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.

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 unless the case is in hearing status or an extension has been granted by the Office of Home and Community-based Services in BMS due to circumstances beyond the individual's control. 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, Deemed SSI and all other full coverage Medicaid 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 **Medicaid** eligibility is the **later** of **the following:**

  - **The first day of the month of application; or**

  - **The first day of the month in which the individual is eligible for payment of HCB Waiver services after a transfer of resources penalty expires. See Section 17.25.**

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.

- Instructing the individual that HCB services will only be paid on or after the HCB approval date.

- Complete a redetermination of eligibility once a year and a face-to-face interview is required. Medical necessity must be verified annually at redetermination with a copy of the last page of a PAS completed within the past 12 months unless the case is in current hearing status or the individual was granted an extension by the Office of Home and Community-based Services. Once the redetermination is complete, the same criteria and procedures used for applications is used. Medicaid eligibility is established and the medical eligibility for services is monitored by BMS.

  The Worker receives an alert in RAPIDS when a redetermination is due.

  Information about Waiver Services, such as self-directed and personal options, is found on the Bureau of Senior Services website at **www.wvseniorservices.gov**. A listing of case management agencies by county is also found on this site.

HOME AND COMMUNITY BASED WAIVER (HCB)

17.18 CASE MAINTENANCE

A. COUNTY TRANSFER

When an HCB recipient moves from one county to another, the case record must be transferred to the new county of residence. Transfer procedures in 17.3,A apply.

B. CHANGES IN INCOME

When the client's income increases to above 300% of the SSI payment level, he is no longer eligible for HCB services. The Worker must:

- Notify the case management agency or WV BoSS.
- Notify the client or his representative by providing 13 days advance notice.
- Take appropriate data system action.
- Evaluate the client for all other Medicaid coverage groups.

C. CHANGE IN MEDICAL CONDITION

When the client's medical condition improves to the extent that HCB services are no longer required, he is ineligible for the HCB coverage group when this is the method by which he qualified for Medicaid. He must be evaluated for all other Medicaid coverage groups. Recipients of HCB services who receive Medicaid under any other coverage group remain eligible for Medicaid, but cannot have HCB services paid any longer.

If the HCB client’s condition changes to the extent that care in a nursing facility is required, the Worker must complete the following before nursing facility services can be paid.

- Insure that a valid PAS was completed on the date the client entered the nursing facility or within the 60-day period prior to entering the facility.
- Complete the post-eligibility process to determine the client’s contribution to his cost of care. See Section 17.9,D for instructions.
- Follow all notification procedures outlined in Section 17.6