NURSING CARE SERVICES

17.16 BILLING PROCEDURES AND PAYMENT AMOUNTS

Payments made to the nursing facility are in accordance with daily rates established by the agency for each facility that has been approved for Medicaid participation. The Bureau for Medical Services (BMS) maintains a hotline for vendors' questions. The Worker must refer all inquiries about billing matters to Provider Services in BMS and must not act as a liaison between BMS and the facility.

HOME AND COMMUNITY BASED WAIVER (HCB)

17.17 THE APPLICATION/REDETERMINATION PROCESS

The application/redetermination process is the same as for SSI-Related Medicaid found in Chapter 1, with the following exceptions:

The Worker is responsible for the following:

- Accepting form DHS-2.FRM, with an attached copy of the last page of the PAS from the contract agency which determines medical necessity. The PAS must not be older than 1 year minus 1 day. Both forms must be presented. The referral will originate from one of the following.

  - A case management agency, when the client chooses to use one; or

  - The WV Bureau of Senior Services (WV BoSS), when the client chooses self-directed case management.

  The DHS-2.FRM has 2 versions. The same information is contained on both, but one includes a third line in the form title which states "Self-Directed Case Management" and the distribution list includes WV BoSS, instead of the case management agency.

- Completing the Asset Assessment at the individual's or authorized representative's request after receiving the approved PAS.

- Accepting an application for the Home and Community Based Waiver Program (HCB) after receipt of the DHS-2.FRM with a copy of the medical necessity information from the case management agency or WV BoSS. SSI and Deemed SSI AG's must provide the DHS-2.FRM and a copy of the medical necessity information. A shortened application, the DFA-LTC-5, is required to determine eligibility for payment of Waiver Services for these groups. **See Section 17.12,D.**

- Processing the application as for any other Medicaid AG, presuming that medical eligibility has been determined. The beginning date of eligibility is the date of application. The date of application is the date that the client or his representative contacts the local office by phone, fax, mail, e-mail or in person to inquire about making an application.

  The appointment must be scheduled within 10 calendar days of the date of the contact. The appointment may be scheduled after 10 calendar days only at the request of the client or his representative. Case management agencies who chose to represent clients have been instructed by BMS to request an application within 7 days of the date the medical approval is received.