TITLE XIX MR/DD WAIVER PROGRAM
FAQ –SUMMARY

503.1 Application and Medical Eligibility

When is it necessary to begin submitting application packets with the new requirements?

The new application packet process will begin when you receive the DD-14 letter from BHHF with a date of November 1, 2006 or later. Applicants with BHHF DD-14 letters dated prior to November 1, 2006 will require the application packets that meet the old manual.

503.4 Re-determination of Medical Eligibility

Will the previous process for re-certifying a member change and if so how?

The DD-2A (Medical Assessment) and most recent DD-3 (Psychological Evaluation) are now the only documents that need to be submitted for annual eligibility; however, additional information may be requested (e.g., IEP's for school aged children, functional assessments, etc.)

507.2 Individual Program Plan Development (IPP)

As per the Waiver manual, numerous codes (Behavioral Specialist, Day Habilitation, etc.) require that the goals have to be listed on the IPP. Since these goals are attached to the treatment plan, is there any way to put "IHP goals attached- see Blue Agency's recommendations dated 1/29/07 by therapeutic consultant"?

This would be acceptable. However, you also need to make sure that the goals and objectives have been approved by the treatment team.

How often will the IPP be reviewed with the new changes to the manual?

The IDT will convene at ninety (90) day intervals to develop, review, and update the IPP. The only exception is when the IDT has agreed to meet at longer intervals based on the needs of the member: such reviews shall occur at least every 180 days or every six (6) months. The IDT is also required to convene for the following events; initial or transfers, critical junctures, and discharges (please refer to Chapter 500 Covered Services, Limitations, and Exclusions, for MR/DD Waiver Services, Section 507.2 and 507.2.1).

What can other providers do if the service coordination agency does not keep the IPP current (i.e. send in the service purchase requests as outlined in the plan)?

Providers need to follow their Interagency Agreements and if resolution is not achieved, then providers may contact BHHF (the Waiver Office) for assistance.

If the member is in a crisis center, can the team hold an IDT meeting to prepare a behavior plan?

The team may hold the meeting at the crisis center to approve the development of the behavior plan.

Page two of the new IPP document (prompts for “my goals/dreams” and “my circle of support”) indicates that those items are only to be updated at the annual IPP meeting. If that information changes during the course of the year, should this section be updated?

Significant changes to the member information required on page two of the DD-5 can be updated at the 90 day or six month review. Otherwise, an update to the information on page two only has to be completed once a year.

IPP development is an event based code but the guidelines in the Waiver manual state there must be a minimum of two events per specialty per IPP meeting. Please clarify.

The MR/DD Waiver manual outlines standards for Individual Program Plan (IPP) development and use of the procedure codes for participation in the meeting. The manual states the team must allocate a minimum of two events per IPP meeting in the individualized member budget. The intent behind this statement was that the team must purchase at least one event for the Service Coordinator and one event for the Therapeutic Consultant to participate in each IPP meeting. The expectation is that a true interdisciplinary team meeting cannot occur with less than these two professionals in attendance since, at minimum, a Service Coordinator and a Therapeutic Consultant must be present.

If the team has reported the annual IPP date to APS as the first day of the month, will the IPP be considered out of date if the date on the last IPP is October 23, 2006, and the date of the annual IPP reported to APS is November 1, 2006?

The policy manual indicates that there is a 30 day window either before the due date of the Annual IPP or after the due date of the IPP.

507.2.1 Interdisciplinary Team (IDT) Composition

Is it required for a psychologist to attend every meeting or just the IDT annual meetings?

The psychologist must attend IDT meetings for those members who have either a co-existing disorder (DSMIV TR Axis I diagnosis), and/or behavioral needs.

Can a supervised psychologist bill for attendance at the IDT meeting?

Yes, they may bill for attendance.

How do I determine that the nurse must participate in the IPP team meeting?

An RN must attend all IPP meetings when the member receives skilled nursing services, or medical services that require RN oversight, or has a medical need as determined by a nurse or physician that would necessitate attending the IDT. The IDT team may choose to invite the nurse for other reasons when the team indicates that the need exists.

Can an LPN participate in the IDT meeting?

If the member receives eight or more hours of skilled nursing services and the LPN is responsible for habilitation programs, the LPN may participate in the IPP and bill the LPN code.

The manual states that the Service Coordinator does not have to do a progress note for attending meetings, if the signature page covers time of attendance and the code billed by participants. Is it necessary for the therapeutic consultants to do progress notes as the meeting notes should reflect why they attended?

Yes, Section 507.2 of the Manual states that "any staff attending the IDT meeting, other than the service coordinator, must record attendance on a progress note, date of attendance, provider agency responsible for the IPP and total time of participation in the IPP".

What is considered a critical juncture?

A critical juncture constitutes a change in need (behavioral, mental health or physical health), service/service units, support, setting, or crisis.

Do I have to attend the entire IDT meeting in order to bill my time for participation in the meeting?

Yes, an event is the IDT meeting in its entirety.

507.3 Service Coordination

On page 39 of the new manual, under Service Restrictions, the last bullet states: "Service coordinators may not evaluate IPP implementation by means of review of 'billing or documentation' or other auditing activities." Does this mean the SC cannot bill for reviewing, processing and approving external billing even though this process measures the IPP implementation?

The service coordinator may not function as a billing person/auditor. The service coordinator may review/monitor implemented services. The manual states that the service coordinator is required to monitor the instructional and service objectives to ensure that objectives are implemented according to the IPP and the SC is to ensure the implementation of services as indicated on the IPP.

Is the service coordinator required to include a therapist's (OT/PT/ST) goals/objectives into the IHP by typing them into the "my goal is" format? If not, what is recommended?

If the OT, PT, and ST develop goals and objectives that are to be implemented by family or paid staff (Example: The PT develops range of motion exercises), then the PT should coordinate with the Therapeutic Consultant, and these goals and objectives need to be included on the Individual Habilitation Plan. If the goal is for the member to receive services from the OT, PT and ST, then the objective is covered in the Individual Service Plan.

Clarify the role of the Service Coordinator at school. Is it billable for the SC to attend IEP meetings? Sometimes parents request that Service Coordinators complete school visits. Is this billable?

The Service Coordinator may conduct advocacy or linkage/referral activities. This could occur with the school. It is the Service Coordinator's primary function to monitor and ensure that MRDD Waiver services are planned and implemented for the member. Therefore, it is not acceptable for Service Coordinators to routinely complete school visits. It would be appropriate if the Service Coordinator were to link with a teacher on a

periodic basis to ensure coordination of care with the child. This would only occur when a problem is identified and should have an outcome relating to MRDD Waiver. Waiver services are not to monitor school services and should not appear to do so. There can be no duplication of services.

507.4 Transportation

Mileage: If mileage is billed, shouldn't this be a separate entry (to ensure exactly what mileage is billed)?

Enter the miles, where the member traveled to and where the member traveled from (destination and return).

Mileage: A parent requests to bill for picking their child up from the bus stop (after the bus has delivered the child to the designated bus stop). There is no applicable goal/objective. Is this acceptable?

This may not occur. This is related to the child's educational day and is not a Waiver service.

Do I need to do a special request to apply for additional mileage and residential habilitation or will there be no changes in services until APS Healthcare evaluates the member?

Everything stays the same until the members next annual IPP or critical juncture.

If a member has 1300 miles listed on an IPP dated April 10, 2006; may the member continue to receive the 1300 miles without a prior authorization from the ASO?

Yes. The current IPP will be honored until the next annual IPP occurs or until the next critical juncture occurs. (Travel must occur within the individual's natural community.)

The manual limits transportation to 700 miles per month without a prior authorization. How do I justify the need for additional transportation miles (A0160-HI)?

Association with Medicaid Service: The need for transportation is based on the member's need to travel to and from a Medicaid reimbursed service such as Day Habilitation services, medical appointments, Respite Care, Adult Companion, and/or to or from specific Residential Habilitation activities which are detailed as an objective in the IPP.

Member's Need: Transportation may not be billed when the reason for travel is based upon staff need or family need only. This service is driven by the member's need to travel. The service must be based upon the assessed need and take into account the needs, wishes, desires, and goals of the member.

Identification on IPP: The travel must be associated with a goal and objective on the IPP. Travel must occur in the member's neighborhood or community to allow for normal activities to occur that is similar to any one else in the community.

Need to Travel: The member may have a need to travel into his/her own neighborhood or community for the purpose of training activities in a natural setting outside of the member's home or a day program facility, community integration during training

activities, social connections during companion or respite services, and education about the member's own community to allow for an increase in learning or integration.

No Generic Travel: Transportation is not intended for "generic" travel but is associated with a specific purpose related to an IPP goal or objective and an outcome for the travel.

For children or adults living with natural parents or adoptive parents: Travel to family events or family routines that would typically occur for any child is not eligible for this service.

Examples of Travel Not Eligible: Travel to visit a grandparent for a family dinner or routine family grocery shopping with a nine year old child when the child would not typically begin to shop for groceries.

Concurrent Billing: Transportation can be billed concurrently only with Residential Habilitation, Day Habilitation, Respite, Pre-Vocational, Supported Employment, and Adult Companion services.

Medical Services Identified on the IPP but not reimbursed by Medicaid: Transportation for vision and dental appointments would be covered for adults who would not receive these Medicaid services if it is addressed in the ISP.

Out of area Medical Appointment: If a member has a medical appointment that is in West Virginia, but is not his or her home community, transportation could be provided if it is addressed in the IPP. (Example, member lives in Charleston and has to travel to Morgantown for neurological appointment.) Please refer to the Chapter 500, Covered Services, Limitations, and Exclusions, for MR/DD Waiver Services, Section 507.4 for medical appointments that require travel out of state.

What is the current reimbursement rate for transportation?

The current reimbursement rate as of August 1, 2006, is $0.45 per mile. This rate is variable and is subject to change. Updates in rates will be posted on the BMS website (see above) or the Remittance Advice banner page (explanation of benefits for claims).

The member's existing IPP provided for 1300 miles per month of transportation. With the new IPP, the team decided 1300 was still needed and requested prior authorization. If, based upon review of the available documentation, APS decided 1,000 miles per month of transportation was enough, what amount of transportation could the member receive while the case was in appeal?

The 1,000 mile per month authorization would be in place until the appeal was resolved. The balance of 300 miles per month could be provided but the provider would be at risk of not being reimbursed for these miles if they lost the appeal.

507.5 Respite

A SFC provider previously received Respite after day program for members living in their homes. If respite is not appropriate to be utilized during the family's time at work, what services is the member eligible to receive.

Possible alternatives to Respite might include:

- If a member is an adult, Adult Companion services may be appropriate; if the adult requires training, then Residential/Day Habilitation may be utilized.

- If the member is a child and requires training, then Day Habilitation and/or Residential Habilitation may be utilized.

Technical Assistance may be obtained through the Waiver Office at 304-558-0627.

Are respite care hours still carried over in a three-month period?

No. Respite has an annual service limit beginning November 1, 2006.

The DD 12 form lists four places to sign on each page. Is this necessary or can they sign the bottom of each page?

The provider must sign each time he/she provides the service and for each block of time the service is delivered. It is not appropriate to sign at the bottom of the page only.

If respite and/or adult companion providers are not providing training and indicate "N/A," are they still required to write a summary?

Yes. It is a summary of the activity. The summary should discuss specifics of the task or activity and should not be a general description. Discuss the task(s)/activity(s) that were performed, and outcome. The content of the summary is important information for the TC and the SC as goals are reviewed and new goals developed

Can respite be a planned scheduled event?

Yes. Respite may be used to allow the primary care-giver to have planned time from the caretaker role for him/herself and/or other family members (Chapter 500, pg 43). Respite, however, is not intended for everyday provision of care for a child or adult in the absence of parent(s) or primary caregiver(s) when the parent(s) or caretaker(s) goes to work.

May Respite or Adult Companion Services (Level 1) be provided in the provider's home if the provider is not a Specialized Family Care (SFC) home?

No, the service must be provided at an approved site. A natural/adoptive home or a Specialized Family Care (SFC) home are considered approved sites.

Can respite be billed if the member is in the hospital for medical (not psychiatric) treatment?

Yes, with Prior Authorization. Respite may be provided in a general medical hospital for acute care only. Respite CANNOT be billed if the member is in the hospital for psychiatric treatment. (Please refer to Section 507.5 Chapter 500 Covered Services, Limitations, and Exclusions, for MR/DD Waiver Services)

507.6.1 Community Residential Habilitation

If a member has Agency Residential Habilitation with one agency and Service Coordination and Day treatment through a different agency, who is responsible for the Community

Residential Habilitation in regards to supervision, program development, staff training and payment to the family as the (pass through).

a. Administrative supervision of staff occurs at the provider level by the agency.
b. Program development occurs by the TC
c. The TC trains staff on goals, objectives, and behavioral plans.
d. The IDT may choose the Residential provider

Since the hourly rate for community residential habilitation has been raised, will the hours of Residential Habilitation that a Specialized Family Care provider is approved to provide daily be decreased? For example, will the hours change from six Residential Habilitation hours of training per day to four Residential Habilitation hours per day as a result of the increased rate?

Community Residential Habilitation service is based upon the member's need. The service has always had a limit of four hours per day with a prior authorization from the Waiver Contact to provide up to six hours per day. Beginning November 1, 2006, when the member has their annual IPP or a critical juncture, the service coordinator must request to exceed four hours per day. This request will go to the ASO. (Please refer to Section 507.6.1 Chapter 500 Covered Services, Limitations, and Exclusions, for MR/DD Waiver Services)

May Respite or Adult Companion Services (Level 1) be provided in the provider's home if the provider is not a Specialized Family Care (SFC) home.

No, the service must be provided at an approved site. A natural home or a Specialized Family Care (SFC) home are considered approved sites.

Will all biological/adoptive families providing community residential habilitation be rolled back to the new four hour a day cap effective with the new MR/DD Waiver manual?

The four hour cap on community residential habilitation is not new. The service has always had a limit of four hours per day with a prior authorization from the Waiver Contact to provide up to six hours per day. What is new/different is that the Waiver Contact will no longer make the decision to allow the provider to exceed the four hour limit. This function will now be assumed by APS Healthcare (the ASO) based on objective data provided by the service coordinator, representing the interdisciplinary team. A community residential habilitation provider may still be allowed to provide up to six hours per day of this service with prior approval by the ASO.

If the member has not had his/her annual IPP meeting and assessments conducted by APS yet, will it be necessary to have the extraordinary care assessment completed by someone else in the interim in order to access Community Residential Habilitation?

No. The extraordinary care assessment is not required until the member's annual APS assessments are completed. The extraordinary care assessment must be completed at the time of the annual APS assessments. It is not necessary to conduct the assessment before the annual IPP is due.

How specific does the service summary on the DD 12 need to be (as the RHP is already completing task analysis)?

The summary should discuss specifics of the task or activity and should not be a general description such as "completing task analysis." Discuss the task(s) that were performed, the success of the training, and outcome. The content of the summary is important information for the TC and the SC as goals are reviewed and new goals developed.

507.6.2 Agency Residential Habilitation

How specific does the service summary need to be (as the RHP is already completing task analysis)?

The summary should discuss specifics of the task or activity and should not be a general description such as "completing task analysis." Discuss the task(s) that were performed, the success of the training, and outcome. The contents of the summary are important information for the TC and the SC as goals are reviewed and new goals developed.

Can I bill Residential Habilitation ratio 1:5 after November 1, 2006?

There was a transition time given to providers to convert to the adjusted ratios. Providers had until December 31, 2006 to make the transition to the residential habilitation ratios. All ratios needed to be updated in the IPP by 12/31/2006. Beginning 01/02/2007, providers could not bill for a ratio higher than 1:4.

507.7 Adult Companion Services

If respite and/or adult companion providers are not providing training and indicate "N/A," are they still required to write a summary?

Yes. It is a summary of the activity. The summary should discuss specifics of the task or activity and should not be a general description. Discuss the task(s)/activity(s) that were performed, and outcome. The content of the summary is important information for the TC and the SC as goals are reviewed and new goals developed

May Respite or Adult Companion Services (Level 1) be provided in the provider's home if the provider is not a Specialized Family Care (SFC) home?

No, the service must be provided at an approved site. A natural/adoptive home or a Specialized Family Care (SFC) home are considered approved sites.

507.8 Day Habilitation Services

Describe the transition of day habilitation ratios.

There was a transition time given to providers to convert to the adjusted ratios. Providers had until December 31, 2006 to transition to the adjusted day habilitation ratios. Until 12/31/2006, 1:1 could be billed as 1:1; 1:2/3 could be billed as 1:2; 1:4/5 could be billed as 1:4 and 1:6+ could be billed as 1:4. All ratios needed to be updated in the IPP by 12/31/2006 by the Service Coordinator. Beginning 1/2/2007 the 1:1, 1:2, 1:3, and 1:4 ratios needed to be implemented by all providers.

May Day Habilitation be billed for adults?

Day habilitation services maybe billed for adults.

If a member is home schooled, can MR/DD Waiver services be billed during the hours of home schooling?

No. Waiver services cannot be billed during this time. Services may be provided directly before or after the school day and/or weekends.

507.10 Supported Employment

Will Waiver pay for Supportive Employment services when the Division of Rehabilitation Services (DRS) also pays for the service?

MR/DD Waiver supported employment services may not be substituted for those services available through DRS. In order to access supported employment services under the MR/DD Waiver program, one must determine if services are currently provided through DRS. If DRS currently pays for supportive employment services, Waiver will not also pay for them. If services are not provided by DRS, the MR/DD Waiver program provider must make a referral to DRS. A copy of the referral must be maintained by the provider agency in the member's record of service. MR/DD Wavier supported employment services must not be provided concurrently. Waiver may reimburse for supported employment services per the member's IPP. No prior authorization is required, but documentation will need to be available for review upon request.

If supported employment was not budgeted in the IPP and the member got a job a month later, would this be considered a critical juncture?

This would qualify as a critical juncture (change in day setting), and the team must request this new service (supported employment) at the time the job became available.

507.11 Therapeutic Consultative Services

What graduate level coursework is considered acceptable by BMS for credentialing the Behavioral Analyst?

Graduate level coursework for the behavioral analyst consists of any coursework that includes behavioral intervention, positive behavioral support, functional analysis, or behavioral analysis.

If one Therapeutic Consultant covers both the day habilitation and residential components in an IDT meeting, can that same person bill two events - one for T2021XXUF and the other for T2021XXUH?

No. Bill only under UF modifier in this situation.

If one Therapeutic Consultant covers both the residential and behavioral components in an IDT, since it all falls under the same code, T2021XXUH, should only one note be written with the details of both residential and behavioral on one note, billed as one event, or should it be separated out into two notes with only one event being billed for both?

One note is all that is needed.

If an individual has a behavior while out on day habilitation and the Residential Therapeutic Consultant is called, should that Therapeutic Consultant bill T2021XXUF since the behavior occurred during day habilitation, or should they bill T2021XXUH since they were dealing with a behavior?

If your agency provides both the residential and day services and you are the Residential Therapeutic Consultant, bill residential.

If an individual receives day habilitation services only and the Therapeutic Consultant completes an ABS, does that Therapeutic Consultant bill T2021XXUF or UH?

If you are the Day Habilitation Therapeutic Consultant, bill the day Therapeutic Consultant service code.

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If most services are from one agency but the recipient and family chooses a site based day program from another agency, can one agency have both a Residential Therapeutic Consultant and a Day Services Therapeutic Consultant?

Yes

If a provider is billing 10 hours of QMRP Level 2 and 20 hours of QMRP Level 1 before November 1, 2006, will they be able to bill 30 hours of Therapeutic Consultant after November 1, 2006. With the Global Authorizations will the new caps need to be met since the IPP will not be changed until the next IPP meeting?

Yes, you will be able to bill the 30 hours of Therapeutic Consultative Services after November 1st per the current treatment plan or critical juncture.

If one agency is providing Therapeutic Consultant service for Community Residential Habilitation and another provides service coordination, who bills for the Community Residential Habilitation?

If they have Residential Habilitation on the Certificate of Need Summary, the service coordination agency bills for the community residential habilitation. However, if the member or family chose another agency and that agency has Residential Habilitation on their Certificate of Need Summary, this would be acceptable as well. It is also necessary for the provider to have a behavioral health license for all services that the agency provides.

Previously, provider credentials for specific levels of QMRP were associated with the provider's level of qualifications to provide the service. If I am qualified to provide QMRP Level 2, may I provide Behavioral Support to all the members on my caseload?

No. Therapeutic Consultation Services are based on the member's need. A provider must meet qualifications prior to the provision of Therapeutic Consultation. However, if the member only meets the criteria for a Skills Specialist service, then the TC must bill Skills Specialist services and may not bill for Behavior Specialist services for that particular member.

May a Behavior Specialist bill for writing residential habilitation goals (e.g., putting away laundry)?

Yes, the Therapeutic Consultant is required to write skills development plans.

Who develops the plans for the member?

The need for a Skills Development Specialist versus a Behavior Specialist/Analyst is based on the member's identified maladaptive behaviors. If the member has maladaptive behaviors, then all program plans (not just the behavior support plan) must be developed by a Behavior Specialist/Analyst.

May the person receive services from both a Skills Specialist and a Behavior Specialist at the same time?

A member may not have a Behavior Analyst (or Behavior Specialist) and a Skills Development Specialist, it must be one or the other, based upon the member's needs.

What happens when a Behavior Specialist/Analyst provides services to a person that needs only Skills Specialist? Can the provider bill for Behavior Analyst?

No. The Skills Specialist would be the most appropriate code to utilize with the member.

If I do not meet the criteria for a Behavior Support Specialist, may I continue to provide this service after November 1, 2006?

Existing employees of provider agencies as of November 1, 2006- Providers are grandfathered into the system for one year which will end October 31, 2007. The provider MUST receive PBS training as developed by the PBS network prior to October 31, 2007 in order to provide Behavioral Support services. Providers must have demonstrated competencies in PBS beginning November 1, 2007, and must meet all other requirements as outlined in the manual. Behavioral Support Services may not be provided beyond that date when an employee does not have the PBS training as developed by the PBS Network.

Employees hired beginning November 1, 2006- All employees who provide Behavioral Support services must receive PBS training as developed by the PBS network and must meet the additional requirements in the manual. New employees are not grandfathered into the system.

What documentation is required regarding the credential of QMRP? For example, do providers still need to determine whether a staff person meets the requirements of QMRP and if so where should this be documented since it is not addressed on the DD-17.

Providers must use the DD-17 for credentialing purposes. Any credential that the provider verifies on this form must be filed in the personnel record. If an individual meets the minimum requirement for either Therapeutic Consultant or Service Coordinator, they are credentialed to be a QMRP.

QMRP is a specific credential that is given to providers of service. It is not the service itself but is merely a qualification. A Therapeutic Consultant or a Service Coordinator must also be a QMRP (Qualified Mental Retardation Professional).

The "Old QMRP" codes will convert to various codes effective November 1, 2006. Will this conversion need to be updated on the IPP?

The function/intent of the QMRP should already be referred to in the IPP. For example:

- Skills Training by the QMRP,
- Positive Behavioral Support by the QMRP,

- RN Nursing by the QMRP
- Occupational Therapy, Speech, Registered Dietician, Physical Therapy
- Treatment Team Members
- The changing of the name from QMRP to Therapeutic Consultant, Services by RN, Participation in the IPP, etc can be updated at the next 90/180 review. If the function/intent is not apparent in the IPP, then an update will need to occur.

If a QMRP 3 was utilized for mental health services provided by a therapist, psychologist or psychiatrist, then arrangements will need to be made to refer the individual to a mental health provider (example: Private Practice Psychologist, Private

Practice Psychiatrist, Community Mental Health Center, or other Mental Health entity. This would be the same process as referring an individual to a dermatologist or orthopedist.)

If a member is admitted to a DD Crisis Respite Site, may the Crisis Respite Site provide/bill for Therapeutic Consultation for 30 days that the member resides at the Crisis Respite Site?

Yes. The DD Crisis Respite Site may provide and bill for Therapeutic Consultation for no more than 30 days while the member resides at the Crisis Site (only when the provider agency is an enrolled MR/DD Waiver agency.) In this situation, the Crisis Respite Site becomes the residential setting temporarily for the 30 day time frame. The "sending agency" may bill for Therapeutic Consultant during the initial admission IPP meeting and before discharge in order to develop or assess the member prior to discharge from the Crisis Site. The "sending" agency may complete monthly data reports for the member if it occurs at the end of the month when the monthly Therapeutic Consultant data reports are due.

In the previous manual, when the QMRP "ran out of units" in QMRP Level II, the QMRP could "bill-down" to QMRP Level I for additional units. Is this appropriate with Therapeutic Consultation codes in the new manual?

No. The Therapeutic Consultant must bill the specific service that the member needs and service to which the staff is qualified to bill. It is not appropriate to "bill-down" to a lower level of service.

If a member has only one Therapeutic Consultant, how will the Therapeutic Consultant bill when the Therapeutic Consultant provides both Residential and Day Habilitation services?

The residential Therapeutic Consultant is always the lead Therapeutic Consultant, and therefore, it is only necessary to bill residential Therapeutic Consultant.

When a Therapeutic Consultant is unavailable due to an emergency, illness, etc. may another Therapeutic Consultant provide services in the absence of the primary Therapeutic Consultant?

In the absence of the member's Therapeutic Consultant due to illness or emergency, another Therapeutic Consultant from the same provider agency may provide the service in the interim.

Can the Therapeutic Consultant fill in for direct care staff?

The member's Therapeutic Consultant may fill in or substitute for direct care staff. In doing so, they take on the role of a direct care staff. In such situations, the Therapeutic

Consultant can only bill the direct care service codes as outlined in the member's current plan. The Therapeutic Consultant codes can not be billed in this circumstance.

Does the Therapeutic Consultant have to sign off on staff notes to document that they are monitoring the programs?

No. The Therapeutic Consultant is responsible for assessment, evaluation and monitoring of the effectiveness of intervention and instruction plans. The Therapeutic Consultant can satisfy this requirement by writing a progress note to reflect they have reviewed the documentation and are monitoring programs. Therapeutic Consultants generally conduct a monthly summary and analysis of behavioral data. The Therapeutic Consultant does not have to sign off on each separate note by other staff.

Therapeutic Consultant/Behavior Analyst requires three years professional experience working with individuals with mental retardation and/or developmental disabilities. Is the requirement the same for professionals with a Bachelor's Degree and those with a Master's Degree?

Yes. The requirement of three years of professional experience applies to individuals with a Bachelor's Degree and those with a Master's Degree.

If a member needs Supported Employment, may the Therapeutic Consultant bill for job development?

Yes, when this need is reflected in the results of the assessments and included as a goal on the individual program plan. Job development activities have a limit of 20 units per quarter.

May an agency "grandfather" a staff person as a Behavior Analyst if they have extensive experience and demonstrated competency (for example by having worked under supervision of a Psychologist, completed training courses etc. but have not completed the graduate level course work?)

The Behavior Analyst cannot be grandfathered in—they must meet the requirements documented in the manual. Only the Behavior Specialist may be grandfathered.

507.12 Extended Professional Services

Where can I locate the CPT code descriptions and rates?

The Current Procedural Terminology (CPT) manual may be purchased from various vendors. For further information regarding the manual, you may go to the website or contact AMA Press.

Website: www.amapress.com
Phone: 1-8006218335

CPT procedural codes are reimbursed at RBRVS rates. The BMS website publishes has published the current RBRVS rate schedule on the website. The conversion factor is published on the website and is located under "Manuals and Instructions - Current Conversion Factors".

Website: http://www.wvdhhr.org/bms/

See MRDD Waiver crosswalk for CPT reference codes.

RBRVS rates change annually. The rates published on the crosswalk are current for 2007. New rates will be available and published on the BMS website for the next year when rates are available.

What procedure code will a psychologist bill for “preparation time”?

It is not appropriate for the psychologist to bill for preparation time when providing psychological evaluation or testing. RBRVS rates include administrative costs.

If a provider of services such as PT and OT is a COTA or PTA (assistants versus fully degreed OTs or PTs), would we still allow them to bill at one rate?

No. OTA/PTA has never been an approved QMRP service provider

If an individual receives an hour speech therapy four times a month and their annual IPP is not until March 2007; do we convert the event code to units until our Annual IPP? In other words bill 16 events a month?

No, an event is the length of one session regardless of the time spent, thus this person would get four events per month.

Which Extended Professional units of service are reimbursed by the event or by 15 minute units?

Speech Therapy and Speech Swallowing Dysfunction are reimbursed by the event and are the only Extended Professional codes billed as an event.

Based on a physical therapy evaluation, the physical therapist may provide a list of exercises that the member must complete daily. Does the physical therapist train the staff, does the therapeutic consultant train the staff, or does the RN train the staff? Other potential examples include training for specialized equipment such as “Therabands” or use of a walker. I think this example could generalize to speech and OT as well.

This decision is left to the discretion of the therapist. The therapist may be comfortable with allowing the therapeutic consultant to train other staff/providers in some cases but not in others. The therapist must decide what can be done within the scope of their license.

Based on the answer to the question above, may the TC or RN go to the PT appointment to know how to train the staff if they are in fact supposed to do the training?

Again, this is up to the discretion of the therapist acting within the scope of their license.

May school age children who are receiving physical therapy and occupational therapy through the school system access MR/DD Waiver to receive these therapies through the summer months when school is not in session?

Yes. They may also receive physical therapy, occupational therapy and speech therapy during the school year when the service is medically necessary, the member’s team requests the service in the IPP and is not a duplication of educational services.

507.13 Skilled Nursing Services

What services may an RN bill if they are providing LPN services?

The RN must bill LPN services if the RN is providing LPN services.

507.14 Crisis Services

May a provider agency bill for 2:1 services during the time that the member is admitted to a DD Crisis Respite Site for 30 days?

No, crisis sites may not bill 2:1 services. Crisis sites are designated for different types of services, i.e., providing staff with a higher level of clinical expertise, a change in environment for those needing that, supports as needed, technical assistance around behavioral issues,

etc. Crisis services are only provided in an ISS/Group Home which is considered the member's home.

Is it appropriate to bill the new crisis code at the DD Crisis sites?

No, the crisis code may not be billed at a crisis site. Crisis services are provided in ISS/Group Home settings only.

The crisis services code T2034 is provided in one hour units with a 14 day annual limit (calendar year). If the provider uses the code for one hour on a given day, does that count as one day out of the 14 day limit per year?

Yes, that is correct.

How may the DD Crisis Respite Site bill for the service?

Admission to a DD Crisis Respite Site is considered a critical juncture. An IDT meeting is required at the time of admission. If the Crisis Respite provider does not have authorization to bill for services rendered to the participant, the service coordinator must request this for the provider for the 30 day time frame.

It is important for the Crisis Respite sites to be in communication with the "sending agency" (Service Coordinator) regarding the authorization process. This is critical for the payment of claims.

If the member does not have Respite services on the current IPP and/or enough units (Respite or TC) to provide the service for 30 days (or less), the service coordinator must indicate the change on the IPP and must request the additional service or service units from the ASO.

507.15 Environmental Accessibility Adaptations

Will Environmental Accessibility Adaptation Services (EAA) be included in the budget?

Yes. When the member purchases EAA services, it will be included in the budget. A DD-19 must be submitted for EAA at the time of request.

507.16 Evaluation Services

What is the role of the Psychological Consultant?

The intent of the Psychological Consultant is to provide expertise to Therapeutic Consultant for a member's complex behavioral issue.

How do I bill for a psychological with the new codes?

Psychological codes with the HI modifier were added for those waiver providers who have a psychologist in their waiver program who can administer the annual or triennial psychological. These services can also be referred externally to be completed. When they are completed by an external psychologist, he or she may bill over their own provider number. These services need to be acknowledged by the IDT whether they are offered by the waiver provider or an external provider and authorized by the ASO.

Please refer to the CPT manual for further details.

90801- This code is similar to an "intake." This evaluation includes a history, mental status, disposition, and communication with family or other sources during the evaluation to obtain information/history. This service is to be performed by a psychologist.

Unit of Service: This service is reimbursed by the event.
When to provide: This service may be provided only when the member is new to the provider. This code should not be billed annually or triennially unless the provider is new.

96101- Psychological Testing with Interpretation and Report- This code includes psychological diagnostic assessment of emotionality, intellectual abilities, personality, and psychopathology. (Testing such as the MMPI, Rorschach, or the WAIS)
Unit of Service: This service is reimbursed by the hour. This is the ONLY code for psychological evaluation that is not reimbursed by the event.
When to provide: This code may be utilized for either the triennial or annual evaluation and is dependent upon the member's need.

96111-HI- Psychological Testing-Developmental-Extended- assessment of motor, language, social, adaptive and or cognitive functioning through standardized developmental instruments with interpretation and report.
Unit of Service: This service is reimbursed by the event.
When to provide: This code may be utilized for either the triennial or annual evaluation and is dependent upon the member's need.

96110-HI- Psychological Testing- Developmental-Limited- This service includes very limited developmental testing such as Developmental Screening Test II, Early Language Milestone Screen with interpretation and report.

Unit of Service: This service is reimbursed by the event.
When to provide: This code may be utilized for either the triennial or annual evaluation and is dependent upon the member's need.

What procedure code will a psychologist bill for "preparation time"?

It is not appropriate for the psychologist to bill for preparation time when providing psychological evaluation or testing. RBRVS rates include administrative costs.

508 Documentation and Record Retention Requirements

How long does a provider have to keep a member's MR/DD Waiver documentation?

MR/DD Waiver provider agencies must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information; Chapter 300, Provider Participation and Chapter 700, General Administration of the Provider Manual. This information can be found on the Bureau for Medical Services' website (www.wvdhhr.org/bms). Chapter 500 of the MR/DD Waiver manual further states that all required documentation must be maintained for at least five (5) years in the provider's file subject review by authorized BMS personnel or contracted agents. Chapter 500, Section DD-26 of the MR/DD Waiver manual includes more detailed information about the specific documentation required for individual provider types (residential habilitation, day habilitation, etc.)

Miscellaneous/Technical Assistance Questions

What is the official start date of the MR/DD Waiver manual?

The implementation for the new manual is November 1, 2006.

What is the date of the implementation of the new MR/DD Waiver codes and rates?

The new codes and rates will be implemented November 1, 2006. CPT codes/RBRVS rates and transportation rates will be posted on the BMS web site as the rates change.

Does Medicaid limit the provider's administrative charges for contracted services?

No. MR/DD Waiver policy and BMS general policy does not specify a limit for administrative charges by a provider agency for a contracted entity. Historically, it was the intent for administrative charges to cover the cost of processing and the provider tax.

May the MR/DD Waiver forms be replicated on the computer?

The forms can be replicated on the computer and formatted to suit the needs of individual providers. All required data elements must be incorporated into the provider specific forms. All Waiver forms require original signatures.

Will the Extraordinary Care Assessment tool be used to determine the need for both Agency Residential Habilitation and Community Residential Habilitation? If the member is a legally competent adult living at home with his parents, may the member receive Community Residential Habilitation?

The Extraordinary Care Assessment must be conducted for a member residing in a family setting for both community and agency residential habilitation. A legally competent adult is able to receive community residential habilitation.

In the previous manual, QMRP Level III was billed for psychiatric medication visits ("med checks"); will this be included in the annual budget?

No. These services are no longer available under Waiver. For members with a qualifying Axis I diagnosis, the member may be referred to a mental health provider. (i.e. Private Psychiatrist, Community Mental Health Center, etc.) These services are not included in the Waiver budget.

If a member needs counseling or therapy and this was previously accessed through QMRP Level II services, how will the member access counseling or therapy now?

Any member who needs counseling or therapy due to a mental health need may be referred to a mental health provider. The ASO provides registration and prior authorization for those services as well and they are based on medical necessity.

I have new staff in need of the PBS Network's positive behavioral support training. Will this training be available and will we receive notice of the training?

Additional training opportunities will occur in the near future. You will receive specific information at a later date. New staff will have until November 1, 2007 to receive the required training.

Is the Human Rights Committee required to review behavior protocols?

If a behavior protocol restricts rights, it must be approved by the Human Rights Committee.

Does a behavior protocol need to list the medications an individual is prescribed?

If the medications are a part of the intervention or treatment of the behavior, then yes, the medications should be listed.

If an individual has a behavior plan or protocol, should the IPP include a corresponding goal/objective?

Yes, there should be a goal/objective to address the behavior in the ISP.

When information is requested or clarified, how will providers be informed?

Training Material: APS training information or PowerPoint presentations will be posted on the APS website.

Waiver Rate/Policy Updates: Updates for Resource-based Relative Value System (RBVRS) rates, transportation, and other waiver rates will be posted on the BMS website. Clarification to Policy and Procedures will be made available through FAQs that will be posted on the BMS web site. Changes in Policy and procedures will be noted in the Chapter 500, Covered Services, Limitations, and Exclusions, for MR/DD Waiver Services.