West Virginia Department of Health and Human Resources
Bureau for Medical Services (BMS)

Personal Care Services Program Chapter 517 Provider Manual

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WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Agenda

- Introductions
- Chapter 517 Personal Care (PC) Services Provider Manual: An Overview of Changes
- Questions and Answers

PC Services
Chapter 517 Personal Care Services Provider Manual: An Overview of Changes

PC Manual

- Introduces the PC Medical Necessity Evaluation Request (MNER) form.
- Medical eligibility for the program will be determined by the Utilization Management Contractor (UMC), which is currently KEPRO.
- Three new initiatives, included in the manual, will be implemented and will NOT go into effect on January 1, 2018:
  - Electronic Visit Verification (EVV) will be implemented by January 2019.
  - Once implemented, each Direct Care Worker (DCW) will be assigned his/her own PC provider number (NPI).
  - Providers will be expected to bill daily.
    - Span billing of any type will be prohibited.

PC Manual (Cont.)

There were no changes made in the PC Manual to the following:

- Medicaid State Plan PC Services are billed on a fee-for-service basis directly to the claims payer (Molina).
- To be medically eligible, a member must have at least 3 deficits on a nursing home Pre-Admission Screening (PAS).
- A person must have traditional Medicaid coverage or be covered under one of the MCOs for their Medicaid coverage. They must not have an Alternative Benefit Plan designation. Coverage types such as Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Premium Assistance and Pharmacy Assistance do not cover PC services.
  - In order to receive Categorically Needy designation, members must contact their local West Virginia Department of Health and Human Resources (DHHR) office.

PC Manual (Cont.)

There were no changes made in the PC Manual to the following:

- Members can receive a maximum of 210 hours of PC services per month.
- Services available under PC services have remained the same.
- BMS requires that PC providers must provide services on evenings and weekends in addition to weekdays.
- West Virginia Clearance for Access and Registry and Employment Screening (WV CARES).
- Provider requirements and office criteria.
- Review process.

Electronic Visit Verification

Section 517.3

EVV System tracks:

- Type of service performed.
- Individual receiving the service.
- Date of the service.
- Location of the service.
- Individual providing the service.
- Time the service began.
- Time the service ended.

This system is to be implemented in West Virginia in conformance with the 21St Century CURES Act in order to avoid reduction of federal match monies to the affected programs.

Conflict of Interest

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Section 517.4

A conflict of interest is when any staff has competing interests due to affiliation with a provider agency, combined with some other action.

- "Affiliated" refers to either an employment, contractual or other relationship with a provider agency where the staff member receives financial gain or potential financial gain or job security when the provider agency receives business serving PC clients. This includes exerting pressure on or requiring that the member use one agency for both waiver and PC services.
- In the event a provider sells their business, the members do not automatically transfer with the sale. Members must be provided freedom to choose from available PC providers in their catchment area. Any effort to coerce a member to transfer to the purchasing PC provider will be considered a conflict of interest and will result in the purchasing PC provider being removed from the PC provider selection list for one calendar year.

Billing

Section 517.18

- Prior to implementation, providers will receive training, most likely from the claims payer (Molina Medicaid Solutions).
- Daily billing is necessitated by the new PC manual. The meaning of this is that each day will be billed separately, with one claim per date of service per DCW (once NPI numbers are assigned to each DCW).
- Daily billing does not mean that providers have to do the service and bill for the service the same day (for example – the DCW did the care on February 22, 2018 and the provider submitted the claim to the claims payer on February 22, 2018).
- It will still be permissible for providers to bill once or twice per month, there will just be more claim numbers submitted during those times.

Medical Eligibility Determination

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Section 517.13.1

- The UMC (KEPRO) is the entity responsible to conduct the PAS to determine a member's medical eligibility for the PC program. The UMC will also determine the person's level of service based on the member's functional deficits and specified medical conditions identified on the PAS.

Initial Request for Evaluation

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Section 517.13.2

- Personal Care MNER form will be used as the first step in applying for PC services. Applicant will begin filling out the form and will be completed and signed by their MD, DO, Nurse Practitioner or Physician's Assistant and submitted to the UMC.
- Once the UMC receives the completed MNER form and verifies other eligibility requirements for PC, the UMC contacts the applicant (or legal representative, if applicable) to schedule the PAS.
- The UMC will complete the PAS with the applicant and obtain a signed PC selection form. The UMC will enter the PAS information into the web portal (PC CareConnection©).
- If medically eligible:
  - A service level will be assigned.
  - The chosen PC provider will be entered into web portal.
  - An anchor date will be issued.
- If not medically eligible:
  - The UMC will issue a detailed denial letter, copy of the PAS summary and a Request for Hearing form.

Circumstances for No Evaluation

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Section 517.13.2

- A request for PC evaluation will not be processed when:
  - The MNER provided is incomplete or incorrect.
  - The person is not a West Virginia resident.
  - An applicant or member does not have PC coverage in their approved benefit plan or is not West Virginia Medicaid eligible. The person receives notification and hearing rights from their local DHHR office if they are found not eligible for West Virginia Medicaid.
  - An applicant or member is already approved for waiver services and does not meet the screening criteria for dual services. The UMC will notify the applicant when the dual service request cannot be processed. The PC agency will be notified through the UMC web portal for members.
  - The UMC cannot reach the applicant/member to schedule or conduct the assessment after three attempts. The UMC will notify the applicant when the request cannot be processed. The PC agency will be notified through the UMC web portal for members.

Redetermination of Medical Eligibility

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Section 517.13.4

- PC members must be reevaluated annually to determine continued medical eligibility. Process follows:
  - Assigned PC agency must submit MNER to UMC no earlier than 90 days prior to anchor date and no later than 45 days prior to member's anchor date.
  - Upon receipt of complete and correct MNER, UMC will contact member (or legal rep, if applicable) and schedule PAS.
  - Once scheduled, UMC will issue notice to member and/or contact person detailing scheduled home visit and time.
  - UMC completes PAS and enters it into the web portal.
    - If medically eligible, level is assigned and authorization is issued.
    - If not medically eligible, UMC will send termination letter with Fair Hearing Rights.

Service Level Change Request

Section 517.13.9

- If, during the course of the member's service year, the member experiences a change in need, the PC agency must document the deficits, diagnoses, and conditions and must obtain documentation from the member's medical care provider to substantiate a request for Service Level Change.
- PC agency must submit all required information via the web portal to the UMC for consideration of a new service level.

Plan of Care Development

Section 517.15

- Plan of Care (POC) is a person-centered plan developed by the PC RN in collaboration with the member that outlines the DCW activities that will be provided to the member.
  - PC RN will use the current PC Standards of Care to develop the POC.
    - PC activities performed outside “routine of the day” must have rationale on Member Assessment explaining need for that service during that time of day.
    - Once POC is developed, the PC agency will begin providing DCW services within 10 calendar days.
    - If something goes wrong and the agency will be unable to begin providing services, the agency must document why and what informal supports are being used in the meantime to facilitate the member’s care or the agency must counsel the member about their right to transfer to another agency.
- PC RN must provide the member or their legal rep with a copy of the PC Member User Guide initially and obtain appropriate signature.
- PC services are not intended to replace supports/services that a child would receive from the school system during the school day or educational hours provided during home schooling.
- PC services do not replace the age appropriate care that any child would need from a parent or legal guardian.

Service Interruptions

Section 517.16.3

- A PC agency must not stop direct care services to a member for any reason, including lack of staff or cooperation between waiver and PC agency, environmental issues that are not addressed in section 517.19 about unsafe environment, etc., without first consulting with the Operating Agency (OA) for technical assistance.
- After technical assistance from the OA and the PC agency is still unable to serve the member within seven calendar days, the PC agency must counsel the member on the right to transfer to another PC agency.
- At no time is it acceptable for a PC provider to not provide PC services for 30 calendar days.
  - If this occurs the PC provider must initiate a transfer to a provider who can meet the member's needs.

Dual Services Request

Sections 517.24, 517.24.1 and 517.24.3

Although a dual PC request will include a prior authorization starting with the waiver anchor date, PC services must not be provided until medical eligibility for PC services has been approved by the UMC. Only upon receipt of a MNER, KEPRO will verify the Aged and Disabled (ADW), Traumatic Brain Injury (TBI) and Intellectual Developmental Disabilities (IDDW) Waivers' "dual" criteria.

As an example in an ADW case:

- KEPRO receives a MNER for a member marked as "dual ADW."
- KEPRO reviews it to ensure the member is already assessed for the service year, and is a Level D.
  - If the member has been assessed and is a Level D, KEPRO will key the ADW PAS into PC CareConnection© and issue a PC authorization.
  - If the member has not been assessed, the UMC will reject the MNER as it cannot be submitted until/unless the ADW PAS has been completed.

TBI will function the same as ADW, described above.

Dual Services Request (Cont.)

Section 517.24.2

- IDDW/PC duals will be different as they must have completed and received authorization for their IDDW service requests for the service year before the UMC can process the MNER. Once the UMC has confirmation the person meets all IDDW/PC dual criteria, then the UMC will schedule and complete the PAS and enter it into the web portal. Once approved, PC CareConnection© will generate the PC authorization.
- The waiver criteria must be established prior to the UMC's processing of the PC request (MNER).

Dual Services Request (Cont.)

Section 517.24

- Duplication of services must be avoided. When requesting dual services, a combined waiver/PC schedule must be submitted. This schedule must contain the following information for people receiving their waiver services through the traditional OR self-directed model.
  - Specify days and times each program will be used during each week.
  - Specify tasks during the time period they are to be completed.

PC Manual (Cont.)

Section 517.7.2

- Plan of Correction is now called Corrective Action Plan (CAP) to avoid confusion with POC.

Section 517.8.5

- RNs who are not certified CPR/First Aid trainers have to keep their CPR/First Aid training current. This is a new RN Training Requirement.

Questions and Answers

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