



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

TABLE OF CONTENTS

SECTION	PAGE NUMBER
Background	5
Program Description	5
Take Me Home, West Virginia (TMH) Overview	6
Provider Participation Requirements	7
512.1 Bureau For Medical Services Contractual Relationships.....	7
512.2 Provider Agency Certification.....	7
512.2.1 Criminal Background Checks	9
512.2.1.3 Employment Fitness Determination	9
512.2.1.4 Provisional Employees	10
512.2.1.5 Variance	10
512.2.1.6 Appeals.....	11
512.2.1.7 Responsibility of the Hiring Entity	11
512.2.1.8 Record Retention	11
512.2.1.9 Change In Employment	12
512.2.2 Office Criteria	12
512.2.3 Quality Improvement System (QIS).....	13
512.2.3.1 Centers for Medicare And Medicaid (CMS) Services Quality Assurances	13
512.2.3.2 Quality Improvement Advisory (QIA) Council.....	14
512.2.3.3 Initial/Continuing Certification of Provider Agencies	14
512.2.3.4 Provider Reviews	15
512.2.3.5 Training and Technical Assistance.....	17

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.2.3.6 Self-Audit 17

512.2.4 Record Requirements 18

512.3 Staff Qualifications And Training Requirements 18

512.3.1 Case Manager Qualifications 19

512.3.2 Case Manager Initial And Annual Training Requirements 19

512.3.3 Personal Attendant Professional Qualifications 19

512.3.4 Personal Attendant Initial Training Requirements 20

512.3.5 Personal Attendant Annual Training Requirements 20

512.3.6 Training Documentation 21

512.3.7 Non-Medical Transportation Services Qualifications 21

512.4 Incident Management 21

512.4.1 Reporting Requirements, Incident Management Documentation And Investigation Procedures 22

512.4.2 Incident Management Tracking And Reporting 24

512.5 Documentation And Record Retention Requirements 24

Program Eligibility And Enrollment 25

512.6 Tbiw Program Eligibility 25

512.7 Financial Eligibility – Pre-Medical Eligibility 26

512.8 Financial Eligibility – Coming Off The Managed Enrollment List 26

512.9 Medical Eligibility 27

512.9.1 Medical Criteria 28

512.9.2 Initial Medical Evaluation 29

512.9.2.1 Results Of Initial Medical Evaluation 30

512.9.3 Medical Re-Evaluation 31

512.9.3.1 Results Of Medical Re-Evaluation 31

512.10 Enrollment 32

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.11 Description Of Service Options 33

 512.11.1 Traditional Service Option 33

 512.11.2 Participant-Directed Service Option 34

512.12 Person-Centered Assessment 37

512.13 Person-Centered Service Plan Development 38

 512.13.1 Six-Month Ongoing Service Plan Development And Service Plan Addendum . 39

 512.13.2 Interim Service Plan Development 40

 512.13.3 Budget Development 40

512.14 Activation of Personal Attendant Services 41

Policy..... 41

512.15 Covered Services 41

512.16 Case Management Services 41

 512.16.1 Case Management Responsibilities 42

 512.16.2 Case Management Reporting..... 44

512.17 Personal Attendant Services 44

 512.17.1 Personal Attendant Responsibilities 45

512.18 Non-Medical Transportation Services 47

512.19 Prior Authorizations 48

 512.19.1 Pre-Transition Case Management 48

 512.19.2 Community Transition Services..... 49

512.20 Billing Procedures 51

512.21 Payments and Payment Limitations 51

512.22 Service Limitations and Service Excursions 52

512.23 Dual Provision Of TBIW and Personal Care (PC) Services 52

512.24 Provision of TBIW and Home Health Agency Services 54

512.25 Voluntary Agency Closure 54

512.26 Involuntary Agency Closure 54

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CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.27 Additional Sanctions 55

512.28 Rights and Responsibilities 55

512.29 Grievance Process 56

512.30 Medical Eligibility Appeals 57

512.31 Transfers to Another Agency or Personal Options 58

512.32 Emergency Transfers to Another Agency or Personal Options 59

512.33 Discontinuation of Services 59

Glossary 60

Change Log 65

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations, and other practitioner information.



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

BACKGROUND

The West Virginia Medicaid Program is administered in agreement with 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 Health and Human Resources (DHHR) is the single State agency responsible for administering the Medicaid Program. This program, therefore, 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, utilizing 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 BMS whether or not the services require prior authorization. All providers of services must maintain current, accurate, legible, and completed documentation to justify medical necessity of services provided to each person receiving Medicaid and made available to the BMS or its designee upon request.

This chapter sets forth the BMS requirements for the Traumatic Brain Injury Waiver (TBIW) program provided to eligible West Virginia Medicaid members. The policies and procedures set forth herein are promulgated as regulations governing the provision of TBIW services by TBIW providers in the Medicaid Program. Requirements and details for other West Virginia Medicaid covered services can be found in other chapters of the BMS Provider Manual.

All forms for this program can be found at:

<http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/TBIW/Pages/Policy-and-Forms.aspx>.

Federal regulations governing Medicaid coverage of home and community-based services under an approved waiver specify that services provided under waiver authority must be targeted to individuals who would otherwise be eligible for placement in a long-term care facility.

PROGRAM DESCRIPTION

The TBIW Program is a long-term care alternative which provides services that enable individuals to live at home rather than receiving nursing facility care. The program provides home and community-based services to West Virginia residents who are financially and medically eligible to participate in the program. Applicants must be at least three years of age and have a documented traumatic brain injury, defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or an injury caused by anoxia due to near drowning. The goals and objectives of this program are focused on providing services that are person-centered, that promote choice, independence, participant-direction, respect, and dignity and community integration. All members are offered and have a right to freedom of choice of providers for services. The BMS contracts with a Utilization Management Contractor (UMC) to implement the administrative functions of the program.

TBIW services include case management, personal attendant, and non-medical transportation.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

TBIW services are to be provided exclusively to the person eligible for services and only for necessary activities as listed in the Service Plan. Enrollment on the TBIW is contingent on a person requiring two or more of the services offered in the TBIW in order to avoid institutionalization, one of which must be Personal Attendant services on a monthly basis either through a Traditional provider or *Personal Options*. The other service required is case management. Individuals may not be enrolled in the TBIW for the sole purpose of obtaining Medicaid eligibility.

Within the TBIW program, members may choose from either the Traditional (Agency) Model or the Participant-Directed Model known as *Personal Options* for service delivery. In the Traditional Model, members receive their services from employees of a certified provider agency. In *Personal Options*, members are able to hire, supervise, and terminate their own employees.

The person receiving TBIW services must receive personal attendant services on a monthly basis unless in a nursing home, hospital, or other inpatient medical facility

TAKE ME HOME, WEST VIRGINIA (TMH) OVERVIEW

Individuals wishing to transition from long-term care facilities to the community often face numerous obstacles including lack of basic household items (including furniture), limited community supports, and no one to help develop comprehensive plans to transition home. Transition Services help address many of these barriers by providing a variety of services and supports to program participants to promote a successful and safe transition to the community.

Transition coordination is the essential part of transition services. Transition coordinators, provided through a contract, work one-on-one with participants and their transition teams to:

- Accept and follow up with referrals from the Aging and Disability Resource Network (ADRN);
- Conduct interviews to share information about options for returning to the community, including the availability of waiver transition services;
- Assess residents' transition support needs, including risk factors that may jeopardize a safe and successful transition to the community;
- Assess and verify residents' readiness to begin transition assessment and planning;
- Facilitate the development of a transition team consisting of the resident, the transition coordinator, the waiver case manager, the facility social worker and other appropriate staff, and anyone else the resident chooses to include in the transition process;
- Work with resident and his/her transition team to develop a written transition plan which incorporates specific services and supports to meet identified transition needs;
- Conduct a Risk Analysis and develop a written Risk Mitigation Plan to address and monitor all identified risks that may jeopardize the resident's successful transition, and;
- Arrange and facilitate the procurement and delivery of needed transition services and supports including waiver transition services prior to transition.

Transition Services Available

There are two services available to assist individuals in transitioning back to the community beginning in January 1, 2019:



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

1. Pre-Transition Case Management (Section 512.19.1): To develop a Waiver Participant Interim Service Plan and ensure that the needed community services and supports are in place on the first day of the participants return to the community; and
2. Community Transition Services (Section 512.20.2): One-time expenses that address identified barriers to a safe and successful transition from facility-based living to the community.

PROVIDER PARTICIPATION REQUIREMENTS

512.1 BUREAU FOR MEDICAL SERVICES CONTRACTUAL RELATIONSHIPS

The BMS contracts with a UMC. The UMC is responsible for day-to-day operations and oversight of the TBIW program including conducting medical eligibility evaluations, determining medical eligibility for applicants and people enrolled in the program, initial and ongoing certification of provider agencies and providing prior authorization for services provided to people enrolled in the TBIW, conducts education for TBIW providers, advocacy groups, and people receiving TBIW services.

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 BMS TBIW website at: <http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/TBIW/Pages/Member-and-Provider-Info.aspx>.

The BMS contracts with a Fiscal/Employer Agent (F/EA) to administer the *Personal Options* Financial Management Services (FMS) program and resource consultant services. The F/EA is as a subagent of the BMS for the purpose of performing employer and payroll functions for persons wishing to self-direct their services through the *Personal Options* FMS.

The BMS contracts with TBIW providers for the provision of services for people receiving TBIW services. All TBIW providers must be certified by the UMC and enrolled as a Medicaid provider.

Please refer to the BMS TBIW website for UMC and *Personal Options* contact information at: <http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/TBIW/Pages/default.aspx>

512.2 PROVIDER AGENCY CERTIFICATION

TBIW provider agencies must be certified by the UMC. A certification application must be completed and submitted to the UMC. Please refer to the [TBIW Program](#) website for program contact information.

An agency may provide case management and/or personal attendant service, provided they maintain:

- A separate certification and National Provider Identifier (NPI) for each service;
- Separate staffing; and,
- Separate files for case management and personal attendant services.

Conflicts of interest and self-referral are prohibited. Conflict of interest is when the case manager, who represents the TBIW person, has competing interests (the same provider agency), takes action on behalf of the TBIW person or influences a TBIW person's "Right to Choose." This action is a benefit to the case

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

manager and the provider agency. Therefore, it is a conflict of interest. Failure to abide by conflict of interest policy will result in the loss of provider certification for a period of one year and all current people being served will be transferred to other case management agencies. Any case manager working for a case management agency that has self-referred a person receiving TBIW services or influenced a TBIW person's "Right to Choose" (transfer) must not bill case management for the month this activity is conducted and will be referred to their professional licensing board for a violation of ethics.

To be certified as a TBIW case management and personal attendant service provider agencies, applicants must meet and maintain the following requirements:

- A business license issued by the State of West Virginia.
- A federal tax identification number (FEIN).
- A competency based curriculum for required training areas for personal attendant staff.
- An organizational chart
- A list of the Board of Directors (if applicable)
- A list of all agency staff, which includes their qualifications.
- A Quality Management Plan for the agency.
- Written policies and procedures for processing complaints and grievances, from staff or people receiving TBIW services, that:
 - Addresses the process for submitting a complaint
 - Provides steps for remediation of the complaint including who will be involved in the process
 - Steps include the process for notifying the person of the findings and recommendations
 - Provides steps for advancing the complaint if the person/staff does not feel the complaint has been resolved
 - Ensures that a person receiving TBIW services or agency staff are 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 a TBIW provider.
- Written policies and procedures for the use of personally and agency owned electronic devices which includes, but is not limited to:
 - Prohibits using personally identifiable information in texts and subject lines of emails;
 - Prohibits the use of personally identifiable information in the body of emails unless the email is sent securely through a Health Insurance Portability and Accountability Act (HIPAA) compliant connection;
 - Prohibits personally identifiable information be posted on social media sites;
 - Prohibits using public Wi-Fi connections;
 - Informs agency employees that during the course of an investigation, information related on their personal cell phone is discoverable;
 - Requires all electronic devices be encrypted.
- Written policies and procedures for people to transfer.
- Written policies and procedures for the discontinuation of person's services.
- Written policies and procedures to avoid conflict of interest (if agency is providing both case management and personal attendant services) must include at a minimum.
- Education of case managers on general conflict of interest/professional ethics with verification;
- Annual signed Conflict of Interest Statements for all case managers and the agency director;



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Process for investigating reports on conflict of interest complaints;
- Process for reporting to the BMS;
- Process for complaints to professional licensing boards for ethics violations.
- Office space that allows for confidentiality of the person receiving TBIW services.
- An Agency Emergency Plan (for people receiving TBIW services and office operations). This plan must include:
 - Office Emergency Back-Up Plan ensuring office staffing and facilities are in place during emergencies such as floods, fires, etc. However, the new temporary facilities must meet all requirements. The Provider must notify the UMC within 48 hours.
 - Providers must inform people receiving TBIW services of their Emergency Back-Up Plan.
 - When the UMC's web portal is available, must accept referrals in the UMC's web portal within five business days or forfeit the referral
- All providers are required to have and implement policies and procedures for people with limited English proficiency and/or accessible format needs that are culturally and linguistically appropriate to ensure meaningful access to services.
- Computer(s) for staff with HIPAA secure email accounts, UMC web portal software, internet access, and current (within last five years) software for spreadsheets.
- Hires and retains a qualified work force.
- Ensure that a person receiving TBIW services is not discharged unless a viable discharge/transfer plan is in place that effectively transfers all services that the person needs to another provider(s) and is agreed upon by the person and/or their legal representative and the receiving provider(s).
- Ensures that services are delivered and documentation meets regulatory and professional standards before the claim is submitted.
- Participate in all mandatory training sessions.

Provider agencies will be reviewed by the UMC within six months of initial agency certification, and annually thereafter ([Refer to Section 512.2.3.3 Initial/Continuing Certification of Provider Agencies](#)).

More information regarding provider participation requirements in Medicaid services can be found in [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.

512.2.1 Criminal Background Checks

Refer to Chapter 700 West Virginia Clearance for Access: Registry & Employment Screening (WV CARES) for Criminal Background Check information.

512.2.1.3 Employment Fitness Determination

After an applicant's fingerprints have been compared with the state and federal criminal history record information, the State Police shall notify WV CARES of the results for the purpose of making an employment fitness determination.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

If the review of the criminal history record information reveals the applicant does not have a disqualifying offense, the applicant will receive a fitness determination of “eligible” and may be employed.

If the review of the criminal history record information reveals a conviction of a disqualifying offense, the applicant will receive a fitness determination of “not eligible” and may not be employed, unless a variance has been requested or granted.

The hiring entity will receive written notice of the employment fitness determination. Although fitness determination is provided, no criminal history record information will be disseminated to the applicant or hiring entity.

A copy of the applicant’s fitness determination must be maintained in the applicant’s personnel file.

512.2.1.4 Provisional Employees

Provisional basis employment for no more than 60 days may occur when:

1. An applicant does not have a negative finding on a required registry or licensure database and the employment fitness determination is pending the criminal history record information; or
2. An applicant has requested a variance of the employment fitness determination and a decision is pending.

All provisional employees shall receive direct on-site supervision by the hiring entity until an eligible fitness determination is received.

The provisional employee, pending the employment fitness determination, must affirm in a signed statement, that he or she has not committed a disqualifying offense, and acknowledge that a disqualifying offense shall constitute good cause for termination. Provisional employees who have requested a variance shall not be required to sign such a statement.

512.2.1.5 Variance

The applicant, or the hiring entity on the applicant’s behalf, may file a written request for a variance of the fitness determination with WV CARES within 30 days of notification of an ineligible fitness determination.

A variance may be granted if mitigating circumstances surrounding the negative finding or disqualifying offense is provided, and it is determined that the individual will not pose a danger or threat to residents or their property.

Mitigating circumstances may include:

- The passage of time;
- Extenuating circumstances such as the applicant’s age at the time of conviction, substance abuse, or mental health issues;
- A demonstration of rehabilitation such as character references, employment history, education, and training; and



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- The relevancy of the particular disqualifying information with respect to the type of employment sought.

The applicant and the hiring entity will receive written notification of the variance decision within 60 days of receipt of the request.

512.2.1.6 Appeals

If the applicant believes that his or her criminal history record information within the State of West Virginia is incorrect or incomplete, he or she may challenge the accuracy of such information by writing to the State Police for a personal review.

If the applicant believes that his or her criminal history record information from outside the State of West Virginia is incorrect or incomplete, he or she may appeal the accuracy of such information by contacting the Federal Bureau of Investigation (FBI) for instructions.

If the purported discrepancies are at the charge or final disposition level, the applicant must address this with the court or arresting agency that submitted the record to the State Police.

The applicant shall not be employed during the appeal process.

512.2.1.7 Responsibility of the Hiring Entity

The WV CARES system will provide monthly rechecks of all current employees against the required registries. The hiring entity will receive notification of any potential negative findings. The hiring entity is required to research each finding to determine whether or not the potential match is a negative finding for the employee. The hiring entity must maintain documentation establishing no negative findings for current employees. **NOTE:** This includes the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) check.

The hiring entity must download the WV CARES registry recheck log report and maintain this report in both electronic and paper format monthly.

512.2.1.8 Record Retention

Documents related to the background checks for all direct access personnel must be maintained by the hiring entity for the duration of their employment. These documents include:

- Documents establishing that an applicant has no negative findings on registries and licensure databases.
- The employee's eligible employment fitness determination;
- Any variance granted by the Secretary, if applicable; and
- For provisional employees, the hiring entity shall maintain documentation that establishes that the individual meets the qualifications for provisional employment.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Failure of the hiring entity to maintain state and federal background check documentation that all direct access personnel are eligible to work, or employing an applicant or engaging an independent contractor who is ineligible to work may subject the hiring entity to civil money penalties.

512.2.1.9 Change in Employment

If an individual applies for employment at another long term care provider, the applicant is not required to submit to fingerprinting and a criminal background check if:

- The individual previously submitted to fingerprinting and a full state and federal criminal background check as required by this policy;
- The prior criminal background check confirmed that the individual did not have a disqualifying offense;
- The individual received prior approval from the Secretary to work for or with the health care facility or independent health contractor, if applicable; and
- No new criminal activity that constitutes a disqualifying offense has been reported.

The WV CARES system retains all fitness determinations made for individuals.

512.2.2 Office Criteria

TBIW case management and personal attendant service provider agencies 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:

- Physically located in West Virginia.
- An agency office site can serve no more than eight contiguous counties in West Virginia as designated in the application. TBIW providers wishing to make changes in the approved counties they serve **must** make the request in writing to the UMC. The UMC will make a determination on the request and inform the provider in writing. No changes in counties served can be made unless approved by the UMC.
- Changes can only be made annually unless it is a request for a provider to expand their service area by the BMS.
- Be readily identifiable to the public.
- Meet Americans With Disabilities Act (ADA) requirements for physical accessibility. (Refer to [28 CFR 36](#), as amended). These include but are not limited to:
 - Maintains an unobstructed pedestrian passage in the hallways, offices, lobbies, bathrooms, entrance and exits
 - The entrance and exit has accessible handicapped curbs, sidewalks and/or ramps
 - The restrooms have call lights and grab bars for convenience
 - A telephone is accessible
 - Drinking fountains and/or water made available as needed
- 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 does not constitute a primary business telephone.)

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Maintain an agency secure HIPAA compliant e-mail address for communication with the BMS and the UMC for all staff.
- At a minimum, must have access to a computer, fax, email address, scanner, and internet.
- Utilize any database system, software, etc., compatible with/approved and/or mandated by BMS.
- Be open to the public at least 40 hours per week. Observation of state and federal holidays is at the provider's discretion.
- Contain space for securely maintaining program and personnel records. (Refer to [Chapter 100, General Administration and Information](#), and [Chapter 300, Provider Participation Requirements](#), for more information on maintenance of records).
- Maintain a 24-hour contact method .
- Change in agency location due to emergencies such as flood or fire for over 30 days requires a site review by the agency.
- Any authentication method for electronic and stamped signatures must meet the following basic requirements:
 - Unique to the person
 - Capable of verification
 - Under the sole control of the person, and
 - Linked to the data in such a manner that if the data is changed, the signature is invalidated.
- Agencies that provide electronic devices to their staff must ensure all personally identifiable information is secure.

512.2.3 Quality Improvement System (QIS)

The Quality Improvement System (QIS) is designed to:

- Collect data necessary to provide evidence to the Centers for Medicare and Medicaid Services (CMS) that Quality Assurances are being met; and,
- Ensure the active involvement of interested parties in the quality improvement process; and
- Ensure remediation and/or systemic quality improvement within the program.

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

- TBIW Administration and Oversight: The Medicaid agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
- Level of Care Evaluation/Re-evaluation: The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, nursing facility, or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).
- Qualified Providers: The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Service Plan: The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.
- Health and Welfare: The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
- Financial Accountability: The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

Data is collected and analyzed for all quality assurances and sub-assurances based on West Virginia's Quality Performance Indicators, as approved by CMS. The primary sources of discovery include TBIW provider reviews, incident management system, complaints/grievances, abuse and neglect reports, administrative reports, the West Virginia Participant Experience Survey-Brain Injury (PES-BI), oversight of delegated administrative functions, and the Quality Improvement Advisory (QIA) Council.

512.2.3.2 Quality Improvement Advisory (QIA) Council

The QIA Council is the focal point of stakeholder input for the TBIW 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 TBIW performance measures as a guide to:

- Review findings from evidence based discovery activities;
- Recommend policy changes to BMS;
- Recommend program priorities and quality initiatives;
- Monitor and evaluate the implementation of TBIW priorities and quality initiatives;
- Monitor and evaluation of policy changes;
- Serve as a liaison between the TBIW program and interested parties; and
- Establish committees and workgroups consistent with its purpose and guidelines.

The Council membership is comprised of former and/or current people receiving TBIW services (or their legal representatives), service providers, advocates, and other allies of the population served.

512.2.3.3 Initial/Continuing Certification of Provider Agencies

Following the receipt of a completed Certification Application, the UMC will conduct an onsite review, if required, to verify that the prospective provider meets certification requirements. This requirement may be waived if the prospective provider is a current Licensed Behavioral Health Center (LBHC) or is enrolled as an Aged and Disabled Waiver (ADW), Personal Care (PC), or Intellectual/Developmental Disabilities Waiver (IDDW) provider at the time of application.

The UMC will notify the BMS fiscal agent, upon satisfactory completion of the onsite review or verification of LBHC, ADW, Personal Care, or IDDW status. The BMS' fiscal agent will provide the provider applicant with an enrollment packet which includes the TBIW Provider Agreement. Once this process has been completed, the fiscal agent will assign a provider number. A letter informing the provider agency that it may begin providing and billing for TBIW services will be sent to the provider agency and to the UMC by the fiscal agent.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

When a case management or personal attendant service provider agency is physically going to move to a new location or open a satellite office, they must notify the UMC 45 days prior to the move. The UMC will schedule an on-site review of the new location to verify the site meets certification requirements. Medicaid services cannot be provided from an office location that has not been certified by the UMC.

In addition, all providers of TBIW services are subject to and bound by Medicaid rules and regulations found in [Chapter 100, General Administration and Information](#) of the BMS Provider Manual.

Once certified and enrolled as a Medicaid provider, TBIW case management and personal attendant service provider agencies must continue to meet the requirements listed in this chapter as well as the following:

- Employ adequate, qualified, and appropriately trained personnel who meet minimum standards for providers of the TBIW program.
- Provide services based on each person's individual assessed needs, including evenings and weekends.
- Maintain records that fully document and support the services provided.
- Furnish information to BMS, or its designee, as requested. (Refer to [Chapter 100, General Administration and Information](#) and [Chapter 300, Provider Participation Requirements](#), for more information on maintenance of records).
- Maintain a current list of people receiving TBIW services.
- Comply with the West Virginia Incident Management System (WV IMS) (when available until such time make incident reports to the UMC).

512.2.3.4 Provider Reviews

TBIW provider agencies are required to submit designated evidence to the UMC every 12 months to document continuing compliance with all certification requirements as specified in this Chapter. This evidence must be attested to by an appropriate official of the provider agency (e.g., Director or Board Chair). If appropriate documentation is not provided within 30 days of expiration of current certification, a Provisional Certification may apply. Provider agencies who receive a Provisional Certification will be required to have an on-site review by the UMC prior to full recertification.

If deficiencies are found by the UMC during document review, the provider must submit a Plan of Correction within 30 days of notice of deficiency. If the Plan of Correction, submitted by the provider to the UMC, requires additional information and/or technical assistance, the additional information must be submitted within 10 business days. If an approved Plan of Correction and required documentation is not submitted within the required time frame, the BMS may hold provider reimbursement and remove the provider from Freedom of Choice Selection forms until an approved Plan of Correction is in place.

A Plan of Correction must include:

- How the deficient practice for the person is cited in the deficiency will be corrected. What system will be put into place to prevent recurrences of the deficient practice;
- How the provider will monitor to assure future compliance and who will be responsible for the monitoring;
- The date each item on the Plan of Correction will be completed; and

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Any provider-specific training requests related to the deficiencies

TBIW providers will be required to participate in an on-site review every year. Any provider who enrolls at least one program participant during a calendar year will be queued for on-site retrospective review the subsequent year and each year thereafter.

All providers without an enrolled person utilizing the TBIW will be required to participate in an on-site certification validation review. Targeted onsite certification reviews may also be conducted based on Incident Management Reports and complaint data. In some instances, when a person's health and safety are in question, a full review of all records will be conducted.

Certification (Validation) Reviews

All providers without a person enrolled will be required to participate in an on-site certification validation review using the Site-monitoring Review Tool.

The UMC staff will validate the information from the most recent completed certification with a review of the agency policy and procedures, the agency Quality Management Plan, personal attendant direct care staff competency based training curriculum, and a walk through of the agency office setting to monitor office criteria compliance. The walk through will include digital verification (digital photos) that the physical office meets policy requirements.

Within 10 business days of the conclusion of the exit interview, the UMC will email a Provider Review Report and draft Plan of Correction, if needed to the provider and to the BMS. If a draft Plan of Correction is required by a provider, they must complete and submit it to the UMC within 30 days of notice of the deficiency. If the UMC returns the draft Plan of Correction to the provider requesting additional information the provider must complete and re-submit the draft Plan of Correction within 10 business days. If the draft Plan of Correction and required documentation is not submitted within the time frame, the BMS may hold provider reimbursement and remove the provider from the Freedom of Choice Selection forms until an approved Plan of Correction is in place.

Retrospective Reviews

Record selection will include a statewide representative sample of records. The monitoring tools used by the UMC to review charts are available on the [TBIW Program](#) website. The Participant Experience Survey Brain Injury Edition (PES-BI) will also be conducted with those people whose charts are selected for review. A proportionate random sample will also be implemented to ensure that at least one person's record from each provider site is reviewed.

Upon completion of each provider retrospective review, the UMC conducts a face-to-face exit summation with the agency director. Following the exit summation, the UMC will make available to the provider a draft Review Report and if necessary a draft Plan of Correction to be completed by the TBIW provider. If potential disallowances are identified, the TBIW provider will have 30 days from receipt of the draft Review Report to send comments back to the UMC. After the 30 day comment period has ended, the BMS will review the draft Review Report and any comments submitted by the TBIW provider and issue a Final Review Report to the TBIW provider's director.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Note: If a lapse occurs for any checks within the WV CARES, the BMS will request reimbursement for paid claims should any disqualifying offenses be found during the lapse time frame.

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 TBIW services. A cover letter to the TBIW provider's director will outline the following options to effectuate repayment:

- Payment to the BMS within 60 days after the BMS notifies the provider of the overpayment; 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; or
- A recovery schedule of up to a 12-month period, through monthly payments or the placement of a lien against future payments.

If the TBIW provider disagrees with the final disallowance report, the TBIW provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in [Chapter 100, General Administration and Information](#) of the BMS Provider Manual. The TBIW provider must still complete the written repayment arrangement within 30 days of receipt of the Final Disallowance Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review 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 identified during the UMC review, then the TBIW provider will receive a final letter and a Final Review Report from the BMS.

For information relating to additional audits that may be conducted for services contained in this chapter please see [Chapter 800, Program Integrity](#) of the BMS Provider Manual that identifies other State/Federal auditing bodies and related procedures.

512.2.3.5 Training and Technical Assistance

The UMC develops and conducts training for TBIW 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.

512.2.3.6 Self-Audit

TBIW providers have an ethical and legal duty to ensure the integrity of their partnership with the Medicaid program. This duty includes an obligation to examine and resolve instances of noncompliance with program requirements through self-assessment and voluntary disclosures of improper use of state and federal resources. TBIW providers must use the approved format for submitting self-audits to Office of Program Integrity (OPI). Failure to submit self-audits may jeopardize the future status of the TBIW provider as a West Virginia Medicaid provider. TBIW providers are required to conduct self-audits, complete an affidavit attesting to the accuracy of the self-audit and submit to the OPI along with the

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

original Excel spreadsheet and repayment forms. The self-audit form can be found on the BMS TBIW website at: <http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/TBIW/Pages/Policy-and-Forms.aspx>.

For more information on sanctions available to the BMS, see [Chapter 800, Program Integrity](#).

512.2.4 Record Requirements

Providers must fully complete all required TBIW forms and follow published forms instructions. Forms and instructions can be found on the BMS TBIW website at:

<http://www.dhhr.wv.gov/bms/Programs/WaiverPrograms/TBIW/Pages/Policy-and-Forms.aspx>

TBIW providers must meet the following program record requirements:

- The provider must keep a file on each person utilizing the TBIW.
- The files must contain all original documentation for services provided to the person by the provider responsible for development of the document (for example the case management agency should have the original Service Plan, the complete service assessment, contact notes, enrollment confirmation, etc.).
- Original documentation on each person must be kept by the Medicaid provider for five years, with any and all exceptions having been declared resolved by the BMS, in the designated office that represents the county where services were provided.

Provider Personnel Records

Legible original copies of personnel documentation including training records, licensure, confidentiality agreements, fingerprint-based background checks etc. must be maintained on file by the provider.

- Minimum credentials for professional staff (case manager) must be verified upon hire and thereafter based upon their individual professional license requirements.
- All documentation on each staff member must be kept by the provider in a designated location office that represents the county where services were provided.
- Verification that the Office of Inspector General (OIG) Exclusion List was checked as appropriate for the position.

TBIW providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the waiver program. Providers must also agree to make themselves, Board Members, their staff, and any and all records pertaining to TBIW services available to any audit, desk review, or other service evaluation that ensures compliance with billing regulations and program goals.

Providers must ensure that all required documentation is maintained at the agency as required by state and federal regulations and is accessible for state and federal audits.

512.3 STAFF QUALIFICATIONS AND TRAINING REQUIREMENTS

All staff must be trained to provide TBIW services in a culturally and linguistically appropriate manner. All training materials must be approved by the UMC.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Prior to using an internet provider for training purposes, TBIW providers must submit the name, web address, and course name(s) to the UMC for review. The UMC will respond in writing whether this internet training meets the training criteria.

People who select *Personal Options* may access their resource consultant through their participant-directed program for UMC approved training materials and assistance.

512.3.1 Case Manager Qualifications

A case manager must be licensed in West Virginia as a social worker, counselor, or registered nurse (RN), and employed by a TBIW case management agency enrolled with Medicaid. Licensure documentation must be maintained in the employee's file. Documentation that covers all of the employee's employment period must be present (Example - if an employee has been with your agency for three years – documentation of licensure must be present for all three years). All documented evidence of staff qualifications such as licenses, transcripts, certificates, signed confidentiality agreements (Refer to [Chapter 100, General Administration and Information](#)), and references shall be maintained on file by the provider. The provider shall have an internal review process to ensure that employees providing TBIW services meet the minimum qualifications.

Resource consultants under the *Personal Options* Model for the F/EA are not case managers.

512.3.2 Case Manager Initial and Annual Training Requirements

- Conflict-free case management training (including a signed conflict of interest statement)
- Training on *Personal Options* Service Delivery Model
- Recognize and reporting abuse, neglect and exploitation training
- HIPAA training
- Person-Centered Planning and Service Plan development
- Must maintain professional licensure training requirements

512.3.3 Personal Attendant Professional Qualifications

A personal attendant professional is an individual paid to provide the day-to-day care to a person utilizing the TBIW including both Traditional and *Personal Option* models.

Medicaid prohibits legally responsible individuals such as the spouse or a parent of a minor child (under the age of 18) of a person utilizing the TBIW from providing waiver services for purposes of reimbursement. Court appointed Guardian(s) are also prohibited from being reimbursed for providing services.

A personal attendant professional must be at least 18 years of age and must have completed the required initial and annual competency based training before providing services to a person utilizing the TBIW.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.3.4 Personal Attendant Initial Training Requirements

- Cardiopulmonary Resuscitation (CPR) training – must be provided by the agency nurse or a certified trainer from the American Heart Association, American Red Cross, American Health and Safety Institute, or American CPR. Additional CPR courses may be approved by the UMC. Please refer to the [TBIW Program](#) website for information. NOTE: CPR may not be provided solely by an internet provider; skills MUST be demonstrated.
- First Aid training – must be provided by an agency nurse, a certified trainer, or an approved internet provider.
- Infectious Disease Control training – must use the current training material.
- Direct-Care Skills – Four hours of training focused on assisting individuals with TBIs with Activities of Daily Living (ADLs) – must be provided by an RN, social worker/counselor, a documented specialist in this content area or an approved internet training provider. At least one hour of the direct-care skills training must be person specific on the job training and must be documented.
- When applicable, one hour training specific to children/adolescents with TBI.
- Abuse/Neglect/Exploitation Identification training – must be provided by an RN, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
- HIPAA – training must include agency staff responsibilities regarding securing Protected Health Information - must be provided by a Registered Nurse, social worker/counselor, a documented specialist in this content area or an approved internet training provider.
- Personal Attendant Professional Ethics – training on ethics such as promoting physical and emotional well- being, respect, integrity and responsibility, justice, fairness and equity - must be provided by an RN, social worker/counselor, a documented specialist in this content area, or an approved internet training provider.
- Health and Welfare – training must include emergency plan response, fall prevention, home safety and risk management must be provided by social worker/counselor, a documented specialist in this content area or an approved internet training provider.
- People-first Language.

512.3.5 Personal Attendant Annual Training Requirements

Cardiopulmonary Resuscitation (CPR), First Aid, Infectious Disease Training, Abuse/Neglect/Exploitation Identification, and HIPAA training must be kept current.

- CPR is current as defined by the terms of the certifying agency.
- First Aid, if provided by an agency RN, must be renewed within 12 months or less. If provided by a nationally recognized organization, current is defined by the terms of the certifying agency. Training will be determined current in the month it initially occurred. (Example: if First Aid training was conducted May 10, 2010, it will be valid through May 31, 2011.)
- Infectious Disease Training, Abuse/Neglect/Exploitation Identification, and HIPAA training must be renewed within 12 months or less. Training will be determined current in the month it initially occurred. (See example above.)

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

In addition, four hours of training focusing on enhancing direct care service delivery knowledge and skills must be provided annually. Specific on-the-job-training can be counted toward this requirement.

512.3.6 Training Documentation

Documentation for training conducted by an agency RN, social worker/counselor, or a documented specialist in the content area must include the training topic, date, beginning time of the training, ending time of the training, location of the training and the signature of the instructor and the trainee or for *Personal Options*, the person and/or their legal representative (if applicable). Training documentation for internet based training must include the employee's name, the name of the internet provider/trainer and either a certificate or other documentation proving successful completion of the training.

512.3.7 Non-Medical Transportation Services Qualifications

In addition to meeting all requirements for TBIW personal attendant professionals, individuals providing non-medical transportation services must have a valid driver's license, proof of current vehicle insurance and registration. Copies of all required documentation will be kept by the provider or if applicable the F/EA.

The TBIW personal attendant professional must also abide by local, state, and federal laws regarding vehicle licensing, registration and inspections upon hire and checked annually thereafter.

512.4 INCIDENT MANAGEMENT

TBIW providers shall have policies and procedures for thoroughly reviewing, investigating, and tracking all incidents involving the risk or potential risk to the health and safety of the people they serve.

The provider is responsible for taking appropriate action on both an individual and systemic basis in order to identify potential harms, or to prevent further harm, to the health and safety of all people served. Incidents shall be classified by the provider as one of the following:

Abuse, Neglect, or Exploitation

Anyone providing services to a person utilizing the TBIW who suspects an incidence of abuse or neglect, as defined in the [Glossary of this Chapter](#), must report the incident to the local West Virginia Department of Health and Human Resources (DHHR) office in the county where the person, who is allegedly abused, lives. Reports of abuse and/or neglect may be made anonymously to the county DHHR office or by calling 1-800-352-6513, seven days a week, 24 hours a day. This initial report must then be followed by a written report, submitted to the local DHHR, within 48 hours following the verbal report. An Adult Protective Services (APS) or Child Protective Services (CPS) worker may be assigned to investigate the suspected or alleged abuse.

Critical Incidents

Critical incidents are incidents with a high likelihood of producing real or potential harm to the health and welfare of the person utilizing the TBIW. These incidents might include, but are not limited to, the following:



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Attempted suicide, or suicidal threats or gestures.
- Criminal activity that is suspected or observed by the person themselves, their families, health care providers, concerned citizens, or public agencies that does not compromise the health or safety of the person.
- An unusual event such as a fall or injury of unknown origin requiring medical intervention if abuse and neglect is not suspected.
- A significant interruption of a major utility, such as electricity or heat in the person's residence, but does not compromise the person's health or safety.
- Environmental/structural problems with the person's home, including inadequate sanitation or structural damage that does not compromise the person's health or safety.
- Fire in the home resulting in relocation or property loss that does not compromise the person's health or safety.
- Unsafe physical environment in which the personal attendant professional and/or other agency staff are threatened or abused, and the staff's welfare is in jeopardy.
- Disruption of the delivery of TBIW services, due to involvement with law enforcement authorities by the person and/or others residing in the person's home that does not compromise the person's health or safety.
- Medication errors by the person or his/her family caregiver that do not compromise the person's health or safety such as medication taken that was not prescribed or ordered for the person, and failure to follow directions for prescribed medication, including inappropriate dosages, missed dosages, or dosages administered at the wrong time.
- Disruption of planned services for any reason that does compromise the person's health or safety, including failure of the person's emergency backup plan.
- Any other incident judged to be significant and potentially having a serious negative impact on the person, but does not compromise the person's health or safety.
- Any incident attributable to the failure of TBIW provider staff to perform his/her responsibilities that compromises the person's health or safety is considered to be neglect and must be reported to [APS](#) or [CPS](#).

Simple Incidents

Simple incidents are any unusual events occurring to a person that cannot be characterized as a critical incident and does not meet the level of abuse or neglect. Examples of simple incidents include, but are not limited to, the following:

- Fall or other incident that does not require minor first aid or medical intervention.
- Minor injuries of unknown origin with no detectable pattern
- Dietary errors with minimal or no negative outcome

512.4.1 Reporting Requirements, Incident Management Documentation and Investigation Procedures

Any incidents involving a person utilizing the TBIW must be reported to the UMC (or when available) entered into the WV IMS within the next business day of learning of the incident. The agency director, designated agency staff, or case manager will immediately review each incident report. All critical

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

incidents must be investigated. All incidents involving abuse, neglect and/or exploitation must be reported to APS or CPS and the UMC (and noted in WV IMS when available).

An Incident Report documenting the outcomes of the investigation must be completed and reported to the UMC (or when available entered into the WV IMS) within 14 calendar days of learning of the incident.

Each Incident Report must be printed, reviewed and signed by the director and placed in an administrative file. Providers are to report monthly if there were no incidents.

If a death occurs in addition to reporting to the UMC (or WV IMS when available), the case manager must complete the Mortality Notification form within the next business day of learning of the death of a person utilizing the TBIW, and send the form to the UMC.

Personal attendant service provider agencies must report to the UMC (or WV IMS when available) monthly the number of hospitalizations which occurred during the month. In addition, providers are to report if there were no incidents.

For *Personal Options*, the resource consultant must report any incidents to the UMC (or in the WV IMS when available) as well as notify the case manager within the next business day of learning of the incident. All incidents involving abuse, neglect and/or exploitation must be reported to APS or CPS, but also must be reported to the UMC (and noted in WV IMS when available). If the case manager becomes aware of an incident before the resource consultant the case manager must report the incident to the resource consultant. The UMC reviews each incident, investigates and reports (enters into WV IMS when available) the outcomes of the investigation within 14 calendar days of the incident.

The WV IMS does not supersede the reporting of incidents to APS or CPS. At any time during the course of an investigation should an allegation or concern of abuse or neglect arise, the provider, or the UMC investigating *Personal Options* related incidents, shall immediately notify [APS](#) per [WV Code §9-6-9](#) or [CPS](#) per [WV Code §49-2-803](#).

An agency is responsible to investigate all incidents, including those reported to APS or CPS. If requested by APS or CPS, a provider shall delay its own investigation and document such request in the online WV IMS (when available). Until then the provider will contact the UMC with such delay requests.

The criteria utilized for a thorough investigation includes but is not limited to:

- Report was fully documented to include the date of the incident, date the agency learned of the incident, facts of the incident type of incident, initial determination of the incident and verification that an approved professional conducted the investigation.
- All parties were interviewed and incident facts were evaluated.
- Person was interviewed.
- Determination of the cause of the incident.
- Identification of preventive measures.
- Documentation of any action taken as the result of the incident (worker training, personnel action, removal of staff, changes in the Service Plan) and
- Change in needs were addressed on the Service Plan.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.4.2 Incident Management Tracking and Reporting

Provider agencies must review and analyze incident reports to identify health and safety trends. Identified health and safety concerns and remediation strategies must be incorporated into the agency Quality Management Plan. The Quality Management Plan must be made available to the UMC monitoring staff at the time of the provider monitoring review or upon request.

The resource consultant has a tracking/reporting responsibility defined in their contract with the BMS.

512.5 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

Documentation and record retention general requirements for TBIW program provider agencies include, but are not limited to:

- TBIW program provider agencies must comply with the documentation and maintenance of records requirements described in [Chapter 100, General Administration and Information](#); and [Chapter 300, Provider Participation Requirements](#) of the BMS Provider Manual. This can be found on the BMS website at <http://www.dhhr.wv.gov/bms/Pages/Manuals.aspx>.
- TBIW program provider agencies must comply with all other documentation requirements of this chapter.
- All required documentation must be maintained by the TBIW provider for at least five years in the file of the person receiving TBIW services file subject to review by authorized BMS personnel or contracted agents. In the event of a dispute concerning a service provided, documentation must be maintained until the end of the dispute or five years whichever is greater.
- 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.
- 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

TBIW program provider agencies must maintain a specific record for all services received for each person utilizing the TBIW Program including, but not limited to:

- Each TBIW provider who provides case management services is required to maintain all required TBIW documentation for state and federal monitors.
- All TBIW program forms as applicable to the policy requirement or service code requirement.
- Agencies may only use forms developed and published by the BMS (refer to [Chapter 300, Provider Participation Requirements](#), for a description of general requirements for Medicaid record retention and documentation). This can be found on the BMS website at <http://www.dhhr.wv.gov/bms/Pages/Manuals.aspx>.
- All providers of waiver services must maintain records to substantiate that services billed by the TBIW Program provider agency were provided on the dates listed and were for the actual amount of time and number of units claimed.



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Day-to-day documentation for services by a provider agency is to be maintained by the provider agency that provides and bills for said service. Monitoring and review of services as related to the Service Plan or monthly summary (visit) are to be maintained in the case management provider record.
- In the course of monitoring of the Service Plan 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.
- Required on-site documentation may be maintained in an electronic format as long as the documentation is accessible to individuals who may need to access it.
- Electronic health record and electronic signature requirements described in [Chapter 100, General Administration and Information](#) of the BMS Provider Manual.

PROGRAM ELIGIBILITY AND ENROLLMENT

512.6 TBIW PROGRAM ELIGIBILITY

Documentation Applicants for the TBIW Program must meet all of the following criteria to be eligible for the program:

- Be three years of age or older.
- Be a permanent resident of West Virginia.
- Have a traumatic brain injury defined as a non-degenerative, non-congenital insult to the brain caused by an external physical force resulting in total or partial functional disability and/or psychosocial impairment or an injury caused by anoxia due to near drowning.
- Be approved as medically eligible for nursing facility level of care.
- Score at a Level VII or below on the Rancho Los Amigos Levels of Cognitive Functioning Scale.
- Ages three to 17 years of age must score at a Level II or higher on the Rancho Los Amigos Pediatric Level of Consciousness Scale.
- Be inpatient in a licensed nursing facility, an inpatient hospital, a licensed rehabilitation facility to treat TBI, or living in a community setting at the time of application.
- Meet the Medicaid waiver financial eligibility criteria for the program as determined by the county DHHR office, or the Social Security Administration (SSA), if an active SSI (Supplemental Security Income) recipient.
- Choose to participate in the TBIW program as an alternative to nursing facility care.

The applicant must first meet the financial eligibility requirements before a determination of the applicant's medical eligibility will be made. A funded slot must be available for him/her to participate in the program. If no funded slots are available, applicants determined financially and medically eligible for the Program will be placed on a waiting list known as the Managed Enrollment List (MEL). As funded slots become available, applicants on the Managed Enrollment List will be notified and provided detailed instructions on continuing the enrollment process. Eligible applicants are assigned an available funded slot on a first on first off basis, i.e. the first person on the MEL is the first person off the MEL.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.7 FINANCIAL ELIGIBILITY – PRE-MEDICAL ELIGIBILITY

The financial eligibility process starts once an applicant applies to the TBIW program by submitting the initial Medical Necessity Evaluation Request (MNER) form to the UMC.

The UMC will process a complete MNER and send the following documents to the applicant/applicant's representative (if applicable): Notice of Receipt of MNER, DHS-2 Form (Yellow), instructions for determining financial eligibility and Service Delivery Model Selection form and Freedom of Choice-Provider Selection forms (case management and personal attendant agencies) with instructions for returning completed selections forms to the UMC.

The UMC will send the Notice of Receipt of initial MNER to referring entity.

The applicant/applicant's representative (if applicable) must submit the yellow DHS-2 form to their local county DHHR office to determine financial eligibility. The yellow DHS-2 form will include an expiration date. It will not be accepted at the county DHHR office after the expiration date.

Upon receipt of the completed Freedom of Choice Case Management Selection form the selected case management agency will be informed by the UMC. Within five business days of receipt of this notification, the case manager must make an initial contact by telephone or face-to-face with the applicant/applicant's representative (if applicable) to offer assistance in determining financial eligibility. The applicant/applicant's representative (if applicable) and/or case manager must submit a yellow DHS-2 form along with a letter from the UMC to the county DHHR office to determine financial eligibility based on TBIW criteria.

Factors such as income and assets are taken into consideration when determining eligibility. An applicant's gross monthly income may not exceed 300% of the current maximum SSI payment per month for participation in the TBIW program. Some assets of a couple are protected for the spouse who does not need nursing home or home and community based care and these assets are not counted to determine eligibility for the individual who needs care in the home.

If the applicant is determined financially ineligible by the county DHHR office a medical eligibility assessment will not be scheduled by the UMC and the MNER will be closed. The UMC will notify the applicant/applicant's representative (if applicable) that the MNER has been closed due to financial ineligibility.

512.8 FINANCIAL ELIGIBILITY – COMING OFF THE MANAGED ENROLLMENT LIST

If the applicant has been placed on the Managed Enrollment List (MEL), when a funded slot becomes available, the applicant and the case management agency will be notified by the UMC.

If applicant is released from the MEL within 90 days from the date on the completed DHS-2 form, financial eligibility is considered valid and the case management agency will submit a request to enroll the person to the UMC.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

If applicant is released from the MEL and 90 days from the date on the completed DHS-2 form has expired, financial eligibility is no longer considered valid and the UMC will send a MEL Letter, a white DHS-2 form and instructions that continuing financial eligibility must be verified by the DHHR county office, to the applicant/applicant's representative (if applicable) and the selected case management agency.

Upon receipt of the white DHS-2 form, the case management agency will sign and date the form and fax the form to the applicant's county DHHR office. The case management agency will inform the applicant/applicant's representative (if applicable) that the DHS-2 form has been submitted to his/her county DHHR office.

The MEL Applicant must be enrolled in the TBIW program within 60 calendar days from the dated DHS-2 form.

Applicants must establish financial eligibility at their local DHHR office. This is evidenced by the DHS-2 form signed by the staff at the local DHHR office verifying the applicant is either financially eligible or ineligible. This process can take up to 30 days for final determination. Therefore, it is imperative the process begin immediately. If the applicant presents the DHS-2 form after the expiration date, 60 calendar days from the dated DHS-2 form, financial eligibility for the TBIW program is denied.

Case managers must notify the UMC when the financial eligibility process has been initiated. If the financial eligibility process and enrollment are not completed within 60 calendar days, the UMC will close the referral and notify the applicant. The letter will include the reason for the closure, the applicable TBIW policy Chapter section(s), notice of free legal services, and a Request for Hearing form to be completed if the applicant wishes to contest the decision. The letter will outline specific timeframes for filing an appeal.

If the applicant wants TBIW services after the closure, a new MNER form is required to be sent to the UMC and the application process started again. The BMS will ensure that all closed referrals will be reviewed before releasing the slot to the next applicant on the MEL.

TBIW services cannot be paid until an applicant's financial eligibility is established and the enrollment process has been completed with the UMC. (Refer to [Section 512.10, Enrollment](#)) If the person has been on another waiver program, no services may be charged prior to an applicant's discharge from the other waiver program.

Termination of the Medicaid benefit itself (e.g., the Medicaid card) always requires a 13 calendar day advance notice prior to the first day of the month that Medicaid stops. Coverage always ends the last day of a month unless otherwise dictated by policy. Examples: (1) Advance notice for termination is dated January 27, Medicaid would end February 28. (2) Advance notice is dated January 16, Medicaid ends January 31. This is true regardless of when TBIW services end.

512.9 MEDICAL ELIGIBILITY

The UMC is responsible for evaluating medical eligibility, conducting assessments, and determining if medical eligibility requirements for the TBIW program are met.

The purpose of the medical eligibility review is to ensure the following:

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- New applicants and existing people utilizing the TBIW are medically eligible based on current and accurate evaluations.
- B. The medical eligibility determination process is fair, equitable, and consistently applied throughout the State.

If the person has been receiving services from another waiver program, no services can be reimbursed prior to an applicant's closure from the other waiver program. The only exception is case management which may be provided 30 days prior to closure.

512.9.1 Medical Criteria

A person must have five deficits as described on the Pre-Admission Screening (PAS) form to qualify for nursing facility level of care. These deficits are derived from a combination of the following assessment elements on the PAS.

Section	Description of Deficits	
#24	Decubitus; Stage 3 or 4	
#25	In the event of an emergency, the person is c) mentally unable or d) physically unable to vacate a building. a) Independently and b) With Supervision are not considered deficits	
#26	Functional abilities of the person in the home	
a.	Eating	Level 2 or higher (physical assistance to get nourishment, not preparation)
b.	Bathing	Level 2 or higher (physical assistance or more)
c.	Dressing	Level 2 or higher (physical assistance or more)
d.	Grooming	Level 2 or higher (physical assistance or more)
e.	Continence, bowel	Level 3 or higher; must be incontinent.
f.	Continence, Bladder	
g.	Orientation	Level 3 or higher (totally disoriented, comatose).
h.	Transfer	Level 3 or higher (one-person or two-person assistance in the home)
i.	Walking	Level 3 or higher (one-person assistance in the home)
j.	Wheeling	Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home. Do not count outside the home.)
k.	Vision	Level 3 or higher (Impaired/ Not Correctable)
l.	Hearing	Level 3 or higher (Impaired/ Not Correctable)
m.	Communication	Level 3 or higher (Understandable with aids)
#27	The person has skilled needs in one or more of these areas: (a) Physical therapy, (b) Speech Therapy, (c) Occupational Therapy, (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.	



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Section	Description of Deficits
#28	The person is not capable of administering his/her own medications or needs prompting/supervision
#34 Clinical and Psychological Data- behaviors	(f) Disoriented), (k) Seriously Impaired Judgment, (m) Cannot communicate basic needs, (p) Physically Dangerous to Self and Others, If Unsupervised

Applicants and people re-determining medical eligibility must also score at the levels on the Ranchos Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale as previously stated in this manual. Information on these tools can be found on the [TBIW Program](#) website.

512.9.2 Initial Medical Evaluation

Following is an outline of the initial medical evaluation process:

- An applicant shall initially apply for the TBIW program by having his/her treating physician (MD or DO), Physician's Assistant (PA), Neuropsychologist, or Nurse Practitioner (NP) (here after called the referent) complete and sign a MNER form including ICD diagnosis code(s). The referent, applicant, family member, advocate, or other interested party, may submit this form by fax, mail or electronically to the UMC. The UMC will not process any MNER form if the referent's signature is more than 60 calendar days old. If the MNER form is incomplete, it will be returned for completion and resubmission within two weeks, and the applicant will be notified.
- Once a completed and signed MNER is received, the UMC will send a yellow DHS-2 form to the applicant, so financial eligibility can be established. The Service Delivery Model Selection form, the Freedom of Choice Case Management Selection form and Personal Attendant Selection form will also be included. Making selections does not ensure eligibility for the TBIW program.
- Once the completed DHS-2 form is returned, if financially eligible, the UMC will attempt to contact the applicant and/or legal representative (if applicable) to schedule the assessment. If contact is made, a notice shall be sent to the individual and legal representative informing them of the scheduled appointment, location, date and time.
- The UMC will make up to three attempts to contact the applicant and/or legal representative (if applicable). UMC will issue a potential referral closure letter to the applicant (or legal representative) and the referent. If no contact is made with the UMC within 10 business days, the referral will be closed. If the applicant chooses to have the evaluation after the referral is closed, a new referral is required if the referent's signature on the MNER is greater than 60 calendar days.
- If the MNER form indicates that the applicant has a guardian or legal representative, the assessment will not be scheduled without the guardian/ legal representative present to assist the applicant.
- If the applicant is not financially eligible, the MNER will be closed and the applicant and/or legal representative will be notified.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.9.2.1 Results Of Initial Medical Evaluation

Approval

If the applicant is determined medically eligible and a funded slot is available, a notice of approved medical eligibility, a copy of the PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale, is mailed to the applicant and/or legal representative (if applicable) and the referent. The notice and assessments will be sent by fax or secure e-mail to the referent, the case management agency, and the personal attendant agency or the F/EA (depending which service model has been selected by the applicant) as well as the TMH office, if applicable. The case manager must use the Initial Contact Log at this point.

If the applicant is determined medically eligible and a funded slot is not available, a notice of approved medical eligibility will be sent to the applicant and/or legal representative (if applicable) and the referent informing them a slot is not currently available and the person will be placed on the MEL and they will be contacted when one becomes available. When a slot becomes available, the applicant and/or the legal representative (if applicable) will be sent a letter. The case management agency, referent, and the (F/EA if applicable) will also be notified. The case manager must use the Initial Contact Log at this point. If the 90 day financial eligibility has expired, financial eligibility must be re-determined. [Please see [Section 512.8 Financial Eligibility - Coming Off the Managed Enrollment List \(MEL\)](#)].

Denial

If it is determined that the applicant does not meet medical eligibility, the applicant and/or the legal representative (if applicable), referent and case management agency will be notified by a Potential Denial-Additional Information Needed letter. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found. A copy of the PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale and the applicable TBIW policy Chapter section(s) will also be included with the Potential Denial-Additional Information Needed letter. The applicant will be given thirty calendar days to submit supplemental medical information to the UMC. Information submitted after the thirty calendar day period will not be considered in the eligibility determination. However, it may be used during a pre-hearing conference or Medicaid Fair Hearing. Please Note: a Potential Denial-Additional Information Needed letter is not a denial of service and a request for Fair Hearing should not be made at this time.

If the review of the supplemental information by the UMC determines the applicant is not medically eligible, the applicant and/or the legal representative (if applicable), case management agency and the referent will be notified by a Final Denial letter. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable TBIW policy Chapter section(s), a copy of the PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale, supplemental medical information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing Form to be completed if the applicant wishes to contest the decision.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

If the applicant's medical eligibility is denied and the applicant is subsequently found medically eligible after the Fair Hearing process, the date of eligibility can be no earlier than the date of the hearing decision.

512.9.3 Medical Re-Evaluation

Annual re-evaluations for medical eligibility for each person utilizing the TBIW must be conducted. The process is as follows:

- A MNER form must be submitted to the UMC after being signed and dated by the person and/or the legal representative (if applicable) and referent. The forms must be provided to the UMC and a copy of the original form with the signatures must be maintained by the referent in the person's file. The case manager must check the reevaluation line at the top of the form. A referent's signature is required annually and must include the ICD diagnosis code(s).
- The request can be submitted up to 90 calendar days prior to the anchor date, and no later than forty-five calendar days prior to the anchor date. A person's medical eligibility is at risk if the MNER submitted less than forty-five calendar days prior to the anchor date. MNERs received after the anchor date does not constitute a reason for an appeal.
- After receiving the reevaluation request, the UMC will attempt to contact the person and/or the legal representative (if applicable) to schedule an assessment.
- If the MNER form indicates that the person has a legal representative the assessment will not be scheduled without the legal representative present to assist the person.
- If the UMC makes the contact, a letter is sent to the person and/or the legal representative (if applicable) and case management agency noting the date, location and time of the assessment.
- If the UMC is unable to contact the person and/or the legal representative (if applicable) within three attempts, a potential closure letter will be sent to the person and/or the legal representative (if applicable) and the case management agency and personal attendant agency and/or the F/EA (if applicable) also the TMH office if applicable.
- If no contact is made with the UMC within 10 business days of the date of the potential closure letter, the UMC will send the final denial letter to the person and/or the legal representative (if applicable) the referent and the case management and personal attendant agency and/or F/EA (if applicable). The UMC will close the case.

512.9.3.1 Results of Medical Re-evaluation

Approval

If the person meets the medical eligibility criteria, a Notice of Approved Continued Medical Eligibility is sent to the person and/or the legal representative (if applicable) and to the case management agency. For a person enrolled in the Traditional Model, this notice includes their completed PAS and the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale. For a person enrolled in *Personal Options*, this notice includes their completed PAS and the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale. The case management agency is responsible for sending the Notice of Approved Continued Medical Eligibility to the Personal Attendant agency.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Denial

If it is determined that the person does not meet medical eligibility, the person and/or the legal representative (if applicable), the referent, and the case management agency will be notified by a Potential Denial letter. This letter will advise the person of the reason(s) for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale and TBIW policy will also be included with the Potential Denial Letter. The person will be given 30 days to submit supplemental medical information to the UMC. Supplemental information received by the UMC after the 30 day period will not be considered. However, it may be used during a pre-hearing conference or Medicaid Fair Hearing.

If the review of the supplemental information by the UMC determines that there is still no medical eligibility, the person (or legal representative), referent, personal attendant agency or the F/EA (if applicable) and the case management agency will be notified with a Final Denial letter. The Final Denial letter will provide the reason for the adverse decision. It will also include the applicable TBIW policy Chapter section(s), a copy of the PAS and the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale, supplemental medical information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing Form to be completed if the person wishes to contest the decision.

If the person elects to appeal any adverse decision, benefits shall continue at the current level only if the appeal is mailed within 13 calendar days of the notice date, and shall continue only until a final decision is rendered by the administrative Hearing Officer. If the hearing decision affirms the denial of medical eligibility TBIW services shall be terminated immediately. Medicaid will not pay for services provided to a medically ineligible person.

512.10 ENROLLMENT

Once an applicant has been determined both financially and medically eligible, the case manager must request program enrollment from the UMC by completing an Enrollment Request Form. The UMC will complete the enrollment and provide a confirmation notice to the case management agency and the personal attendant service provider agency or the F/EA, if the person chose *Personal Options*.

No Medicaid reimbursed TBIW services may be provided until the case management agency is in receipt of the person's Enrollment Confirmation Notice. For monthly reporting purposes, agencies are to report a person utilizing the TBIW as active the month the agency receives their confirmation notice for that person.

The case management agency is responsible for maintaining a copy of the Enrollment Request Form and the Enrollment Confirmation Notice in the person's file. The personal attendant agency is responsible for maintaining a copy of the Enrollment Confirmation Notice in the person's file.

The F/EA must maintain a file which contains the Enrollment Confirmation Notice for a person choosing *Personal Options*. The confirmation notice initiates the initial phone contact to the person within three business days.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

The person's waiver case will be closed if services are not provided within 180 days of the date of enrollment in the program.

512.11 DESCRIPTION OF SERVICE OPTIONS

Two service options are offered in the TBIW:

1. Traditional Service Option
2. Participant-Directed Service Option (as provided by the *Personal Options* Financial Management Service)

A person who receives services may choose either service option at any time by completing a Request to Transfer Form.

512.11.1 Traditional Service Option

The Traditional Service Option is available to every person who receives TBIW services.

If the person who receives services chooses this service option, all services accessed will be done so through a TBIW provider after being determined necessary, appropriate, and within the assessed needs. The TBIW provider has employer authority as well as fiscal responsibility for the services listed on the service plan of the person who receives services. These services are provided where the person who receives services resides and participates in community activities.

The following services are available via the Traditional Service Option:

- Personal attendant
- Case management
- Non-medical transportation

When a person who receives services accesses all services via the Traditional Service Option, the assessed budget is utilized to access services. Based on assessments, the team identifies needed services and addresses those on the Service Plan.

Once the team determines the services, the case manager documents on the Service Plan and requests the units agreed upon in the UMC web portal when available, until such time request for units will be made to the UMC. All requested units must be within the assessed budget.

The hourly wage of agency staff employed by a TBIW provider is determined by the agency that employs the staff person, and must comply with all local, state, and federal employment requirements. All Agency Staff hired by a TBIW provider must meet the requirements listed in the applicable [Agency Staff Qualifications in Section 512.3 and its subparts](#).

If receiving all services via the Traditional Services Option, the TBIW provider is the common law employer, or employer of record, of the agency staff hired.

As the common law employer, the TBIW provider is responsible to:

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Recruit and hire qualified agency staff;
- Provide required training to agency staff, including training on needs specific to the person who receives services;
- Determine agency staff work schedule and how and when agency staff should perform the required tasks;
- Determine agency staff daily activities;
- Evaluate agency staff performance;
- Maintain and process agency staff payroll;
- Maintain documentation in a secure location and ensure employee confidentiality; and
- Discharge agency staff, when necessary.

With regard to the provision of Traditional Option services, the UMC is responsible to:

- Conduct agency satisfaction surveys with a sample of persons who receives services and their representatives (when applicable), and receive and analyze the survey results and report them to the BMS annually; and
- Conduct provider reviews on a defined cycle using an approved review protocol based on TBIW requirements.
- Authorize services within the person's assessed budget.

512.11.2 Participant-Directed Service Option

The Participant-Directed Service Delivery Model is available to every person who receives TBIW services.

The person who chooses this service option has the opportunity to exercise choice and control over the participant-directed services they choose and the individuals and the organizations who provide them (employer authority); and/or how the portion of their budget associated with participant-directed services is spent (budget authority). The participant-directed services over which persons who receive services have the opportunity to exercise choice and control are personal attendant and non-medical transportation.

Once all of the equivalent monies are transferred into the their budget, the person who receives services and their representative (if applicable), along with their *Personal Options* resource consultant, create a spending plan. At this time, the person who receives services and their representative (if applicable) chooses the types of services, the amount of services, and the wages of the person's employees within the parameters of their entire budget.

The hourly wage of personal attendant staff employed by a person who receives TBIW services may not exceed the Medicaid rate minus all mandatory deductions and must be at least the current minimum wage amount. All personal attendant staff hired by the person who receives services must meet the requirements listed under [Personal Attendant Section 512.3.3](#), [Section 512.3.4](#), [Section 512.3.5](#), [Section 512.3.6](#), and [Section 513.3.7](#).

The person who chooses to participant-direct their TBIW services will do so with the support of a FMS through the *Personal Options* program. If utilizing *Personal Options*, the person who receives services is the common law employer, or employer of record, of the personal attendant staff hired.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

To assist with functions related to being the common law employer, the person who receives services may appoint a program representative. A program representative may not be a paid employee providing *Personal Options* TBIW services to the person who receives services.

As the common law employer, the person who receives services 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 personal attendant staff, develop a spending plan for the participant-directed budget, and create an emergency personal attendant staff back-up plan to ensure staffing, as needed;
- Recruit and hire their personal attendant staff;
- Provide required training to personal attendant staff, including training on needs specific to the person who receives services;
- Determine personal attendant staff work schedule and how and when the personal attendant staff should perform the required tasks;
- Determine personal attendant staff daily activities;
- Evaluate personal attendant staff performance;
- Review, sign, and submit personal attendant staff timesheets to the *Personal Options* FMS;
- Maintain documentation in a secure location and ensure employee confidentiality;
- Discharge personal attendant staff, when necessary; and
- Notify the case manager of any changes in service need.

The *Personal Options* FMS acts as the F/EA to the person who receives services, 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 person who receives services;
- Monitor spending of budget funds in accordance with approved spending plans;
- Submit claims to the state's claim processing agent on behalf of the person who receives services/employer;
- Process and pay invoices for non-medical transportation in the person's approved participant-directed spending plan;
- Assist persons who receive services in exercising employer authority;
- Assist the person who receives services in verifying workers' citizenship or legal alien status (e.g., completing and maintaining a copy of the USCIS Form I-9 for each support service worker the person who receives services employs);
- Assist in submitting criminal background checks through the WV CARES of prospective personal attendant staff;
- Collect and process personal attendant staff timesheets;
- Operate a payroll service, (including withholding taxes from workers' pay, filing and paying Federal (e.g., income tax withholding, Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA), state (e.g., income tax withholding and State Unemployment Tax Act (SUTA), and, when applicable, local employment taxes and insurance premiums);
- Distribute payroll checks on behalf of the person who receives services;

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Execute simplified Medicaid provider agreements on behalf of the Medicaid agency;
- Provide orientation/skills training to persons who receive services about their responsibilities when they function as the employer of record of their personal attendant staff;
- Provide ongoing information and assistance to common law employers; and
- Monitor and report data pertaining to quality and utilization of the *Personal Options* FMS as required to the BMS.
- Evidence of initial and annual personal attendant training as required by policy.

The *Personal Options* FMS is not the common law employer of the personal attendant staff of the persons who receive services. Rather, the *Personal Options* FMS assists the person who receives services/Common Law Employer in performing all that is required of 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 through the resource consultants to common law employers to support their use of participant-directed services and to perform effectively as the common law employer of their personal attendant staff. I&A provided by the *Personal Options* FMS include:

- Common law employer orientation sessions once the person who receives services chooses to use participant-directed services and enrolls with *Personal Options*;
- Skills training to assist common law employers to effectively use participant-directed services and the FMS and perform the required tasks of an employer of record of personal attendant staff.
- Common law employer orientation provides information on:
 - The 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, service coordinator, BMS),
 - How to use *Personal Options*,
 - How to effectively perform as a common law employer of their personal attendant staff,
 - How to ensure that the common law employer is meeting Medicaid and *Personal Options* requirements, and,
 - How a person who receives services would stop using participant-directed services and begin to receive traditional services, if they so desire.

The *Personal Options* FMS provides Information & Assistance (I&A) supports to persons 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 persons who receive services, their representative, personal attendant staff, and the BMS. The materials also address what is required of the person who receives services in order to be a common law employer, and provide a venue through which a person who receives services may enroll in the Participant-Directed Service Delivery Model. The *Personal Options* FMS also makes available materials to persons who receive services and their representatives (when applicable), to implement and support their use of participant-directed services and performing as employer of record.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

If the Participant-Directed Service Delivery Model is selected by the person who receives services, 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 assisting with the completion of enrollment packets for common law employers;
- Providing and assisting the common law employer with employment packets;
- Presenting the common law employer with the *Personal Options* FMS' role in regards to payment for services;
- Assisting common law employers with determining budget expenditures (hiring);
- Assisting with the development of an individualized spending plan based upon the annual budget;
- Making available to the person who receives services/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 person who receives services, representative, case manager, and the BMS; and
- Explaining all costs/fees associated with participant-directing to the person who receives services.

With regard to the provision of participant-directed services, the UMC is responsible to:

- Distribute the *Personal Options* FMS satisfaction survey, developed by the BMS, to persons who participant-direct their services or their representatives (when applicable) and receive and analyze the survey results and report them to the BMS annually; and
- Conduct *Personal Options* FMS performance reviews on a defined cycle using a review protocol based on the *Personal Options* FMS requirements.
- Review and authorize training materials developed by the F/EA.

People receiving TBIW services may appoint a program representative to help them with the responsibilities of self-direction. This may be a family member or friend. They cannot be paid for assisting a person with their employer responsibilities or hired by a person to provide personal attendant services. The program representative must be at least 18 years old. (Refer to the F/EA *Personal Options* Program and Employer Guide for more information and details).

If a person continually has difficulties managing their services and there is supporting documentation the F/EA resource consultant in consultation with BMS may require the person to appoint a program representative to assist with employer responsibilities. If the person refuses to choose a program representative, the person will be required to transition to a Traditional Service Model. In rare cases it may be recommended that a person transfer from *Personal Options* to a Traditional Service Model so that services can be more closely monitored. the resource consultant will consult with the BMS when recommending a person change to a Traditional Service Model. The BMS will make the final decision if a person will be required to make the transition.

512.12 PERSON-CENTERED ASSESSMENT

Assessment is the structured process of interviews which is used to identify the person's abilities, needs, preferences, and supports; determine needed services or resources; and provide a sound basis for

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

developing the Person-Centered Service Plan. A secondary purpose of the assessment is to provide the person with a good understanding of the program, services, and expectations. Once the Enrollment Confirmation Notice has been received by the case management agency the case manager will schedule a home visit within seven calendar days to complete an assessment.

The case manager must work with all service providers to ensure that the program meets the person's needs.

A new assessment must be completed when a person's needs change. Changes in a person's needs are to be incorporated into the Person-Centered Service Plan. Case managers are to share any changes in a person's assessment with all service providers listed on the person's Service Plan. The personal attendant provider agency is to share any changes observed in the person with the case manager. A copy of all assessments must be provided to the person and/or their legal representative (if applicable) and the personal attendant provider agency and the F/EA, if self-directing.

512.13 PERSON-CENTERED SERVICE PLAN DEVELOPMENT

The case manager is responsible for development of the Person-Centered Service Plan in collaboration with the person and/or their legal representative (if applicable). All Service Plans must be developed using a person-centered approach as required by the CMS. CMS specifies that service planning must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. It is required that the person-centered planning process be directed by the person receiving waiver services, and may include representatives and others chosen by the person to contribute to the process. The minimum requirements for person-centered plans developed through this process, include:

- A person-centered plan with individually identified goals and preferences,
- Will assist the person in achieving personally defined outcomes in the most integrated community setting,
- Ensure delivery of services in a manner that reflects personal preferences and choices, and
- Contribute to the assurance of health and welfare.

Participation in the development of the Initial Service Plan is mandatory for the person and their representative (if applicable) and case manager.

The person and their representative (if applicable) may choose to have whomever else they wish to participate in the process (personal attendant provider agency staff, other service providers, informal supports, resource consultant (if applicable) etc.).

The Service Plan meeting must be scheduled and held within seven calendar days of the person's assessment. If agreed upon by the case manager and the person receiving TBIW services the assessment and Service Plan meeting can be held at the same time or sooner. The assessment and Service Plan meetings cannot exceed the total time frame of 14 calendar days from the date of the confirmation of enrollment without prior notification to the UMC.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

The Service Plan must detail all services (service type, provider of service, frequency) the person is receiving, including any informal/natural supports (family, friends, etc.) that provide assistance and address all needs identified in the PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale, and the assessment, etc. For children enrolled in the public school system, the Service Plan must identify the type of educational services (public or home schooled) and the hours during the day in which these services are provided. The Service Plan must also address the person's preferences and outcomes. It is the case manager's responsibility to ensure that all assessments are reviewed with the person and considered in the development of the Service Plan.

The case manager must send the person's Service Plan, assessment, and Request for Service Authorization form (which identifies the person's budget) to the UMC within five calendar days of the Service Plan meeting. The UMC will review the request for service authorization and when approved will provide the Prior Authorization Notice and approved final Budget to the case management agency, Personal Attendant Agency or the F/EA (if applicable). It is the case management agency's responsibility to send a copy of the Service Plan, Person-Centered Assessment and the approved final budget to the person and/or their legal representative (if applicable) within seven business days from receipt of approval from the UMC. The case management agency must have the original documents in the person's file.

The Service Plan must contain reference to any other service(s) received by the person, regardless of the source of payment. A TBIW provider agency that provides private-pay services to a person must ensure that documentation is maintained separately.

TBIW services are not intended to replace supports/services that a child would receive from the school system during a school day or educational hours provided during home schooling.

If there is a disagreement regarding services listed on the Service Plan being developed, the person or legal guardian if applicable can follow the agency's grievance process. The person will receive services listed on the Service Plan that is being disagreed with throughout the grievance process.

512.13.1 Six-Month Ongoing Service Plan Development and Service Plan Addendum

Participation in the six-month Service Plan and Annual Service Plan development is mandatory for the person and their representative (if applicable), the case manager, and the personal attendant provider agency. The person and their representative (if applicable) may choose to have whomever else they wish to participate in the process such as personal attendant professional, family members, other service providers, informal supports, resource consultant (if applicable) etc.

A Service Plan Addendum is completed to document a change in the person's needs. These changes would include such things as an additional service needed after release from a hospital, a person wants to change days of week or times they receive services, or an informal support is going to provide the service for the person as opposed to the personal attendant. **A Service Plan Addendum does not take the place of a required six-month or annual Service Plan meeting.**

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.13.2 Interim Service Plan Development

In order to begin services immediately to address any health and safety concerns, an Interim Service Plan may be developed and implemented upon the confirmation of a person's enrollment by the UMC. The Interim Service Plan can be in effect up to 21 calendar days from the date of a person's Enrollment Confirmation Notice to allow time for assessments to be completed, the Service Plan meeting to be scheduled and the Service Plan to be developed.

If the case management agency develops an Interim Service Plan, the personal attendant provider agency must initiate personal attendant services within three business days.

An Interim Service Plan is only available to people who have chosen to use the Traditional Service Model.

512.13.3 Budget Development

A person's budget is developed once their Person-Centered Service Plan is completed. A person utilizing the TBIW program would have access to an annual maximum budget of \$35,000.00. Not everyone will receive the maximum budget amount. An individual budget is based on the frequency of program covered services as outlined in the Person-Centered Service Plan.

The UMC will prorate a person's budget when necessary to align with the person's anchor date.

People choosing *Personal Options*, the Participant-Directed Model, will also develop a Spending Plan based on the budget developed from the Person-Centered Service Plan. The Spending Plan helps people determine how their budget will be used.

The maximum amount of a person's participant-directed budget is the equivalent monetary value of direct care services units (personal attendant) and non-medical transportation units as outlined in the person's service plan.

Once all of the equivalent monies are transferred into the person's participant-directed budget, the person and/or their legal/non-legal representative (if applicable), along with their *Personal Options* resource consultant, create a spending plan. At this time, the person and/or their legal/non-legal representative (if applicable), choose the types of services, the amount of services, and the wages of the person's employees within the parameters of the entire participant-directed budget.

For people new to *Personal Options*, the first month's budget should be prorated to reflect the actual start date of services.

Note: Refer to the [Section 512.15 Covered Services](#) of this Chapter and the [BMS TBIW website](#) to review the current rates.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.14 ACTIVATION OF PERSONAL ATTENDANT SERVICES

Once the Service Plan is developed, the agency providing personal attendant services will begin providing direct care services within five business days, using the Personal Attendant Worksheet to document all services provided.

If the current agency providing personal attendant services is unable to meet this timeline, they must request an emergency transfer unless the person has informal supports in place to safely wait for provider staffing.

TBIW service hours not provided that are listed on the Personal Attendant Worksheet which is part of the Service Plan cannot be made up on a different day. In the *Personal Options* Model, service hours not provided as planned, may be made up on a different day, but not carried over into a new month. Permanent or long-term changes in the services/service hours listed on the Personal Attendant Worksheet must be made through an addendum to the Service Plan by the case manager for both Traditional and Personal Options models.

A copy of all original Personal Attendant Worksheets must be maintained in the person's file to verify services provided.

POLICY

512.15 COVERED SERVICES

The following services are available to people on the TBIW if they are deemed necessary and appropriate during the development of and listed on their Service Plan:

- Case management services
- Personal attendant services
- Non-medical transportation services

TBIW services, eligible for reimbursement by Medicaid, are to be provided exclusively for the person utilizing the program and only for necessary activities as listed in their Service Plan. They are not to be provided for the convenience of others living in the household or others whom the person utilizing the program has contact. Although informal supports are not mandatory in the TBIW program, the program is designed to provide formal support services to supplement, rather than replace, the person's existing informal support system.

512.16 CASE MANAGEMENT SERVICES

Case management activities are indirect services that assist the person in obtaining access to needed TBIW services, other State Plan services, as well as medical, social, educational, and other services, regardless of the funding source. Case management responsibilities also include the completion of the person's assessment, the development of the person's Service Plan, and budget development, the ongoing monitoring of the provision of services included in the Service Plan, monitoring continuing eligibility, health, safety, welfare, and advocacy. Case Managers are required to make at least a monthly

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

telephone contact and a home visit every six months with the person and/or legal representative (if applicable).

Case management includes the coordination of services that are individually planned and arranged for people whose needs may be life-long. The practice of case management helps to avoid duplication and provision of unnecessary services, and to ensure a balance of services. The case manager takes an active role in service delivery; although services are not provided directly by the case management agency, the case manager serves as an advocate and coordinator of care for the person. The case manager must be available to respond to a person in crisis whenever needed. This involves collaboration with the person receiving TBIW services, family members, friends, informal supports, health care, and social service providers.

Procedure Code: T1016 UB
Service Unit: Unit = 15 minutes
Service Limit: 192 - 15 minute units annually

Prior Authorization: All units of service must be prior authorized before being provided.

Documentation Requirements: All contacts with, or on behalf of a person, must be legibly documented within the person's record, including date and time of contact (includes start and stop time), a description of the contact, and the signature of the case manager. At a minimum, the case manager must make contact with the person and/or their legal representative (if applicable) once per month and document the contact on the Case Management Monthly Contact Form. Case management agencies may not bill for non-medical transportation services.

Resource consultant's working for the F/EA are not case managers.

512.16.1 Case Management Responsibilities

The case manager is responsible for follow-up with the person to ensure that services are being provided as described in the Service Plan. Initial contact, via telephone or face-to-face, must be made within seven calendar days after personal attendant services have begun by the personal attendant provider agency. At a minimum, a monthly telephone contact with the person and/or their legal representative (if applicable) and a home visit every six months must be conducted to ensure services are being provided as per the Service Plan, ensure quality of services and to identify any potential issues. Monthly telephone contact must be documented on the Case Management Monthly Contact Form and include detailed information on the status of the person. If a person and/or their legal representative (if applicable) cannot be reached by telephone for the monthly contact, a home visit must be made. At a minimum, the case manager must complete a six month Service Assessment and Service Plan. This must be a face-to-face home visit with the person.

Specific activities to assure that needs are being met also include:

- Assure financial eligibility remains current.
- Assure the health and welfare of the person.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Address a person's changing needs as reported by the person and/or their legal representative (if applicable), personal attendant professional, or informal support.
- Address changing needs determined by the monthly contact with the person.
- Refer and procure any additional services the person may need that are not services the personal attendant provider agency can provide.
- Coordinate with all current service providers to develop the six months Service Plan and the Annual Service Plan (or more often as necessary). It is mandatory that the person and/or their legal representative (if applicable), the case manager and the personal attendant provider agency be present at the six-month Service Plan meeting and the Annual Service Plan meeting.
- Provide the Service Plan to all applicable service providers that are providing services to the person, the TMH transition navigator if applicable and to the *Personal options* resource consultant (if applicable) within seven business days.
- Provide copies of all necessary documents to the person and the personal attendant service provider agency such as Enrollment Confirmation Notice, PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale, and Service Assessment and Service Plan within time frames (Refer to [Section 512.9](#) and [Section 512.10](#))
- Annually submit a MNER to the UMC 90 calendar days prior to the anchor date.
- Upload all required documents into the UMC web portal (when available) such as the enrollment requests, Service Plans, prior authorizations, budgets, assessments, legal representative information, MNER and any other pertinent information.
- Evaluate social, environmental, service, risks and support needs of the person.
 - In collaboration with the person and/or their legal representative (if applicable), develop and write a Person-Centered Service Plan which details all services that are to be provided including both formal and informal (if available) services that will assist the person to achieve optimum function.
- Coordinate the delivery of care, eliminate fragmentation of services, and assure appropriate use of resources.
- Proactively identify problems and coordinate services that provide appropriate high quality care to meet the individualized and often complex needs of the person.
- Provide advocacy on behalf of the person to ensure continuity of services, system flexibility, integrated services, proper utilization of services and resources, and accessibility to services.
- Ensure that a person's wishes and preferences are reflected in the development of a Person-Centered Service Plan by working directly with the person and/or their legal representative (if applicable) and all service providers.
- Inform and assist people and/or their legal representatives (if applicable) of their rights, including information about grievance (Refer to [Section 512.29 Grievance Process](#)) and Fair Hearing processes (Refer to [Section 512.30 Medical Eligibility Appeals](#)).
- Inform people and/or their legal representatives (if applicable) about their choices of service delivery models (Refer to [Section 512.11 Description of Service Options](#))
- Assure that a person's legal and human rights are protected.
- Monitoring the person's risk management, safety and welfare and notify the UMC of concerns.
- Ensuring a seamless transition between Traditional and *Personal Options* Service Delivery Models.
- Report suspicion of abuse/neglect to APS and CPS as case managers are mandatory reporters.



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Discuss whether a legal/non-legal representative is desired and/or needed by a person and inform the UMC and the *Personal Options* resource coordinator (if applicable) of any changes in legal/non-legal representatives on the next business day that the case manager became aware of such a change.
- Providing or linking people with program materials in a format that they can use and understand.
- Explaining person-centered planning and philosophy to people.
- Explaining to people the roles and supports that will be available through each service delivery model.
- Reviewing and discussing the person's budget which is determined by individual needs documented in the person's Service Plan and authorized by the UMC.
- Ensuring that people know how and when to notify the case manager about any operational or support concerns or questions.
- Notifying the UMC and the resource consultant of concerns regarding potential issues which could lead to a person's disenrollment.
- Follow-up with the person regarding additional services or support based on the submission of a critical incident.

512.16.2 Case Management Reporting

The case management agency will complete and submit required administrative and program reports (i.e. Case Management Agency Monthly Report and Monthly Incident Report) as requested by either BMS or the UMC. Monthly reports must be submitted by case management agencies to the UMC by the 6th business day of every month.

512.17 PERSONAL ATTENDANT SERVICES

Personal attendant services are defined as long-term direct care and support services that are necessary in order to enable a person to remain at home rather than enter a nursing home, or to enable a person to return home from a nursing home.

More than one personal attendant agency can provide direct care services to a person receiving services on the TBIW. The agency the person selected on their Freedom of Choice Personal Attendant Form is the primary agency and is responsible for coordinating services. The Service Plan must indicate which agency is the primary agency. There cannot be a duplication of services.

Traditional Model Procedure Code: S5125 UB

Personal Options Model Procedure Code: S5125 UC

Service Unit: 15 minutes

Ratio: 1:1

Service Limits: Personal Attendant Services are limited by the person's budget.

Prior Authorization: All units of service to the Traditional provider must be prior authorized before being provided.

Documentation Requirements: All services provided to a person must be legibly documented on the Personal Attendant Worksheet and maintained within the person's record.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.17.1 Personal Attendant Responsibilities

The Personal attendant's primary function is to provide hands-on personal care assistance outlined in the Service Plan. As time permits, Personal Attendants may also provide other incidental services to personal care assistance such as changing linens, meal preparation, and light housekeeping (sweeping, mopping, dishes, and dusting). At no time may the time spent on incidental services exceed the amount of time spent on hands-on personal care assistance. Personal attendants may also assist the person to complete essential errands and community activities. All services provided must appear on the Service Plan and must be fully documented on required forms and comply with BMS documentation standards. The Personal attendant must inform the case manager of any changes in the person's health, safety, or welfare. (Examples: a person falls (whether the personal attendant was present or not), bruises (whether personal attendant knows origin or not), etc.). Personal attendants must complete all required TBIW training per BMS policy.

Personal attendant services can be provided on the day of admission and the day of discharge from a nursing home, hospital or other inpatient medical facility.

Personal attendant services may include direct care assistance with the following types of ADL:

- Bathing
- Grooming
- Dressing
- Eating
- Prompt for self-administration of medications

Essential Errands: Essential errands are activities that are essential for the person receiving TBIW services to live as independently as possible and remain in his/her own home. Essential errands involve going outside of the person's home for the purpose of conducting the errand with the person or on behalf of the person (when the person is unable to travel outside the home). Examples of essential errands include; grocery shopping, banking, picking up prescriptions, going to the Laundromat. The case manager must document on the Service Plan or the Service Plan Addendum if the person is unable to travel outside the home for any given period of time. These activities are not intended for the benefit of the Personal attendant, family, friends, or others. If informal supports, family, friends, or other resources are available, these resources must be utilized before personal attendant services. Special caution is advised for those people who live with their personal attendant or their personal attendant is a relative to ensure services are for the sole benefit of the eligible person to avoid disallowances. Travel must be conducted in the person's immediate community unless otherwise documented on the Service Plan. The essential errand must have a beginning and ending destination.

Activities include the following types of Instrumental Activities of Daily Living (IADL) for essential errands:

- Shopping for groceries and cleaning supplies or food pantries
- Pick up of prescriptions or over the counter medications at the pharmacy
- Local payment of bills (utility bill(s), phone bill, etc.)
- Banking transactions such as deposits and withdrawals
- Post Office to pick up bills or pay bills
- Assistance with DHHR for benefits or financial eligibility

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Community Activities

Community activities are those that offer the person receiving TBIW services an opportunity to participate and integrate into their local communities and neighborhoods. The purpose of community activities is for person to have the opportunity to interact with others in their immediate community and utilize community resources where other individuals without a disability might go and engage in community life. The person's immediate community is a reasonably close proximity to the person's home.

The person must accompany the personal attendant on the community activity. These activities are not intended for the benefit of the personal attendant, family, friends, or others. If informal supports, family friends or other resources are available, these resources must be utilized before personal attendant services.

Special caution is advised for those people who live with their personal attendant or their personal attendant is a relative to ensure services are for the sole benefit of the eligible person. Community activities may not exceed 30 hours per month. The community activity must have a starting and ending destination.

Activities such as those listed below are examples but not exclusive:

- Going to a local restaurant for a meal
- Shopping at a local department or specialty store
- Going to the park in the person's neighborhood
- Checking out books or CD's at the local library
- Hair cut at the local beauty salon or barber shop

All personal care assistance needs as outlined on the Service Plan must take place before essential errands or community activities can occur.

Personal attendants must complete the personal attendant worksheet daily, documenting the time of services (including start and stop times) and the condition of the person.

Provider agency staff and employees of people using the *Personal Options* model cannot perform any service that is considered to be a professional skilled service or any service that is not on the person's Service Plan.

Personal attendant services are not intended to replace support services that a child would receive from the school system during a school day/year or educational hours provided during home schooling.

Functions/tasks that cannot be performed include, but are not limited to, the following:

- Care or change of sterile dressings.
- Colostomy irrigation.
- Gastric lavage or gavage.
- Care of tracheostomy tube.
- Suctioning.
- Vaginal irrigation.



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Give injections, including insulin.
- Administer any medications, prescribed or over-the-counter.
- Perform catheterizations, apply external (condom type) catheter.
- Tube feedings of any kind.
- Make judgments or give advice on medical or nursing questions.
- Application of heat.
- Nail trimming if the person is diabetic.

If at any time a personal attendant is witnessed to be, or suspected of, performing any prohibited tasks, the provider agency, or the case manager must be notified immediately.

512.18 NON-MEDICAL TRANSPORTATION SERVICES

Non-medical transportation provides reimbursement for personal attendants that perform essential errands for or with a person receiving TBIW services or community activities with a person. (See [Section 512.17.1](#) for more information on essential errands and community activities).

Non-medical transportation must be utilized for the person's needs and cannot be for the benefit of the personal attendant, person's family or person's friends. Family, neighbors, friends, or community agencies that can provide this service, without charge, must be utilized first. The person may be transported by the personal attendant in order to gain access to incidental services and activities as specified in the Service Plan. Mileage can be charged for essential errands and community activities related to the Service Plan.

Non-medical transportation must occur in the person's local home community unless otherwise stated in the Service Plan and must be the closest location to the person's home.

Non-Emergency Medical Transportation (NEMT) is available through the State Plan for transportation to and from medical appointments and must be utilized. Non-medical transportation cannot be used to transport people on the TBIW to any medical appointments.

The case manager must document on the Service Plan the availability of the person's family, friends, or other community agencies to provide non-paid non-medical transportation first. Special caution is advised for those people who live with their personal attendant or their personal attendant is a relative to ensure services are for the sole benefit of the eligible person to avoid disallowances.

Non-medical transportation services may be provided within 30 miles of the West Virginia border only to people residing in a county bordering another state.

Activities that are incidental to the delivery of personal attendant services are provided only when neither the person utilizing TBIW services nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for the provision.

Traditional Model Procedure Code: A0160 UB
Personal Options Model Procedure Code: A0160 U2

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Service Unit: 1 unit - 1 mile

Service Limit: 300 units per Calendar Month

Prior Authorization: All units of service must be prior authorized before being provided.

Documentation Requirements: All transportation with, or on behalf of, the person receiving TBIW services must be included in the Service Plan and include the date, miles driven, travel time, destination, purpose of travel and type of travel (essential errand or community activity). The Service Plan must document the purpose of the travel and the destination. The personal attendant must document on the Personal Attendant Worksheet accurate miles traveled, exact location of the beginning and ending destination and reason for the travel.

512.19 PRIOR AUTHORIZATIONS

Prior authorization requirements governing the provision of all West Virginia Medicaid services apply pursuant to [Chapter 300, Provider Participation Requirements](#) of the BMS Provider Manual.

In order to receive payment from the BMS, a provider must comply with all prior authorization requirements. The BMS in its sole discretion determines what information is necessary in order to approve a prior authorization request. Prior authorization does not guarantee payment. All services provided within the TBIW program must be authorized with the UMC. The case manager is responsible for ensuring that all prior authorization requests are forwarded to the UMC.

512.19.1 Pre-Transition Case Management

Procedure Code: T1016 U2

Service Unit: 15 minutes

Service Limit: 24 units

Prior Authorization Required: Yes

Service Definition: This service is not available until January 1, 2019.

The purpose of the pre-transition case management service is to ensure that waiver services are in place the first day of the participant's transition to the community. Prior to the participant's transition from the facility, pre-transition case managers will:

- Participate in the transition assessment and planning process to help ensure that home and community-based services and support needs are thoroughly considered in transition planning;
- Conduct the person-centered assessment as required by waiver policy;
- Complete the required waiver interim service plan;
- Facilitate the development of the assessment for those eligible for and planning to enroll in the TBIW program when returning to the community;
- Facilitate the development of the service plan by the selected waiver personal attendant agency;
- Coordinate with the personal attendant agency to ensure that personal attendant services are in place the first day the resident returns home;
- Enroll the participant in the waiver program immediately prior to their transition home. Individuals who have been determined eligible are not "enrolled" in the program until they are ready to receive services. Residents of nursing homes may apply and be determined eligible but are not

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

enrolled into the waiver until they have been discharged from the facility (transitioned) and begin waiver services.

Limits

Individuals eligible to receive this service:

- Live in a nursing facility, hospital, Institutions for Mental Disease (IMD), or a combination of any of the three for at least 90 consecutive days; and
- Have been determined medically and financially eligible for the TBIW program; and
- Wish to transition from facility-based living to their own homes or apartments in the community consistent with the CMS Settings Rule (1915(l)); and
- Have a home or apartment in the community to return to upon leaving the facility that is consistent with the CMS Settings Rule (1915(l)); and
- Require waiver transition services to safely and successfully transition to community living; and
- Can reasonably be expected to transition safely to the community within 180 days of initial date of transition service.

The pre-transition case management service may be billed up to 24 units (a unit is 15 minutes) only one-time following transition to the community. This service is not available once the resident transitions to the community and enrolls in the waiver. The case management agency will receive authorization for this service via the Pre-Transition Case Management Services Authorization letter that will be sent from TMH transition manager, or the designee, to the case management agency provider.

NOTE: Pre-transition case management qualifications are the same as case manager qualifications listed in [Section 512.3.1](#) with the exception that the case manager must be fully licensed as a social worker, therapist or registered nurse.

512.19.2 Community Transition Services

Procedure Code: T2028 U2

Service Unit: Unit = \$1.00

Service Limit: 4000 units

Prior Authorization Required: Yes

Service Definition: This service is not available until January 1, 2019.

Community transition services are the primary waiver service available to support qualifying individuals' safe and successful transition from facility-based living to the community. Community transition services are one-time expenses necessary to support individuals wishing to transition from a nursing facility, hospital or IMD to their own home or apartment in the community. Allowable expenses are those necessary to address barriers to a safe and successful transition identified through a comprehensive transition needs assessment and included in an approved individualized transition plan. Community transition services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other services. Community

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

transition services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

The components of the community transition service include:

- Home Accessibility Adaptation Modification: Assistance to individuals requiring physical adaptations to a qualified residence. This service covers basic modifications such as ramps, widening of doorways, purchase and installation of grab-bars and bathroom modifications needed to ensure health, welfare and safety and/or to improve independence.
- Home Furnishings and Essential Household Items: Assistance to individuals requiring basic household furnishings to help them transition back into the community. This service is intended to help with the initial set-up of a qualifying residence.
- Moving Expenses: Includes rental of a moving van/truck or the use of a moving or delivery service to move an individual's goods to a qualified residence. Although this service is intended as a one-time set-up service to help establish a qualified residence, under certain circumstances it may be used throughout the transition period to relocate a member.
- Security Deposit: Used to cover rental security deposit.
- Utility Deposits: Used to assist participants with required utility deposits for a qualifying residence.
- Transition Support: Provides assistance to help individuals with unique needs based on assessed needs and necessary for a successful transition.
- Personal Emergency Response System (PERS): One-time payment that includes initial installation upon transition to the community and service for the initial transition period (one year).
- Equipment: Items and services and necessary to enable individuals to interact more independently and/or reduce dependence on physical supports and enhance quality of life (e.g. lift chairs, bathing aids such as handheld showers, shower chairs, transfer boards and portable showers). These items or services must be justified in the transition plan.
- Transportation: Assists participants with transportation service prior to transition in order to gain access to community activities, services and resources (i.e. food pantry). This service is used when other forms of transportation are not otherwise available. This service does not replace the Medicaid non-emergency transportation (for medical appointments) or emergency ambulance services.
- Specialized Medical Supplies: Includes purchases of various specialized medical supplies that enable individuals to maintain or improve independence, health, welfare and safety and reduce dependence on the physical support needed from others. The service includes one-time purchases of incontinence items and food supplements needed as a bridge until Medicaid covers once the participant transitions home.

Services or supports that address an identified need in the transition plan, and decreases the need for other Medicaid services, or increase the person's safety in the home, or improves and maintains the individual's opportunities for full membership in the community may be considered.

Limits

The total expenditure for community transition services cannot exceed \$4000 per transition period. community transition services cannot be used to cover the following items. **Please Note:** This is not intended to be an all-inclusive list of exclusions:



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Rent;
- Home improvements or repairs that are considered regular maintenance or upkeep;
- Recreational or illegal drugs; alcohol;
- Medications or prescriptions;
- Past due credit card or medical bills;
- Payments to someone to service as a representative;
- Gifts for staff, family, or friends;
- Electronic entertainment equipment;
- Regular utility payments;
- Swimming pools, hot tubs, spas or any accessories, repairs or supplies for these items;
- Travel;
- Vehicle expense including routine maintenance and repairs, insurance and fuel/gasoline;
- Internet service;
- Pet/Service/Support Care, including food and veterinary care;
- Experimental or prohibited treatments;
- Education;
- Personal hygiene services (manicures, pedicures, haircuts, etc.);
- Discretionary cash; or
- Assistive technology

Any service or support that does not address an identified need in the transitional plan, or decrease the need for other Medicaid services, or increase the person's safety in the home, or improve and maintain the person's opportunities for full membership in the community is excluded.

The FMS is responsible for validating vendor qualifications prior to processing invoices and verifies that the item is on an approved transition plan. The TMH transition manager verifies the item is not on the exclusions list and a receipt is present for the purchase.

512.20 BILLING PROCEDURES

Claims must not be processed for less than a full unit of service. Consequently, in filing claims for Medicaid reimbursement the amount of time documented in minutes must be totaled and divided by the minutes in a unit of service to arrive at the number of units billed. After arriving at the number of billable units, billing 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. Claims will not be honored for services (inclusive of service code definitions) provided outside of the scope of this Chapter or outside of the scope of federal regulations.

512.21 PAYMENTS AND PAYMENT LIMITATIONS

TBIW providers must comply with the payment and billing procedures and requirements described in [Chapter 600, Reimbursement Methodologies](#) of the Provider Manual.



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

No TBIW services may be charged while an individual is inpatient in a nursing home, hospital, rehabilitation facility, or other inpatient medical facility, except for personal attendant services on the day of admission and day of discharge.

Thirty days prior to discharge from one of these programs, case management services may be billed to plan the person's discharge to ensure services are in place.

512.22 SERVICE LIMITATIONS AND SERVICE EXCULSIONS

Services governing the provision of all West Virginia Medicaid services apply pursuant to [Chapter 300, Provider Participation Requirements](#) of the BMS Provider Manual and applicable sections 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 the TBIW program services described in this chapter.

TBIW services are made available with the following limitations:

- Any person receiving TBIW services must live in West Virginia and be available for required services;
- All TBIW regulations and policies must be followed in the provision of the services. This includes the requirement that all TBIW 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 person's Service Plan; and
- Person's budgets and limitations described in this manual must be followed.

Reimbursement for TBIW services cannot be made for:

- Services provided outside a valid Service Plan;
- Services provided when medical and/or financial eligibility has not been established;
- Services provided when there is no Service Plan;
- Services provided without supporting documentation;
- Services provided by unqualified staff;
- Services provided outside the scope of the service definition; or
- Services that exceed service limits.

512.23 DUAL PROVISION OF TBIW AND PERSONAL CARE (PC) SERVICES

Approval of the provision of both TBIW and PC services to the same person will be considered if the following criteria are met:

- Any PC services provided to a person receiving TBIW services must be approved by the reviewing agencies. The Dual Service Provision Request form must be submitted to the UMC.
- The PC agency can continue to provide PC services under their existing authorization to the newly enrolled person utilizing the TBIW until the TBIW covered services are authorized by the UMC.
 - The PC Agency stops providing PC services to the person receiving TBIW services unless: the person receiving TBIW services has direct-care (personal attendant) needs

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

exceeding those available through the TBIW and PC services are reflected on the person's TBIW Service Plan. The PC agency may continue to provide the PC services to the person receiving TBIW services on the existing authorization until its expiration

- If PC services are still necessary at the expiration of the PC authorization, the PC agency will submit a Dual Request for the continuation of PC services following the applicable policies set forth in *Chapter 517 Personal Care Services*. The case manager must document that the person has direct-care (personal attendant) needs that cannot be met by the TBIW. A person utilizing the TBIW must be receiving maximum direct-care (personal attendant) services before PC services may be requested.
- All policy set forth in [Chapter 517, Personal Care Services](#), must be followed. PC policy supersedes TBIW policy for this request.
- There must be a PC RN Plan of Care that reflects the TBIW services provided and the additional Personal Care services to be provided for both Traditional and Personal Option models. Personal Care services must also be reflected on the person's TBIW Service Plan. These plans must be coordinated to ensure that services are not duplicated. PC and TBIW Personal Attendant services cannot be provided during the same hours on the same day. A service planning meeting between the case manager and PC RN must be held with the person and/or the legal representative (if applicable) in the person's residence and documented. For *Personal Options*, the meeting must include the Resource Consultant and the person and/or legal representative (if applicable).
- The PC RN may use the current PAS completed by the TBIW UMC used to determine medical eligibility for the TBIW services. However, it must be reviewed to assure the information is current and reflective of the person's needs. See the applicable policies set forth in [Chapter 517, Personal Care Services](#).
- The TBIW case manager is responsible for the coordination of the two services; this includes coordinating the planning meeting with the PC RN, the case manager and the person and legal representative (if applicable).
- The West Virginia Personal Care Dual Service Request Form must be signed by the TBIW case manager, PC RN and the person and/or legal representative (if applicable). Original signatures are required; i.e., "signature of person on file" is not acceptable.
- All PC providers should submit the Dual Service requests to the UMC web portal. Please refer to the TBIW Program website for Program contact information. Documentation submitted must include a copy of the current TBIW PAS, TBIW service assessment and Service Plan, PC PAS (if applicable), PC RN Plan of Care, and any documentation that substantiates the request. Additionally, a narrative describing how services will be utilized and verification that TBIW and PC services will not be duplicated must be submitted. Approvals/denials will be based on the documentation submitted, appropriate program policy manuals, PC standards, and professional judgments. The person and/or legal representative (if applicable), personal attendant service agency provider representative, PC RN, TBIW case manager or the resource consultant through *Personal Options* (the participant-directed model) (if applicable) will receive notification of denial or approval from the reviewing agency. If the request is denied or the hours approved are less than requested the notification will include Fair Hearing information.
- The BMS will conduct post-payment review of these combined services for duplication and/or inappropriate services.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.24 PROVISION OF TBIW AND HOME HEALTH AGENCY SERVICES

People who have been determined eligible for and are enrolled in the TBIW program may receive services from a home health agency that do not duplicate TBIW services. Home health agency services provided to the person utilizing the TBIW must be coordinated by the TBIW case management agency, and in general may only include skilled nursing care or therapy services for post-hospitalization stays or acute episodes of chronic conditions. The need for home health services must be documented in the person's Service Plan. Documentation of the referral from the person's attending physician must be maintained in the person's records of both the TBIW provider agency and the home health agency. Please refer to [Chapter 508, Home Health Services](#) for additional information.

Other Medicaid services a person receiving TBIW services may be eligible to receive at the same time would be Hospice ([Chapter 509](#)) and Private Duty Nursing ([Chapter 532](#)). Duplication of services is not allowed. Please refer to the chapters referenced above for additional information.

512.25 VOLUNTARY AGENCY CLOSURE

A provider agency may terminate their participation in the TBIW program with 30 calendar day's written notification of voluntary termination. The written termination notification must be submitted to the BMS fiscal agent and to the UMC. The provider must provide the UMC with a complete list of all the people currently on the TBIW that will need to be transferred.

The UMC will provide selection forms to each of the people on the agency's list, along with a cover letter explaining the reason a new selection must be made.

If at all possible, a joint home visit with the person will be made by both the agency ceasing participation and the new one selected in order to explain the transfer process. Services must continue to be provided until all transfers are completed by the UMC. If a joint visit is not possible, both providers must document how contact was made with the person to explain the transfer process.

The agency terminating participation must ensure that the transfer of the person is accomplished as safely, orderly and expeditiously as possible.

The agency must submit their final continuing certification for any part of the year they provided services prior to closing.

512.26 INVOLUNTARY AGENCY CLOSURE

The BMS may administratively terminate a provider agency from participation in the TBIW program for violation of the rules, regulations, or for the conviction of any crime related to health care delivery.

Likewise if the provider is a corporation, its owners, officers, or employees who have violated said rules and/or regulations or have been convicted of a crime related to health care delivery, may be excluded from further participation in the TBIW program. After notice of intention to suspend or terminate enrollment, the provider may request a document/desk review. Refer to [Chapter 100, General Administration and Information](#), for more information on this procedure.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Prior to closure, the provider will be required to provide the UMC with a complete list of all people currently utilizing the TBIW that will need to be transferred. The UMC will provide selection forms to each of person on the agency's list, along with a cover letter explaining the reason a new selection must be made. The UMC will ensure that the transfer of all people is accomplished as safely, orderly and expeditiously as possible.

The agency must submit their final continuing certification for any part of the year they provided services prior to closing.

All program records must be made available to the BMS upon closing.

512.27 ADDITIONAL SANCTIONS

If the BMS or the UMC receives information that clearly indicates a provider is unable to serve people new to the waiver due to staffing issues, the person has health and safety risk(s), etc. or has a demonstrated inability to meet recertification requirements, BMS may remove the agency from the Provider Selection Forms and from the provider information on the [BMS TBIW website](#) until the issues/concerns are addressed to the satisfaction of BMS. Health and Safety deficiencies deemed critical may include other sanctions including involuntary agency closure.

512.28 RIGHTS AND RESPONSIBILITIES

At a minimum, Case management agencies must communicate in writing including accessible format as requested to each person and/or their legal representative (if applicable) receiving TBIW service initially, upon admission to the agency "transfer" and annually the following:

Their right to:

- Transfer to a different provider agency, from Traditional services to *Personal Options*, or from *Personal Options* to Traditional services.
- Address dissatisfaction with services through the provider agency's or *Personal Options*' grievance procedure.
- Access the West Virginia DHHR Fair Hearing process.
- Considerate and respectful care from their provider(s).
- Freedom from abuse, neglect, and exploitation.
- Take part in decisions about their services delivery process and Person-Centered planning.
- Confidentiality regarding TBIW services.
- Access to all of their files maintained by the Agency providers and/or the F/EA.
- Freedom from retribution when expressing dissatisfaction with services or appealing service decisions

And their responsibility to:

- Notify the TBIW personal attendant service agency within 24 hours prior to the day services are to be provided if services are not needed.
- Notify personal attendant service agency, case management agency or the resource consultant promptly of changes in Medicaid coverage.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- Comply with the Person-Centered Service Plan.
- Notify their case management agency and the resource consultant (if applicable) of a change in residence or an admission to a hospital, nursing facility or other facility.
- Notify their case management agency and the resource consultant (if applicable) of any change of medical status or personal attendant care needs.
- Maintain a safe home environment for all service providers.
- Verify services were provided.
- Communicate any problems with services to the case management agency or the resource consultant (if applicable).
- Report any suspected fraud to the case management, personal attendant agencies or the Medicaid Fraud Unit at (304)558-1858.
- Report any incidents of abuse, neglect or exploitation to the case management, personal attendant agencies or the resource consultant (if applicable), and/or APS/CPS at 1-800-352-6513.
- Report any suspected illegal activity to their local police department or appropriate authority as well as the provider agency or resource consultant (if applicable).
- Cooperate with all scheduled in-home visits.
- Notify the case manager and resource consultant (if applicable) of any changes in their legal representation and/or guardianship and provide copies of the appropriate documentation.
- Not ask personal attendant professionals to provide services that are excluded by policy or not on their Service Plan. (Refer to [Section 512.17 Personal Attendant Services](#)).
- Utilize family, friends, neighbors and community agencies that can provide transportation before utilizing TBIW non-medical transportation services.
- Notify their resource consultant within 24 hours when they terminate an employee if the person is utilizing *Personal Options*.

512.29 GRIEVANCE PROCESS

A person who is dissatisfied with the services they receive from a provider agency have a right to file a grievance. All TBIW provider agencies will have a written grievance procedure. The UMC will explain the grievance process to all applicants and people utilizing the TBIW at the time of initial application/re-evaluation. Applicants, people utilizing the TBIW and/or their legal representative (if applicable) will be provided with a Grievance Form at that time. However, each provider may have their own grievance form. Service providers will only afford people a grievance procedure for services that fall under the particular service provider's authority; for example, a case management agency will not conduct a grievance procedure for personal attendant service agency activities, nor will a personal attendant service agency conduct a grievance procedure for case management agency activities.

A person may by-pass the level one grievance and file a level two grievance with the UMC if he/she chooses. The grievance process is not utilized to address decisions regarding medical or financial eligibility, a reduction in services or case closure. These issues must be addressed through the Medicaid Fair Hearing process.

The grievance procedure consists of two levels:

Level One: TBIW Provider

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- A TBIW provider has 10 business days from the date they receive a Grievance Form to hold a meeting, in person or by telephone. The meeting will be conducted by the agency director or their designee with the person and/or their legal representative (if applicable). The agency has five days from the date of the meeting to respond in writing to the grievance. If the person is dissatisfied with the agency decision, he/she may request that the grievance be submitted to the UMC for a Level Two review and decision.

Level Two: The UMC

- If a TBIW provider is not able to address the grievance in a manner satisfactory to the person and the person requests a Level Two review, the UMC will, within 10 business days of the receipt of the Grievance Form, contact the person and/or their legal representative (if applicable) and the TBIW provider to review the Level One decision. Level Two decisions will be based on Medicaid policy and/or health and safety issues.

512.30 MEDICAL ELIGIBILITY APPEALS

If a person is determined not to be medically eligible, a written Notice of Final Decision, a Request for Hearing form and the results of the assessments are sent by certified mail by the UMC to the person and/or their legal representative (if applicable). A notice is also sent to the person's case manager. The termination may be appealed through the Fair Hearing process if the Request for Hearing form is submitted to the Board of Review within 90 days of receipt of the Notice of Final Decision.

If the person and/or legal representative (if applicable) wishes to continue existing services throughout the appeal process, the Request for Hearing form must be submitted to the Board of Review within 13 days of the person and/ or legal representative's (if applicable) receipt of the Notice of Final Decision.

If the Request for Hearing form is not submitted to the Board of Review within 13 days of the person and/or legal representative's (if applicable) receipt of the Notice of Final Decision, reimbursement for all TBIW services will cease.

A pre-hearing conference may be requested by the person and/or legal representative (if applicable) once a Fair Hearing has been requested at any time prior to the Fair Hearing and the UMC will schedule the meeting. At the pre-hearing conference, the person and/or legal representative (if applicable), the UMC, and the BMS will review the information submitted for the medical eligibility determination and the basis for the termination. If the person and BMS come to an agreement during the pre-hearing conference the UMC will withdraw the person's hearing request from the Board of Review. All parties will be notified by the UMC in writing that the issue(s) have been resolved and the hearing request has been withdrawn.

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 person is eligible financially for Medicaid services without the TBIW program, other services may be available for the individual. If the termination based on medical eligibility is reversed by the Hearing Officer, the person's services will continue with no interruption.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

512.31 TRANSFERS TO ANOTHER AGENCY OR *PERSONAL OPTIONS*

A person utilizing the TBIW program may request a transfer to another provider agency or *Personal Options* at any time. If a person wishes to transfer to a different provider agency a Request to Transfer form must be completed and signed by the person and/or their legal representative (if applicable). The form may be obtained from the current provider agency, the new provider agency, or the UMC. Once completed and signed by the person, the form must be submitted to the UMC. The UMC will then coordinate the transfer and set the effective date based on when required transfer documents are received. The effective date of transfers will be the first date of the next month if the transfer is received by the 17th of the month.

At no time should the transfer take more than 45 calendar days from the date that the transfer request signed by the person is received at the UMC, unless there is an extended delay caused by the person in returning necessary documents.

Transferring Agency Responsibilities:

- To continue providing services until the UMC notifies them that the transfer has been completed.
- If it is a Case Management agency transfer, to provide the receiving case management agency, on the day of the transfer, a copy of the current PAS, the applicable Rancho Los Amigos Scale, the Service Plan, a copy of the Enrollment Confirmation Notice and any other pertinent documentation.
- If it is a personal attendant service agency transfer, to provide the receiving personal attendant service agency, on the day of the transfer, with a copy of the current PAS, the Rancho Los Amigos Levels of Cognitive Functioning Scale or the Rancho Los Amigos Pediatric Level of Consciousness Scale, the person's Service Plan and any other pertinent documentation.
- To maintain all original documents for monitoring purposes.

Receiving Agency Responsibilities:

- Personal attendant service agencies must meet with the person and/or their legal representative (if applicable) within seven business days to review the Service Plan.
- If it is a case management agency transfer, a service assessment must be conducted within seven business days of the transfer effective date.
- Develop the Service Plan within seven business days of the transfer effective date.
- Provide copies of the newly developed Service Plan to the person and/or legal representative (if applicable), personal attendant agency, resource consultant (if applicable) and to the UMC within seven business days.

The Service Plan from the transferring case management and/or personal attendant service agency must continue to be implemented until such time that the receiving case management and/or personal attendant service agency can develop and implement a new service plan to prevent a gap in services.

People who transfer from Traditional services to *Personal Options*, as well as, from *Personal Options* to Traditional services are processed by the UMC and will include both the case manager and the resource

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

consultant to ensure that all necessary documentation is shared and that there is no gap in the delivery of service.

512.32 EMERGENCY TRANSFERS TO ANOTHER AGENCY OR *PERSONAL OPTIONS*

A request to transfer that is considered an emergency, such as when a person suffers abuse, neglect, or harm, will be reviewed by the UMC and the UMC will take appropriate action. The case management agency, the personal attendant service agency that the person is transferring from or the person using the *personal options* and/or their legal representative (if applicable) must submit supporting documentation that explains why the person is in emergency status. The UMC will expedite the request as necessary, coordinating with the person and agencies involved.

512.33 DISCONTINUATION OF SERVICES

The following require a Request for Discontinuation of Services Form be submitted and approved by the UMC:

- No Personal Attendant services have been provided for 180 continuous days – example, an extended placement in long-term care or rehabilitation facility.
- Unsafe Environment – an unsafe environment is one in which the personal attendant and/or other agency staff are threatened or abused and the staff’s welfare is in jeopardy. This may include, but is not limited to, the following circumstances:
 - The person or other household members demonstrate sexually inappropriate behavior; display verbally and/or physically abusive behavior; and/or threaten a personal attendant and/or other agency staff with guns, knives, or other potentially dangerous weapons, including menacing animals or verbal threats to harm the personal attendant and/or other agency staff.
 - The person or other household members display an abusive use of alcohol and/or drugs and/or illegal activities in the home.
- The person is persistently non-compliant with the Service Plan.
- Person no longer desires services.
- Person no longer requires services.

The Request for Discontinuation of Services Form must be submitted to the UMC. The UMC will review all requests for a discontinuation of services. If it is an appropriate request, and the UMC approves the discontinuation, the UMC will send notification of discontinuation of services to the person (or legal representative) with a copy to the case management agency or F/EA. Fair Hearing rights will also be provided except if the person (or legal representative) no longer desires services. The effective date for the discontinuation of services is thirteen calendar days after the date of the UMC notification letter, if the person (or legal representative) does not request a hearing. If it is an unsafe environment, services may be discontinued immediately upon approval of the UMC and all applicable entities are notified, i.e. police, APS/CPS.

When the UMC receives an unsafe closure request, they will review and make a recommendation to the BMS based upon the evidence submitted. Documentation to support the unsafe environment should

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

come from multiple sources if possible, i.e., the personal attendant agency and the case management agency.

Recommendations include:

1. Suspend services for up to 90 days to allow the person receiving TBIW services time to remedy the situation. The case manager will reassess at 30, 60 and 90 days and make a recommendation to the UMC at any time during the 90 days suspension to reinstate services.
2. Immediate closure.

It is the case management agency's responsibility to ensure the health and safety of the person receiving services during any time that services are suspended. In all cases, the person receiving services must be provided their right to a Fair Hearing by the UMC. However, due to the nature of unsafe environment closures a person would not be eligible for the option to continue existing services during the fair hearing process.

All discontinuation of services (closures) must be reported on the Case Management Monthly Report.

Note: Once the UMC Web Portal is available discontinuation of services (closures) will be required to be uploaded.

The following do not require a Request for Discontinuation of Services Form but must be reported on the Case Management Monthly Report:

- Death
- Moved Out of State
- Medically Ineligible
- Financially Ineligible

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.

Abuse: The infliction or threat to inflict bodily injury on or the imprisonment of any child or incapacitated adult.

Activities of Daily Living (ADL): Activities that a person ordinarily performs during the ordinary course of a day, such as mobility, personal hygiene, bathing, dressing, eating, and skills required for community living.

Advanced Practice Registered Nurse (APRN): As defined in [West Virginia Code §30-7-1](#): A registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advanced practice registered



CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

nurse that shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner.

Annual "Anchor" Date: The annual date by which the person'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 determined by the UMC. This fixed date will serve as the 'due date' for the Annual Person-Centered Assessment and Service Plan and the reevaluation of the person's medical eligibility, as well as the start date for TBIW service authorizations.

Board of Review: The agency under the West Virginia DHHR and the Office of Inspector General that provides impartial hearings to people and/or applicants who are aggrieved by an adverse action including denial or termination of eligibility.

Budget Authority: People choosing *Personal Options*, the Participant-Directed Model for services, have choice in the types and amounts of services, wage rates (allowed by the BMS) and of their employee's to meet their needs and are within their annual budget approved by the UMC.

Community Integration: The opportunity to live in the community, and participate in a meaningful way to obtain valued social roles as other citizens.

Community Location: Any community setting open to the general public such as libraries, banks, stores, post offices, etc. within a justifiable proximity to the person's geographical area.

Competency Based Curriculum: A training program which is designed to give people the skills they need to perform certain tasks and/or activities. The curriculum must have goals, objectives and an evaluation system to demonstrate competency in training areas.

Days: Calendar days unless otherwise specified.

Direct Access: Physical contact with or access to a person's property, personally identifiable information, or financial information.

Dual Services: When a person is receiving TBI Medicaid Waiver services and Personal Care services at the same time.

Emergency Plan: A written plan which details who is responsible for specific activities in the event of an emergency, whether it is a natural, medical or man-made incident.

Felony: A serious criminal offense punishable by imprisonment and/or alternative sentencing at the discretion of a judge within limits by statute.

Financial Exploitation: Illegal or improper use of a person's or incapacitated adult's resources. Examples of financial exploitation include cashing a person's checks without authorization; forging a person's signature; or misusing or stealing a person's money or possessions. Another example is deceiving a person into signing any contract, will, or other legal document.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Fiscal Agent: The contracted vendor responsible for claims processing and provider relations/enrollment.

Fiscal/Employer Agent (F/EA): The contracted agent, under *Personal Options*, which receives, disburses, and tracks funds based on a person's approved service plans and budgets; assists people with completing *Personal Options* enrollment and worker employment forms; conducts criminal background checks of prospective workers; and verifies worker's information (i.e., social security numbers, citizenship or legal alien verification documentation). The F/EA also prepares and distributes payroll including the withholding, filing, and depositing of federal and state income tax withholding and employment taxes and locality taxes; generates reports for state program agencies, and people receiving TBIW services; and may arrange and process payment for workers' compensation and health insurance, when appropriate.

Home and Community Based Services (HCBS): Services which enable individuals to remain in the community setting rather than being admitted to a Long Term Care Facility (LTCF).

Incapacitated Adult: A person incapable of handling his/her medical, financial or personal affairs and through a legal process has been deemed to be incapacitated.

Incident: Any unusual event occurring to a person that needs to be recorded and investigated for risk management or quality improvement purposes.

Incidental Services: Secondary activities performed by the personal attendant such as light housecleaning, making and changing the bed, dishwashing, and laundry for the sole benefit of the person receiving TBIW services.

Informal Supports/Informal's: Family, friends, neighbors or anyone who provides a service to a person and not reimbursed.

Instrumental Activities of Daily Living (IADL): Skills necessary to live independently such as abilities used to shopping for groceries, handling finances, performing housekeeping tasks, preparing meals, and taking medications.

Legal Guardian/Guardian: A person appointed by the court who is responsible for the personal affairs of a protected person. [[WV Code §44A-1-4\(5\)](#)]

Legal Representative: One who stands in the place of and represents the interest of another (i.e. Power of Attorney, Medical Power of Attorney, Medical Surrogate).

Legally Responsible Person: A spouse or a parent of a minor child (under the age of 18) that is legally responsible to provide supports that they are ordinarily obligated to provide.

Medicaid Fair Hearing: The formal process by which a person receiving waiver services 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 and terminations. This process is conducted by an impartial Board of Review Hearing Officer.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Misdemeanor: A less serious criminal offense than a felony which is punishable by a fine or imprisonment in jail for less than a year.

Neglect: “Failure to provide the necessities of life to an incapacitated adult” or “the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult” (See [WV Code §9-6-1](#)). Neglect would include inadequate medical care by the service provider or inadequate supervision resulting in injury or harm to the incapacitated member. Neglect also 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 results in negative outcome or places the member in serious jeopardy; a pattern of failure to provide adequate nutrition, clothing, or health care; failure to provide a safe environment resulting in negative outcome; and/or failure to maintain sufficient, appropriately trained staff resulting in negative outcome or serious jeopardy. This may also include medication errors and dietary errors resulting in a need for treatment for the member.

Person-Centered Planning: A process-oriented approach which focuses on the person and his/her needs by putting him/her in charge of defining the direction for his/her life, not on the systems that may or may not be available.

Personal Attendant Professional: The individual who provides the day-to-day care to people on the TBIW including both Traditional and *Personal Options* Models.

Personal Attendant Services: Long-term direct care and support services that is necessary in order to enable a person to remain at home rather than enter a nursing home, or to enable a person to return home from a nursing home.

Physician’s Assistant: An individual who meets the credentials described in West Virginia Code Annotated, [§30-3-13](#) and [§30-3-5](#). A graduate of an approved program of instruction in primary health care or surgery who has attained a baccalaureate or master’s degree, has passed the national certification exam, and is qualified to perform direct patient care services under the supervision of a physician.

Pre-Hearing Conference: A meeting requested by the applicant or person receiving Medicaid services and/or legal representative (if applicable) 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 Fair Hearing.

Prior Authorization: A utilization review method used to control certain services which are limited in amount, duration, or scope. The prior approval necessary for specified services to be delivered for an eligible person by a specified provider before services can be rendered, billed, and payment made.

Program Representative: An individual selected by a person receiving TBIW services using the *Personal Options* Model, to assist them with the responsibilities of self-direction.

Qualified Residence: Take Me Home, West Virginia (TMH) defines as:

- A person’s own home;
- A person’s family’s home;

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

- A person's own apartment, or
- Certain group homes with four or fewer people.

Quality Management Plan: A written document which defines the acceptable level of quality, for a waiver agency and describes how plan implementation will ensure this level of quality through documented deliverables and work processes.

Remediation: The act of correcting an error or a fault.

Representative Sample: A small quantity of a targeted group such as customers, data, people, products, whose characteristics represent (as accurately as possible) the entire batch, lot, population, or universe.

Resource Consultant (RC): A representative from the F/EA FMS who assists the person receiving services 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 person with locating staff, helping to complete required paperwork for this service option; and helping the person select a representative to assist them, as needed.

Scope of Services: The range of services deemed appropriate and necessary for a person.

Sexual Abuse: Any of the following acts toward an incapacitated adult or child in which an individual engages in, attempts to engage in, or knowingly procures another person to engage in such act, notwithstanding the fact that the incapacitated individual may have suffered no apparent physical injury as a result of such conduct:

- 1) Sexual intercourse/intrusion/contact; and
- 2) Any conduct whereby an individual displays his/her sex organs to an incapacitated adult or child for the purpose of gratifying the sexual desire of that individual, of the person making such display, or of the incapacitated adult or child, or for the purpose of affronting or alarming the incapacitated adult or child.

Sexual Exploitation: When an individual, whether for financial gain or not, persuades, induces, entices, or coerces an incapacitated adult or child to display his/her sex organs for the sexual gratification of that individual or third person, or to display his/her sex organs under circumstances in which that individual knows such display is likely to be observed by others who would be affronted or alarmed.

Social Worker: An individual who is fully licensed with the ability to practice in West Virginia.

Spending Plan: A budgeting tool used in the *Personal Options* Model to help people accurately plan how and when their budget will be used.

Transfer: Changing from the provider from which a person is receiving services to another provider or changing service delivery model from Traditional to *Personal Options* or vice versa.

UMC Web Portal: A HIPAA compliant software system that couples technology with clinical practice to offer an effective, efficient platform for UMC services.

CHAPTER 512 TRAUMATIC BRAIN INJURY WAIVER (TBIW)

Utilization Management Contractor (UMC): The contracted vendor responsible for day-to-day operations and oversight of the TBIW Program including conducting medical eligibility evaluations, determining medical eligibility for applicants and people enrolled in the program, initial and ongoing certification of provider agencies and providing prior authorization for services provided to people enrolled in the West Virginia Medicaid Traumatic Brain Injury Waiver Program.

West Virginia Incident Management System (WV IMS): A web-based program used by providers and *Personal Options* staff to report simple and critical incidents as well as abuse, neglect, and exploitation incidents to the UMC and BMS.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Traumatic Brain Injury Waiver (TBIW)	October 1, 2015
Take Me Home	TBIW	January 1, 2019
Overview	TBIW	January 1, 2019
Pre-Transition Case Management	TBIW	January 1, 2019
Community Transition	TBIW	January 1, 2019