Aged & Disabled Waiver Provider
Conference Call Questions
2015

January 20, 2015

63. I have 3 clients who have been scheduled WVMI visits the day before their anchor date. I would like to do extensions on them. Can you tell me how to go about doing this now that the new system is in place? Is there a special form to be used and to whom it should be addressed.

Answer: When the PAS cannot be completed prior to the member's anchor date, the CMA, HMA or F/EA user may request a continuation of services until the PAS can be completed. This action is performed in ADW CareConnection©. Detailed instructions for submitting the service continuation request are provided on page 35 of the ADW CareConnection© web user manual for CMA, HMA and F/EA users and are summarized below:

The user should select Service Continuation from the Member Detail Menu to initiate the process. The user will then select the Enter new Service Continuation Request Hyperlink. The user will select a Reason for Continuation from the available drop down items:

- Member/rep cancellation,
- Member/rep refused/unavailable for visit,
- Assessment coordinator no show/cancel/illness,
- Assessment coordinator scheduling conflict/hearing,
- Inclement weather,
- Annual MNER not submitted within 45 days prior to anchor date,
- Other (if other is chosen, a comment is required).

The system will send notification to APS to review the request.

64. After reviewing of the December Q&A. We have found some of our POC's for the ADW are not as detailed on the Essential Errands and Community Activities. Should we correct the POC now or wait and do with the next visit? I'm concerned that if we are monitored we would have a payback if we don't correct these POC now.

Answer: The SP should have the day and time documented for the activity. Per # 16, bullet # 2 of the SP Instructions**: Indicate each day the activity will be provided**. Your POC should follow the SP.

1st Review the SP and use the day of the week specified, if the CM did not complete the SP he/she should contact the member to discuss what day the member prefers the activity and complete an addendum to the SP. The addendum must be signed by the member and sent to the PA/HM RN to correct the POC.

Per the POC instructions the day and time is documented for the activity. Per #1, bullet 6, of the Plan of Care instruction sheet: **Enter the day of the week services are to be provided**. Any POC out of compliance should be corrected.

65. Member has dx of confusion, dementia or Alzheimer's. Is it mandatory for a family member, an informal, the MPOA, the POA, the legal guardian, or a contact person to be present at the meetings?

Answer: Per the Cyrus court order *if the individual has identified a guardian, no home visit shall be scheduled without presence of the guardian, contact person or legal representative; and/or if the Evaluation Form indicates that the individual suffers from Alzheimer's, multi-infarct, senile dementia, or related condition dementia, no home visit shall be scheduled without another individual designated by the applicant present to assist the individual during the interview.*

Per policy section 501.5.1.3 D. If the MNER form indicates that the applicant has Alzheimer's, multi-infarct, senile dementia, or related condition dementia; or if he/she has a guardian, contact person or legal representative, the assessment will not be scheduled without the guardian, contact person or legal representative present to assist the applicant.

66. (HMer is informal or is family member) The Member resides with HMer; or the HMer resides in Member's home; or, both will be in attendance for a holiday or at the family gathering. Can the HMer document care on the POC (worksheet) & the agency bill for care which HMer provides? (even though HMer would be present and is family member or informal anyway)

Answer: No, the Homemaker taking the member to a family function is not a community activity and would not be billable.

Announcements:

When the ADW Claimant no longer has a medical necessity, such as in the case of someone losing a hearing regarding medical eligibility it is the Case Management Agency's responsibility to notify the DHHR Department per Chapter 17.26 of the DHHR's Income Maintenance Manual.

A list of Economic Service Worker(s) (ESW) for every county with an email address, phone and fax number is on the www.wvseniorservices.gov web site under the Documents Center and will be kept up to date by BoSS. You may have a quicker response from the ESW if you email your questions and documents instead of faxing or mailing.

The **only** MNER accepted by WVMI via fax is an Initial. Any others will be returned to the provider. The provider must upload all re-eval MNER's in CareConnection©.

Comments/questions from the January 20, 2015 call:

Question # 63: APS commented that an extension for a re-evaluation is only necessary if the actual appointment is past the Anchor Date. If the appointment is prior to the Anchor Date, no extension

request is necessary. (Detailed instructions on how to request an extension in CareConnection© have been added to question #63.)

Question #64: Provider: How far back should they (Providers) go to correct a Plan of Care?

BoSS stated the following regarding creating a Plan of Care and/or Service Plan:

- The Plan of Care form with instructions was updated in April 2012.
- The Service Plan form with instructions was updated in November 2012.
- Planning training was conducted in July 2014 which gave examples of specifying the day for community activities.
- The Question & Answer document mentioned this topic in December 2014 (question #61 and in the "Other questions/comments from the call").
- The Questions & Answer document mentions other resources for transportation in September 2011.

BoSS stated that ADW policy requires a member's informal supports, friends/family or other resources to be utilized first for services, including transportation. If there is a reason why the alternative resource cannot be used, this must be documented on the Service Plan.

Provider: So if there is no other means of transportation (informal supports) the HM can provide and be paid for transportation?

BoSS: Yes. Refer to the July 2014 Planning Instructions regarding how to document on the Service Plan when no other alternative is available. (Page 18)

Provider: Brooke County has clients who are upset that they are being asked to specify the days they participate in certain activities, for example, what day they go to the grocery store.

BoSS: With person-centered planning, you must talk to the client and there must be a specific Plan. This provides instruction to the homemaker on what to do each day and lets the member know what to expect. Medicaid services cannot meet every need. For example: if the member's plan indicates trips to the grocery store on Monday and Friday. The member drops a gallon of milk on Wednesday (needs to go to the grocery store), document this on the worksheet.

Provider: The instructions on BMS's website for the POC say "as needed".

BMS/BoSS: The Plan of Care Instructions say to be specific. Community activities are addressed here specifically and there is an example of the day of the week.

It also says above this instruction on the Plan of Care Instruction sheet, "must be specific when using PRN or as needed. Example: Vacuum Monday or as needed. This statement was to address when people

were using PRN all the time. Even this statement says to give a specific day and not to use just "as needed".

It's obvious that things will happen that are going to require the homemaker to go outside of the Plan of Care, but those instances should be rare and there must be adequate documentation as to why it changed.

Provider: Their agency has been monitored several times and adding the specific day of the week for activities has never been brought up. The client may not want to participate in an activity every week. They're not sure how to be specific on the POC.

Susan Given @ BMS: Monitoring is claim-specific. The issue may not come up during a monitoring visit. The decision of what services the member receives should not be left up to the HM. Some members demand to be taken places at certain times and in this instance, you can use the POC to explain to the member what services they are supposed to receive and when. The HM should not be deciding the service plan or member activities. In addition, the POC and Service Plan keeps the RN informed of what's going on with each member.

February 17, 2015

67. If a HMA has travel limitations such as a limited number of days to travel or a limited amount of miles per week, how should a Case Manager from another company address that? Should the Case Manager be telling members that there are no limits set by Medicaid? This makes it difficult for a HMA to enforce travel limitations.

Answer: The Case Manager, PA/HM RN and member will determine if a need for transportation exists at the Service Plan meeting. If the member has no other resources such as family, friends, community or NEMT (state contracted medical transportation) the transportation need will be discussed and planned. Example: Identified need for groceries and go to the post office so a day of week should be planned and both could be accomplished on the same day. (Tuesday morning (am) shop at Food Land and stop at post office.

68. If the Case Manager is not choosing a specific date for services to be done, can the HMA RN put a specific day on the POC? Example: Service Plan states mopping is "1 x per week and prn" and "F" is placed in all 5 days homemaker services are provided.

Answer: The day of the activity/service should be determined at the time of the SP meeting by the member, CM and PA/HM RN and documented on the SP. The PA/HM POC is developed from the Service Plan which should be complete and include the day of the planned activity/service.

<u>Announcement:</u>

New Call-in number: (877) 278-2734
PIN: 779160 (unchanged)

Please be aware that if you are not able to make it to your office, this dial-in number will work from your home or cell phone.

March 17, 2015

69. When a member gets an increase in a level of care it cannot start until the anchor date, what if it is a decrease?

Answer: *This question was answered in # 57.*
The newly determined service level will be effective upon the member's Anchor Date. If you determine an increase in hours needs to begin immediately you should submit a request for a service level change to APS Healthcare at wvadwaiver@apshealthcare.com. ***Likewise, if you cannot substantiate the need for services at a higher level, those services can be decreased before the anchor date (this should be happening any way). Just because someone is authorized at a certain level, doesn't mean they have to receive those hours if they don't need them.***

70. A homemaker rides with a family member to take Member to the Dr. due to member being so hard to manage. Is this billable time for the homemaker if it is within the hours she works?

Answer: *Yes, the Service Plan documentation must support the need and then it must be on the members POC.*

71. When are you going to revise/update the POC to allow more space for the details you are now wanting on there? For example: it is impossible to write specific details to include medical appointment frequency with the specific MD, especially if the client has a team of 8 – 10 specialists they see throughout the year. The information cannot be currently typed in with those details and it be printed off for the homemaker/client to see.

Answer: *The specific information such as MD name, type of specialist, date and time of the apt. must be on the Service Plan (which the PA/HM RN and member should have a copy). The Case Manager is responsible for coordinating the services and if no family, neighbors, friends, or community agencies can provide this service, without charge first. The CM should utilize MTM for medical transportation.*

FYI, MTM accepts applications from PA/HM employees to become a "Volunteer Driver" and will pay the driver per mile for the travel. (www.mtm-inc.net *) If the PA/HM provides the service during the POC hours for ADW the "service" time would be billable under the ADW service code S5130.*

The POC should note the date and time of the appt. If the member has a different scheduled appt. monthly during the hours of service, the PA/HM RN would need to document the date and time of the appt. on the POC for that month which should follow the Service Plan.

72. Should a homemaker be scheduled working hours while their client is in dialysis?

Answer: No

73. Are homemakers permitted to purchase alcohol for their client?

Answer: BMS has no policy regarding the purchase of alcohol and/or tobacco/nicotine related products. If upon request, and the HM/PA is performing an essential errand for a member, the provider may choose to purchase alcohol and/or tobacco/nicotine related products for the eligible member. If, however, the eligible member requests a trip only for the purchase of alcohol and/or tobacco/nicotine related products, this would not qualify as an essential errand and shall be considered a non-reimbursable trip. The provider assumes all risks associated with the purchase. (This answer will be discussed during the April 21 call.)

74. The conference call questions packet, page 15 & 16 regarding Community Activities states there is a ***proposed*** definition for a Community Location in the new ADW manual. When will the new ADW manual be complete/finished?

Answer: The new ADW manual will be completed once the ADW renewal is approved by CMS.

75. Can you re-word the Notice of Decision letter that is mailed to the client to reflect their range of hours for their approved level? Some clients look at that letter and have great difficulty understanding why they do not get those hours every month and not looking at the "cannot exceed 93 hours per month"

Answer: Any revision to this form would have to come from APS and WVMI.

76. When a CMA or HMA completes an incident report, is a telephone notification sufficient to let the other agency know of the incident? Does each agency need to complete their own incident report?

Answer: The agency who receives the report of the incident will submit the report and report the incident to the other provider.

77. If the PA/HM is not a relative of the member, what kind of guidelines are suggested for visiting friends or relatives?

Answer: Visiting a friend or relative in their home is not considered a community activity. A community activity such as meeting friends at a local restaurant in the community for lunch would be acceptable. The member is then interacting with others in the community.

Questions/Comments from call:

Question A: Can a member visit a friend in a nursing home?

Answer: If the nursing home is in the member's community, and they participate in a group activity at the nursing home, for example, having lunch in the dining room, playing bingo, etc., then yes. If it would involve just the member and friend in the friend's room, it would not be considered a community activity. By definition, "community integration" is the provision of services which allows a person to live and participate in his/her community and the activities it offers to all citizens.

Question B: The Policy manual states that a provider has 10 calendar days to begin direct services for a new ADW member. Is this correct?

Answer: Yes, although 10 days should be treated as the maximum. We would hope that direct services could begin sooner than that.

Question C: Do providers need to revise forms that use the term "Homemaker" and replace it with "Personal Attendant"?

Answer: No. It will not be required. The forms committee will review the forms and make recommendations for changes based on the new Waiver Application approval.

Question D: Have clients on ADW been sent information on the rules governing transportation?

Answer: No. BoSS does not send information to ADW members. However, the Quality Council published the Transportation Took Kit which was intended to be a guide for providers. The rules, including limitations, regarding transportation should be explained to ADW members so that there is no confusion. The policies governing transportation have not changed since 2006, however, there has been more of an effort recently to enforce the policies that have been in place.

Question E: Can a member visit their husband/wife in a nursing home?

Answer: Again, if the nursing home is in the member's community, and if they participate in group activities at the nursing home, then yes, it would be considered a community activity. "Community integration" is the provision of services which allows a person to live and participate in his/her community and the activities it offers to all citizens.

Question F: When a provider receives an allocation (initial referral) for a new ADW member but the PAS is not attached to their record in CareConnection©, what should they do?

Answer: If you receive a member referral in CareConnection© that does not have a PAS attached, you can contact WVMI at (800) 982-6334, option 3 or APS at (866) 385-8920 and ask them to upload it to the member's record. If you have to leave a message, please provide the member's name and their APS ID number from CareConnection©.

Question G: Taylor County has no MTM transportation providers in their county. Can they utilize and bill for alternate transportation options?

Answer*: *Yes, if you document the fact that MTM is not represented in your county. However, you may want to encourage your homemakers to apply to become volunteer drivers for MTM. In doing so, the homemaker can bill for mileage and the provider can bill for service time.

Question H: Some members don't understand why they can only do things that are listed on their Plan of Care. And if our agency limits the member's activities, they will just transfer to another agency that will not be as strict. How do we deal with this?

Answer*: *Members agree to, and are expected to follow program guidelines. The ADW program, both the benefits and limitations, should be thoroughly explained to each member during the initial assessment. If a member transfers away from your agency and you become aware that the new agency is providing services outside the parameters of the ADW program and/or the member's Plan of Care, notify either Cecilia Brown or Linda Wright at the Bureau of Senior Services at (304) 558-3317 and they will follow up.

Reminder(s): Continuing Certification Report 2015

The new system will be available soon and due to the amount of additional information we are collecting, importing the employee data over to the new system is not feasible. You need to spend this time getting all employee training dates in a format that makes it easy for you to add the information for the 2014/2015 reporting period. The system is currently being piloted by five providers and the

response is very positive. BoSS will contact all providers once training plans for the new Continuing Certification Reporting system is confirmed.

IMPORTANT NOTICE: Medical Necessity Evaluation Request (MNER) submitted incompletely and/or incorrectly could impact the assessment scheduling, medical eligibility and service level when the MNER data transfers over to the PAS.

Forms Committee:

The Quality Improvement Council is creating a Forms Committee to review all Medicaid forms. Anyone interested in participating on this committee should contact Cecilia Brown at (304) 558-3317 or Cecilia.a.brown@wv.gov.

April 21, 2015

78. We were monitored last week and were told that clients must go to closest grocery store for their monthly groceries. The problem is that we live in a very rural area and our closest grocery is very expensive and if our clients are forced to buy their food there then they are going to run out of food by the end of the month.
My clients should not have to go without food and many have no family and/or friends that are able to drive them to another, more affordable, grocery. I am only asking if these clients would be allowed to go to Mineral County and buy their food at Save a Lot, where they can afford to purchase more food for their minimal budget. What is the solution?

Answer: Refer to question 62, section entitled Other questions/comments from the call, part c.

79. Once again, per monitor, client is allowed one trip to pharmacy per week. Medicaid will only fill a Rx 3 days prior to last pill and when clients are taking many (about 20 or so) meds then it is IMPOSSIBLE to get all Rx's filled on the same day. There is no way we can change this and our client CANNOT go without their meds. What is the solution?

Answer: Refer to question 61, part 3 of the answer.

Further clarification from call*: Is it policy that a member can only go to the pharmacy once per week? No. The Plan of Care should consolidate trips to make the travel reasonable. For any unexpected instances, you should just document the situation in the Plan of Care. Be efficient and reasonable with travel.*

Comment 1*: Most drug stores deliver prescriptions, depending on location. Also, some medications can be delivered through the mail.*

80. As before, per our monitor, everything has to be local. How far is local? I currently have a client that lives 20 miles, one way, from town so therefore local to her is at least 40+ miles round trip. As I said before, we live in a very rural area and local to us is not local to someone from Charleston. What is the solution?

Answer: In rural settings, it can be common practice to have to travel a distance to grocery stores, pharmacies, etc. For the member, it would be the closest location to the member. What is local for this member may be in a neighboring city (it is reasonable travel because everyone in the area must travel to the next town to grocery shop due to no stores in the area). For situations where they travel 40 miles round trip, consolidate the trips. Example: Traveling to the store on Fridays to grocery shop and pick up prescription at the pharmacy at the same time. The person would not need to travel every day. Please keep in mind, the member's personal care comes first.

81. According to the memo sent out July 24th by Susan Given, once the Anchor Date is established, it does not change, but I have noticed on a few people that have had a PAS extension done, the Anchor Date has changed. So is this the exception to the rule?

Answer*: *Yes, this is an exception to the rule. Please provide APS with an APSID to research and make sure it is not a system issue.

82. Can you reformat the current PAS evaluation so all of the member's diagnoses are visible? They do not all fit and get cut off and we don't always have a Medical Necessity Evaluation Request available to see what the MD has listed.

Answer*: *Users can print the PAS in landscape –or- can print in portrait orientation at 85%. Doing so will display the narrative fields when printed. The MNER should also always be available in the attach documents feature in CareConnection©. APS will explore changes to the PAS, as an enhancement at a future date.

83. Is there a Notification for potential closures? The only way I have found this out is by doing a member search for letters. Then it can be too late!

Answer*: *No, there is no notification to providers for a potential closure. However, users can always use the 'Search_Member' feature and input the variable of eligibility status = Member-Potential Closure.

84. How can you remove a client from the notifications on CareConnection if they are new to the program but they have chosen not to proceed with the Financial Eligibility process?

Answer: Open member detail then choose eligibility status history. You will see change status under the "action" tab. Click close on the new eligibility status and choose the reason. Note effective date and submit.

***Comment*:** A Provider on the call doesn't have access to the "Action" tab in CareConnection©. Contact Tami Shamblin at APS at (304) 343-9663.

85. Are we required to fax a copy of our Incident Report to the other agency (HMA/CMA) or is just a phone call of the incident sufficient notification?

Answer*: *Communication between the Case Manager and PA/HM Agency is critical and should include any information regarding the member. Sharing a copy of the Incident Report is not required by policy but the expectation of informing and discussing an incident with other disciplines either by fax or phone is very important.

86. If the member has a diagnosis of Alzheimer's, and there is not designated MPOA/Legal Rep., can the member sign for themselves?

Answer: If the member is still alert and oriented, then it may be possible for the member to sign for themselves. The member would need to be evaluated. If it is a relatively new diagnosis, the member could be exhibiting very few symptoms of Alzheimer's Disease and still possess the ability to make his/her own decisions. It is required that a MPOA/DPOA/legal rep sign on the member's behalf when the member has been diagnosed with Alzheimer's Disease and is undergoing the initial PAS process or the re-evaluation process with WVMI.

87. If the member has a diagnosis of Alzheimer's, can the contact person sign assessment/SCP signature pages, or does it have to be someone with legal representation?

***Answer*: If the member lacks capacity due to suffering with Alzheimer's Disease, then no, a contact person cannot sign the assessment/SCP signature page. These are considered medical documents and thus are held to a higher standard requiring appropriate representation and signatures.**

Further clarification from call: *If member is alert and oriented and is still making decisions, then they can sign. However, if they are incapacitated, a MPOA, POA or legally appointed representative should be used. The CM should work with the family and hopefully a representative would be in place in plenty of time. If there are no family members to assist with this process, the court could appoint someone or the member's physician could appoint a health surrogate. There are many variables to consider and each one should be dealt with on a case by case basis.*

88. If the member has a diagnosis of Alzheimer's, and lives alone, and there is no one else to speak with, how do we complete CM monthly contacts?

Answer: This question involves a lot of variables. If the member lacks capacity to make decisions and have a meaningful contact with the case manager, why does the member live alone? It seems unsafe and it seems that other steps should be taken immediately to ensure the safety of the member.

IMPORTANT NOTICE: With the advent of anchor dates and the new ADW CareConnection, there has been some confusion about requesting a change in level of care when the most recent PAS delineates a need for a higher level of care than last year. For example, a person's anchor date is 3/1/15 and her PAS was completed on 2/1/15 and the new PAS necessitates a level of care D. Her level of care last year was level C. It is a health and safety risk to continue for the next month at level C when it has already been demonstrated that this person needs care at level D. Understandably, her agencies want to begin providing care for her at the appropriate level as soon as possible. In order to be paid at the correct level, you must request a Change in Level of Care through the ADW CareConnection (Refer to section 3.9.1 of the ADW CareConnection Web User Manual; disregard documentation requirements since PAS was just completed). This is simply doing the appropriate computer screens to request that change. The paperwork that was required in the past is not associated or needed in this situation because the PAS was just done. *Information in gray highlighted area is currently incorrect. Please see answer to question 91 for the correction to the highlighted information. All other information in this note remains correct.* For more information or a walk-through on completing a request for change in level of care in this situation, please feel free to contact APS Healthcare at (304) 343-9663. APS Healthcare can also send you an electronic version of the Provider Manual for ADW CareConnection. Also, please remember that if a change in level of care is necessitated by something other than the completion of the yearly PAS, you will need to complete the entire process for Change in Level of Care including the necessary documentation.

Questions/Comments from call:

Question A: We cannot request a level of care change until a member's Anchor Date, right?

Answer: No, you can request it at any time whether it's an increase or decrease. (See above.)

May 19, 2015

Questions/Comments from call:

Questions B: Please explain to me why I need to retrain an aide who is transferring to us from another in-home care agency?

We hired an aide that had current CPR/First Aid and all of her annual trainings were current but we were told we must teach those subjects to her again. Since both our agency and her former agency are subject to the same training guidelines, I do not understand why training by her former agency could not

be considered to be valid. I have looked for aide transfer instructions in the ADW and PC manuals but do not see it.

Answer: The aide in question must have received the training from a certified and nationally recognized provider for CPR/First Aid training. The following providers are certified to provide CPR/First Aid training: American Heart Association, American Red Cross, American Health and Safety Institute, American CPR and the National Safety Council. The aide must carry her card certifying that she completed the training with her and provide a copy of it to her current employer. When/if she moves to another employer, then she will be able to produce her proof of training and it will carry over to her next employer.

Question C: Related to Question 1, above, do we have to re-do the background check also?

Answer: Yes. However, when the WV CARES CIB system is activated and a background check has already been done for an employee, you will not have to request one again if the employee changes agencies.

June 16, 2015

89. On a Case Management Assessment page 4 there is a box where you check yes or no for "unsafe feelings in neighborhood". Even though we check the appropriate box and save the assessment it will uncheck the box automatically. Also, on page 5 of the CM Assessment in the emotional assessment section it will check both yes and no boxes under "do you feel you cannot think clearly" even though we choose only one. Can this be fixed? Thanks!

Answer: This is may be an issue with the formatting of the PDF version of the form. The Bureau will evaluate this formatting issue and make any necessary corrections to the formatting. If corrections are made, an amended version will be posted to the website.

Questions/Comments from call:

Question D. When is the new Manual coming out for review?

Answer: We are reviewing the manual now so it should be released soon. It cannot be posted until we know if there will be any changes made to the Waiver by CMS.

NOTE: Questions for this call should be submitted to Susan Silverman at susan.r.silverman@wv.gov or FAX to (304) 558-5547.

July 21, 2015

90. Regarding dual services coordination, the manual reads, "…the coordination of the dual service request is the responsibility of the Case Manager. This includes the coordinating the planning meeting which includes the ADW RN, the Personal Care RN and the member…." I would like clarification as to whether the ADW case manager is required to attend the planning meeting.

Answer: Yes, the Case Manager is responsible for coordination and must attend the meeting to ensure services are not duplicated and member needs are being met.

91. Please clarify the process when a member receives a Level of Care increase during a WVMI Re-evaluation in month(s) prior to Anchor Date, in order for the homemaker agency to be reimbursed. In an April 2015 Directive Susan Silverman stated we must (request) a change in Level of Care through CareConnection without submitting the forms. When I did this Renee at APS Healthcare told me I must withdraw this and fax a Level of Care Request.

Answer: Electronic submission via ADW CareConnection© for the LOC increase due to the Re-Evaluation will not be possible at this time. It has been found that this workaround is not compatible with the system design. When a member needs the higher level of service prior to their new anchor date as determined by the most recent PAS, please fax the Request for Service Level Change form and a brief narrative stating the reason for request to APS Healthcare at 866-212-5053. APS will process the request manually and the agency will receive fax confirmation of the result. As noted in the April 2015 FAQ, if a change in level of care is necessitated by something other than the completion of the yearly PAS, you will still need to complete the entire process for Change in Level of Care in CareConnection including the necessary documentation.

92. Pertaining to RE-writing the POC's to be more specific, is the Case Manager required to go back on each case a(nd) complete a SP Addendum? What is being completed by the Homemaker is not changing, it is only expanding, in more detail, on what it is meant when "Food" and "Medical Appointments" are listed on the SP.
Examples:

(1) The POC might just say "Medical appointment" and to be more specific "Dr. Jones at least once a month, Dr. Smith once a month, Dr. Jane 2 times a month/medical appointments only on Wednesday's"
(2) The POC might just say "Food" and to be more specific "Food lion on 2nd and 4th Tuesdays, Free Pantry 1st Wednesday, Aldi 1st days of the month"

Answer: The PA/HM must follow the Service Plan (SP) developed at the time of the SP meeting and should be as specific as your examples above. If you are rewriting the POC to follow the SP, an Addendum would not be needed. The SP Addendum is required only if the SP changes.

Example: The PA/HM RN notifies the CM that a member requested a change in hours. The SP Addendum would show the need for the change and confirm the change with the member to ensure compliance.

93. This concern is in reference to Q&A #72 "Should a homemaker be scheduled working hours while their client is in dialysis?" "No". The only documentation I have been able to find regarding this question is from a memo dated May 16, 2012 from Penney Hall. In it, she instructed that there was no distinction to be made between billing for homemaker services for a Member's doctor appointments and billing for homemaker services for other medical appointments for the Member. If I am not mistaken, this memo was in reference at least partly to address Provider questions about dialysis appointments.

Recently, one of our Members missed her scheduled dialysis appointment because of failure of MTM transport to arrive as confirmed. That is unacceptable for a dialysis patient.

Please refer RNs to the documentation that indicates that there has been a change in the billing process for dialysis patients since the above memo was received in May 2012.

Answer: We ran this question by Susan Given, current Program Manager at BMS and she stated that, "They could not bill for the time they are waiting for the member to get dialysis. They may want to consider using NEMT for this." So the Personal Attendant/Homemaker could transport the member to and from dialysis, but could not bill for the time waiting on the member. Also, we would encourage the member to make a complaint to MTM about the no-show driver.

IMPORTANT NOTICE: Please make sure that you check ADW CareConnection every day to see if you have new referrals. If you have new referrals, please accept or deny them as soon as possible so you don't delay a member's services. Remember, people sign up for the program because they need help and the longer it takes you to accept their referral, the longer they go without help. If you need a password reset for CareConnection, please contact APS Healthcare asap to get that reset. Their phone number is 304-343-9663. Tell the receptionist that you need a reset for ADW CareConnection. The receptionist will send you to the correct person for a reset.

Questions/Comments from call:

Question E. Does the Homemaker RN have to approve every change that varies from the Service Plan?

Answer: Yes. If there is a change to the current Service Plan, the Homemaker RN must sign off on it.

Question F. How can we find out about changes to ADW Policy?

Answer: Although BMS and BoSS try to inform all providers about important changes in ADW policy, we may not be able to communicate them all. Therefore, we would suggest that you periodically check for changes on the BMS website. All changes to Chapter 501 – ADW Policy can be found at the following link:
http://www.dhhr.wv.gov/bms/Provider/Documents/Manuals/bms_manuals_chapter%20501%20ADW.pdf (***This link is at the top of the Forms page on the BMS website.)***

Question G. How are providers notified of potential closures in CareConnection?

Answer: Currently there is no notification in CareConnection for 'potential' closures.

MTM Non-Emergency Medical Transportation

If you have a complaint regarding the service you have received from MTM, proceed to the link below to file the complaint with them.

https://www.mtm-inc.net/west-virginia/

To file a complaint: 1-866-436-0457. (There is also a form you can submit online.)
If your ride is late: 1-844-549-8354. (If your ride is at least 15 minutes late.)

August 18, 2015

94. Can CareConnection be modified? Our agency received Notification SDM-member transferred today. When going in the link, it lists the member's name and effective date of the transfer for both HM and CM agencies and now neither HM or CM can access the chart to see which agency the member transferred to. We are unable to fax the Service Plan etc., unless the new agency calls us to let us know where the member transferred to.

Answer: The Bureau of Senior Services emails a copy of the Transfer Notice to both the new and old agencies and to the Case Management agency. BoSS either emails it to the director of the agency or to the person within that agency that is traditionally associated with handling transfers or to both people.

95. Can a "contact us" link be added to CareConnection? It would be nice to have this available for any problems with notifications on there that we cannot "dismiss" and requires us to call various people to have them removed. Example for member hold expiration notification: it can be "viewed" but not dismissed. Going in the link then denies access to the chart because the member is closed.

Answer: Some notifications in ADW CareConnection© are dismissible; others require action on the user's part to remove the notification. For the system to dismiss the Member Hold Expiration notification, the user must perform one of three actions: update the Projected End Date and submit with a future date; submit Closure Hold Outcome and Actual Hold End Date; or move the member to Discharged status.

In the event a user continues receiving a notification they cannot act on, they can contact their assigned APS staff or call the AD Waiver department of APS Healthcare at 866-385-8920 to have the notification deleted.

96. At this time is there a plan for Family Nurse Practitioners and Physician Assistants to be able to sign off on the MNERs. If so, when will it become effective***?***

Answer: Yes, it should become effective when the new ADW manual is released sometime this fall.

September 15, 2015

97. Some of my referrals for the Waiver Program have gotten letters saying they are medically eligible for the Waiver Program but there is no slot available at this time and they will be notified when a slot is available but are not getting the yellow sheet to begin the financial review. However, some of my referrals are getting that yellow paper. Should everyone be getting that yellow form in their letter?

Answer: The yellow DHS-2 forms are not sent with the Initial Notice of Decision letters. Yellow DHS-2s will be sent on or near the first of each calendar month to individuals newly added to the Managed Enrollment List. If you have a question about a yellow DHS-2, please email WVADWaiver@apshealthcare.com or call and ask for an ADW support staff.

98. Once a Service Plan Addendum is completed by CM, is mailed to member for signature, then once we receive that back and submit to PA/HMA, how many days do they have to start services per the Addendum?

Answer: You can start immediately on a verbal from the CM. The CM can provide you a copy of the Addendum once it is signed.

99. Are CMgt Agencies supposed to be utilizing the Member Hold Request in Care Connection for Members admitted to NH, Members admitted for Rehab, hospital admissions and psychiatric hospital admissions and whenever Member goes out of state to visit a relative or on vacation? We have not been doing this – we didn't know – errored inadvertently.

Answer: The Member Hold feature in the Aged and Disabled Waiver CareConnection© allows for tracking of members who are not accessing Aged and Disabled Waiver services for various reasons. Please refer to page 20 of the AD Waiver CareConnection Web User Manual for instructions on how to use this feature.

Questions/Comments from the call:

Question H. An eligible person chooses a Case Management and Homemaker agency prior to enrollment, and then changes their mind and wants to transfer to different agencies. Can they transfer at any time?

Answer: Yes. One of the main focuses of the ADW program is member choice, and therefore, whenever someone chooses another agency, we will process that change.

Question I: How long does it take to get a slot after being determined medically eligible for the ADW program?

Answer: The time varies based on multiple factors. Slots are made available in each fiscal year based on available funding. However, if someone doesn't enroll within 60 days of becoming medically eligible or if someone is closed for not accessing services in 180 days, these "unduplicated" slots (meaning the slots were never used because someone never received services in the current fiscal year) could be used by the next person on the Managed Enrollment List.

Question J: Do slots stay with a particular agency? In other words, if a member at Agency A dies, or for some other reason goes off of the program, does the now open slot stay with Agency A?

Answer: No. Slots go into a "pool" and are assigned on a first come, first serve basis. They are not assigned to certain agencies.

Question K: Is there a new manual and forms?

Answer: Yes. CMS approved West Virginia's Waiver Application for the ADW program. The resulting ADW manual has been posted for a 30-day public comment period. Some forms have been revised also. Follow this link to go online to review and make comments:
http://www.dhhr.wv.gov/bms/Public%20Notices/Pages/Aged-and-Disabled-Waiver-Chapter-501-is-available-for-public-comment-until-5-p.m.,-October-15,-2015.aspx (You may need to hold the "Ctrl" key to activate link.)

Question L: What about the 1,200 reduced slots mentioned in the ADW Application?

Answer: The Application covers a five-year period and BMS must try to estimate the number of slots based on available funding. The reason that the application predicted fewer slots each year is because the projected amount of funding for the entire 5-year period is the only funding you can

mention in the application. Over a period of five years, your dollar will buy less, thereby reducing the amount of people served. At times, WV BMS receives additional funding for the ADW program and when that occurs, it raises the number of people who can be served.

Question M: When will Case Managers get an increase in pay? Minimum wage goes up and expenses go up, but Case Manager's compensation stays the same.

Answer: The Bureau of Senior Services does not set reimbursement rates. You would have to contact the Bureau for Medical Services.

Question N: Who made the decision about the new Morpho Trust background check contract?

Answer: The Bureau of Senior Services was not involved in renewing that contract. You may be able to get more information on the bid process by contacting the WV Purchasing Division at (304) 558-2306.

October 20, 2015

No call conducted in October due to ADW Manual Training.

November 17, 2015

100. We are looking to clear up a few matters concerning the mileage. If we're understanding this correctly, MTM will provide the transportation for scheduled Medicaid appointments only. We have different situations that arise where our participants need transported because they have no informal support to take them. They are medical-related but not actual pre-scheduled appointments such as blood work prior to day surgery or picking up a prescription from the doctor office. Are we still able to claim this mileage as an essential errand?

Answer: For blood work prior to surgery, your staff could take the participant, but your staff would need to sign up with MTM as a Friends and Family driver and use that mechanism to bill NEMT (non-emergency medical transportation). They would need to call the number on the form about 5 days prior to the appointment to tell MTM that they were transporting the person that day. No mileage for medical appointments or medical testing can be billed to the ADW program as per mandate from the federal government. To pick up the prescription from the doctor's office, that would be an essential errand and you can bill ADW non-medical transportation to do that.

101. If we have a participant that is to have day surgery in Clarksburg (approximately 60 miles away), will MTM take them to the surgery and then come back later and pick them up? If not and the PA takes them to the hospital for the surgery, they are not able to stay because they cannot be paid for the time.

They would need to leave, drive the 60 miles home and then drive back to pick up the participant. This would be twice the mileage necessary.

Answer: You are correct for the day surgery in that the Personal Attendant can't bill for the wait time because surgery is a Medicaid facility code meaning that once the person gets back into the facility, there are staff available to take them to the bathroom, tend to any other needs they have, etc. If I were the Personal Attendant, I would go off the clock and shop around the area, buy my groceries, whatever, until I could go back and pick up my participant. In the end, if you didn't want the PA to do this, then you could have the participant use MTM. And yes, MTM would come back and get them.

Questions/Comments from the call:

Question O: Clarify the five days' notice as it pertains to being a friends and family MTM driver.

Answer: Actually, according to MTM, you do not need to give five days' notice as a friends and family driver. You can, but it is not a requirement. You can actually call the day of the trip but you still must supply all required information and receive your trip number.

Question P: What about coming home from the hospital? Can we bill NEMT for bringing the member home? Or physical therapy? Can the PA transport member?

Answer: Yes. To and from the hospital or physical therapy facility, as long as the participant is in the car.

Question Q: Is there a list of Facility vs Non-Facilities?

Answer: No, but you may contact the Bureau of Senior Services on a case-by-case basis.

Question R: Has there been a decision made about when to use the new PAL?

Answer: You may either do all assessments at once or wait until they become due. It is up to each agency.

Question S: Is the ADW Training Record Form that was handed out recently mandatory?

Answer: Yes, because it contains space for all required information.

Question T: Is it billable if a member calls to request a home visit by the RN?

Answer: Probably not. The ADW program is not providing medical care. If the participant is feeling ill, they should go to their own physician. If they feel they need more hours, then they could request a re-evaluation and you would follow policy for that request and billing.

Question U: Regarding the Care Plan, do we still need to pick a specific day for a doctor's appointment?

Answer: When the Case Manager and RN are creating the Service Plan, they should try to be as specific as possible and list purpose of outings, day(s) of the week, specific destination, frequency, etc. It may be difficult to be this specific for doctor's appointments but most other Essential Errands and Community Activities should include this detail. Any changes to the Plan due to unforeseen circumstances can be documented in the participant's file.

Question V: When will forms be fillable and savable?

Answer: We will offer both fillable pdf and WORD formats when the new forms are posted. The WORD version of the form will include a disclaimer to ensure that no changes have been made to the original content of the form.

Question W: Do you still want MTM travel recorded on the Plan of Care?

Answer: Yes, you still need to include it because part of the time will be billable. It is also part of the participants Service Plan.

Question X: When should be begin using the new ADW Training Record form? We just recently conducted some trainings in July.

Answer: You can begin using the form now, if you wish.

Question Y: On page three of the Personal Attendant Log, what do you want in the boxes that say "Time In" and "Time Out:"? The instructions are unclear as to what you want there. And also, the PA may work at different times on different days.

Answer: That was intended to be the time in and out, or the hours that it is projected that the Personal Attendant will be working, for example, Time In: 10:00 a.m. and Time Out: 1:00 p.m., if the PA will normally work three hours per day. It would be completed by the RN when they are developing the Service Plan. The request for this information came from the Medicaid Fraud Division. As you pointed out, the hours may be different on different days, so we will review the form and the instructions to see if we need to make any changes.

Question Z: Is the Personal Attendant Log going to remain the same as the form handed out at training?

Answer: In most respects, yes. There may be some formatting or other changes due to questions or comments made during the training sessions, but for the most part, it will remain the same.

Question AA: Is review time of the Personal Attendant Log billable?

Answer: Yes, because you are allowed to bill one unit for review per month.

Question BB: Do we have to wait for the Case Manager to sign off on the Personal Attendant Log?

Answer: No. Sometimes you may need to initiate services before the Case Manager can sign it.

Question CC: When someone transfers to another agency, when are reviews to be done?

Answer: If it is a Personal Attendant agency transfer, you will have to go ahead and do an initial assessment right away, but you can use the Case Management assessment that is already in place, until it needs to be done again. (It should be attached to the participant's record in CareConnection.) In addition, you do not have to be on the same schedule, but you can align them if you want to whenever the next six-month or annual assessment is due. The Service Plan meeting with the Case Manager and RN is mandatory and is done every six months.

Question DD: Can we bill for an initial assessment on a transfer?

Answer: Only if it has not been billed already. Remember, T1001 can only be billed every 300 days but T1002 can be billed once per month.

Question EE: For dental and eye appointments, can we bill that as an Essential Errand?

Answer: Yes. Medicaid does not pay for these services.

Question FF: What if someone has the flu? Can MTM pick them up that day?

Answer: There is an emergency MTM phone number, (844) 549-8354, and they may be able to provide transportation that day, however, if the Personal Attendant has signed up to be a friends and family driver, they can notify MTM that they are taking the participant, receive their trip number and take them that day.

Question GG: Regarding Community Activities and Essential Errands, can the RN make changes to the Service Plan if something changes?

Answer: Yes, there is some leniency. Just be sure to document the reason for the change.

Question HH: Is shopping at the mall a Community Activity?

Answer: Yes, within reason.

Question II: When changing to the Personal Attendant Log (PAL), do we need to do a new assessment?

Answer: Every participant needs to be "converted" to the new PAL by May 30, 2016. The switch to the new PAL can be done when the assessment would normally be due or you can do them all at once.

December 15, 2015

102. Is there a plan to fix the text boxes in the new PDF forms. In the Assessment it is very difficult to enter information when some of the text boxes will wrap text and others will not. In addition, the font size varies greatly. The problem with the word format as noted at the bottom of the SP is "any alterations of the original form will result in improper documentation and disallowance". When can we expect the formatting issues to be corrected? Thanks.

Answer: We are currently working on these issues and hope to have them corrected A.S.A.P. The reference to alteration of the original forms is in reference to content, not necessarily the appearance of the forms.

Questions/Comments from the call

Question JJ: When do you bill for reviewing the PAL?

Answer: There is an automatic billing of one unit per month. The RN must sign the PAL to verify that it has been reviewed.

Question KK: If the RN completes the PAL, do they then just send it to the Case Manager?

Answer: The RN and Case Manager should do an initial visit together. If there is a change in between assessment dates, the RN can update the PAL and make sure the Case Manager gets a copy of it.

Question LL: If someone has a change in hours, for example, but their assessment isn't due, do we use the old forms or use the new PAL?

Answer: Until the assessment is due, use the old forms.

Comment: There were many questions regarding completing the Person Centered Assessment and Personal Attendant Log. BoSS will review and revise the instructions to make them more clear.