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

MEDICAID PERSONAL CARE SERVICES

QUESTIONS AND ANSWERS

PRE-ADMISSION SCREENING (PAS)

1. **Question:** Are we allowed to accept a faxed copy of the PAS from the physician?
   Answer: Yes. As long as the physician signed the PAS and it is an original signature (not a stamp, etc.)

2. **Question:** What happens if the physician does the PAS early – how does this affect the anchor date and provider billing? Same question if he does it late – does this change the anchor date?
   Answer: The anchor date is the annual date by which the member's medical eligibility must be recertified. It is the first day of the month in which the member's PAS determined their medical eligibility. The anchor date ALWAYS remains that date.

3. **Question:** Will the PCMEA change?
   Answer: The document has not changed, only the name. As in the Aged & Disabled Waiver, it is now called the Pre-Admission Screening (PAS).

4. **Question:** Can the RN bill for the initial PAS?
   Answer: Yes, after medical eligibility has been determined.

5. **Question:** If the physician does not sign the PAS, do we send it to the UMC (APS Healthcare) anyway?
   Answer: No, the PAS is not complete if it is not signed by a physician.

6. **Question:** Do we need the new Physician Certification Form as well as the physician signature on the PAS?
   Answer: Yes, if the agency RN was the individual who completed the PAS.

7. **Question:** If I receive a referral and complete a PAS and it appears they are not going to be eligible, do I still need to submit the PAS to the UMC (APS Healthcare)?
   Answer: Yes, you must submit all PAS's to the UMC for them to make the medical eligibility determination. If the UMC determines they are not medically eligible, they will notify the applicant and provide them with their Fair Hearing rights.

8. **Question:** Can I complete the PAS and the RN Assessment at the same time?
   Answer: Yes.

9. **Question:** Can the RN complete the initial assessment and plan of care while doing the initial PAS?
   Answer: Yes – but you would not be able to bill for any services until medical eligibility has been determined.

10. **Question:** Do we have to send the PAS to IRG if the person is not financially eligible?
    Answer: No

11. **Question:** Is the PAS transferrable from one agency to another?
    Answer: We originally thought that we could transfer these but have since realized this is not possible in certain systems. The "transfer to" agency will need to send the Personal Care Transfer Notice (provided by the Bureau of Senior Services, the new Plan of Care and the existing PAS to WVMI. WVMI will update the member's record and set up the prior authorizations.

12. **Question:** Can the physician electronically sign the forms?
    Answer: Yes, as long as he/she adheres to Medicaid policy pertaining to electronic signatures (Refer to Chapter 300).

13. **Question:** Will the PAS need to be completed the month before the anchor date and submitted to APS Healthcare prior to the anchor date to prevent it from the being expired?
    Answer: You can submit the PAS up to 60 days prior to expiration. As far as the submission, it is really no different than it is now.

PRIOR AUTHORIZATIONS

1. **Question:** What is the turnaround time for a prior authorization request?
   Answer: The UMC (APS Healthcare) has 5 business days to process prior authorization requests.

2. **Question:** When we request a prior authorization, can we submit for a Level 2 right from the beginning?
3. **Answer:** Yes, but you must submit the documentation required for a Level 2 prior authorization.

4. **Question:** Do we need to send Prior Authorization requests for Level 1 and then go back and submit for Level 2?
   Answer: If you think the person will meet the requirements for Level 2, you can submit the required documentation for Level 2 straight from the beginning.

5. **Question:** When are the prior authorizations to begin?
   Answer: Starting January 1, 2014, all new applicants are to be submitted for prior authorization. Your current members you would submit when their PAS comes due.

6. **Question:** Will the agency receive notification from the UMC (APS Healthcare), that an individual has been medically denied?
   Answer: Yes. The member will also receive notification along with a Fair Hearing Request Form.

7. **Question:** Will the prior authorization be transferrable from agency to agency?
   Answer: Yes, the prior authorization is transferrable from agency to agency.

COMMUNITY SERVICES

1. **Question:** How can we bill in the community?
   Answer: Community services in the Personal Care program are not the same as they are in the Aged & Disabled Waiver program. In Personal Care, the community is the location of the personal care service, not the service itself. So, in order to bill, the direct care worker must be providing personal care services. Example: A quadriplegic on the Personal Care program requests assistance to attend a dinner out with friends. The direct care worker can transport or meet the member at the restaurant to provide planned direct care services the member would require during the dinner. The same services that would be required at home during dinner, just at a different location. Such as feeding, grooming, toileting, etc. The time spent providing the direct care service for the member would still be billable just as if you had provided the service in the home (Same service/different location).

2. **Question:** Do we have to offer community services to the member?
   Answer: It is not mandated at this time but the Bureau for Medical Services would hope that reasonable requests would be considered.

3. **Question:** Can an agency set their own agency limitations regarding community services?
   Answer: Yes, if your agency decides that they cannot provide services in the community, they are not mandated to do so.

BACKGROUND CHECKS

1. **Question:** How do we do the FBI background check?
   Answer: The prospective employee must request the FBI background check and the results will be provided to that prospective employee.

2. **Question:** If we depend upon the prospective employee to bring in the FBI background check results, how can we make sure it is accurate and not altered?
   Answer: If the document appears legitimate without obvious alteration, you can accept it in good faith. If it appears to be altered, you should report it to the FBI and not hire the prospective employee.

3. **Question:** If the DHHR Protective Services check shows a finding, can they provide Medicaid Personal Care services?
   Answer: No, they cannot provide Personal Care services. They can contact their local DHHR to see if it is possible to have the record expunged.

4. **Question:** If a direct care worker has a receipt for an FBI background check, can they go ahead and work before the actual results have been returned?
   Answer: If there is proof that the background check has been initiated, then yes they can work while waiting on the results.

5. **Question:** How long should we wait for the FBI background check results?
   Answer: You need to be reasonable because this is a health & safety issue. Thirty days is reasonable – if the background check is not back within that timeframe, you should look into the situation.

6. **Question:** Can the agency ask the FBI for the results?
   Answer: No, the results must go to the prospective employee.

7. **Question:** How do we verify that we checked the OIG list monthly for Operating Agency monitors?
   Answer: Agencies are doing this in a variety of ways. The monitors just need to be able to see that the check has been completed monthly.

INCIDENT MANAGEMENT SYSTEM (IMS)

1. **Question:** Will there be training provided on the new Incident Management System?
   Answer: Yes. Training will be provided when the system is ready. The target date for the new Incident Management system is May, 2014.
2. **Question:** Until the new web-based Incident Management System is available, how do we report incidents?
   Answer: Complete an Incident Report Form and conduct follow-up/investigation within 14 days of learning of the incident. The agency director must review and sign each incident report. Maintain an administrative file of incident reports and make available for monitoring reviews. If

the agency has no incidents for the month, complete the "No Incident Report" Form. It is one form for the entire year. Enter for each month there are no incidents for the month. Maintain this in the administrative file as well.

TRAINING

1. **Question:** If a worker has used a lift, does this qualify them as a specialist for training?
   Answer: Only if that individual has extensive experience and knowledge working with lifts (working with one or two member does not qualify as "extensive experience and knowledge".)

2. **Question:** Do we need to be certifying our direct care workers for CPR for children?
   Answer: If they are going to provide Personal Care services to a child, then yes.

3. **Question:** Was the timeframe requirements for training removed?
   Answer: Yes.

4. **Question:** Is the four hours of annual training in addition to the mandatory annual training requirements (CPR, First Aid, OSHA, Abuse, Neglect and Exploitation and HIPAA)?
   Answer: Yes, you must provide four hours of training focused on enhancing direct care service delivery knowledge and skills.

5. **Question:** If the RN does member specific on-the-job training, does this training have to occur in the member's home?
   Answer: Yes.

6. **Question:** Can member specific on-the-job training be counted toward a workers four hours of annual training?
   Answer: Yes.

7. **Question:** What is a qualified internet training provider?
   Answer: The agency RN should be able to determine quality, competency based training.

8. **Question:** Can the Direct Care Worker Guide be used as part of our training?
   Answer: Yes.

9. **Question:** If the agency RN is the one who does the CPR instruction, how long is the training valid?
   Answer: The agency RN must be a certified CPR trainer and the CPR is current as defined by the terms of the certifying agency.

10. **Question:** Does a CNA have to complete the required direct care worker training?
    Answer: Yes.

PLAN OF CARE

1. **Question:** If we are no longer using the Personal Care Standards, how do we determine that environmental did not exceed one-third of the service time?
   Answer: The Plan of Care will allow you to calculate the time spent on environmental tasks. There is a section specifically for this where you document the time assigned for each task and the total time spent. Examples are provided on the Plan of Care Instruction Sheet.

2. **Question:** Can we bill more than one time per month for the review of the Plan of Care?
   Answer: Yes, if you have enough units (time spent reviewing the POC) to bill more than once.

3. **Question:** When the manual goes into effect January 1, 2014, when are members Plan of Care due?
   Answer: You do each member's Plan of Care as they come due. Example: If you have a member whose Plan of Care is due March 3, 2014 – you would use the new Plan of Care form at that time.

4. **Question:** Can the RN review the direct care workers documentation on the POC of services provided, once per month?
   Answer: Yes.

ESSENTIAL ERRANDS

1. **Question:** Can we take members to medical appointments, the grocery store and the pharmacy?
   Answer: Yes, these are essential errands and the time spent on essential errands is billable. The member may or may not go with the worker on essential errands.

2. **Question:** Are paying bills and going to DHHR for financial eligibility considered essential errands?
   Answer: Yes. Essential errands are errands that are necessary to assist a member to remain in their own home.

3. **Question:** Regarding essential errands, do you include the travel time to and from the site to conduct the essential errand (ex. grocery store) in the total time of the essential errand?

Answer: Yes. Ex. If it took you 15 minutes to get to the grocery store, 30 minutes to shop, and 15 minutes to return to the member's home – total billing time for this essential errand would be 1 hour.)

DISCONTINUATION OF SERVICES

1. **Question:** How long does it take to process an unsafe closure request?
   Answer: The time it takes to process can vary based on many factors such as communication required, documentation submitted to support the request, etc.

2. **Question:** If a member is non-compliant with services, what should we do?
   Answer: You should first try to work through the issues with the member. If unsuccessful, then you may submit a request for discontinuation of services with documentation to support the non-compliance.

3. **Question:** Does an agency have to notify the Operating Agency (Bureau of Senior Services) when a member is found medically ineligible?
   Answer: If it is an existing Personal Care member, the agency would report the closure on their monthly report to the Operating Agency (Bureau of Senior Services).

DUAL SERVICES

1. **Question:** For dual services, can we use the Aged & Disabled Waiver PAS?
   Answer: Yes. However, it must be reviewed to assure the information is current and reflective of the member's needs. The Personal Care RN is responsible for the development of the Personal Care Nursing Plan of Care and for submitting the prior authorization to the Utilization Management Contractor (APS Healthcare).

RN ASSESSMENT

1. **Question**: Do we still need to do a 6 month RN Assessment?
   Answer: Yes.

2. **Question:** Is the 6 month RN Assessment going to be due on a specific date of the month or at the end of the month it was completed?
   Answer: At the end of the month.

FORMS

1. **Question:** Can we change the forms?
   Answer: No. Do not make any changes to the forms. If an agency wants to make up its own type of form for a specific purpose, that is fine. However, monitors will be reviewing for the forms required per policy.

2. **Question:** Will the forms be available electronically?
   Answer: Yes.

OTHER

1. **Question:** Will the Personal Care direct care worker get reimbursed for mileage?
   Answer: No. There is not a transportation service in Personal Care.

2. **Question:** Are weekend and evening services required?
   Answer: Yes, if members need services on weekends and/or evenings. The member's needs must need.

3. **Question:** Can an agency serve individuals outside of the county their agency is located?
   Answer: Yes, there are no restrictions in Medicaid policy on the counties an agency can serve. Agencies need to notify the Operating Agency (Bureau of Senior Services) of the counties they serve.

4. **Question:** Do we have to have a 24 hour contact method for our agency?
   Answer: Yes – Examples of this are cell phone, pagers, message systems that an agency employee frequently checks, etc.

5. **Question:** If the member is unable to write their name, is an x acceptable?
   Answer: Yes, but you need to document that the person is unable to sign and witness with your signature.

6. **Question:** If a member is eligible for Level 2 services but they only want Level 1 hours, is that o.k.?
   Answer: Yes, but the member's needs must be met and it must be documented how they are being met (Ex. informal supports, etc.)