



**Administrative Services Organization  
(ASO) Provider Operations Manual for  
Title XIX MR/DD Waiver - Version 1.0**  
*For Providers of West Virginia Title XIX MR/DD Waiver*

Presented by:

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*On behalf of the  
State of West Virginia  
Department of Health and Human Resources*

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## **INTRODUCTION**

APS Healthcare, Inc. (APS) was formed in Iowa on October 26, 1993. The company was originally named Principal Behavioral Health Care, Inc. and was the managed behavioral health care subsidiary of Principal Health Care, Inc. In 1997 APS acquired the company and changed its name to American Psych Systems, Inc. Since its acquisition, the company has continued to be a Specialty Healthcare Company. In 2001, the name was changed to APS Healthcare, Inc. to reflect our transition to a full service specialty company with public sector, employer, and disease management interests.

APS was originally founded as a behavioral healthcare company and has used strategic acquisitions to evolve into a Specialty Healthcare Company with expertise in all areas of health, wellness and productivity improvement. The company has capitalized on its more than 20 years of experience in behavioral change to create health/wellness programs that are unique in the industry. The use of a behavioral change paradigm as a part of all our programs has allowed us to be more effective in helping people to positively change their health behaviors and choices. APS operates under the belief that managing healthcare for the mind and body improves overall health and reduces total healthcare spending.

APS has expertise in serving both commercial and public sector entities. Our dedicated Public Sector Division covers the gamut of public sector enrollee populations and types of products including: Medicaid, indigent care, and children's services as well as case management, disease management, medical, behavioral, child welfare, External Quality Review Organization, MR/DD, PRO, and other specialty contracts.

APS differentiates itself from other Specialty Healthcare Companies through our highly experienced management team and staff, provider partnerships, delivery of quality programs at competitive rates, investment in technology, and commitment to outstanding customer service.

APS has an exceptional commitment to customer service demonstrated by:

- Investing the time to understand our clients' healthcare challenges and requirements;
- Developing practical, innovative, and electronic solutions that help people lead healthier lives;
- Customizing our products and services to meet the unique needs of our clients and exceed their expectations; and
- Achieving results.

APS leadership in automation is well established, as the first company to use automated, web-based assessment, authorization and quality reporting in a statewide Medicaid Program in Georgia in 1999. Because of our internet-based system and independence from legacy technologies, our system virtually eliminates incomplete provider submissions, allowing us to efficiently perform documentation verification and utilization management processes.

## **OVERVIEW**

In July 2000, the West Virginia Department of Health and Human Resources (WV-DHHR) selected APS Healthcare, Inc. (formerly American Psych Systems) to serve as the Administrative Services Organization (ASO) to enhance the provision of quality services for West Virginia's Medicaid recipients. Starting in August 2003, APS Healthcare, Inc. (APS) embarked on a contract with WV-DHHR that includes Medicaid and Bureau for Behavioral Health and Health Facilities consumers as well as services connected with the Bureau for Children and Families. An emphasis in the new contract will be the concept of integration as APS assists DHHR in enhancing health care for families, those receiving Title XIX MR/DD Waiver services, improving the core capacity of the provider network, and fortifying system efficiency.

APS works collaboratively with the State, consumers, families, and providers throughout West Virginia to continually improve the quality and accountability of services. Serving as the ASO on behalf of the DHHR (the Department), APS administers a statewide utilization management system incorporating focused quality improvement services, consumer education and empowerment activities, regional/statewide and on-site provider trainings, provider utilization management analysis, and clinical consultations, technical assistance, data analysis, reporting, and other activities in support of the Department's goals. APS works in partnership with stakeholders to successfully build program accountability, enhance efficiencies, and improve overall behavioral health outcomes. APS also serves in a consultative role to the Department and offers recommendations regarding the behavioral health system. The focus of the materials in this manual will be services provided within the Title XIX MR/DD Waiver Program.

## **MISSION**

APS-WV's mission is to assist the West Virginia Department of Health and Human Resources in designing and managing a high quality, accountable public sector service system for behavioral health, child welfare, and Title XIX MR/DD Waiver services through state of the art utilization management, technical assistance, training, consultation and collaboration that will result in improved services and outcomes for all stakeholders.

## **COMMITMENT**

APS is committed to creating and maintaining supportive relationships with all MR/DD Waiver stakeholders. Highlights of this commitment include:

- Provider training sessions on the budget allocation process, service utilization, documentation, and best of promising practices in a variety of formats held throughout the State. APS conducts training and technical assistance to assist in improving the internal utilization management structure of provider practices;
- Coordination with other regulatory bodies within DHHR (OHFLAC, OQPI, BHHF) to streamline and clarify documentation expectations;
- Ongoing education of providers and consumers on a variety of topics/issues;
- Broad communication of upcoming activities, including updates on program operations, articles of interest to the general public, and quarterly electronic newsletters. Special attention will be given to profiling provider advancements and quality improvement initiatives;
- Updates of ASO operational procedures to MR/DD Waiver Providers and postings to the APS website, [www.apshealthcare.com](http://www.apshealthcare.com);
- Collaboration with provider initiatives to recognize and advance quality improvement initiatives that address opportunities to improve care and services for individuals and communities;
- Involvement with the State, Individuals, Families, and Providers to help to improve the quality of services through utilization management, provider practice and program surveys, quality reviews, data analysis, and technical assistance;
- As the ASO, the goal of APS is to stimulate, recognize, and support continual improvement efforts to assist stakeholders in preparing for changes toward a person-centered philosophy in ways that recognize and build upon the strengths of local delivery systems and community resources.

## **APS-WV ROLE IN THE TITLE XIX MR/DD WAIVER PROCESS**

As the ASO of WV's Title XIX MR/DD Waiver Program, APS-WV is committed to assisting in the design and administration of a process and software tool which complements and supports the philosophy of person-centered planning. This philosophy encompasses a process whereby individuals with disabilities, with the support of their families/ significant others, direct the planning and allocation of available resources to meet their life hopes/ dreams, goals, and needs.

APS will strive to fairly and equitably allocate available MR/DD Waiver funds and assist in the state's movement toward the person-centered philosophy through:

- Conducting independent, unbiased assessments by competent and trained evaluative staff;
- Developing a state-of-the-art internet-based electronic application and process that considers the individual, family, community, and support factors to establish an Individualized Waiver Budget for each person receiving MR/DD Waiver services;

- Reviewing selected services to ensure critical health and safety needs are addressed by the interdisciplinary team;
- Completing Retrospective Consultations with service providers to ensure that each consumer's individualized budget is effectively implemented;
- Providing training and education for all stakeholders to assist the state in the movement toward a person-centered planning philosophy;
- Providing a framework for recording, reporting, and analyzing specific information for federal, state, and quality requirements;
- Facilitating quality improvement activities related to all APS functions including Quality Improvement Councils for Providers and individuals;
- Interfacing with the state's claims payer to facilitate proper reimbursement of provided services.

## **RELATED REGULATORY INFORMATION**

### **MR/DD Waiver Eligibility**

The West Virginia Bureau for Medical Services, Bureau for Behavioral Health & Health Facilities coordinates medical eligibility and benefit determination for individuals through the MR/DD Waiver eligibility system. APS should NOT be contacted for any question regarding an individual's MR/DD Waiver eligibility. It is the Bureau of Behavioral Health & Health Facility's responsibility to register each eligible individual requiring services.

*APS Healthcare does not verify Medicaid eligibility, dates of eligibility, or the accuracy of Medicaid numbers. It is the responsibility of the provider to verify this information, as well as verifying service registration information prior to submission of requests for payment.*

After program benefit eligibility is determined, service registration and prior authorization can be obtained through submission of all appropriate data by the Service Coordination Agency.

### **Certification Standard**

*Providers should carefully review State guidelines to assure that programs and/or provider groups meet all criteria required by related entities (such as OHFLAC, HCA (CON), BMS, BHHF), where appropriate.*

## **QUALITY IMPROVEMENT**

The vision and mission of DHHR for the APS-West Virginia ASO includes a continuous and central commitment to quality. APS Healthcare, Inc. is wholly committed to quality service and quality programs. Rather than relegating “quality” to a department on the organizational chart, APS-WV is committed to incorporating the principles of quality service and continuous quality improvement into each activity and program.

Recognizing that the only effective means to achieve service and system excellence is through an ongoing effort, APS-WV bases the progressive, far-reaching quality improvement plan on the DHHR vision for Continuous Quality Improvement (CQI) methodologies. To materially improve system performance, quality improvement efforts must be pervasive in every aspect of operation. The APS-WV integrated quality management strategy involves the monitoring and evaluation of measures related to all participants and functions. This approach unites individuals, families, providers, DHHR and APS-WV, resulting in system wide flow of information from service recipient to policymaker, yielding higher satisfaction among all stakeholders.

APS-WV uses the Shewhart-Deming Model, a four-step improvement process, “Plan-Do-Check-Act” (PDCA) to monitor and assess quality. The application of this model has resulted in a structure that relies on a Contract Management Team for oversight of system progress and contract deliverables, Quality Improvement Advisory Councils for review and input, and the APS-WV Management Team and staff for planning, implementation, and review of activities. Data structure and reports are designed based on the outputs required by DHHR to meet the goals specified within the current contract. Performance Indicators are developed for APS-WV and these are monitored by QI Councils. Stakeholders review these Performance Indicators quarterly.

APS-WV recognizes the importance of stakeholder input in implementation and performance activities. APS-WV’s quality improvement structure demonstrates the belief that stakeholder collaboration is essential to developing community-wide understanding and ownership of desired system outcomes. Individuals, family members, and advocates provide critical feedback about the responsiveness and effectiveness of services in meeting individuals’ needs. Similarly, providers who put forth effort to meet system requirements while addressing individuals’ needs, contribute an important perspective on systems operations, and the resulting impact. For that reason, a process that ensures ongoing feedback and continuous quality improvement is central to the approach of the APS-WV ASO.

### **QUALITY IMPROVEMENT PROGRAM KEY FUNCTIONS**

Key functions of the Continuous Quality Improvement Program include:

- Promoting quality ASO services, best and promising practices, and beneficial outcomes for members the Title XIX MR/DD Waiver Program;

- Developing, implementing, and maintaining a comprehensive Quality Improvement Plan for APS-WV;
- Assessing the results of the QI Plan to determine effectiveness and revising as needed to enhance outcomes;
- Evaluating the effectiveness and impact of ASO services on provider performance and service delivery through performance indicators and outcome analysis;
- Ensuring that the Quality Improvement process is collaborative through stakeholder input and facilitation;
- Reviewing ASO products and activities and making recommendations regarding quality improvements;
- Planning and recommending resource development internally and externally;
- Researching and developing resources to facilitate positive system change, to improve the effectiveness of services, and to enhance outcomes.
- Coordinating quality efforts with the MR/DD Waiver QA/QI Advisory Council.

In developing the design of services, both new and existing, APS-WV will develop performance indicators that enhance integration. These include structure, process, and outcome indicators that are specifically intended to achieve system accountability and efficiency.

### **OUTCOME MEASURES**

Moving to the next level of continuous quality improvement, DHHR and APS have a joint goal in assuring that performance indicators include outcome measures. APS-WV proposes that outcome measures focus on the following areas:

- Specific measures related to individual involvement in individual program planning, in provider quality improvement planning, and in ASO advisory functions;
- Provider performance including cost, quality of service, and business practices;
- System outcomes related to capacity, accessibility, and cost.

The focus will lend itself to an increasingly detailed system analysis and will facilitate data based decision-making regarding future steps for quality improvement in the Title XIX MR/DD Waiver Program service delivery system. APS-WV will build upon established Quality Improvement processes as we incorporate expanded stakeholder involvement. The Quality Improvement process, work group models, and phase-in approach, which have been successful in past contracts, will be used to involve new providers in the development and implementation process.

## **DOMAINS**

Continuous Quality Improvement of the APS Title XIX MR/DD Waiver program will be determined and measured on the following standardized domains:

- Effectiveness
- Efficiency
- Accountability
- Accessibility

Through collaboration between the DHHR Bureaus, QI Advisory Councils, APS and other stakeholders, specific outcomes and measurements will be developed that are consistent with the State's overarching quality improvement efforts.

## **STAFF RESOURCES**

The staff resources available in the APS-WV Title XIX MR/DD Waiver Department include:

- An Information Integration Department focused on analysis of data and implementation of resulting quality improvement initiatives;
- Service/ Support Facilitators who conduct functional assessments to provide individuals and families with Individualized Waiver Budgets;
- Individual and family education to ensure understanding of their role as a stakeholder in the MR/DD Waiver Program;
- Registration Coordinators that conduct registration and prior authorization reviews and are responsible for oversight of service quality including ensuring that the individual health and safety needs have been addressed by the team;
- Provider Educators whose role emphasizes training, consultation, and technical assistance activities that are responsive to provider needs;
- A Consumer Educator whose role includes outreach, education, referral, and feedback to those receiving MR/DD Waiver services, and their families/ supports;
- Administrative functions that support the overall needs of the operation.

APS-WV's Quality Improvement Program has demonstrated a commitment to developing and implementing effective continuous quality improvement activities through stakeholder involvement. This collaborative approach is driven through the following two Advisory Councils that convene at least quarterly and address concerns related to APS-WV and MR/DD Waiver Program service delivery:

- A Consumer and Family Advisory Council, consisting of individuals, family members, and advocates, addresses MR/DD Waiver service improvement and empowerment issues;
- A Provider Advisory Council consisting of providers from the array of entities served by the ASO, addresses improvement in ASO and provider processes as well as the issues of concern specific to the West Virginia Title XIX MR/DD Waiver Program.

The Contract Management team for the DHHR ASO serves as an interagency QI Council by devoting a regular portion of their meeting time to discuss the findings of the ASO Continuous Quality Improvement efforts. This feedback loop fosters communication with DHHR, allows for the expansion of information sharing with other government agencies when needed, and most importantly provides the venue for making decisions relative to the entire CQI process.

### **ADVISORY COUNCIL KEY FUNCTIONS**

Key functions of the Quality Improvement Advisory Councils include:

- Promoting quality ASO services, MR/DD Waiver services, and beneficial outcomes for individuals;
- Assessing the results of the APS QI Plan to determine effectiveness and make recommendations as needed to enhance outcomes;
- Evaluating the effectiveness and impact of ASO services on provider performance and service delivery through performance indicators and outcome analysis;
- Ensuring that the APS Quality Improvement process is collaborative through stakeholder input and facilitation;
- Reviewing ASO products and activities and making recommendations regarding quality improvements;
- Planning and recommending resource development internally and externally; and
- Researching and developing resources to facilitate positive system change, to improve the effectiveness of services and to enhance outcomes.

This focus will lend itself to an increasingly detailed system analysis and will facilitate data-based decision making about next steps in MR/DD Waiver Program Quality Improvement.

*This ASO Manual was developed to answer your questions and to serve as an operations manual for provider staff. From time to time it may be necessary to update this manual. Providers may receive replacement sections, when necessary, with explanations of changes, additions, or deletions. Periodically, providers will also receive APS informational letters, updates, and newsletters. In addition, Frequently Asked Questions (FAQs) will be tracked and answers posted to the APS website, with frequent updates.*

### **ASO FUNCTIONS**

APS Healthcare, Inc. - West Virginia is fully dedicated to orienting and training all MR/DD Waiver service providers on registration and service authorization policies and procedures.

APS Healthcare supports a comprehensive service purchasing and review program to ensure and enhance the appropriate utilization of MR/DD Waiver services. The service purchasing program is based on the State's MR/DD Waiver requirements and the APS mission and philosophy. It is designed to assure compliance with state program guidelines and state and federal regulatory bodies.

This program encompasses a full service continuum of administrative services that include individualized assessments, budget determinations, initial and subsequent registrations, authorizations, trainings, technical assistance, consultations, and stakeholder education. These administrative and service components, described in detail throughout this manual, are utilized to develop an accountable system that helps attain the State's goals for quality, accessibility, cost-effectiveness, and ultimately, movement toward a person-centered planning philosophy. These services are also designed to support key community goals of individual choice of services (based on need) and providers, individual empowerment, and involvement in the Individual Program Plan process with support of a person-centered philosophy through Individualized Waiver Budgets.

## **ADMINISTRATIVE**

The general scope of work for the Administrative Department is twofold: to provide comprehensive utilization management and to consult with DHHR on its long-range plans for the MR/DD Waiver Program. With this mandate, the overall responsibility is one of planning and managing the internal operations for MR/DD Waiver program utilization management with an emphasis on continual analysis that culminates in providing recommendations on the future system for providing state of the art programs in West Virginia. Through the ASO functions, the Administrative Department addresses the DHHR goals of effectively managing change, integrating systems of service provision, improving accountability, addressing regulatory concerns, exploring service options, improving the innovative use of technology, facilitating collaborative opportunities, and designing a coordinated system with effective outcomes for all stakeholders.

Specific duties required to achieve these goals include, but are not limited to, the following:

- Overseeing the design, development, and implementation of all activities related to the statewide Utilization Management Program for the MR/DD Waiver Program;
- Coordinating the state, regional, and community relations specific to this contract;
- Coordinating executive-level provider relations and problem solving issues related to the specific UM activities;
- Assisting the state with determining a fair and equitable distribution of available MR/DD Waiver funding;
- Providing necessary data to make appropriate, quality decisions;
- Overseeing the process for individualized assessments for each MR/DD Waiver member resulting in an Individualized Waiver Budget;

- Providing consultation and education that will assist the state with future systems planning.

APS-WV also assures that provider interactions are managed in a professional manner and, through the administrative function, provides a mechanism for providers to file complaints. This function includes issues relating to the general operation of the ASO and not complaints involving specific authorizations for services. Each complaint is documented on a complaint log and tracked through resolution. All provider complaints will be responded to in a timely fashion and all written complaints will receive a written response.

#### Quarterly Newsletter

APS distributes a quarterly newsletter through the website which provides a forum for sharing information about behavioral health care conferences and resources, as well as updates about new APS operational procedures and changes in the program.

#### Key Contacts and Help/Information Lines

Providers can contact the following APS representatives for routine assistance and resolution of inquiries:

<b>Executive Director</b> Jennifer Britton, Ph.D.	304 343-9663, x222
<b>Associate Director-Service Integration</b> Helen Snyder	304 343-9663, x246
<b>Information Integration Director</b> Rebecca Jamnick	304 343-9663, x223
<b>MR/DD Waiver Director</b> Randall K. Hill	304 343-9663, x231

#### West Virginia Office Information:

APS Healthcare, Inc. - West Virginia  
100 Capitol Street, Suite 600  
Charleston, West Virginia 25301

Administrative Phone Number: 304 343-9663  
MR/DD Waiver Toll Free: 1-866-385-8920

Fax: 304 343-9010

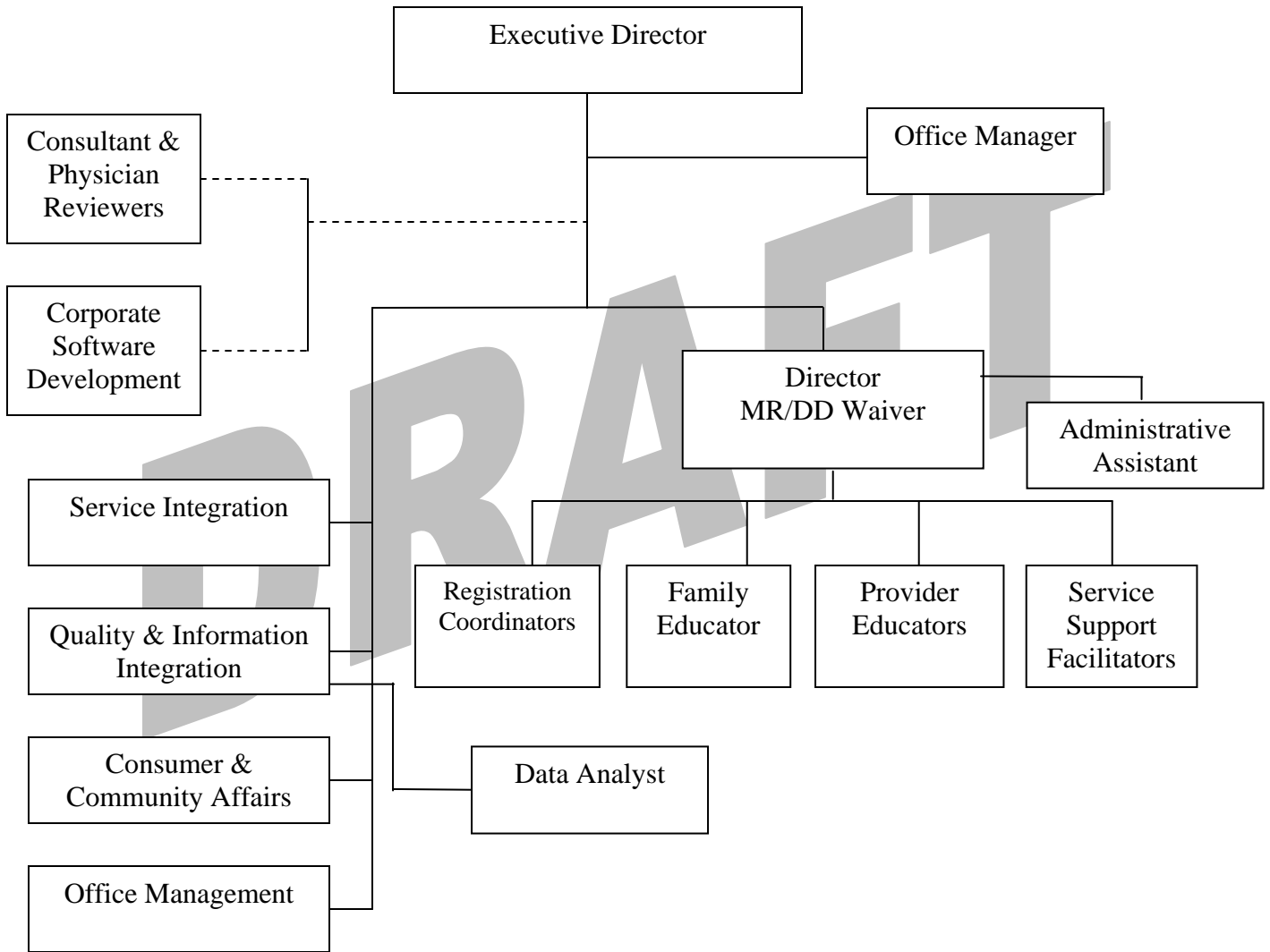
Internet Address: [www.apshealthcare.com](http://www.apshealthcare.com)

APS - WV staff are available by phone 8 a.m. to 5:30 p.m., Monday through Friday.

Organizational Chart

# MR/DD WAIVER ORGANIZATION CHART

(PRESENTLY IMPLEMENTING THE PROGRAM THROUGH A GRADUAL PHASE-IN)



## **SERVICE SUPPORT FACILITATOR**

Service Support Facilitators initiate contact with the interdisciplinary team once APS-WV receives eligibility information from BHHF. Service Support Facilitators conduct individualized Waiver Assessments including:

- The Inventory for Client and Agency Planning (ICAP);
- The Supports Intensity Scale (SIS) (when applicable);
- The Extraordinary Care Assessment (when applicable).

Assessments will be conducted using a structured interview format to ensure consistency and inter-rater reliability. The structured interview will also allow the Service Support Facilitator to capture any individualized information which may not be obtained through standardized assessments. Results from the Individualized Waiver Assessments will be used to determine each Individualized Waiver Budget. Service Support Facilitators:

- Conduct on-site assessments for all individuals who receive services through the Title XIX MR/DD Waiver Program;
- Provide individuals, families, and support persons with education relative to need. Education may include information about APS-WV, assessment and budgeting process, person-centered planning, self-advocacy, empowerment, the Chapter 500 Title XIX MR/DD Waiver Manual, available services, units, rates, and available providers;
- Provide assessment results and Individualized Waiver Budget to the interdisciplinary team for use in making informed decisions when choosing MR/DD Waiver services;
- Provide input on provider training and communication needs to APS Provider Educators related to policies and procedures based on the analysis of information obtained through the assessment process and other provider contacts.
- Identify service gaps through the assessment process and provider education to the IDT regarding changes or additions to MR/DD Waiver services and needed alternative services.

## **REGISTRATION COORDINATOR**

Registration Coordinators conduct all registration/ prior authorization functions. The Registration Coordinator serves as the primary contact for information regarding utilization management guidelines and specific service registration and prior authorization requests. The system is supported by a secure website designed for provider notification of the status of registrations and prior authorization requests.

Registration Coordinators are committed to using their expertise and their administrative knowledge to develop and deliver a utilization management system that will ensure appropriate access to MR/DD Waiver services. The goal is to promote stakeholder teamwork and partner with MR/DD Waiver service providers to improve the quality of services for individuals in West Virginia.

Registration Coordinators:

- Develop appropriate utilization management guidelines, protocols, and prior authorization rules for the services provided under the West Virginia Title XIX MR/DD Waiver Program;
- Develop the data set of needed information to be used for registration and prior authorization requests for services;
- Review registration and prior authorization requests within established time frames per authorization guidelines;
- Refine, edit, update, and disseminate utilization management criteria to providers and other staff;
- Integrate utilization of the Individualized Waiver Budget, assessment results, and the Individualized Program Plan related to registrations and prior authorization for appropriate MR/DD Waiver services;
- Provide input on training and communication to providers and internal staff related to policies and procedures based on the analysis of information obtained through provider consultations and utilization data analysis;
- Establish individualized recommendations for provider technical assistance and training related to service provision;
- Identify service gaps and provider education regarding changes or additions to MR/DD Waiver services and needed alternative services.

## Utilization Guidelines

APS Healthcare works proactively with providers to build consensus around the services provided to individuals under the MR/DD Waiver Programs. APS believes that the relationship between service standards and provision is one of assistance and collaboration rather than one of control. The intent of service standards is to inform and guide, not to overrule professional judgment.

To effectively register and/ or prior authorize service requests, objective and measurable utilization management criteria based on service standards and processes have been developed and included in the manual of UM Guidelines for MR/DD Waiver service providers. These criteria support fair, impartial, and consistent UM decision making that serves the best interests of individuals. APS Healthcare continues to work with its stakeholders and the Department to refine these criteria throughout the program. Any newly developed or refined criteria will be distributed to providers and adequate training will be provided for any refined criteria.

UM Guidelines provide criteria for the service listings including target population, admission criteria, procedure code, service unit, service limits, prior authorization, reauthorization, definition, site of service, documentation, service restrictions, provider qualifications, and service combinations/exceptions. The elements of these service listings are the basis for utilization management in conjunction with APS registration coordination staff.

- ❖ Refer to Title XIX MR/DD Waiver UM Guidelines at the APS Website: [www.apshealthcare.com](http://www.apshealthcare.com)

*Providers should review and maintain this Provider's Operations Manual, the UM Guidelines, and all related updates.*

*Providers should frequently review the APS website for current information regarding ASO policies and procedures.*

*In addition, providers must thoroughly review State guidelines for MR/DD Waiver services as articulated in State provider manuals and other State communications.*

APS supports the use of advanced technology as much as possible to reduce manual processing and associated error rates and costs. Therefore, we encourage cooperation and active interface with State-based and provider-based management information systems to automate and streamline the registration and prior authorization process as much as possible for providers.

## Registration/ Authorization Process

APS utilizes this system for the purpose of registering/ prior authorizing services delivered to MR/DD Waiver members. All data is submitted electronically.

Services and supports are chosen by the interdisciplinary team at the Individual Program Plan Meeting. The Service Coordinator submits registration/ prior authorization requests and chosen providers to APS. Requests are then reviewed by an APS Registration Coordinator to ensure the team's recommended services are within the Individualized Waiver Budget and the rules outlined in the Chapter 500 Title XIX MR/DD Waiver Program Manual. If there are no requests to exceed the Individualized Waiver Budget, service limits, and all health and safety needs have been addressed by the IDT, the Individualized Budget can be authorized as requested, and APS-WV will refer services to all chosen providers for acceptance or rejection.

If these conditions have not been met, the Registration Coordinator will contact the Service Coordinator to discuss the requested services and arrive at an agreed-upon budget and service mix that meets the individual's needs.

## Step by Step Registration/ Prior Authorization Process

1. The Service Coordinator completes and updates the individual's case information (including demographic and medical data) and reviews assessment budget information sent by APS-WV.
2. The individual's IDT convenes to develop/update the IPP and to choose services, service amounts, and service providers.
3. Service Coordination Agency submits all information through the APS Title XIX MR/DD Waiver Application.
4. Information received from the Service Coordination Agency is reviewed by the APS Registration Coordinator to ensure purchased services are within the Individualized Waiver Budget, within the rules outlined in the Chapter 500 Title XIX MR/DD Waiver Manual, and address all health and safety needs.
5. If all requests meet service criteria, APS disseminates service referrals to providers selected by the IDT. If all service requests do not meet service criteria (an exception to service parameters is noted), an APS Registration Coordinator will contact the Service Coordination Agency to negotiate a modification to service(s) and/ or the Individualized Waiver Budget. This negotiation may involve the Service Coordination Agency providing explanation/ additional information based on the IDT recommendations to justify the exception.
6. If selected providers accept service referrals via the APS Title XIX MR/DD Waiver Application, APS awards payment authorization numbers which are returned to those providers. If selected providers do not accept service referrals, APS forwards this information to the IDT so that they may select an

alternate provider. This process is repeated as necessary until a provider has been identified for each requested service.

7. Depending on the individual service, APS will forward four (4) quarterly authorizations or one (1) annual authorization to each service provider chosen by the IDT. Refer to Utilization Management Guidelines for specific service information.

### Registration/ Prior Authorizations Negotiation for MR/DD Waiver Services

DHHR has developed Policy and Procedures for Reviews and Negotiations of registration/ prior authorization determinations to be implemented by APS-WV. These procedures are designed to efficiently address registration/ prior authorization negotiations without disruption in necessary care.

Unsuccessful APS/ Provider negotiations resulting in reduction or denial of a service may be further appealed by following established state procedures for Administrative or Fair Hearing Appeal for reduction or denial of service. Refer to Appendix I of this manual.

### **PROVIDER EDUCATION**

Provider Educators direct activities to stimulate, recognize, and support efforts to improve the provision of MR/DD Waiver services. In addition, Provider Educators help assure quality outcomes are achieved through deliberate, focused training and evaluation of the MR/DD Waiver system.

Provider Educators provide ongoing and specific feedback to agencies in order to assist them in improving both their documentation practices and their utilization management structures. Relative to documentation practices, providers receive on-site technical assistance/ trainings, feedback from chart reviews, and consultative reports that may be utilized as tools to enhance agency performance. In the utilization management arena, providers receive a systems analysis which allows for ongoing/ continuing growth in developing needed structures to assure improved outcomes. As program performance data are analyzed over time, providers are educated on the results and attend training that assists in improving their own internal utilization management structure.

*Please note that upcoming training events can be found on the APS website:  
[www.apshealthcare.com](http://www.apshealthcare.com)*

### Training & Technical Assistance

Training and technical assistance are designed to meet providers' needs and will be delivered in two distinct venues involving on-site trainings at the provider location and regional/statewide trainings at convenient locations. A sample of topics includes:

- Person-centered Planning;

- Appropriate Use of Service Codes;
- Service Coordination;
- System for Data Submission;
- Use of the WV APS Title XIX MR/DD Waiver Application;
- Purchasing Services;
- Registration/ Prior Authorization Procedures;
- Budget/ Service Negotiation;
- Best Documentation Practices;
- Individual Program Plan Development;
- Alternative/Complementary Services;
- Mechanisms to Assure Staff Competency; and
- Utilization Management.

APS Provider Educators are also accessible by phone or e-mail for providers to contact regarding questions or issues about the program.

#### Provider Trainings

APS-WV offers training in venues designed to meet the needs of providers. Training topics are identified through an annual provider needs survey, consultation score results, provider input, and stakeholder recommendations through the QI Council process. Training modules are developed through research and consultation to address the targeted areas. Training gatherings may include lecture, panel discussion, question and answer sessions, and/or small group discussions or may be individualized for a specific provider.

APS trainings may be statewide, regional, or provider specific. To accommodate the needs of our wide range of providers, trainings on some topics may be open to all interested parties (subject to facility limitations), while others may be offered by invitation only. While every effort will be made to provide adequate advance notice to providers, some trainings may require a short planning time frame to address pressing concerns and meet the needs of providers. Training announcements include the training topic, learning objectives, target population, dates, time, location, and continuing education information. Training information may be provided through phone calls, mailings, email, fax and/or website posting. A training module or topic objective will be established for all trainings, along with a roster of participants and completed evaluations.

APS works with various licensing/credentialing boards to gain approval for continuing education credits. Providers are encouraged to watch for training updates on APS-WV website, [www.apshealthcare.com](http://www.apshealthcare.com).

### Orientation

The provider orientation program is APS Healthcare's first step in the development of long-lasting partnerships with providers. Orientation is offered to assure that providers develop effective utilization management. During the initial implementation of the ASO process, APS holds extensive provider orientation trainings. As the ASO process continues, orientation with new providers is scheduled as they begin participation and with existing providers as new services are established. Orientation activities are provided in the form of focused training or technical assistance, depending upon the needs of the provider.

### Focused Training

In addition to statewide and regional trainings, APS also provides focused or specialized trainings. Trainings are tailored to meet the specific needs of providers. It is recommended that providers take advantage of these on-site trainings by allowing access to front-line staff. Focused or specialized trainings can assist providers as they seek to improve their performance in areas that have a direct impact on the actual day-to-day processes staff members encounter, especially as they relate to documentation requirements.

### Feedback

In accordance with the APS Quality Improvement Plan, stakeholder input is solicited through a variety of means to insure that the training provided is based on identified needs and is clear, relevant, beneficial, and of high quality. Evaluations are requested for all training sessions. The results of the training evaluations are reviewed for future training needs and for internal quality improvement. APS also conducts an annual survey of provider training needs. Consultation scores are reviewed monthly to identify and target further training issues. Additionally, the Quality Improvement Council process provides ongoing stakeholder input into the development of quality provider training.

- ❖ Refer to the APS website at [www.apshealthcare.com](http://www.apshealthcare.com) for information regarding upcoming trainings.

### Technical Assistance

APS is dedicated to providing responsive technical assistance to West Virginia's Title XIX MR/DD Waiver providers. APS is available for consultative technical assistance, which is scheduled around the consultation process, or general technical assistance that is available on both a scheduled or non-scheduled/as-needed basis. Providers are encouraged to utilize technical assistance provided through APS Healthcare. All technical assistance is available by telephone, written communication, or face-to-face communication, and all technical assistance activities are tracked.

### Consultative Technical Assistance

APS' Provider Educators are assigned, so that they can develop an in-depth understanding of each provider's quality improvement needs. With this knowledge, Provider Educators provide customized technical assistance to providers on issues regarding service provision, utilization management, and the registration/ prior authorization process.

Consultative technical assistance is centered on the consultation process and follows pre-set timelines. The Exit Interview, or Exit TA, is provided at the end of the on-site review and involves a summation of the initial findings of the consultation/review.

The Consultation Follow-up Technical Assistance addresses areas for improvement identified through the review process and follows the delivery of the Consultation Review report to the provider. This Technical Assistance is to occur within ten (10) working days after the review report is mailed to the provider, giving the provider time to review the report.

- ❖ To request any type of technical assistance, contact APS Healthcare at (304) 343-9663.

### Consultations

APS Healthcare, Inc. has developed a process for retrospective consultation (review) that is user-friendly for all provider groups. APS Provider Educators conduct retrospective consultations of provider documentation practices and in some cases, provider utilization management processes relative to their level of interaction with the ASO and WV-DHHR. The intent of this consultation process is to assure that each consumer's individualized budget is effectively implemented. Technical assistance is offered as needed so that improvements can be attained and sustained. The ultimate goal of the consultation process is to assist providers in achieving positive outcomes for individuals and families through the services provided. Provider Educators are assigned specific providers with the expressed intent of developing an ongoing relationship where communication and collaboration become routine. Within a consultative atmosphere, providers are given an optimal opportunity to succeed in meeting the documentation standards set forth by WV-DHHR.

The consultation process is guided by a thorough set of record review procedures, and supported by a number of record review tools and provider record review scoring protocol as well as questions that evaluate the organizational competence of a provider group. Consultations may include a Core component related to the Organization's UM Structure, individual involvement and Staff Credentialing activities as well as a Clinical Core review related to assessment, planning and progress reports. Provider Educators also provide focused consultations for the specific services provided to individuals by an organization or provider. Technical assistance and follow-up activities are made available to providers on a consistent basis. The tools and scoring instruments are reviewed by the APS Provider Quality Improvement Council and sanctioned by DHHR staff.

Provider Educators present feedback to providers pertaining to areas of strength as well as recommendations for improvement when needed. The results of consultations provide opportunities to identify best of promising practices, to address training needs, and to determine provider network capabilities from a systemic view.

APS-WV staff works collaboratively with other DHHR regulatory bodies (Office of Health Facilities Licensure and Accreditation (OHFLAC), Office of Quality and Program Integrity (OQPI) [formerly SURS], and the Bureau for Behavioral Health and Health Facilities (BHBF) in order to develop consistency and congruence among these entities regarding documentation standards.

APS-WV Healthcare conducts consultative reviews of all participating Title XIX MR/DD Waiver Providers.

### Consultation Procedures

#### Clinical Records Sample

With all Title XIX MR/DD Waiver Providers, a sample of records of individuals receiving MR/DD Waiver Services will be requested for review. These samples are intended to reflect a representation of the individuals receiving services by a provider and are based on the volume and complexity of the provider's service array. All service denials are included for review.

#### Schedule/Notification to Providers

Consultations will be scheduled in advance by the designated Provider Educator for a specific provider. Providers will be contacted by phone in advance of a site visit. A list of records for potential review will be provided by fax or electronically in advance of the scheduled visit, generally allowing three days notice for large providers and one day for smaller providers to allow time to pull the requested records. All site visits will occur as scheduled. In the event that a scheduling conflict arises, the consultation will be rescheduled for the earliest possible date agreeable to all parties.

#### On-site Review

Educators will conduct on-site reviews at participating providers. As agents of the Bureau of Medical Services, educators will explain the purpose of the consultation activities that may include interviews with key staff and a review of policies and procedures as well as the review of specific charts. The educators will maintain confidentiality and providers are asked to provide an area for record review at their facility that is conducive to preserving confidentiality. If questions arise, providers will be given the opportunity to provide an explanation or to locate missing or misfiled information. Before the educator leaves the facility, an exit review will be conducted.

#### Exit Review

Upon completion of the consultation review, the educator will conduct an exit review with provider staff. A summary of the initial findings will be discussed and areas for improvement will be identified. Educators will also offer training on

identified areas of need. If fraud is suspected, providers will be notified during the exit review.

#### Authorization Adjustment

Retrospective focused service consultations of Title XIX MR/DD providers are structured to insure that each individual's budget is effectively implemented and to provide feedback to providers for continued improvement of performance. It should be noted that, based upon the retrospective focused service consultations, APS does not institute a payback or void adjust; this remains the responsibility of the provider and the Bureau of Medical Services.

#### Consultation Report

A Consultation Report, which includes a discussion of the results along with recommendations, will be delivered to the provider within thirty business days of the last date of consultation. Although formal corrective action plans are not currently mandated, providers should utilize the results of the Consultation Report to determine training needs and to implement quality improvements. Subsequent consultations are expected to reflect improvements by providers and will be utilized for provider profiling and systems recommendations.

#### 10-day Follow-up

Within ten business days of the distribution of the Consultation Report, the consultant will contact the provider to answer any further questions, to discuss corrective actions, and to provide technical assistance and schedule training if necessary.

#### Feedback to Providers

Provider Data Analysis supports a variety of quality improvement and quality control activities including registration coordination and training. Using data generated from individual provider consultations, APS routinely evaluates a provider's performance, which drives decisions as to whether more frequent consultations, surveys, and/or focused training will be conducted.

A central feature of the consultation feedback system is that it identifies providers who may be in need of additional training and guidance. APS attempts to work with these providers on a more intensive basis to strengthen areas identified through the consultation review process. A training representative assists these providers to clarify procedures and documentation standards. Additional education initiatives can include training of the provider's administrative staff, reorientation on the ASO and UM procedures, and as necessary, individualized technical assistance provided on-site.

Statistics are generated for each MR/DD Waiver service provider for comparison with statewide data. Examples of key quality of care standards to be measured may involve:

- Regular reports that include the number of individuals served, the most frequently utilized services, and utilization patterns surrounding Individualized Budgeting and purchasing of services.
- System Change and Outcomes: Uniformity between service registrations/purchases and services actually received by the individual (unmet needs).

In addition, individual feedback regarding satisfaction with services and with treatment outcomes will be addressed through consumer focus groups, Individual Program Plan reviews, consumer follow-ups, and individual complaint summaries.

To keep providers informed, APS also provides Frequently Asked Questions (FAQ's), a quarterly newsletter, and archived tips of the month on the website at [www.apshealthcare.com](http://www.apshealthcare.com).

## **CONSUMER AND FAMILY EDUCATOR**

The Consumer and Family Educator is responsible for community liaison activities and works to promote individual and community awareness by providing educational trainings on empowerment and personal accountability with regard to treatment planning and service delivery. Families are educated on the process of actively participating in Individual Program Planning activities to promote the philosophy of person-centered planning. The goal of the Consumer and Family Educator is to solicit input and feedback from stakeholders regarding improvement of services while addressing the unmet needs of those individuals receiving MR/DD Waiver services in West Virginia.

The Consumer and Family Educator provides education, promotes empowerment and volunteerism, assists communities in developing active networks for the delivery of alternative or complementary services that support the individual's needs, educates providers on individual choice, identifies needed services, and educates the public on the functions of the ASO. This includes:

### **Individual Education**

Empowering individuals and families with information about their rights and responsibilities during interaction with providers and the ASO is a central function of this department. Individuals and families are informed with respect to their rights and responsibilities. Individuals and families are also educated regarding their role/choice in Service Coordination. This is the essence of consumerism and empowerment.

### **Provider Education**

The Consumer and Family Educator educates providers about their duties not only to consumers, but also to the ASO. Providers are informed of their responsibilities in serving the individuals and family members. Providers are instructed that individuals have the right to choose from whom they will be receiving Service Coordination or any array of services. The individual has a right and the responsibility to actively participate in his or her Individualized Program Plan for best outcomes.

### Community Education

Information and education regarding the ASO is supplied to the community including, but not limited to: senior groups, religious groups, civic organizations, educational institutions, parent groups, business groups, and local government entities. Education is provided to communities about persons with Mental Retardation/Developmental Disabilities (MR/DD), to aid in the reduction of stigma and to bring awareness of issues in regard to gaps in services.

### Peer and Community Assistance

Peer assistance is conducted for individuals, the community, and their families to learn to deal with problems associated with Mental Retardation/Developmental Disabilities (MR/DD). This includes assisting organizations to obtain grants, and other resources to assist individuals and provide a network of support.

### Focus Groups

In depth focus groups are conducted with stakeholders who are directly impacted by the MR/DD Waiver system. These groups assist in assessing outcomes and in guiding the direction of MR/DD Waiver services.

### Information and Referral

When individuals, providers, and others involved in the treatment of an individual have issues, needs or questions regarding their care, their concerns should be addressed. There are times when a simple referral to a community or advocate organization achieves an answer sought regarding these various issues.

If a concern regarding service delivery, reduction in services, or miscommunication between a provider and/or client or guardian, needs resolution, the Consumer and Family Educator makes an inquiry with the appropriate parties. After all information is gathered and presented to the APS-WV Management team, a decision is then made to provide accurate information, refer to an outside entity, and/or assist in resolving the miscommunication. If there is no resolution, it is then determined to be a consumer complaint.

### Individual Complaints

To assure that all individual relations are managed in a professional manner, APS provides a mechanism for consumers and/or their families to file complaints. Each complaint is documented on a complaint log and tracked through resolution. All individual complaints will be responded to in a timely fashion and all written complaints will receive a written response.

### Denials: Review of Individual Notifications

In accordance with the APS Quality Improvement Plan, the Consumer and Family Educator conducts ongoing reviews of notifications for denied service authorizations.

The following procedure is used in conducting reviews of individual notification of denials in the above-mentioned instances.

### Initial Request

The Consumer and Family Educator reviews denials of service authorizations each month. The Service Coordinator is contacted by phone and a copy of the Denial Notification letter, signed by the individual or guardian, is requested for each denial. If their signature could not be obtained, the attempt to notify them and/or the reason should be documented and signed by staff.

### Review

When the copy of the Denial Notification letter is received the Consumer and Family Educator will review the information to determine whether the individual and/or guardian was notified, or whether an attempt to notify is documented. Data on Consumer Notification of Denials will be provided to the MR/DD Waiver Program Director for retrospective review, included in Contract Reports, reviewed by Contract Management as needed, and utilized in provider profiling.

### Follow-up

If the information is not received from the provider within ten (10) business days of the initial request, the Consumer and Family Educator will follow up with a second phone call to request the information from the clinical staff. If the information is not received within five (5) business days of the second phone call, a Letter of Request will be sent to the provider. The provider will be given an additional ten (10) business days to submit the information. The Consumer and Family Educator will not provide further contact. It is the responsibility of the provider to assure that this information is made available to individuals.

### Further Actions

If the Consumer Notification of Denial information is not received within 10 business days from the date the Letter of Request is sent:

- The Provider Educator for that provider will be notified;
- The Consumer and Family Educator will document the provider's failure to respond; and
- Documentation regarding failures to respond will be reviewed for Contract Reports, Quarterly QI Reviews, and Provider Profiling.

### Appeals

Denials of requests for service and/or reduction in amount of service requested may be appealed by following the established state procedures for administrative fair hearing appeals as outlined in Chapter 500 of the Title XIX MR/DD Waiver manual.

## INFORMATION INTEGRATION

The Information Integration Department is responsible for planning, executing and maintaining all hardware and software needs for information management. Additionally, this Department provides the analysis and reporting activities for all standard and ad hoc reports. These reports are for internal analysis as well as those generated for dissemination to Department of Health and Human Resources, other state agencies, providers and other stakeholders.

Major activities of this Department include the following:

- Preparation of programs to process data and solve problems (e.g., WV Title XIX MR/DD Waiver provider file transfers);
- Consultations with internal and external IS Coordinators;
- Clarifies program intent and determines extent of programming;
- Analyzes test runs for program development and revision;
- Manages and analyzes data for recommendations on system changes, utilization projections, and quality improvements;
- Design reporting formats and collects necessary data;
- Provides for tracking of consultation, quality and utilization data;
- Maintains network infrastructure, PC and related hardware and software, and;
- Liaison to entities interfacing with the APS system.

### Secure Website Instructions & Data Submission Information

Individual Provider entities may refer to the APS website for specific instructions.  
[www.apshealthcare.com](http://www.apshealthcare.com)

## Claims Submission and Reimbursement

(From the State's Claims Processing Fiscal Intermediary)

To ensure timely processing of claims, all required completed individual and provider information, including approved authorization confirmation numbers, should be submitted with all claims. Please continue to submit your claims directly to WV Bureau of Medical Services Claim's Payer as you have in the past, along with the approved authorization confirmation number for the claim.

**APS Healthcare is not responsible for accepting provider claims, claims/payment research, or other claims related inquiries.**

*The contracted State Medicaid intermediary has responsibility for claims payment for this program and receives an upload of approved service authorizations. Providers should continue to submit billing information and any questions regarding payment directly to the State's Medicaid claims payment intermediary.*

## Performance Indicators

In regard to the West Virginia Title XIX MR/DD Waiver Program, APS works with stakeholders to identify a select number of provider performance indicators to monitor, track, report upon, and address in support of DHHR approved quality improvement goals. By examining a limited number of indicators that are highly relevant to provider-based utilization management, APS intends to minimize the burden for providers in demonstrating compliance.

APS monitors performance on these indicators through processes including provider profiling, consultations, evaluations, surveys, and other tools. These indicators will be refined over time to ensure their applicability and utility. To improve the Title XIX MR/DD Waiver system, profiling will be phased-in by focusing on mechanics, data/information flow, linkage to case information, and accurate case and service data. Ultimately, profiling will include evaluating outcomes and provider networks.

## Provider Profiles

Integral to the success of the West Virginia Title XIX MR/DD Waiver Program is the ability to provide practitioners with accurate feedback on how they compare with their peers. APS works with stakeholders to generate management reports to assess provider performance on the basis of utilization data. These reports allow MR/DD Waiver Service providers to confront major issues internally, identify role models within their organization, and develop practice standards benefiting individuals and payers alike.

The APS profiling process evaluates provider performance across a number of dimensions utilizing a variety of information to create a profile for each provider. Profiles are based on utilization patterns and cooperation with administrative protocols. Sources of information include provider participation, utilization management data, consultation activities, and other relevant sources of information.

APS -WV will address additional critical issues of interest to DHHR and BMS through profiling of providers on additional measures such as:

- Compliance with UM criteria for appropriate use of MR/DD Waiver services;
- Comprehensive Consultation findings concerning appropriate documentation of services billed; and
- Documentation of individual and family involvement in Individual Program Planning.

### ASO REPORTING

The APS-WV ASO produces monthly, quarterly and annual reports of utilization management activities, service request registration and pend rates, denials, utilization trends, and ad hoc reports for the Bureau for Medical Services.

Additionally, reports are prepared regarding analysis for provider satisfaction, results of provider reviews, and consultations and comparison to previous benchmarks, financial analysis of specific service utilization, ad hoc analysis of specific issues upon request, and other reports as requested by DHHR.

APS Healthcare also regularly develops standardized reports for use in UM, surveys, provider profiling, training/technical assistance activities and other outcomes initiatives. This reporting system includes all relevant registration/utilization information, and full reporting capability in adherence to program requirements.

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## APPENDIX I

### APS Healthcare WV Title XIX MR/DD Waiver ASO

#### **POLICY AND PROCEDURE:**

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**SUBJECT: Service Purchase Requests: Authorization Resolution and Timelines, Pend, Review, Negotiation, and Level 2 Negotiation Process**

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#### POLICY

All MR/DD Waiver services requested under WV ASO guidelines must meet the following criteria:

- The service mix must be within the Individualized Waiver Budget;
- All services must be within individual service limits;
- All health and safety needs must be met.

Registration/Authorization requests are processed in a timely manner by the ASO. Those requests that are authorized automatically will be returned within two business days. Those that require Registration Coordinator review will be returned within five business days of receipt of all additional, necessary information from the provider.

Exceptions to these timelines may be authorized by DHHR for such issues as maintenance of the database, acts of nature, etc.

#### DEFINITIONS

**PEND STATUS:** Service request that, upon computer review, does not meet the UM Criteria or program policy for that service. Examples include not meeting:

- **Financial guidelines;**
- **Service requirement guidelines;**
- **Health and safety needs;**
- **UM criteria.**

**INITIAL REVIEW:** A first review of a pended service authorization request by a Registration Coordinator to determine if information submitted via the APS Title XIX MR/DD Waiver Application is sufficient to justify services/service mix requested.

**PROVIDER:** Provider contracted with the State to provide MR/DD Services covered by WV Medicaid ASO.

**REVIEW STATUS:** Status that indicates the service purchase request has been placed in review and is actively under discussion with Provider staff.

**NEGOTIATION:** The process whereby a service purchase request which is in Review status following Registration Coordinator review is modified or changed in some way from the original request or is closed.

**LEVEL 2 NEGOTIATION:** A process whereby a service purchase request has gone through negotiation with provider and registration coordinator AND has not reached a satisfactory result for the provider AND is requested by the provider to be reviewed by APS' WV's Management/Specialist. Provider is required to submit a written rationale to the Registration Coordinator to request Level 2 Negotiation.

**CLOSED STATUS:** Service authorization that is closed for any one of the following reasons:

- Service purchase request was submitted by mistake,
- Service purchase request was never needed/provided or request was a duplicate (a requested service that currently has authorization)
- Service purchase request is closed by the Registration Coordinator to allow the provider to submit corrected or missing information.

**SERVICE EXCEPTION DENIAL:** A final decision by APS-WV following the Review, Negotiation and Level 2 Negotiation to deny a request to exceed an individual service limit. The service, up to the limit, as denied in Chapter 500 Title XIX MR/DD Waiver Manual may be authorized during the appeal/fair hearing process. A service limit exception may be denied for any of the following reasons:

- the documentation does not warrant the requested service(s);
- the documentation does not warrant the service purchase request;
- Provider, with IDT input, does not agree with the recommended service amount;
- the consumer is ineligible for the requested service.

**APPEAL:** A request for APS Healthcare, following Review and Reconsideration, to change a decision it has made in regard to a denial of authorization for service.

## **PROCEDURE FOR REVIEW AND SERVICE AUTHORIZATION**

1. The case information for review and service authorization for services requested is submitted by the service coordinator/utilization manager electronically. Requests are evaluated based on established UM guidelines for the particular service code and the Individualized Budget. Service purchase requests that meet criteria are approved and a referral is sent to the chosen provider(s). Service purchase requests that do not

- meet the criteria are automatically pended for review by an APS Registration Coordinator.
2. The Initial Review by an APS Registration Coordinator will take place within two business days of receipt of the pended authorization request. (Service purchase requests appear on the APS Registration Coordinator's list approximately one business day after submission by the provider.) The service purchase request may be Approved, Closed, or placed on Review status as appropriate. This Initial Review does not require discussion with the provider.
  3. Pended requests that require additional information will require the Registration Coordinator to contact the Service Coordinator/Utilization Manager within five business days to request the necessary information.
  4. Provider Utilization Management staff will have three business days to gather additional information if there is insufficient clinical justification to approve a service. During this second review of pended authorizations, information may be given to the Registration Coordinator that will enable the service authorization to be authorized or closed.
  5. If there is still insufficient information to authorize a service purchase request, the Service Coordinator/Utilization Manager will have three business days to indicate need for a negotiation. During this negotiation, the Registration Coordinator and the Service Coordinator/Utilization Manager negotiate an agreed upon service purchase request which is modified or changed in some way from the original request or is closed.
  6. If the service purchase request is not resolved (authorized, modified or closed) following negotiation, the Service Coordinator/Utilization Manager will have 2 days to request in writing that a Level 2 Negotiation be conducted. At this time, the service purchase request will be reviewed by APS-WV Management/Specialist to determine appropriateness. The result of a Level 2 Negotiation is that the service purchase request is modified or changed in some way from the original request through an agreement between APS-WV Management/Specialist and the Service Coordinator/Utilization Manager –OR- is denied.
  7. Service purchase requests that pend for missing data are the responsibility of the Service Coordinator/Utilization Manager. APS will close the request for which data is unavailable and instruct the provider to resubmit the corrected request.

## APPENDIX II

### APS Healthcare WV Title XIX MR/DD Waiver ASO

#### **POLICY AND PROCEDURE:**

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**SUBJECT: Denial and appeal process  
Title XIX MR/DD Waiver providers on behalf  
of consumers**

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#### POLICY

This policy outlines the negotiation and appeal process for providers on behalf of individuals.

All services provided through the Title XIX MR/DD Waiver program under the WV Medicaid ASO guidelines must be determined necessary by the individual's Interdisciplinary Team and reflected through documentation on the Individualized Program Plan.

#### **DEFINITIONS**

**APPEAL:** The process for APS Healthcare to change a decision it has made, following Review and Negotiation, in regard to a denial of authorization for service.

**PROVIDER:** Provider contracted with the State to provide Title XIX MR/DD Waiver services covered by WV Medicaid ASO.

**CONSUMER/INDIVIDUAL:** An individual eligible for services in the Title XIX MR/DD Waiver Program.

**REGISTRATION COORDINATOR:** APS staff member with a background in services to persons with MR/DD who is responsible for review of service requests.

**DENIAL:** A final decision by APS-WV, following the Review process and the Negotiation process, to deny authorization for service. Service authorization may be denied for any one of the following reasons:

- the documentation does not warrant the requested service(s);
- the documentation does not warrant the amount of service requested;
- the provider (with treatment team input) does not agree with the recommended change.

## **PROCEDURES**

### **Review Process for Pended Service Authorization**

1. When an authorization is pended by the computer for review, a Registration Coordinator conducts an initial review. If needed, the Registration Coordinator contacts the Service Coordinator/Utilization Manager to discuss the individual's needs and/or insufficient or inconsistent data in greater detail. (Refer to Service Purchase Requests: Authorization Resolution and Timelines, Pend, Review, Negotiation, and Level 2 Negotiation Process).
2. After the Review process, one of the following outcomes may occur:
  - a. The service is registered/authorized;
  - b. An alternative service or amount of service is negotiated;
  - c. An appropriate non-billable service is negotiated;
  - d. The service is not registered/authorized for one of the following reasons: the individual is ineligible for the requested service(s) or the provider and/or individual does not agree with the recommended service denial.
  - e. The authorization request is closed.

### **Negotiation Process**

1. Negotiation of service may occur through two means: Negotiation with Registration Coordinator or Level 2 Negotiation with Manager/Specialist.
2. In cases where a Negotiation results in a recommendation for a different service or service amount than requested, the Registration Coordinator will be prepared to review/approve the new authorization request and to close the initial request for service.
3. Provider personnel are responsible for submission of the service authorization requests for the individual's new level of care.

### **Level 2 Negotiation**

Service coordinator requests Level 2 Negotiation within two days of unsuccessful Negotiation/Resolution with Registration Coordinator.

In the event that a service is denied following the Level 2 Negotiation process a letter detailing the reasons and dates of service that are not authorized will be sent. Notice of the denial will be sent to the Provider of services and it is the Provider's responsibility to ensure that the individual and/or the representative is fully informed of the denial, the reasons for denial and related consumer rights.

### **Appeal of denials**

1. To request an Appeal of a Denial, Providers will send a written request to the MR/DD Director within five working days following receipt of the notice. The MR/DD Director, or Executive Director in their absence, will document the substance of the Appeal on the Appeals Log on the day of receipt.
2. The results of the Level 2 Negotiation will be sent to the Service Coordinator following the review.

## **APPEALS PROCESS**

### **Provider Appeals**

If a Provider wishes to appeal further based upon adverse consequences, the Provider may file an appeal with DHHR upon receipt of the Denial letter or may assist an individual in requesting an Appeal under state guidelines. DHHR will notify the APS Healthcare Executive Director and/or Quality Improvement Manager of the outcome.

### **Consumer Appeals**

Upon receipt of a denial letter, individuals and/or their legal representative may appeal the Denial directly to BMS for a Fair Hearing under state guidelines. DHHR will notify the APS Healthcare Executive Director or Associate Director of the hearing outcome.

### **Treatment and Pay Considerations (per State Guidelines)**

During the Review, Reconsideration and Appeal process, only those services being appealed will continue as outlined in the previous IPP. All other services will be provided according to the most current IPP. If services being appealed are part of an initial IPP and have not been previously offered, the service being appealed cannot be offered to the member. Regardless of the outcome of the Appeal, the service will be authorized through the duration of the appeal for those individuals who have received the denied service within the past ninety (90) days and for whom continuation of service was requested and denied. Waiver coverage will continue during the course of the Review, Reconsideration, and Appeal process. Providers will hold their claims for payment until the end of the process, at which time the Provider and individual will be notified of the duration and scope of reimbursable services.

If the individual is new to MR/DD Waiver, defined as individuals who have not received Title XIX MR/DD Waiver services within the past ninety (90) days or who have not received the service specified in the service registration request there is no assurance of coverage during the Appeal process. If providers choose to render service, they do so at their own risk. Services rendered will only be covered if the reconsideration or appeal decision reverses the initial denial of service.

## APPENDIX III

### **APS Healthcare WV Title XIX MR/DD Waiver ASO POLICY AND PROCEDURE:**

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**SUBJECT: MANUALS AND REFERENCE MATERIALS  
TITLE XIX MR/DD WAIVER PROVIDERS ON BEHALF  
OF CONSUMERS**

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#### **Manuals and Reference Materials**

For information about the ASO in West Virginia and to locate general information, updates, upcoming events, manuals and contact information, refer to the APS website: [www.apshealthcare.com](http://www.apshealthcare.com). The following items can be located on the website and can be downloaded:

- Utilization Management Guidelines;
- Instructions for Completing the Title XIX MR/DD Waiver Application Data Set;
- Consultation Review Tools;
- Secure Website Access Instructions;
- EDI File Formats and Web Users Manual;
- FAQ's;
- Training Materials.

## APPENDIX IV

### APS Healthcare WV Title XIX MR/DD Waiver ASO POLICY AND PROCEDURE:

**SUBJECT: GLOSSARY OF TERMS, ABBREVIATIONS,  
AND ACRONYMS**

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#### **Glossary of Terms, Abbreviations, and Acronyms**

The following are definitions of key terms for the West Virginia Title XIX MR/DD Waiver program. If you would like additional terms included, please send your suggestions.

**AAHC** - American Accreditation Healthcare Commission, formerly URAC

**APS Healthcare, Inc. (APS)** - the External Review Organization chosen by the State.

**ASO** - Administrative Services Organization chosen by the Department to develop and implement a statewide system of utilization management and a provider-based system for individuals receiving Title XIX MR/DD Waiver Services.

**Appeal** - Following the Review and Negotiation process, a request for APS Healthcare to change a decision it has made in regard to a Registration Coordinator's denial of authorization for service.

**BHHF** – Bureau for Health and Health Facilities; the Bureau that determines eligibility and provides oversight for the Title XIX MR/DD Waiver program.

**BMS** - Bureau for Medical Services; a provider of the State of West Virginia.

**CMS** – Centers for Medicaid & Medicare Services (formerly HCFA); federal provider that regulates and contributes financial resources to State Medicaid programs.

**Complaint** - Dissatisfaction formally communicated, verbally or in writing, to any APS staff by an individual or provider that does not involve an authorization denial.

**Consumer/Individual** – An individual receiving Title XIX MR/DD Waiver services.

**Department of Health and Human Resources (“the Department” or “DHHR”)** - A department of the government of the State of West Virginia which includes BMS and BHHF.

**HCA** – Health Care Authority.

**HCFA** - Health Care Financing Administration; the federal provider that regulates and contributes financial resources to State Medicaid programs.

**IS-** Information Services.

**NCQA** - National Committee for Quality Assurance.

**OHFLAC** – Office of Health Facilities Licensure and Accreditation.

**OQPI** – Office of Quality and Program Integrity.

**Outcomes** - A set of quantitative measures, which track the progress of the service delivery system toward the goals and the expectations of the consumer, and in accord with accepted practice and regulation.

**“Pended” or “Pending”** – The status of an authorization or reauthorization request that has been initially found not to meet criteria for appropriateness. The request is considered pending until telephonic review has occurred between the APS Registration Coordinator and requesting provider.

**PERMS** - Performance Measures, a standard quality report card system developed by the American Managed Behavioral Healthcare Association.

**Provider Profile** - The collection of aggregate statistical data on a practitioner or institution to compare practice and use patterns, identify inappropriate or best practices, or assess other characteristics of practice.

**QI** - Quality Improvement, the continuous process of planning, identifying, monitoring, analyzing results, instituting corrections and evaluating the progress of a system or organization.

**QIC** - Quality Improvement Committee.

**QISMC** - Quality Improvement Standards for Managed Care.

**Unisys** - The Medicaid intermediary currently responsible for paying provider claims for the West Virginia Medicaid programs.