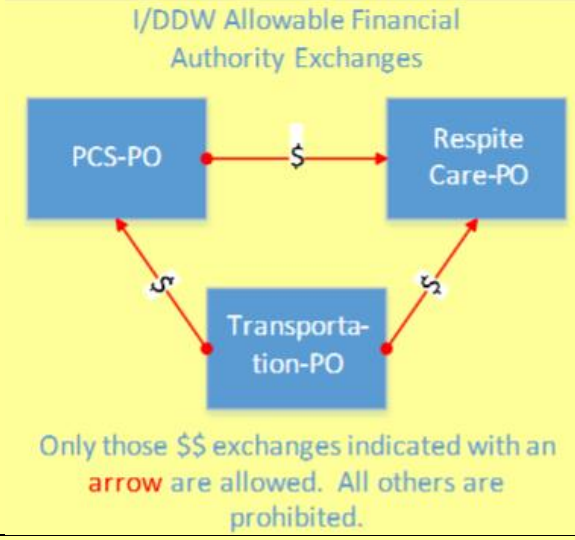
West Virginia Incident Management System (WV IMS): A web-based program used by IDDW providers and *Personal Options* staff to report simple and critical abuse, neglect, and exploitation incidences to the UMC and the BMS.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Intellectual and Developmental Disabilities Waiver (IDDW)	December 1, 2015
Entire Chapter	Intellectual and Developmental Disabilities Waiver (IDDW)	February 1, 2018
Throughout the Entire Chapter	Except to the extent services in excess of the individualized budget are approved pursuant to the procedures and standards in Section 513.25.4.2.	February 1, 2018
Throughout the Entire Chapter	CareConnection® has been changed to UMC's portal.	February 1, 2018
Throughout the Entire Chapter	Member has been replaced by the word "person" wherever possible.	February 1, 2018
Program Description	This sentence was removed from this section: There is one Participant-Directed Financial Management Services available to assist persons with self-directing these services: *Personal Options Model.* This sentence was added to this section: Personal Options is the Participant-Directed Financial Management Services model available to assist persons with self-directing their services.	February 1, 2018
Section 513.2	Training on Direct-Care Ethics for Direct Support Professionals, Day Services, Person-Centered Support, LPN, and Respite that minimally addresses: Focus on the person who receives services, including commitment to person-centered supports as best practice; Promoting the physical and emotional well-being of the person; Integrity and responsibility; Confidentiality; Justice,	February 1, 2018

REPLACE	TITLE	EFFECTIVE DATE
	fairness, and equity; Respect; Relationships; Self-determination; and Advocacy.	
Section 513.2	This bullet was changed to read: Any staff person who provides transportation services must have a valid driver's license. In addition, the agency must maintain documentation that any staff person who provides transportation services via personal vehicle abides by local, state, and federal laws regarding maintaining current vehicle licensing, insurance, registration, and inspections.	February 1, 2018
Section 513.2	To ensure complete impartiality, the Service Coordinator and other agency personnel, with the exception of the legal representative of the person being assessed or the Specialized Family Care Provider, will be excused when the Freedom of Choice form is completed during the annual functional assessment. If the person has a legal representative that is not in attendance, the legal representative must sign the Freedom of Choice within 10 days.	February 1, 2018
Section 513.2.3	The Quality Improvement System (QIS) is designed to collect the data necessary to provide evidence that the CMS Quality Assurances are being met; and ensure the active involvement of interested parties in the quality improvement process.	February 1, 2018
Section 513.3.17	This section was changed to read: In addition to meeting all requirements for IDDW Staff in Sections 513.2 - 513.2.1, the provider is required to maintain documentation that agency staff providing transportation services have a valid driver's license. If a personal vehicle is used, the provider must maintain documentation of proof of current vehicle insurance, inspection, and registration. Staff must also abide by local, state, and federal laws regarding vehicle licensing, registration, and inspections.	February 1, 2018
Section 513.2.3.6	IDDW agencies are required to submit evidence to the UMC every year to document continuing compliance with all certification requirements as specified in this manual. This evidence report must include a signed attestation from an appropriate official of the provider agency (e.g. Executive Director, Board Chair, etc.). The report may be sent from a provider's HR system, as an excel spreadsheet or as other report that includes all applicable fields and documents the employee's training dates. This form must be submitted electronically to the UMC. This self-review tool allows providers to incorporate into their Quality Assurance and	February 1, 2018

REPLACE	TITLE	EFFECTIVE DATE
	Improvement processes a method to ensure quality services occur and CMS Quality Assurances are met. Each provider will be required to submit a self- review annually. The exact due date will be communicated to the provider at least two months prior to the due date.	
Section 513.4	All incidents must be entered into the WV IMS within 24 hours of the provider becoming aware of the occurrence. If the provider becomes aware of the incident on a weekend or holiday, it is acceptable to enter the incident the following business day.	February 1, 2018
Section 513.5	The original physical copy of the annual assessment completed by the person, his/her guardian and/or his/her IDT. Once the annual assessment is completed, and the person or his/her guardian has signed the document attesting to its accuracy and completeness, it will be the duty of the Service Provider to ensure that the document is not altered, copied, or distributed in any manner. However, the Service Provider must make the original physical copy annual assessment available to the person, his/her guardian and his/her IDT at the Service Provider's offices, upon request, to review only. The Service Coordinator provider agency may store the document electronically but must be able to make the document available upon request of the person or their legal representative.	February 1, 2018
Section 513.5	Two bullets under the Specific Requirements section were combined into one bullet: Each IDDW provider is required to maintain all required IDDW documentation on behalf of the State of West Virginia and for state and federal monitors, including all IDDW Program The names of forms as applicable to the policy requirement or service code requirement.	February 1, 2018
Section 513.8	Bullets were added to the required components of the WV-BMS-IDD-05: • Tentative Weekly Schedule (including both paid and unpaid supports and any other programs providing any type of service, i.e. Personal Care, Private Duty Nursing, etc.) • The names of the individuals providing PCS Family, In-Home Respite and Out-of-Home Respite (both Traditional and Personal Options) This sentence was added to this section:	February 1, 2018

REPLACE	TITLE	EFFECTIVE DATE
	If a finalized IPP needs any changes, the team must complete an addendum IPP to reflect those changes before service requests will be considered.	
Section 513.9.2	Both Family Person-Centered Support: *Personal Options* and Transportation Miles: *Personal Option* monies may be transferred into Respite: *Personal Options* to increase this service. Transportation Miles: *Personal Options* monies may also be transferred to Family Person-Centered Supports: *Personal Options* to increase this service. Respite: *Personal Options* monies may not be transferred into Family Person-Centered Support: *Personal Options* or Transportation Miles: *Personal Options*. Participant-Directed Goods and Services monies may not be transferred into Respite: *Personal Options,* Family Person-Centered Supports: *Personal Options* or to Transportation Miles: *Personal Options* nor may any of these service monies be transferred into Participant-Directed Goods and Services 	February 1, 2018
Section 513.9.2	This paragraph was added: There are many reasons why a person may not use their entire allocated budget (hospitalization, periodic increase of informal/non-paid supports, etc.). Any unused funds from one month may not be carried over to later months within the person's annual budget period. The *Personal Options* vendor assigns a *Personal Options* resource consultant to assist and support each self-directing person to develop and monitor monthly spending plans. The resource consultants will ensure the	February 1, 2018

REPLACE	TITLE	EFFECTIVE DATE
	person/representative is aware of under-utilization and/or any attempts to overspend the monthly spending plan.	
Section 513.10	This paragraph was changed to read: Any Qualified Support Worker who provides transportation services must have a valid driver's license. If using a personal vehicle, the agency must ensure the QSW has proof of current vehicle insurance and registration and abides by local, state, and federal laws regarding vehicle licensing, registration, and inspections.	February 1, 2018
Section 513.14.1	Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the person's need. Appliances compliant with the American Disabilities Act (ADA) is not sufficient to meet this requirement.	February 1, 2018
Section 513.14.2	This service may not be used for adaptations or improvements to the vehicle that are of general utility (such as running boards), and are not of direct medical or remedial benefit to the individual.	February 1, 2018
Section 513.15.1	This was removed: This service will only be available for three years following the implementation date of this manual and upon purchase of this service in the UMC portal for the individual receiving services. It is expected that after this service ends that transition to Pre-Vocational services, Job Development services, Supported Employment services, or Person-Centered Services will occur for persons receiving services.	February 1, 2018
513.15.1	This sentence was added: Medications and health care maintenance tasks may be performed by LPNs or AMAPs at this site.	February 1, 2018
Section 513.15.2	This was added: Tasks of a benefit to a provider are those tasks, performed by a person, for which the provider would otherwise have to pay an employee to complete. A person taking out trash generated by the whole room or setting (not just the person's personal trash) would be an example of a task benefiting the provider. A person being trained to clean up after him/her self would not fall in this category. This was removed: Services are expected to occur over a two-year period, with integrated employment at a competitive wage being the specific outcome. It is expected that after two years, transition to Supported Employment will take place. • After two years of access, a transition from this service to Job Development or Supported Employment must occur.	February 1, 2018

REPLACE	TITLE	EFFECTIVE DATE
	This was added: • Accessing and managing any personally available funds. Persons may receive minimum wage. If the IDDW provider benefits from the person's labor, then the person must be paid The words "and community settings" were removed from this sentence: **Site of Service:** This service may be provided in a licensed IDD Facility-Based Day Program facility and community settings.	
513.15.2	This sentence was added: Medications and health care maintenance tasks may be performed by LPNs or AMAPs at this site.	February 1, 2018
Section 513.15.3	This was removed: Services are expected to occur over a two-year period, with attaining and maintaining integrated employment at a competitive wage being the specific outcome. It is expected that on or before two years, transition to Supported Employment will take place or Job Development Services will cease.	February 1, 2018
Section 513.15.4	**Site of Service:** This service may be provided in an integrated community work setting and may not be provided in any setting owned or leased by an IDDW Provider agency. Most of the member's co-workers in the setting do not have disabilities.	February 1, 2018
Section 513.16.1	PDGS monies may not be transferred into Family Person-Centered Supports: *Personal Options,* Respite: *Personal Options* or Transportation Miles: *Personal Options.* Appliances of any kind (kitchen, bathroom, etc.) are not allowed unless the appliance is specifically adapted/modified to meet the person's need. Appliances compliant with the American Disabilities Act (ADA) is not sufficient to meet this requirement.	February 1, 2018
Section 513.17.1.2	The equivalent monetary value for Family PCS: *Personal Options* services may be used to increase Respite: *Personal Options* but cannot be used to increase Transportation: *Personal Options* or Participant-Directed Goods and Services.	February 1, 2018
Section 517.17.3	These sentences have been removed: IDDW providers who currently serve more than four individuals per setting must submit a transition plan to BMS for approval by June 30, 2016. This transition plan must include timelines for transitioning the setting to four or less people before March 2019. BMS will consider the plan and	February 1, 2018

REPLACE	TITLE	EFFECTIVE DATE
	approve it if it is feasible to complete the transition in a timely manner that is reasonable and appropriate for the people involved. These sentences have been added: Eight licensed group homes have been grandfathered in under the new Integrated Settings Rule and these 8 sites may continue to serve more than 4 individuals. Contact BMS for a list of those specific sites.	
Section 513.17.3	Staff providing Licensed Group Home PCS cannot be a family member of the person who receives services. For the purposes of providing Licensed Group Home PCS services, family members include: biological/adoptive parents or step-parents, biological/adoptive adult siblings or step-siblings, biological/adoptive grandparents or step-grandparents, and biological/adoptive aunts/uncles or step-aunts/-uncles only. Spouses of persons who receive services are excluded from providing services. All people residing together in one of these settings must be served by the same IDDW residential provider.	February 1, 2018
Section 513.17.4.1	All people residing together in one of these settings must be served by the same IDDW residential provider.	February 1, 2018
Section 513.17.4.2	Unlicensed Residential PCS: *Personal Options* cannot be provided in a setting owned or leased by an IDDW provider.	February 1, 2018
Section 513.18.1.2	Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the person, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the person is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver. • The equivalent monetary value for Respite: *Personal Options* services cannot be used to access additional Transportation Miles: *Personal Options* services, Person-Centered Supports: Family Personal Options or Participant-Directed Goods and Services.	February 1, 2018
Section 513.18.2.1	Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the person, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the person is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc.	February 1, 2018

REPLACE	TITLE	EFFECTIVE DATE
	When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver.	
Section 513.18.2.2	Respite for the primary caregiver can also occur anytime the primary caregiver is not providing care to the person, thus, when a child is in school, the primary caregiver is receiving a form of respite. When the person is attending a Facility-Based Day program, then the primary caregiver is receiving a form of respite, etc. When a child is visiting with their non-custodial parent then this is considered an unpaid or natural type of respite for the primary caregiver. • The equivalent monetary value for Respite: *Personal Options* services cannot be used to access additional Transportation Miles: *Personal Options* services, • Person-Centered Supports: Family Personal Options or Participant-Directed Goods and Services.	February 1, 2018
Section 513.20.1	This paragraph was added: ***Effective July 1, 2018 or the individual's next anchor date, whichever is later, any medication administration and performance of health care maintenance tasks as described in W. Va. CSR §64-60-1 et seq. should be provided by a trained Approved Medication Assistive Personnel (AMAP). If an RN or LPN performs AMAP tasks, then the RN or LPN must bill the appropriate direct care code for Person-Centered Support and will be reimbursed at the Person-Centered Support rate.**	February 1, 2018
Section 513.21.1 and 513.21.2	This bullet was changed to read: Person must be present in vehicle if mileage is billed. If more than one person receiving IDDW services is present in the vehicle, then the total mileage will be divided between the number of persons present in vehicle.	February 1, 2018
Section 513.21.2	The equivalent monetary value for Transportation Miles: Personal Options may be used to increase access to Family PCS: *Personal Options* and Respite: Personal Options, but not Participant-Directed Goods and Services.	February 1, 2018
513.21.3	This sentence was added: The driver must have a valid driver's license.	February 1, 2018
Section 513.25.4.2	The entire section has been changed.	February 1, 2018
Entire Chapter	"Service coordination" terminology is changed to "case management" throughout the chapter.	April 1, 2021

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	"Person(s) who receives services" terminology changed to "member" throughout the chapter.	April 1, 2021
Entire Chapter	Hyperlinks have been added to link forms and websites throughout entire document.	April 1, 2021
Entire chapter	"Participant Directed Supports" changed to "Person Centered Supports" throughout chapter	April 1, 2021
513.2	Provider Enrollment and Responsibilities: Added language to second bullet: "NOTE: This requirement does not apply to case management-only agencies."	April 1, 2021
513.2	Addition of Electronic Visit Verification as required by 21st Century CURES Act	April 1, 2021
513.3.10	Addition of option for providers to screen workers' driving records through the WV CARES automated WV Department of Motor Vehicles registry.	April 1, 2021
513.3.12	Addition of CFCM certification to CM staff qualifications	April 1, 2021
513.4	Incorporation of policy clarification 91 into section	April 1, 2021
513.4	Removal of case management case load limit and requirement to notify BMS when limit is exceeded.	April 1, 2021
513.4	Addition of reporting requirements and responsibilities within the IMS system	April 1, 2021
513.4	Addition of revised purchase order for IDDW services	April 1, 2021
513.6.4	Removal of language pertaining to maximum service capacity related to case management.	April 1, 2021
513.8.1	Addition of the option to hold IDT meetings virtually if member, legal representative and team agree.	April 1, 2021
513.8.1.1 and 513.8.1.2	Addition of language to clarify 7 and 30-day IDT meeting processes	April 1, 2021
513.9.2	Removal of limitation from *Personal Options* services which prevents members from accessing unused funds to put toward future months' services.	April 1, 2021
513.12.1 and 513.12.5	Addition of Limitation/Cap stating agency staff may not bill dietary therapy for completing administrative activities	April 1, 2021
513.12.1, 2, 3, and 4	Removed public community location from site of service.	April 1, 2021
513.12.5	Addition of dietary therapy (Participant-Directed Option, *Personal Options Model)* Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021
513.12.6	Addition of occupational therapy (Participant-Directed Option, *Personal Options Model*) Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021

REPLACE	TITLE	EFFECTIVE DATE
513.12.7	Addition of physical therapy (Participant-Directed Option, *Personal Options Model*) Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021
513.12.8	Addition of speech therapy (Participant-Directed Option, *Personal Options Model)* Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021
513.13.1	Updated language to state the residential provider is responsible for the initial testing of electronic monitoring equipment.	April 1, 2021
513.14.3 and 513.14.4	Language updated to state that the case manager must be informed that the EAA service was completed. Changed "IDDW provider" to "Personal Options vendor."	April 1, 2021
513.14.3	Addition of Environmental Accessibility Adaptations Home (Participant-Directed Option, *Personal Options Model*) Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021
513.14.4	Addition of Environmental Accessibility Adaptations Vehicle (Participant-Directed Option, *Personal Options Model*) Note – this is an existing traditional service but adding to *Personal Options* services to ensure members' access upon implementation of CFCM.	April 1, 2021
513.15.4	Changed language to "This service must be provided in an integrated community work setting unless the member is self-employed, and may not be provided in any setting owned or leased by an IDDW provider agency. An integrated setting requires that most of the member's co-workers in the setting do not have disabilities."	April 1, 2021
513.17.1.2	Addition of Person-Centered Support: *Personal Options* service, formerly Family Person Centered Support *personal options* S5125-UA to be billed by staff living in the member's home S5125-UA-UK to be billed by staff living outside the member's home.	April 1, 2021
513.17.3	Removal of outdated information pertaining to transition plan	April 1, 2021
513.18	Removal of language describing forms of respite other than paid IDDW respite services.	April 1, 2021
513.19.1	• Removed Service Coordination code T1016 HI and replaced with G9002-U3 case management Natural Family & SFC and • G9002-U4 case management ISS and Group Home. These per-member-per-month event codes replace	April 1, 2021

REPLACE	TITLE	EFFECTIVE DATE
	the previous 15 minute unit Service Coordination code • Specified that member transfers from one Case Management agency to another case management agency are to be effective on the first of a following month. • Added detail regarding conflict-free Case Management. • Changed case manager visits to day program settings from every other month to quarterly • Added that case manager is required to purchase services within seven days of the IDT meeting/IPP addendum. • Sanctions outlined for consistent poor performance of case management agencies. • Removed non-billable activities for Case Management • Added that Case Management can be billed when member is temporarily in a facility or has hold status. • Removal of required progress “note” and addition of required progress “log” for case management services • Removal of “clinical outcome” requirement for Case Management log requirements and addition of service code • 1st bullet under Limitations/Caps changed to, “transfer from agency must finalize documentation related to member services but will not be able to bill during this time” • Removal of language requiring WV-BMS-IDD-12 to be submitted within the month the Home Visit did not occur.	
513.19.1	Addition of MOU requirement to address liability issues between agencies.	April 1, 2021
513.21	Removal of odometer reading from mileage documentation requirements.	April 1, 2021
Home and Community-Based Settings Requirements	Addition of HCBS Settings Requirements	December 21, 2023
Home and Community-	Added missing text to *Provider-Controlled Settings* (first 3 bullets) and changed references to "member" to "setting” in	September 25, 2024

REPLACE	TITLE	EFFECTIVE DATE
Based Settings Requirements	*Transition of Members* Updated logos and DHHR refences to DoHS	
Entire Chapter	Background - Addition of language updating “DHHR” to “DoHS” throughout the Policy Manual. Program Description - Addition of language regarding the ongoing Home and Community Based Services (HCBS) Setting review process. Revision of language to conform with HCBS settings requirements. HCBS Service Requirements - Addition of language added to reflect that initial training is required, and ongoing education is encouraged. Addition of language to describe forms required for new service site locations. Addition of language added to clarify requirements of the Statewide Transition Plan.	TBD 2026
	Section 513.1 - Addition of language describing the purpose and expected use of Policy Clarifications. Addition of language describing EVV vendor choice and operational requirements. Section 513.1.1 - Addition of language clarifying staff training requirements for WV APBS. Section 513.2 - Addition of language describing contracting process for professional therapy service providers. Addition of language describing training document retention practices and agency training reciprocity. Addition of language explaining the role of OHFLAC and OIG in conducting background checks for licensed professional staff. Addition of language describing use of affidavit as evidence of compliance with transportation provider qualification requirements. Addition of language regarding training requirements for identifying, reporting and documenting suspected abuse, neglect, and exploitation (ANE). Revision of language to permit electronic signature of training verification documentation by trainee and instructor. Addition of language clarifying the responsibilities for provider agencies to retain training documentation.	TBD 2026

REPLACE	TITLE	EFFECTIVE DATE
	Addition of language permitting case management to serve as a member's payee, on a case-by-case basis, with authorization from the BMS. Addition of language regarding case manager's responsibility to document inability to obtain executed Freedom of Choice form within required timeline. Addition of clarification to acknowledge that case managers are not required to be licensed. Addition of language to describe reciprocity and acceptance of training completed while employed by another IDDW provider agency. Addition of "culturally and linguistically appropriate" description. Removal of language regarding disallowance of reimbursement for failure to retain conflict of interest forms. Section 513.2.2 - Removal of language regarding annual limitation of provider agency's ability to expand service area. Addition of language clarifying secure distribution of personal health information or personal identifiable information. Addition of language regarding utilization of social media with HIPAA compliant consent. Section 513.2.3.3 - Addition of language clarifying use of teleconference or other secure means to conduct an exit conference. Addition of language extending the timeframe to conduct an exit conference to 120 days. Addition of language updating address to submit desk review findings. Section 513.2.3.4 - Addition of language updating the timelines for the provider self-review process. Section 513.3.1.2 - Addition of language regarding requirements for documentation of supervision activities. Section 513.3.1.3 - Removal of language requiring First Aid training for skilled nursing staff. Section 513.3.1.7 - Addition of language to update reference to current Behavioral Health Centers Licensure Legislative Rules (Title 71 Series 25).	

REPLACE	TITLE	EFFECTIVE DATE
	Section 513.4 - Addition of language added regarding the discontinuation of the DD-11 and a description of the new reporting process via the Atrezzo system. Addition of language to update the description of “Simple Incidents.” Addition of language regarding IDT coordination and cooperation. Addition of language to update process regarding submission of Notification of Death in Atrezzo IMS. Section 513.5 - Addition of language to clarify use of payment holds for failure to provide requested documentation. Addition of language to allow provider agencies to maintain and recognize training records provided by other IDDW provider agencies. Revision of language to reflect new flexibilities regarding case management monthly contracts. Section 513.6.1.1 - Additional description for qualifications for contracted staff responsible for conducting medical eligibility assessment. Section 513.6.2.1 - Revision of medical eligibility description to reflect revisions in application. Section 513.6.2.3 - Addition of language to clarify requirements of the annual assessment. Section 513.6.3 - Addition of language to include and clarify the title of the “Slot Allocation Letter.” Addition of language to clarify the process for application and enrollment upon receipt of the “Slot Allocation Letter.” Section 513.7.1 - Revision of language to include description of qualifications for contracted staff responsible for conducting annual eligibility redetermination. Section 513.8 - Addition of language to clarify order of services purchased. Addition of language to clarify the process for obtaining signatures from IDT members who participate in the IPP via electronic means. Addition of language to update the contents of the IPP.	

REPLACE	TITLE	EFFECTIVE DATE
	Removal of language regarding activities occurring prior to the IDT meeting. Addition of language clarifying the requirements of the IPP Signature Sheet. Addition of crisis services to first bullet. Addition of Crisis Plan incorporation into the IPP. Removal of "Progress Log" and addition of "Signature Sheet" to document the member's participation in the IDT. Addition of language to clarify the timeline for discharge following extended admission to a crisis site. Addition of language to update ability to transfer Transportation funds to unlicensed residential person-centered support. Revision of graphic to depict ability to transfer transportation funds to unlicensed residential person-centered support. Section 513.10.1 - Revision of language to reflect change in case manager in-person visit frequency. Addition of "Functional Behavior Assessment" and removal of "Functional Assessment." Addition of "as necessary" to 9th bullet. Addition of DSP responsibility to develop the tentative habilitation schedule. Section 513.10.2 - Removal of "physically" from 4th bullet to allow BSP to attend IPP meeting via electronic means. Section 513.11.11 - Revision of language to reflect extension of timeframe for prior authorization and flexibility in utilization of crisis services, as well as frequency of review by IDT. Revision of language to reflect increase in crisis intervention services available units. Addition of "routine" to last bullet under "Limitations/Caps." Section 513.12.1 - Revision of language to reflect CMS technical guidance revision to waiver application. Addition of "therapist's office/location of practice" to description of site of service. Section 513.12.2 - Revision of language to reflect CMS technical guidance revision to waiver application. Section 513.12.3 - Revision of language to reflect CMS technical guidance revision to waiver application.	

REPLACE	TITLE	EFFECTIVE DATE
	Section 513.12.4 - Revision of language to reflect CMS technical guidance revision to waiver application. Section 513.12.5 - Revision of language to reflect CMS technical guidance revision to waiver application. Section 513.12.6 - Revision of language to reflect CMS technical guidance revision to waiver application. Section 513.12.7 - Revision of language to reflect CMS technical guidance revision to waiver application. Section 513.12.8 - Revision of language to reflect CMS technical guidance revision to waiver application. Section 513.13.1 - Revision of allowable units for electronic monitoring services for individuals over age 18 residing in natural family/specialized family care home settings for members aged 18 and older. Addition of language regarding functionality of electronic monitoring device and member control over use of device in alignment with updated CMS technical guidance. Revision of language to reflect the correct number of units and hours available for the electronic monitoring service in unlicensed residential settings. Revision of language to reflect the correct number of units and hours available for the electronic monitoring service in natural family/specialized family care homes. Section 513.14.1 - Addition of *Personal Options* Environmental Accessibility Adaptations, Home and/or Vehicle and/or participant-directed goods and services in 7th bullet under “Limitations/Caps.” Section 513.14.2 - Addition of language to include Personal Options EAA “Home and/or Vehicle” in 3rd bullet under “Limitations/Caps.” Section 513.4.3 - Removal of “case management agency” and addition of “Personal Options Vendor” in 9th bullet under “Limitations/Caps.”	

REPLACE	TITLE	EFFECTIVE DATE
	Section 513.14.4 - Addition of clarifying language to describe the types of car seats that may be purchased with EAA Vehicle funds. Section 513.15.2 - Removal of “may” and addition of “must” to site of service description. Addition of language regarding payment requirements in the absence of Department of Labor certification. Section 513.15.3 - Addition of language to clarify that a provider’s office is not considered a community setting. Section 513.15.4 - Addition of new language to clarify that Supported Employment may not be billed without documentation of a referral to the Division of Rehabilitation Services (DRS). Section 513.16.1 - Removal of reference to exclusion of nutritional supplements. Addition of language regarding allowance for furniture designed to meet member’s special needs and related to the qualifying diagnosis. Addition of language to clarify that participant-directed goods and services are not intended to replace the responsibility of parents or family members to provide for routine goods and services that would be purchased for an individual in the absence of a disability. Section 513.17.1.1 - Revision of language to describe types of family members that may provide family person-centered support services. Section 513.17.1.2 - Removal of reference to limitation on the transfer of Unlicensed Residential Person-Centered Supports funds in the “Limitations/Caps” section. Section 513.17.2.1 - Addition of language regarding Approved Medication Assistive Personnel (AMAP) changes. Addition to language in the site of service section to clarify that the Home-Based Agency Person-Centered Support service may not be billed while a member is working or volunteering at a provider-owned/controlled site. Removal of case management provider name from the list of required content in the Direct-Support Service Log.	

REPLACE	TITLE	EFFECTIVE DATE
	Addition of language clarifying limits on service units if the member is still attending public school. Section 513.17.3 - Addition of language regarding AMAP changes. Removal of case management provider name from the list of required content in the Direct-Support Service Log. Section 513.17.4 - Addition of language regarding AMAP changes. Section 513.17.5 - Revision of language to reflect increases in Crisis units and new flexibilities regarding prior authorization for this service. Removal of case management provider name from the list of required content in the Direct-Support Service Log. Section 513.18.1.1 - Addition of language regarding Electronic Visit Verification (EVV) requirements for In-Home respite. Removal of case management provider name from the list of required content in the Direct-Support Service Log. Addition of clarifying language to describe the purpose of In-Home Respite (Traditional Option). Addition of language regarding EVV requirements for In-Home respite. Section 513.18.1.2 - Addition of clarifying language to describe the purpose of In-Home Respite (Traditional Option). Section 513.18.2.1 - Removal of “may” and addition of “must” in the description of the site of service. Section 513.18.2.2 - Removal of “may” and addition of “must” in the description of the site of service. Section 513.19.1 - Revision of language to reflect change in requirements for case manager in-person visit frequency. Addition of “via secure electronic means as necessary” to description of process to disseminate the IPP. Addition of new language to allow for the provision of case management when a member’s status is “Member Hold” in	

REPLACE	TITLE	EFFECTIVE DATE
	the UMC's web-based portal" if warranted by the member's needs. Addition of language to clarify who may communicate physician orders to direct-care staff. Section 513.20.1 - Addition of language added regarding the permissible scope of indirect LPN services. Section 513.20.2 - Addition of language regarding the new skilled nursing medication administration service. Addition of language to clarify that RNs may only bill to conduct training on person-specific medical needs with unlicensed direct-care staff. Section 513.21 - Addition of language to clarify that transportation services cannot duplicate State Plan transportation services. Addition of language to describe the requirement that the need for the provision of direct support services concurrently with transportation services must be documented in the IPP. Section 513.21.3 - Removal of requirement to document total number of miles for the trip. Additon of language to clarify that the transportation provider cannot be the provider of direct care services during a transportation event. Addition of language to reflect that crisis services may be billed concurrently with transportation. Section 513.23 - Addition of language to clarify that claims can be processed for less than a full unit of service. Section 513.24 - Addition of language to clarify payment limitations and documentation required when a member is incarcerated. Section 513.25.2 - Revision of language to reflect new requirements for case manager in-person visit frequency. Section 513.25.4.2 - Change of references to "ICAP" and "ABAS" to "standardized functional assessment." Addition of language added to clarify that that a request for services more than the budget may be submitted to the BMS at any time during the member's service year.	

REPLACE	TITLE	EFFECTIVE DATE
	Section 513.26 - Addition of language to reflect the new death notification process that is in the UMC web-based portal. Removal of “home visit” and addition of “contacts” to update the method and frequency of the member’s engagement with the case manager. Addition of language to clarify that the case management provider may not discharge a member who chooses to self-direct part or all of their services. Definitions - Addition of language in the definition of Intellectual Disability to reference the most current version of the DSM. Removal of defined list of participant-directed services to reflect the broader range of services a member may choose to self-direct. Addition of language to Public Community Location definition to clarify that a provider’s office is not considered a public community location.	

CHAPTER 513 INTELLECTUAL AND DEVELOPMENTAL DISABILITIES WAIVER (IDDW)

REPLACE	TITLE	EFFECTIVE DATE