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.

  NOTE: When the applicant's eligibility for, or enrollment in, this program is pending, due to the lack of a waiver slot or other reason, he must not be refused the right to apply due to his pending status for the HCB Waiver group, but must be evaluated for any or all DFA programs.

  EXAMPLE: John Bumgardner applies for HCB Waiver which requires a medical eligibility decision by the HCB Waiver Program and a financial determination by an Income Maintenance Worker. While his medical eligibility decision is pending, he visits his local DHHR Office and applies

for SNAP. Although his medical eligibility for HCB Waiver has not been determined and a financial determination cannot be made by the Worker for HCB Waiver, his pending status for this program does not prevent his evaluation for all other Medicaid groups for which he may qualify.

- 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.