Personal Care Provider
Conference Call Questions
2014

February 18, 2014

1. If the PC RN completes a six month visit and feels that the member could benefit from an increase in time to a Level 2, what needs to be faxed into APS Healthcare? Would we need to include the prior Plan of Care/worksheet? Would we need to include the prior PAS (PCMEA}? Would we need to do a new Plan of Care?

Answer: Refer to PC Medicaid Policy manual section 517.20 (pg. 23}.You would need to include the followng:

- ***The completed APS Healthcare Prior Authorization Fax Sheet***
- ***The PAS with the dated physician's signature and the dated provider agency's signature***
- ***The Physician Certification Form***
- ***The Nursing Assessment and Plan of Care***
- ***Other documentation the RN feels is relative to making a determination for Service Level 2 (narrative)***
    - ***The prior Plan of Care and prior PAS do not need to be included but you can if you choose to.***

2. On the front page of the PAS, there is a question asking for the providers address. Whose address goes on this line?

Answer: The Personal Care provider agency address.

3. Why do we have to assign a day of the week for environmental services?

Answer: Services must be scheduled. You are making a plan to assure that member's needs are met. This schedule gives direction and instruction to the direct care worker. When you have "unexpected" events occur, you do the environmental service needed due to that event and document why it occurred.

4. If a physician refuses to sign the Physician Certification letter, what do we do?

Answer: If a physician refuses to sign a Physician Certification letter, to us that signifies he/she is not willing to validate that individual's medical eligibility for the program. You would not be able to submit for a prior authorization under these circumstances.

5. If the PAS expires before the physician signs it, is there an extension request or do we stop services?

Answer: There are no extension requests (service continuations) in the Medicaid Personal Care program. If you allow a PAS to expire, your agency is still responsible for providing services to that member without reimbursement. You can submit a PAS up to 60 days before expiration.

6. The new Member Assessment does not address dishwashing and the GI/GU findings section is missing.

Answer: The form has been modified and these have been added.

7. Do we have to give the member a copy of the Member Assessment? I am concerned about others who have drug issues seeing the medication sheet.

Answer: Yes, you must give the Member Assessment to the member: They have a right to their health care documents. You must address the types of concerns mentioned in another manner not by denying them the right to their health care record.

8. Where do I put take out garbage, empty and clean bedside commode on the Member Assessment and the Plan of Care?

Answer: Use the "other" category on both the Member Assessment and the Plan of Care.

9. Regarding the Service Level on the Plan of Care, the example in the instructions says 0-60 for Level 1 and 61-210 for Level 2. Is this what I put or do I put something closer to the actual number of hours?

Answer: Yes, you can put what is in the example. Or you can write Level 1, Level 2, or you can put actual hours. All would be acceptable.

10. What is the Anchor Date?

Answer: The annual date by which the member's eligibility for continuing Personal Care services must be recertified. The Anchor Date will be the first of the month in which the member's PAS determined medical eligibility for Personal Care services. The member's Anchor Date will serve as the due date for re-eligibility each year as well as the start date for all prior authorizations.

11. The new Anchor Date methodology is causing my Assessments and Plans of Care due dates to be off. How do I know when to do these now?

Answer: Do not try to match your PAS due dates with the due dates. If your six month and annual

Assessment and Plan of Care. You do the Assessment and Plan of Ca e when they are due and when they are needed due to member changes.

12. How do we calculate the 1/3 environmental?

Answer: You plan for your members as needed whether that is daily, weekly, etc. The RN monitors calculate based on the provider's billing frequency.

13. How do we handle members that had a prior authorization before the new manual went into effect and their current prior authorization expires before the new PAS is due? (Ex. current prior authorization granted before new manual went into effect expires 6/30/14 but PAS does not expire until 11/15/14.

Answer: Your current prior authorization will be good until the new PAS expiration. (Ex. current prior authorization good until PAS expires in November. Remember you can submit the new PAS up to 60 days prior to expiration)

14. The environmental section of the Plan of Care is too small to type in – can this be fixed?

Answer: It has been reformatted and is up on the Bureau for Medical Services website.
http://www.dhhr.wv.gov/bms/Programs/PCS/Pages/Policy-and-Forms.aspx

15. The Plan of Care where we have to write "Time Arrived" and "Time Left", what do we do when the direct care worker's time varies?

Answer: Changes to schedules should be the exception, not the rule. This is a planned service. The comment section is where you document when changes do occur and the space provided should be sufficient space if the changes are in fact the exception, not the rule. If it is not, then the issue may be staffing and scheduling.

16. Does a Personal Care chart with dual services need a PAS and Physician Certification on file?

Answer: The PAS is required to be in the chart (for dual you can use the ADW PAS) and the Physician Certification is only required if the PC RN is the one who completed the PAS.

17. When do we do the RN assessment for a dual service member?

Answer: You do the RN assessment at 6 months and at the annual.

18. Can we get a step-by-step form that states what documents/forms need to be submitted with prior authorizations and dual services?

Answer: The APS Healthcare fax sheets for prior authorizations and dual services include exactly what you need to submit.

March 18, 2014

19. When forms are updated or revised, it would be helpful if the date of the revision was on the form. Would that be possible?

Answer: Current forms are on the website. We have recently made changes (primarily formatting) to the Member Assessment, Plan of Care, Monthly Report, RN Initial Contact Log and the Transfer Form. Yes, we will start adding the revision date to the bottom of the forms. In fact, we have already done so with the ones listed above after we received your suggestion. All current forms are on the Bureau for Medical website at http://www.dhhr.wv.gov/bms/Programs/PCS/Pages/Policy-and-Forms.aspx . Anytime a form is updated or revised, you will be notified via email from the Bureau of Senior Services.

20. On page 2 of the "Definitions of the Personal Care Terms", it states, "Routine skin care such as applying body lotion after bathing or application of suntan lotion is not considered medically necessary". We feel it is medically necessary especially if an individual is on diuretics, if they are not mentally capable of applying lotion, or if they are obese and not able to reach certain areas. Is applying lotion allowed to be used on the Plan of Care or not?

Answer: Yes, but not as a "routine" item on the Plan of Care. There must be a medical/clinical basis for application of lotion and it must be documented.

21. If you receive a prior authorization after the beginning of the month with an authorization date (anchor date) of the beginning of the month, when is the first date for which you can bill hours? The anchor date or the date of receipt?

Answer: The anchor date.

22. Can you use the previous logs in 2014 if you received approval for hours in December for services beginning in January? Or is the new form required?

Answer: We are not sure what you are referring to when you state "logs". If you want to resubmit your question with more specific language please do so. As for forms, they are to be utilized as of the effective date of the manual (January 1, 2014). Use them as they come due for each individual member (Plan of Care, Member Assessment) or as they are needed for individual members (Transfer Form, Discontinuation of Services, etc.).

23. Can ADL's and IADL's that are assigned a specific day be changed to a different day if the direct care worker notes why and would it be able to be billed?

Answer: This question was addressed on the last conference call on February 18, 2014. Please refer to that document – it is question/answer #3 and question/answer #15. The document is posted on the Bureau of Senior Services website at www.wvseniorservices.gov and the Bureau for Medical Services website at http://www.dhhr.wv.gov/bms/Programs/PCS/Pages/default.aspx

24. Why can't we save information that we type on the Plan of Care?

Answer: You can save information on the Plan of Care. It has been tested both internally as well as with selected providers. If you are unable to save, it may be a technology issue on your end such as outdated software.

25. Can you please add provider name to the top of the Plan of Care?

Answer: The form was developed specifically with the member's name because it is the member's Plan of Care. If you want, you can write your agency name somewhere on the form.

26. Can you please confirm that you can bill two T1001 events in one year?

Answer: Yes, but this is currently being addressed by the Bureau for Medical Services with Molina so that this is permissible. The billing must be at least 300 days apart. If you have billing that is denied due to this, contact Susan Given at Susan.A.Given@wv.gov

27. If a request for Level 2 has been denied due to lack of points to substantiate Level 2, why do I need to resubmit a request for Level 1?

Answer: If you submit for a Level 2 and they don't meet Level 2 criteria but they do meet Level 1 criteria, they will be approved for Level 1. They will also get a Notice of Decision from APS Healthcare informing them that they have been denied at Level 2 and that notice will include a Request for Hearing form.

28. If the RN Assessment and the Plan of Care are not completed before the PAS has been approved, how can you submit for Level 2 Services?

Answer: You can't, these documents are required for a Level 2 prior authorization.

29. I have a member who was approved for extended hours for 80 hours a month. This approval was done in 2013. Now the member needs more time. Can I just go ahead and increase the hours up to the maximum of 210?

Answer: Yes, as long as it is medically/clinically justified and documentation supports that justification.

30. If a member transfers to us and he was receiving extended hours, but our agency RN feels under her professional opinion that the member only qualifies for a Level One, should this not be reported as potential abuse of the program?

Answer: Yes, this should be reported to Medicaid Recipient Fraud (304-558-1970) as well as Medicaid Fraud (304-558-1858). You should only provide the hours the person actually needs despite the LOC – the RN needs to document the situation.

31. What does the Tr stand for on a member's medical card after their 11 digit Medicaid #? I've seen this on cards and when I call EDI I am told it is a QMB card. We cannot provide Personal Care if all they have with Medicaid is QMB, correct?

Answer: Tr stands for Traditional Medicaid. For a while, Medicaid had traditional, enhanced and basic. All Medicaid is now traditional. So, you will see this on cards that are QMB as well. QMB cards will not cover Personal Care services.

32. According to policy, a felony offense prohibits a direct care worker from working (in the direct care worker field) if the offense was within the last 10 years. Policy also dictates that a direct care worker cannot work at all (in the caregiving) field if there is a CPS/APS substantiation of maltreatment. This seems inequitable. Why should a direct care worker be punished forever for an offense that carries no legal penalty but be excused after 10 years for a legal offense of the highest level?

Answer: The only offenses listed in Medicaid policy that has the 10 year limitation is felony DUI and felony drug related offenses. There is a process for individuals to apply to DHHR to request findings be removed from their DHHR Protective Services Record Check. Information on how to do this was sent out via email to providers last week.

33. It would be very helpful and less time consuming for providers if the name of the member was on the Personal Care Prior Authorization instead of just the Medicaid number. Is that possible?

Answer: Yes, APS Healthcare will add the person/member's name to the prior authorization. Please ensure HIPAA compliance with any communication regarding Protected Health Information (PHI).

34. Can we get a step-by-step form that states what documents/forms need to be submitted with prior authorizations and dual services?

Answer: The APS Healthcare fax sheets for prior authorizations and dual services include exactly what you need to submit.

35. In late January, I submitted a PAS to APS Healthcare that was due in mid-February. I was under the assumption the anchor date would be in February since that was when it was due previously but when I received it back the anchor date was 1/1/14.

Answer: The anchor date will be the first day of the month in which APS Healthcare approved the prior authorization.

36. I called APS about a PAS that I had sent approximately 30 days before its expiration. I was told that we did not need to send it in that early.

Answer: You can and should submit up to 60 days before the expiration.

37. Due to severe weather the past couple of months, some direct care workers have not been able to work their regular schedules. I am concerned that environmental could be over the one-third allowed.

Answer: The Bureau of Senior Services RN monitors review environmental based on the billing period, not on a daily basis.

38. On the Member Assessment, where do we get the financial eligibility date?

Answer: That is the date you verify financial eligibility. Providers do this in different ways such as by looking at the card or by calling their local DHHR office.

39. There are some missing items on the Plan of Care – doing dishes, care of medical equipment, vital signs, etc.

Answer: A couple of items have been added (such as dishes). If there is a specific item not on there, you can use the comment section. Doing vital signs is not a policy requirement but you can do them if you choose.

40. If a Level 1 PAS and Member Assessment were done prior to January 1, 2014 and there is no Physician Certification Form available (because it was done before the new policy). If there are changes with the member that the RN feels justifies a Level 2, what must be submitted to WVMI?

Answer: This question was answered on the February 18, 2014 conference call. Refer to Question/Answer #1. If the RN was the one who completed the PAS, you would have to get a Physician Certification Form.

41. Can I get paid for a Plan of Care developed before the anchor date starts?

Answer: Not for initials because they are not yet medically eligible. Yes, for re-evaluations because they have current medical eligibility.

42. Why does WVMI send back the entire PAS? It is wasting our paper. Sending back just the correction request would be sufficient.

Answer: WVMI must send back the entire PAS. Please thoroughly check your PAS for accuracy before submitting to eliminate WVMI having to return it.

43. With daily schedules being fluid, why do we have to assign specific times for the worker? It would be easier to document the time after the fact rather than before.

Answer: Please refer to Question/Answer # 3 and #15 from the 2/18/14 conference call. This is a planned service and services must be scheduled.

44. If a member is totally bedbound and is only transferred with a hydraulic lift, why can't #26 i (walking) on the PAS be marked n/a?

Answer: Yes, you can mark N/A. Or you can write in something that explains the situation such as non-ambulatory. Putting something in the field assures our RN monitors that it wasn't a field that was overlooked by accident – it informs them that the field actually doesn't apply to this person for a specific reason.

45. During the last call, it was stated that all prior authorizations in place prior to the start of the new manual were automatically approved until their PAS is due again. Does this hold true for dual services as well?

Answer: Yes.

46. Does the UMC send the individual/member notification of approval or denial for services and what Service Level they are? Do they get a copy of their PAS?

Answer: The Bureau for Medical Services does not require that the UMC send approval notices to members for Personal Care services. In the event that a member is denied either eligibility for Personal Care or requested Level of Care (e.g. request is for Level 2 but member can only be approved for Level 1) the member will be sent a Notice of Decision with information about their Fair Hearing Rights and a copy of their Pre-Admission Screening assessment. Approvals are communicated to the provider of service via authorization correspondence. If the member requests a copy of their PAS or information about their approval, the provider should accommodate the request.

Program Updates:

1. Make sure you are using the PAS on the Bureau for Medical Services website.
2. Several forms have been updated and the revision dates are on the bottom of the forms. They are located on the Bureau for Medical Services website.
3. If you have a member who is a Level 1 that needs a Level 2, a new PAS does not need to be done.
4. If you have a prior authorization that was prior to the implementation of the new manual (1/1/14), the prior authorization is good until the PAS expires.
5. Regarding the Molina provider enrollment/re-validation process; the asked-for "approval" letters from BoSS. We have done those letters for each provider and electronically sent them to Molina. We also mailed you a copy of your letter. If you have questions about what Molina needs for your NEMT, you need to contact them or your local DHHR to discuss. BoSS does not administer NEMT services for Medicaid.

April 15, 2014

46. Specialized Family Care currently does not have access to WV CARES. Is there a need for the program to have access to that? Is there a need for the program to have any kind of separate Incident Management System?

Answer: The WV CARES system is not up and running at this time. Providers will be notified when it is ready. There is no need for the SFC program to have a separate Incident Management System.

47. Specialized Family Care currently does not have access to the website to check for Medicaid fraud. Is there a need for the program to have access to that site? If not, how can the program access this information during its provider application process?

Answer: We are not sure what website you are referring to. If you are referring to the OIG Medicaid Exclusion list, that list can be obtained at http://exclusions.oig.hhs.gov All Personal Care providers are required to conduct Criminal Investigation Background Checks per policy 517.10. If this did not answer your question, please contact the Bureau of Senior Services at (304)558-3317 for technical assistance or resubmit your question for next month's provider conference call.

48. What process would you prefer the Specialized Family Care program use in submitting any issues or complaints from providers?

Answer*: They should utilize the grievance process in the Personal Care manual. It is located in Section 501.15. Additional assistance can also be accessed at the Bureau of Senior Services.*

48. Is the Personal Care RN Assessment necessary when establishing dual services? Or can we use the Aged & Disabled Waiver Member Assessment to develop our Plan of Care. Is that correct and the only documentation required of the Personal Care RN at that visit is the RN Member Home Visit Form?

Answer: Dual Service Provision for ADW Members can be found in Section 517.22.1. The Personal Care RN must use the Aged & Disabled Waiver Member Assessment and the Aged & Disabled Waiver Plan of Care to determine member need for Personal Care services. (Refer to policy for Personal Options members). The Personal Care RN would then be responsible for the development of the Personal Care Nursing Plan of Care and for submitting the prior authorization request to the UMC.

49. The Personal Care manual states that staffing must take place within 10 calendar days after receipt of approval from WVMI. If the direct care worker is going to be a family member who is unable to start working within that 10 day period and the member refuses services from anyone other than this family member, may we document in the member chart the circumstances and still be considered in compliance?

Answer: Yes, document the specifics of the situation.

50. Before the new manual went into effect, our RN monitor had instructed us not to bill for the PAS visit until the PAS was back from the physician and signed by the RN. Is this still in effect with the new manual?

Answer: There is no billing code for billing for the PAS. You cannot bill for anything on an initial until medical eligibility has been established. Once medical eligibility has been established, you can conduct the Member Assessment and Plan of Care and bill T1001.

51. Before the new manual went into effect, we were sending two PAS's per year so that we would have one that was good for each 6 month period that we were asking for a prior authorization. We were

completing one PAS at the 6 month visit and one with the annual PAS visit – but we were only billing for the annual PAS visit. That is why we have members that their prior authorization expires for example June 30, 2014 but their PAS may not expire until November, 2014. Since we did a 6 month visit in the fall of 2013 and sent a PAS then, when their AA comes due this spring can we bill for the AA even though we are not sending a PAS till the fall of 2014?

Answer: You are not following policy. A PAS is to be conducted annually. Regarding the Member Assessment, yes – again, there is no billing code for completing the PAS. The Member Assessment should be completed per policy annually and billed under Service Code T1001.

52. If a direct care worker makes a mistake on the Plan of Care/worksheet and it needs corrected, is it legal for someone else to contact the worker and document on the Plan of Care/worksheet the correction. According to Policy Section 517.21.1 it states that the RN or direct care worker are to explain any variance. Is it legal for someone else to make any corrections or additions in the comment section?

Answer: No, you must follow policy. You cannot change someone else's medical documentation. To do so constitutes Medicaid Fraud.

53. Is the time for travel on essential errands counted towards the 1/3 environmental care?

Answer: Environmental care tasks are tasks performed in the home. Ex. Making/changing bed, laundry, vacuum/sweep, dust. They cannot exceed 1/3 of the total Plan of Care. Essential errands (IADL's) are errands outside of the home and include grocery shopping, medical appointments, pharmacy, etc. Travel time is to be calculated and included in your essential errand time.
(Question/Answer Revised on 6/12/14)

54. Does the direct care worker have to provide personal care daily? Some members only want to take a bath every other day. Are they still eligible for daily service?

Answer: The member's Plan of Care should reflect the assessed needs and preferences of the member and should be person-centered. Medical eligibility requirements are that the person must have three deficits in activities of daily living. This is not a program to provide housekeeping for individuals who do not have personal care needs. If individuals can perform their own personal care needs and only want light housekeeping, they should not be medically eligible for the program.

55. The total time planned for environmental is the total for the month, not the pay cycle correct?

Answer: This question was addressed on the 2/18 conference call. It is located on the Bureau of Senior Services website at www.wvseniorservices.gov Question # 12.

56. The new WV Personal Care Prior Authorization Request Form and the WV Personal Care Dual Services Request Form no longer have a field to put in your email address. Why is this? Will the response be emailed to the Director? Or who?

Answer: Since January 1, 2014, APS has worked with the licensed WV Medicaid Personal Care provider agencies to identify the agency contacts who receive the Personal Care authorizations. Secure emails

are sent directly to these verified contacts for their records and to distribute as appropriate within their agency and/or to contracted providers. Each agency determined their own contacts, so the title of contact person(s) varies from agency to agency. Please link with a supervisor at your agency if you have questions about who serves as the contact.

57. When doing the Initial visit to get the PAS, can the RN also complete the Member Assessment at that same visit, or are two separate visits required?

Answer: Any services provided prior to medical eligibility are not billable. You must have established medical eligibility before you complete the Member Assessment and Plan of Care in order to be reimbursed by Medicaid.

58. The old Molina website allowed my staff to check the continuing eligibility of Personal Care members monthly at the beginning of each month. The new website does not have the same ability. How do we determine a member is still eligible at the beginning of each month? Can this feature be put back on the website?

Answer: The new web portal does have the feature to check eligibility. If you click on " from entry" and then eligibility verification you can enter in 2 pieces of demographic information for the patient and then enter in your dates of service for the month you are checking and it will populate what plan the member is on and give you the effective and termination dates of the card.

59. If the Plan of Care period is from February, 2014 to July, 2014 – when can the 6 month or annual visit be made?

Answer: With the dates you provided in your example, the 6 month or annual visit would need to be completed by July 31, 2014. Your next Plan of Care period would be August 2014, to January, 2015.

60. I have a member who receives 10 hours of service weekly (2 hours M-F). Monday is laundry day and it takes 60 minutes to complete. The member was admitted to the hospital on Tuesday and didn't receive any other services for the remainder of the billing cycle. Even though the Plan of Care is under the 1/3 total environmental time, for this billing cycle, due to the hospitalization, the environmental is 50%. Will the RN monitors take this into consideration?

Answer: Yes, as always this should be documented.

61. I have an ADW member that is total care. He is non-ambulatory, bedridden and blind. What is a reasonable amount of Personal Care hours that he can be provided each day? If he has ADW hours Mon-Fri for seven hours each day, is ten hours for Sat/Sun excessive?

Answer: If a member has the need, they could technically receive up to 155 hours of ADW services (Level D) and up to 210 hours per month of Personal Care services. This needs to be based on this person's needs and assuring that there is no duplication of services. For this particular case, we would

want to know why this person needs 3 hours additional services on Saturday and Sunday that he does not have Monday – Friday.

62. What documentation is needed in the member's Personal Care file when they are receiving dual services?

Answer: All documentation pertinent to the services for that member should be in the file – both the ADW pertinent documents and the Personal Care pertinent documents.

63. I have an ADW Level D member that I submitted a prior authorization for Personal Care services in February 2014 and was approved. The PC authorization is from February 2014 through January, 31 2015. The ADW PAS expires in June 2014. Should the PC authorization expire when the ADW PAS expires or does it expire on January 31, 2014. If not, which one is the anchor date?

Answer: Until implementation of CareConnection©, ADW members do not have an anchor date. At this time, for members receiving ADW and Personal Care dual services, the Personal Care anchor date will continue to be determined by the date of Personal Care eligibility decision. Once CareConnection© is implemented for Aged and Disabled Waiver, we will extend authorizations to align Personal Care and ADW Anchor Dates.

May 20, 2014

64. Specialized Family Care homes have limited contact with the nurse and guardian of the member. We are not set up like some agencies where the care provider and RN are in the same organization. Are the signatures of both the nurse and guardian necessary in cases of Specialized Family Care? If they are necessary, can those signatures be faxed?

Answer: The RN must sign the required documents per policy. Ideally, the guardian should be the one to sign. However, in the real world there may be situations where this is not realistic, e.g., the guardian lives in another state. In those situations, the guardian may authorize another person to sign certain forms. The guardian's written authorization should be obtained and maintained in the member's record. Medicaid policy states that member files must contain original documentation. Faxed signatures are not acceptable.

64. Does the companion exemption apply to Specialized Family Care homes?

Answer: No, it does not. However, the Department of Labor has issued new rules regarding shared living programs which includes adult foster care. For more information go to http://www.dol.gov/whd/regs/compliance/whddfs79g.htm

65. Do training requirements (Section 517.8.2) apply to Specialized Family Care homes?

Answer: Yes, Medicaid policy in that section states "the documented evidence of training for Specialized Family Care must be kept on file by the Bureau for Children and Families or their contractor."

66. If I do an in-between visit 4/27/14 and the 6 month visit is due in May, can this be counted as the 6 month visit or do I need to go back out again in May?

Answer: Yes, the 4/27/14 visit can be your 6 month visit. You would then start your "new clock" for the annual from your 4/27/14 visit.

67. I am having a problem with the points. The people who only need a small amount of time are fine and the people who need a lot of time are fine. However, the middle section of people are getting left out, for example, someone who needs 3 to 3 ½ hours seven days a week. Level 1 at 60 hours per month will only cover 1 ¾ - 2 hours daily seven days a week. If the points for Level 2 were dropped to 9 or 10 points it would be very helpful for this group of people.

Answer: This has been shared with the Bureau for Medical Services for their consideration.

68. If the RN goes out and does a PC initial Member Assessment on someone who called in on the phone and it seemed like they would qualify. Then after the home visit assessment it seems questionable. Then it is determined that the individual is not medically eligible. Can the RN bill for the initial assessment.

Answer: No, you cannot bill for any services until such time that an individual is determined medically eligible and has a prior authorization.

69. If Dual Service Prior Authorizations are automatically extended until the next Personal Care PAS is due, do we need a 6 month dual service meeting. Do we have a new dual service signature form?

Answer: Yes. We are not sure what you are referring to when you ask about a "dual service signature form". Please resubmit the question with more detail for the next conference call or contact the Bureau of Senior Services to discuss.

70. If the Personal Care RN can use the ADW PAS and the Member Assessment for the annual dual services Prior Authorization request, do we need an RN Assessment from the PC RN for the annual visit? What code is billed if a PAS isn't completed – annual has always been T1001 with PAS.

Answer: Yes, you would do your annual RN Assessment. You will still bill T1001 for your annual RN Assessment.

71. At the 6 month interval for dual services, do we need a PC RN Assessment and a Plan of Care?

Answer: Yes.

72. We already have to list our agency address at the top of each PAS. According to question 2 on the February 18th call, we have to list it again for #15 on the PAS. Why is that? It is redundant.

Answer: We understand that, but we cannot alter the PAS.

73. On #26, letter I (walking), on the PAS, what do we put if someone is unable to ambulate? Someone that is not able to walk needs more time than a person that is a Level 3 or 4.

Answer: The PAS document does not have a level higher than 4 under section #26, I (walking). If a person is non-ambulatory, the highest level (level 4) under this section, should be marked. This allows a deficit to be given for this section as well as the maximum number of points to be awarded.

74. Why does an individual have to be a Level 3 or 4 in walking (letter I, #26 on PAS) in order to get points for wheeling (letter j)? We have numerous individuals that ambulate quite well using a cane. However, these same people could not wheel independently. In fact, most of these people would be total assistance in wheeling.

Answer: If they ambulate quite well in the home with a cane or other assistive devise, they would not use a wheelchair in the home. Keep in mind this is how they function on a regular basis in the home.

June 17, 2014

75. We received multiple questions regarding essential errands (IADL's) and environmental tasks. Here is some information to answer all of the questions received regarding these areas of policy.

Answers:

- Activities of Daily Living (ADL's) should always be the primary focus. These direct care services (bathing, dressing, grooming, toileting, etc.) are the priority. These should always be planned first and should take precedence over essential errands (IADL's) and environmental tasks.
- Environmental Tasks – these are tasks performed in the home. Ex. Making/changing bed, laundry, vacuum/sweep, dust. They cannot exceed 1/3 of the total Plan of Care.
- Essential Errands (IADL's) – Essential errands examples errands outside of the home and include grocery shopping, medical appointments, pharmacy, etc. Essential errands and any ADL services provided in the community may not exceed 20 hrs. per month.
- Remember in Personal Care, the community is defined as a location of the ADL service. If you take a member to a restaurant or other community setting, you can only bill for the time you provide ADL services during that activity (such as the time it took to feed the member).
- When performing essential errands and any ADL services provided in the community, travel time is to be calculated and included in the 20 hours per month. It is the time spent from the time they leave their home until they return to their home.
- Personal Care direct care services are the priority, after they have been planned to meet the needs of your member, essential errands and environmental can be planned. Informals should always be utilized when available.
- For assistance with individual cases, you may contact the Bureau of Senior Services at (304)558-3317 for technical assistance.

An example we received: a mother who is the member's direct care worker. The member receives two hours of Personal Care daily. The mother took him to the doctor and that appointment used the allocated two hours for that day. The Personal Care Services should have taken priority over the

essential errand. Informals (the mother) would have then been utilized for the essential errand.
Note: Due to the evaluation of this specific area in policy – ***the answer to Question # 9 from the 4-15-14 provider conference call has been changed/corrected***. It is available on the Bureau of Senior Services website at www.wvseniorservices.gov

76. Are there any circumstances that would permit a change to the plan period on the Plan of Care other than six (6) month and annual?

Answer: Yes. The Plan of Care should be modified as necessary to address changes in the member's condition. During the conference call it was also explained that if you have a change during the plan period, your new plan period can be the date it began and the end date can be the same as the current plan period end date. Example: You have a POC with a plan period dated May, 2014 to October, 2014. You have a change in July and develop a new POC based on that change. The new POC plan period could be dated July, 2014 to October, 2014.

77. The instructions for completing the Plan of Care state to put the current service level and the hours per month on the form. However, when the new form was revised, the hours per month were removed. Can either the form or the instructions be revised to reflect the change?

Answer: Yes, the instructions have been revised and posted on the Bureau for Medical Services website at www.dhhr.wv.gov/bms
78. Is the Member Assessment going to be a form which we can save and update or are we to do it over every 6 months. You cannot save the form that is on the website.

Answer: You can save the Member Assessment form that is on the website. You are required to conduct a new assessment of your members every 6 months.

79. Regarding the new Plan of Care, are we just updating when it is time for us to see a member at their 6 month or annual or is there a certain time frame in which all members should be using that Plan of Care?

Answer: You must complete a new Plan of Care at 6 months and at the annual. The new Plan of Care form should be used when it comes due for each individual member after January 1, 2014.

80. Can we complete (but not bill for) the Member Assessment during an initial visit, or once the signed PAS is received must we then make a second visit to complete the Member Assessment?

Answer: If you want to bill T1001, they have to have been determined medically. You need to have a Member Assessment that has been conducted after medical eligibility has been determined.

July 15, 2014

81. We now use the ADW PAS when applying for dual services. We have a member whose ADW PAS is due in September. Do we need to re-apply for authorization in September or do we continue through the end of December on our current authorization?

Answer: If the ADW member has a September 1 anchor date for ADW, the ADW authorization would be from 9/1/14 to 8/31/15. The agency can use the existing Personal Care authorization through the end of the current authorization. If the member still needs dual services past the end of the current Personal Care authorization, the agency would submit the current ADW PAS and would receive an authorization that ran through the end of the ADW authorization period (end date of 8/31/15).

August 19, 2014

82. On the Personal Care Pre-Admission Screening form near the top of the first page, could there be a box the doctor could sign saying the doctor states the client does not qualify for the Personal Care Program? This would eliminate the doctor's need to fill out the whole form – which is very time consuming.

Answer: No, the PAS form cannot be changed. The doctor is not mandated to complete the form if he/she doesn't assess the need to make a referral or continue PC services, however if the doctor completes and submits the PAS, it must be submitted to APS Healthcare for medical eligibility determination.

83. I recently had a medical provider send me back the PAS and for #26 she circled Level one for A thru M and for #32 she wrote in "Does Not Qualify" and she signed and dated it. The rest of the PAS aside from page one was left blank. I faxed this to APS Healthcare and WVMI faxed me back stating the whole thing needs completed and sent it back to the doctor over a month ago and she has never mailed it back and I'm assuming she won't.

Answer: A doctor is not mandated to complete the form, if he/she doesn't assess the patients need for PC services.

84. I need to make sure I understand the anchor date since that is the new eligibility date for new members not the Physician's signature date. I received a new personal care referral and made a home visit on July 17, 2014 to complete the PAS, Nursing Assessment and POC. I faxed the PAS and Physician Certification for the physician to review and sign. The Physician signed and dated the documents July 21st. I submitted the documents to APS to determine medical eligibility and was approved with an Anchor date of July 1, 2014. Since the Anchor date determines medical eligibility can I bill for the T1001 since it was conducted after July 1st?

Answer: Yes. Anchor Date is established based on the month in which medical eligibility is approved. The authorization for Personal Care will start based on this Anchor Date; therefore, the provider could bill and be reimbursed for the T1001 service. If, however, the request is submitted at the end of one calendar month, but not approved until the beginning of the next calendar month, no authorization would be in place for the T1001. The UMC has 5 business days to review the request (but may take longer to establish medical eligibility based on missing/incomplete documentation submitted and/or questions about the request.

85. If an Annual visit was completed on 6/3/2014, including both PAS & Member Assessment, and I fax down for prior authorization on 7/1/2014, why can't I bill T1001 on the date I receive prior-authorization?

Answer: Refer to question # 26: The billing for T1001 must be at least 300 days apart. If you have billing denied, contact Susan Given at Susan.A.Given@wv.gov

86. If the POC scheduled hours change whether by member/representative request or staffing changes, does a home visit need to be made? (ex.: POC hours M-F 9am-12pm changed to M-F 9:30am – 12:30pm?)

Answer: No, not if you have made contact with the member and verified the request.

87. Have you heard anything from the DHHR about the different "Tiers" and how they affect eligibility?

Answer: The tiers have to do with co-payments that are now required by some Medicaid members. It is based on income, however, the Personal Care program has no co-pay. So, you may have a member that is required to pay co-pays on others services, but not Personal Care. Attached is more information on tiers.

Announcement:
The question numbering was changed to assist in referencing duplicate questions.

September 16, 2014

88. If a doctor decides a current Personal Care member no longer qualifies for PC services and he/she does not sign the PCMEA (or does not complete it fully), how would a monitor, who comes to review the chart know this? What proof would I have as to why services are no longer being provided? How should I avoid being penalized for this? And what prevents the member from going to a different doctor who will sign it and/or to a different agency which will get a doctor to sign this? You might say well this would be fraud and needs to be reported, but this would be hard to prove. Why not try to prevent fraud before it happens?

Answer: You can't submit a PAS to APS Healthcare that is incomplete or without a physician's signature. You could make a notation in the member's record. The member would no longer be medically eligible. A member also has a right to change doctors and if any provider becomes aware of recipient fraud, that provider must report it to the Office of Inspector General. The number is 304-558-1970.

Comment(s): B.K. stated that she had a member whose primary physician would not sign her PAS. B.K. suspected that her client was going to try to switch doctors just to get her PAS signed, and then eventually return to her original, primary physician. B.K. reminded the member that if she did switch, the new doctor would be considered her primary physician. B.K. thought that the member never followed through.

October 21, 2014

89. According to prior questions, applying lotion after bathing is considered routine skin care. Routine skin care is included with grooming in the Definitions of Personal Care Terms. Do I understand this correctly? If so, which section on the POC would you suggest for the application of skin lotion when I consider it important, in my nursing judgment, due to factors such as impaired ambulation, incontinence, obesity, etc.?

Answer: Under "Description of Services" go to "Skin Care" and note "apply lotion after bath".

90. If a member transfers from Personal Care Services to A/D Waiver services, do we have to submit a Request for Closure form to BoSS?

Answer: Yes. A member of PC services would be closed due to no longer requiring services. There is no "transfer" from one program to another.

November 18, 2014

No questions submitted.

Additional Questions/Comment from call:

Two Personal Care Clients living in the same home. How do you bill for two Personal Care clients living in the same home and not overlap? You need to be reasonable when billing for this situation. Obviously you will cook and do laundry, for example, for both clients at the same time, but you cannot bill two hours for client 1 plus two hours for client 2 for the same service. Keep in mind that you cannot bill for more hours in a day than the homemaker actually works.

New Continuing Certification Tracking System. There were questions during the call regarding the new system. Following are some highlights:

- Data will not be imported from the old system into the new system. You will be required to enter employee information into the system again; however, you may print information from the old system to a spread sheet which will help with the data entry into the new system.
- Employees will be entered into the system one time only and you can designate at that time whether they are ADW, PC, HM or CM. Additionally, if an employee provides services for both ADW and PC, you will designate that by checking ADW and PC when you initially enter them into the system and it will track their certificates for both programs/services.
- Most recent date of training (last date) should be entered in the new system.
- Alerts for upcoming training needs will be displayed on the Preview screen.
- The old system will not be deleted and you will continue to have access to it.
- Trainings/webinars will begin soon.
- You will have at least three months to get data entered into the new system.

December 16, 2014

91. If there is no billing code for the PAS (see answer to question #50..."there is no billing code for billing the PAS...." after medical eligibility has been established you can conduct the Member Assessment and Plan of Care and bill T1001." If this is the rule, that T1001 is the billing code for the Member Assessment and the Plan of Care, then why can't we bill it for the 6 month "Member Assessment and Plan of Care", and in between visit Member Assessments and Plan of Care?

Answer: The T1001 service code is an event code which has a limit of 1 per year.

92. Why can't I conduct my PAS, Member Assessment and Plan of Care all at one time on an annual visit? I already have a current prior authorization number as my visit must be done up to 60 days prior to the expiration.

Answer: You can conduct the PAS, Member Assessment and Plan of Care at one time on an ***annual visit*** because the member is currently medically eligible for the program, however if you are conducting an ***"Initial PAS"*** for an applicant, medical eligibility has not yet been determined. You can't bill for services prior to medical eligibility.

93. If I am doing an initial visit and it is very obvious the prospective member will be a level 2, (example terminal cancer), should I not complete all forms at that time? I will need to have all forms completed to send for a level 2 request and this would expedite services to the member. I would not be billing anything until the date I receive the prior authorization.

Answer: Yes, the example given regarding prior authorization of WV Medicaid regarding "A new request for PC services after 1.1.2014" reads:

- ***PAS or Physician's Certification form is dated 2/7/2014***
- ***PC provider submits request to UMC 2/17/2014***
- ***UMC makes eligibility determination 2/24/2014***
- ***Anchor date=the first of the month in which UMC makes the determination of eligibility=2/1/2014***
- ***Member's service year = 2/1/2014 through 1/31/2015***
- ***Authorization start date = 2/1/2014***
- ***Authorization end date = 1/31/2015***
- ***If member wishes to continue receiving services the next year, the PAS must be dated within 60 days prior to the member's Anchor Date (or within 60 days prior to 2/1/2015), and request must be submitted prior to 2/1/2015.***

So, according to this example you can complete all documents and submit to the UMC and bill for the services provided because the prior authorization would begin the first of the month.

94. I have a new member to sign up who has a multitude of health problems. I already know from our conversation that she will be (and needs), Level 2 services. How will I be able to bill for her since I must complete all the forms at my initial visit, since they all must accompany my request?

It seems to be a "catch 22" that I cannot do a Member Assessment until I have a Prior Auth., but I cannot

get a Prior Auth. without a Member Assessment.

Answer: Please refer to the answer to question 93.

Questions/Comments from call:

a. How can we bill for a re-evaluation if it is done within the 60-day window prior to expiration of the member's PAS.
Answer: This was addressed in question number 26 (see below):

"26. Can you please confirm that you can bill two T1001 events in one year?
Answer: Yes, but this is currently being addressed by the Bureau for Medical Services with Molina so that this is permissible. The billing must be at least 300 days apart. If you have billing that is denied due to this, contact Susan Given at Susan.A.Given@wv.gov."

If this would be denied for some reason, you may bill it as T1002.

Reminders:
A request for ***Fair Hearing*** must be sent to BMS per the instructions on the bottom of the Request for Fair Hearing form.

A request for ***Discontinuation of Services*** must be submitted per policy to the Bureau of Senior Services (BoSS) with supporting documentation by faxing the request and supporting documentation to BoSS.

If you have any questions regarding the Fair Hearing process or Requests for Discontinuation of services please contact Tammy Grueser RN at 304-558-3317 ext. 137 or email to tamra.r.grueser@wv.gov.

Please contact Cathy Richardson, Transfer Coordinator at 304-558-3317 ext. 118, if you have any questions regarding member transfer.

You may submit questions at any time via email at seniorservicesmedicaid@wv.gov or susan.r.silverman@wv.gov.