



CHILDREN'S WAIVER PROGRAM



TECHNICAL ASSISTANCE MANUAL

Revised Edition - May 2004

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SECTION 1: INTRODUCTION

The Children's Waiver Program (CWP) is administered by the Michigan Department of Community Health (MDCH) and funded with State and Federal Medicaid dollars. This program is designed to provide in-home services and supports to Medicaid-eligible children with developmental disabilities, who would otherwise be at risk of out-of-home placement into an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The overall funding for this program is controlled by the amount of state dollars appropriated by the Michigan Legislature. Federal regulations governing home and community-based services waivers allow the state to limit enrollment to a number that is supportable within the state appropriation. This requires MDCH to carefully monitor and manage the program's costs as the higher the average per enrollee cost, the fewer the individuals who can be enrolled.

The CWP is based on legislation found in Title XIX of the Social Security Act. As a Medicaid-funded program, services covered under the CWP are available to individuals under 18 years of age who meet the CWP criteria and qualify for Medicaid under the regular Medicaid eligibility provisions. In addition, the state received approval to waive the parental deeming requirements and view the waiver candidate as a family of one. As a family of one, only the child's income and assets are considered in determining financial eligibility for Medicaid. The CWP candidate becomes eligible for Medicaid coverage while residing in the birth/adoptive family home or in the home of a relative who is the child's legal guardian.

The purpose of the CWP manual is to describe for families and Community Mental Health Services Programs (CMHSP) all aspects of the program, as approved by the Centers for Medicare and Medicaid Services (CMS). The manual provides technical assistance for outreach and screening of children who may be eligible, the application and approval process, and a description of services and supports. This manual replaces the initial CWP Manual of 1993 and the Revised Edition of 1997. The manual also includes the addition of a glossary of terms, list of resources for families and case managers, parent-to-parent section, choice voucher guidelines, expanded description of administrative hearing procedures, and an expanded description of quality assurance. The revisions are a result of the expressed needs and wishes of the children and families we serve.

The following principles are the foundation upon which the CWP is based:

- The Michigan Mental Health Code established the right for all individuals to have their Individual Plan of Services (IPOS) developed through a person-centered planning (PCP) process.
- The MDCH has advocated and supported a family approach to service delivery for children and their families. This approach recognized the importance of the family and the fact that supports and services impact the entire family. Therefore, in the case of minors, the child/family is the focus of service planning, and family members are integral to the planning process and its success. The wants and needs of the child/family are considered in the development of the IPOS.
- Consumer choice and control will be considered and accommodated whenever possible. A voucher system is now available to enhance family choices.

- Supports such as family, community and school resources must be accessed prior to requesting waiver services. Private insurance and Medicaid state plan coverage (e.g., Children's Special Health Care Services [CSHCS], Medicaid Health Plans) must also be accessed before requesting CWP services.
- Quality Assurance reviews are utilized to monitor compliance with the Mental Health Code, the Medicaid Provider Manual, and the MDCH/CMHSP Contract. Refer to Section 15.

How To Use This Manual

Significant information is highlighted in the boxes at the beginning of each section.

The Glossary contains definitions of terms, as well as any corresponding abbreviations or acronyms, used throughout the manual.

The Appendix provides sample documents used in the CWP.

Throughout the manual you will find some symbols that draw special attention to key items.



This symbol is used to alert the reader to documentation



This symbol is used when a physician's prescription is required.



This symbol identifies helpful hints.



This symbol is used when prior authorization from MDCH is required.

Dear Parents:

As a parent new to the Children's Waiver Program (CWP), or one whose child has been on the CWP for a while, you may wonder what the CWP really is and how you can make it work for your family. This program focuses on promoting community-based services and supports that will enable a child to remain with his or her family, while reaching his or her full potential. Starting with members of a team you have chosen, a plan is built around all the identified strengths, needs and goals of your child and family. Community resources, services and supports funded through the CWP, are included in the plan to meet the child's identified needs. This is known as person-centered planning/family centered practice.

This manual was developed to provide you with an understanding of the CWP process and to inform you of the services and supports that are available to your child and family. As you know, from past experiences, you must be informed to be an effective advocate for your child.

The following section was written by parents to inform, support and assist in the process of tailoring a plan of services and supports to meet the needs of your child and family. It covers three areas. The first area highlights important information regarding program parameters and procedures. The second area provides practical "how to" tips. The third area consists of a directory of resources and services for children with special needs. It is our hope that you will find the information in this section helpful.

From parents of children on the Children's Waiver Program

SECTION 2: PARENT-TO-PARENT

Program Requirements and Procedures

After your child has been determined to be clinically eligible for the CWP, if your child is not currently eligible for Medicaid, financial eligibility must be determined. Annual redetermination of financial eligibility is also required. The local Family Independence Agency (FIA) completes the financial determination and the necessary forms will be mailed to your family's home. In determining financial eligibility, only your child's income and assets are considered under this program's approved waiver of the Social Security Act's parental deeming requirements.

- Your child will receive Medicaid services in addition to CWP services, if they need and qualify for them. A mihealth card will be sent to your home. If you do not receive your child's mihealth card, notify your case manager. If you don't receive a new one each month, you must also contact your case manager.
- An annual Medical Examination form (FIA-49 form) and other identified assessments are used to develop and maintain a current Individual Plan of Services (IPOS).
- Your child's IPOS shall be developed within 7 days of commencement of services. The IPOS consists of a supports plan and a treatment plan that establishes meaningful and measurable goals for your child. This IPOS is completed through a planning process (Refer to Section #12) involving your child, family, friends, case manager and other professionals necessary to address the identified needs of your child.
- The IPOS is a working document that must remain current with a copy available in your home. It must be implemented by all caregivers. Upon completion of the initial IPOS and any subsequent revisions of the IPOS, you will receive a notice of your right to an Administrative Hearing.
- Because the CWP is a home-based, family centered program, case managers should arrange face-to-face visits in your home (as specified in the IPOS) at your convenience. Whenever possible, these visits should be coordinated with other team members. Additional visits with your child may be necessary in other community settings (school, hospitals, etc.) to facilitate coordination of services.

Child Profile

You may wish to develop a written profile of your child, listing his or her strengths, weaknesses, preferences, likes and dislikes. Your profile will help the caregiver see your child as an individual and help your child make an easier transition to a new caregiver. (See "Suggestions for Working with John"). You may also wish to explain how your child prefers to be bathed, what your child likes to eat (such as peas mixed with mashed potatoes), that he or she never misses the television show "Blues Clues", and that he or she likes to sleep with the red stuffed dog. It may be important to let your caregivers know that your child understands "potty" but not "toilet", or that your child likes to listen to Alvin and the Chipmunks before falling asleep. It should be identified in the written profile that your child will not wear a short-sleeved shirt and he or she likes to stay in their

room alone for the first ½ hour after returning from school. The caregiver will need to know what his/her favorite snack is and that your child dislikes orange Kool-Aid. Tell the caregiver that your child is afraid of the dark and sleeps with a nightlight. Let the caregiver know the best way to interact with your child.

Record Keeping

It is helpful to establish a basic filing system to organize the IPOS, assessments, bills and other information pertaining to your child. Since the records may be transported during medical visits, you may wish to put this information in a three-ring binder.

From these records, a summary of your child's condition may be compiled for use by caregivers and for emergency situations. It may include the following information:

- Current medications including dosages and times of administration
- Known allergies and immunization record
- Hospitalizations, surgeries, tests, scans and blood work with dates and places where services were provided
- List of all physicians (e.g., pediatricians, dentists, primary family doctors and other specialists) with their addresses and telephone numbers
- Emergency numbers of parents (including work numbers) and significant family members
- Insurance information (e.g., copy of private insurance policy, Medicaid card, insurance statements, medical expense receipts)
- Authorization for medical treatment of your child
- School records (e.g., IEPC, MET)
- Information regarding your child's diagnosis
- Your child's financial and benefit information (e.g., Social Security, Family Support Subsidy, copy of Medicaid application, CSHCS)
- A copy of the summary should be available to each caregiver for general information and for emergencies. Some parents post this information on a bulletin board in the home. The summary should be updated whenever a change occurs.

Working With Caregivers In The Home

One of the greatest challenges for a family using waiver services is the adjustment to working with caregivers in the home. There will be people visiting and working in your home and the loss of privacy is inevitable. Other concerns may include your role as the "employer" and the impact staffing may have on your other children. Consistent staffing is imperative to assist your family in meeting your child's needs and achieving identified goals. Respite services can provide relief and

additional time to devote to other family members.

It is important that you clearly identify and define the role the caregivers will assume. Focus on your family priorities, habits, values and beliefs, taking into consideration the other children and adults in your home. In a two-parent family, the couple should decide which responsibilities each would handle. The caregiver needs to know that you are a family unit rather than a family with a member who is disabled. This changes the focus of the caregiving from a narrow, individual emphasis to a broader view of a caregiver's role as one who facilitates family functioning, rather than isolating the child and engaging the child exclusively in separate activities. It is important that children with special needs be encouraged to participate with other family members.

After a general discussion of family priorities you may wish to discuss specific areas. It is important that the caregiver understands his or her role and the importance of following the IPOS. Procedures for scheduling or canceling work hours must be in place. The family, or the CMHSP agency in collaboration with the family, may schedule staff hours. It is important that all participants are familiar with procedures and follow them appropriately. Staff work schedules will be based on the needs of your child and family.

House rules should be established and reviewed periodically with caregivers. You may wish to give them a written summary of your house rules. The following is a sample list of suggestions:

- Specify rules on smoking, phone use, where to park staff vehicles, use of television/computer/stereo/air conditioning, etc.
- List instructions or limitations on use of microwave, stove and refrigerator. Specify whether you wish staff to bring their own food or if you prefer they eat with your family.
- When your family is available to relieve the caregiver for a break, the length of time and the area where he or she can relax should be specified.
- Trust, privacy and confidentiality issues (e.g., expectations that family information will not be shared) should be discussed with your caregiver.
- List home security issues (e.g., when are doors to be locked and windows locked).
- Indicate how your child should be transported and where the caregiver may take your child for an outing, as identified in the IPOS.
- Indicate your expectations for interacting with other family members.
- Make it clear that caregivers may not bring or invite other individuals to your home.
- Inform caregivers of the procedure they should follow when responding to telephone calls and visitors in the absence of family members.
- List areas of the home that are off limits.

Retaining Staff

Staff turnover can be expected. It is better for everyone if it can be kept to a minimum.

Experienced parents have learned that the following approaches may be helpful:

Be clear about your expectations of caregivers. Encourage questions, suggestions and discussion.

Provide the caregiver with new information or changes in the IPOS. (Include forms used for documentation of program activities.)

Encourage the caregiver to be invested in your child. Family and caregivers should work as a team. Develop a relationship with the caregiver and resolve difficult issues before they grow to overwhelming proportions.

If conflict develops, try to resolve it with the caregiver by referring back to the IPOS and house rules. If resolution is not achieved, the issue should be discussed with your case manager.

Frequently express your appreciation to caregivers for a job well done. You may wish to celebrate the caregiver's birthday, the anniversary of employment and holidays.

You may wish to consider establishing an area for the caregiver in your home. It could be a bookshelf or drawer to store paperwork, books, pamphlets and personal possessions.

Be considerate and flexible.

Suggestions for Working With "John"

Every child is an individual, and it is important that a child be seen as one. Below is a sample of a written profile that includes information about John's likes, strengths, eating habits, things to watch for and how to best interact with John.

- Treat him with respect.
- Assume he understands all you are saying (even if he appears not to be listening).
- Acknowledge and greet John.
- Approach him slowly giving him lots of space. John often feels trapped.
- Speak to him slowly, firmly and quietly. He is sensitive to some noises.
- Explain to him (simply) what is going to happen before it happens. This will make his problem with transitions easier.
- John does not like to be touched but he does like to interact from a distance.
- Doing things he enjoys is a good way to initiate interactions. Examples include: Eating, playing music, singing, playing ball (roll, bounce, throw, catch), swimming, going for a walk, carrying things in a container, swinging and jumping.

- Give him choices. Do you want to _____ or _____?
- If he is having a seizure or a tantrum, give him lots of space and quiet time until he calms down. John's seizures could be shoulder jerks or his head dropped slightly and eyes rolled back or 2-3 second stares when he does not move. Some of his most challenging behaviors seem to occur after a seizure or series of seizures. Do not expect to see his normal behavior or responses.
- John likes to have something to hold and carry. Things he often carries are soft blocks, balls, flat cards (laminated), bowls, buckets and little toys.
- He likes music. Singing to him is calming. Christmas songs and nursery rhymes are some of his favorites.
- Small steps of improvement may be noticed after repeating an idea many times. He is always learning but progress is slow.

SECTION 3: ELIGIBILITY

- The child must meet criteria for admission to an Intermediate Care Facility for Mentally Retarded or persons with related conditions (ICF/MR).
- The child must reside with his or her birth or adoptive parents, a relative with legal guardianship, or in specialized foster care (with a permanency plan to return home within 30 days).
- The child must be under the age of 18.
- The child must meet or be below Medicaid income and asset limits when viewed as a family of one (the family income is waived).
- To maintain eligibility, a Waiver Certification form and Medical Examination form (FIA-49) must be completed and submitted to MDCH annually.
- The CMHSP must have determined that without the services of the CWP the child is at risk of an ICF/MR out-of-home placement.
- At least one waiver service per month must be provided to maintain eligibility.

Introduction

The CWP is based on legislation found in Title XIX of the Social Security Act. This legislation allows the state to provide waiver services to a targeted population who, without waiver services, would be at risk of placement into an ICF/MR. Legislation also allows, for those children who are not Medicaid eligible in their own right, the state to waive parental income, viewing the waiver candidate as a family of one. The CWP candidate then becomes eligible for Medicaid coverage while residing with their family. To be eligible for the CWP, all of the following requirements must be met.

Eligibility Requirements

A child must have a developmental disability as defined in federal law.

If the child is older than nine years of age, the child must have a severe, chronic condition that meets all of the following requirements:

- Is attributable to a mental or physical impairment or a combination of mental and physical impairments
- Is manifested before the individual is 22 years old
- The condition is likely to continue indefinitely

- Results in substantial functional limitations in three or more of the following areas of major life activity:
 - 1) Self-care
 - 2) Receptive and expressive language
 - 3) Learning
 - 4) Mobility
 - 5) Self-direction
 - 6) Capacity for independent living
 - 7) Economic self-sufficiency
- Reflects the individual's need for a combination and sequence of specialized, interdisciplinary treatment services that are of an extended duration and aggressively directed toward the acquisition and/or maintenance of skills and behaviors necessary for the child to function with as much self-determination as possible. (Active treatment)

If the child is under age nine, the child must either meet the criteria above or must have a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability, as defined above, if services are not provided.

A child must meet criteria for admission to an ICF/MR and be at risk of out-of-home placement.

The child must reside:

- With their birth or adoptive parents
- In specialized foster care (with a permanency plan to return home within 30 days)
- With a relative of the child when that relative has been named the legal guardian for that child under the laws of the State of Michigan and is not a paid foster parent for that child
- In an ICF/MR facility, but with appropriate community support, could return to their birth or adoptive home or to the home of a relative. The relative must be named the legal guardian for that child under the laws of the State of Michigan and not be a paid foster parent for that child

The child must be under the age of 18.

The family is willing and able to:

- Participate in the development of the IPOS
- Allow services to be provided in the family home
- Provide care and supervision beyond the services authorized as outlined in the Category of Care/Intensity of Care Decision Guides (Appendices 10-a and 17-a)
- Obtain and submit required documentation (e.g., annual Medical Examination Form FIA-49, signing the Individual Plan of Service and the annual FIA financial determination form)

The child must meet or be below Medicaid income and asset limits when viewed as a family of one (the family income is waived).

NOTE: No eligibility determination is made until the following occurs:

- 1) A CWP pre-screen application is completed by the CMHSP, signed by the parent and submitted to MDCH for review and scoring.
- 2) The pre-screen score places the child on the top of the Priority Weighing List.
- 3) An opening occurs within the CWP.
- 4) The child receives an invitation to apply for the CWP.
- 5) The MDCH receives a completed application packet for the child from the CMHSP.



The Waiver Certification form is required with the initial CWP application, annual renewal, and if the child's Category of Care or Intensity of Care changes (Refer to Section 10 and 17). The Waiver Certification form and Medical Examination form (FIA-49) must be filled out completely to confirm that the child meets criteria for an ICF/MR and the CWP.

SECTION 4: SERVICE DESCRIPTIONS AND PROVIDER QUALIFICATIONS

- All private insurance and Medicaid state plan coverage (e.g., CSHCS, Medicaid Health Plans, Home Help, etc.) must be exhausted prior to using similar CWP services.
- CWP services are billed on a fee-for-service basis.
- The type and amount of service provided and billed under the CWP must be determined necessary to meet the needs of the child, to prevent institutionalization, and be identified in the IPOS.
- Each CWP service is provided and billed according to the amount, frequency and duration stated in the IPOS.
- Qualified providers of the family's choice deliver each service and support.
- Waiver services and supports do not include personal care or the cost of room and board.
- Prescriptions for occupational and physical therapy must include a diagnosis, frequency, and duration of the service.
- A physician's referral is required for Speech Therapy.

Introduction

Children enrolled in the CWP are one of two groups excluded from Michigan's Capitated Specialty Mental Health Medicaid Managed Care 1915(b)(c) concurrent waiver programs. In addition to waiver services, CWP recipients have access to non-CWP Mental Health coverage (i.e. Mental Health Clinic/Rehabilitation, Targeted Case Management, Personal Care) from their CMHSPs on a fee-for-service basis as approved coverage under Michigan's Medicaid state plan. Section 19 will give billing instructions for CWP services. Parameters on the use of specific services are included with each description. Documentation requirements are noted for each service and marked with a . If a physician's order, prescription, referral or approval is required, the symbol  is used. A  indicates that prior review and approval from MDCH is required. (Refer to Section 10 for quantity and frequency parameters).

WAIVER COVERED SERVICES:

Specialty Services

Description

This is an alternative service that can be used in lieu of, or in combination with, traditional professional services. The focus of Specialty Services is to interact with the child, family and staff to

accomplish the goals identified in the IPOS. Service providers must meet the CMHSP provider qualifications, including appropriate licensure/certification. Specialty Services may be used in addition to the traditional professional therapy model included in Medicaid. The IPOS ensures the child's health, safety and skill development and maintains the child in the family home. Services must be directly related to an identified goal in the IPOS that is signed by the physician. Providers are identified through the planning process and participate in the development of an IPOS based on strengths, needs and preferences of the child and family. Specialty Services may include the following activities: Child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes in the IPOS. Services provided under Specialty Services include: Music Therapies, Recreation Therapies, Art Therapies, and Massage Therapies.

Under very limited circumstances and on a time-limited basis, parents and stepparents, who possess appropriate licensure/certification, special skills, documented training and are a qualified provider (Refer to provider qualifications at the end of this section), may function and be paid as a provider for this service. This would require documentation that the service being provided is not personal care, the service was not provided during time that the family is responsible for providing the care, and other qualified non-familial providers of these services are not currently available. This may not exceed a three-month period and may not be used more than twice in one year.

Service Parameters

Services may be billed up to four sessions of therapy per month. Hourly care services are not covered under Specialty Services.



The CMHSP must maintain a record of all Specialty Service costs for audit purposes.

Community Living Supports

Description

Community Living Supports (CLS) provide assistance to the family in the care of their child, while facilitating the child's independence and integration into the community. The supports, as identified in the IPOS, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. Skill development related to activities of daily living such as bathing, eating, dressing, personal hygiene, household chores, and safety skills might be included. It may also promote mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of the child, thus enabling the child to attain or maintain their maximum potential. The supports listed above may serve to reinforce skills or lessons addressed in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings.

Under very limited circumstances, a parent or stepparent who possesses appropriate licensure/certification, special skills, documented training, and is a qualified provider (Refer to

provider qualifications at the end of this section), may function and can be paid as a provider of this service. This would require documentation that the service being provided is not personal care, not provided during time that the family is responsible for providing care, and other qualified non-familial providers of these services are not currently available. Reimbursement for parents and stepparents may not exceed 248 hours over 30 consecutive days, and may not be used more than twice in one year.

Service Parameters

This service must be billed in 15-minute units. Expenses incurred through CLS may include the Mental Health Aide staffing, staff mileage (to the child's home), transportation cost for the child's planned community outings, integrated community supports (as identified in the IPOS), quality management oversight, choice voucher and other administrative overhead charges. The CMHSP must maintain records of CLS charges using the "Format For Calculating The Children's Waiver Community Living Supports Per Hour Charge" form (Appendix 4-a).

The CMHSP must bill actual costs and will receive Medicaid reimbursement up to the screen amount.

Individuals who are identified in the IPOS as service providers must meet provider qualifications as defined at the end of this section.



A log of CLS services must be maintained in the child's record that documents provision of activities outlined in the IPOS.



Provider qualifications and standards (listed at the end of this section) must be maintained for all staff providing services to the child and family.



All service costs must be maintained in the child's record for audit purposes.

Enhanced Transportation

Description

Transportation costs may be reimbursed if they are: (1) Separately specified in the IPOS; (2) provided by people other than staff performing CLS; and (3) necessary to enable a child served by the CWP to gain access to waiver and other community services, activities, and resources. This service is an enhancement of transportation services covered under Medicaid. Family, neighbors, friends, or community agencies that can provide this service without charge must be utilized before seeking funding through the CWP. The availability and use of natural supports should be documented in the record.

Service Parameters

Transportation is limited to local destinations. Local is defined as destinations within the child's county or a bordering county.

Parents of children served by the waiver are not entitled to enhanced transportation reimbursement.

Transportation costs are included in the CLS rate and may not be billed separately. Transportation costs may be reimbursed when separately specified in the IPOS and provided by people other than staff performing CLS.

For transportation services other than CLS, the transportation procedure code is billed on a daily basis.

The CMHSP must bill actual costs and will receive Medicaid reimbursement up to the Medicaid screen amount.



A log of transportation destinations must be maintained in the child's record, and be outlined in the IPOS.



All service costs must be maintained in the child's record for audit purposes.

Respite Care Services

Description

Respite care services are provided to the child on an intermittent or short-term basis because of the parent's absence or need for relief. Respite is intended to support the parent who is the primary caregiver. This service can be provided in the child's home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative who meet provider qualifications. Parents or guardians may not be considered a provider nor be reimbursed for this service. In addition to the maximum monthly respite allocation of 96 hours, vacation respite can be used for up to 14 days per year in a minimum of 24-hour increments. (Refer to the provider qualifications found at the end of this section.)

Service Parameters

Cost of room and board cannot be included as part of respite care, unless the care is provided in a respite care facility that is not a private residence.

Respite provided in an institution (i.e., ICF/MR, nursing home, or hospital) is not covered by the CWP.

When a child requires skilled nursing interventions for 24 hours, the maximum daily amount that one nurse can provide is 16 hours. When the family is not available to provide the additional 8 hours of care, a second nurse will be required to cover the remainder of the 24-hour period.

Non-Family Training

Description

This service provides coaching, supervision and monitoring of CLS staff by professional staff (LLP, MSW, or QMRP). The professional staff will work with parents and CLS staff to implement the IPOS. The IPOS describes the services required: (1) To improve the child's social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive; and (2) addresses behaviors injurious to the child or others, or that cause property damage.

Service Parameters

This service must be billed per session, with a maximum of four sessions per month.



Provider qualifications and standards must be maintained for all staff providing services to the child.



Documentation is required verifying that individual CLS staff has been trained in the appropriate areas of the child's IPOS, identifying the specific methodology.



The IPOS must identify the appropriate frequency of coaching, supervision and monitoring services.

Family Training

Descriptions

This service provides training and counseling services for the families of children served on the CWP. For purposes of this service only, "family" is defined as the people who live with or provide care to a child served on the CWP, and may include a parent or sibling. "Family" does not include individuals employed to care for the child. Training includes instruction about treatment regimens and use of equipment specified in the IPOS and must include updates, as necessary, required to safely maintain the child at home.

Family training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs.

Service Parameters

All family training must be included in the child's IPOS and must be provided on a face-to-face basis.

This service must be billed per session, up to a maximum of four sessions per month.



Provider qualifications and standards must be maintained for all staff providing services to the family.



The child's IPOS identifies the service to be provided, the family members that will participate and the goals, frequency, and duration of direct contacts.

Specialized Medical Equipment and Supplies (Refer to Section 16)

Description

Specialized medical equipment and supplies may include assistive technology such as devices, controls, or appliances specified in the IPOS which enable the child to increase his abilities to perform activities of daily living with a greater degree of independence than without them; or to perceive, control or communicate with the environment in which the child lives. This service includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under Medicaid or through other insurance. The item must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is defined as a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the IPOS. All items must be determined to be essential to the health, welfare, safety, and independent functioning of the child as specified in the IPOS.

Service Parameters

All items shall meet applicable standards of manufacture, design and installation. All applicable warranty and insurance coverage must be sought and denied before requesting funding for repairs through the CWP. Exclusions include items that are not of direct medical or remedial benefit or that are considered to be experimental. "Experimental" means that the validity of use of the item has not been supported in one or more studies in a refereed professional journal. Furnishings and other non-custom items that may routinely be found in a home are excluded. Items that would normally be available to any child and would ordinarily be provided by families are excluded. Items that are considered family recreational choices are not covered. The purchase or lease of a vehicle and any repairs or routine maintenance to the vehicle is not covered. Educational supplies and equipment expected to be provided by the school are not covered. Vehicle modifications are limited to the installation of lifts, tie-down systems and raised roof or doors in a family-owned full-size van. The modification must be necessary to ensure the accessibility of the child with mobility impairments when that vehicle is the child's primary means of transportation. Generators may be covered for a child who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment.



There must be documentation in the IPOS that the specialized medical equipment continues to be of direct medical or remedial benefit to the child.



The CMHSP, or its contract agency, must document that a repair is more cost-effective than replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the CMHSP, or its contract agency, must provide evidence of training in the use and maintenance of the equipment to prevent future incidents.



The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented.



Requires prior approval either from the CMHSP or MDCH, depending on the request.



Physician's prescription or Certificate of Medical Necessity (CMN) is required and is valid for one year from the date of signature (see glossary).

Environmental Accessibility Adaptations, otherwise known as Home Modifications (Refer to Section 16)

Description

Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home specified in the IPOS which are necessary to ensure the health, welfare and safety of the child, or enable the child to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment. Requests for EAAs must be prior authorized by the CWP Clinical Review Team (CRT) following denial by all applicable insurance sources (e.g., private insurance, CSHCS, Medicaid). All services shall be provided in accordance with applicable state or local building codes.

Service Parameters

Standards of value purchasing must be followed. The EAA must be the most reasonable alternative, based on a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded EAA (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with all applicable local codes. Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, or are not of direct medical or remedial benefit to the child. EAAs that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for

safe operation of the specified equipment and are not intended to correct existing code violations in a child's home. The EAA must demonstrate cost-effectiveness. The family must apply, with the assistance of the case manager if needed, to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. All work must be completed while the child is enrolled in the CWP.



Acceptances or denials of alternate funding sources must be documented in the child's records. The CWP is a funding source of last resort.



Requires prior approval MDCH.



Physician's prescription or CMN is required and is valid for one year from the date of signature.

ADDITIONAL COVERED SERVICES PROVIDED BY THE CMHSPs:

Health Assessment

Description

A health assessment includes activities provided by a registered nurse, physician assistant, and nurse practitioner, or dietitian to determine the child's need for medical services and to recommend a course of treatment within the scope of practice of the nurse or dietitian.

Psychiatric Evaluation

Description

Psychiatric Evaluation is a comprehensive evaluation, performed face-to-face by a psychiatrist, that investigates a child's clinical status and includes the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination.

This examination concludes with a written summary based on a recovery model of positive findings, a biopsychosocial formulation and diagnostic statement, an estimate of risk factors, initial treatment recommendations, estimate of length of stay when indicated, and criteria for discharge.

Psychological Testing

Standardized psychological tests and measures rendered by full, limited-licensed, or temporary-limited-licensed psychologists.

Service Parameters

The child's record must indicate the name of the person who administered the tests, the actual tests administered, the results of the tests and any recommendations.



The protocols for testing must be available for review.

All Other Assessment & Testing

Description

Other assessments and testing includes generally accepted professional assessments or tests, other than psychological tests, that are conducted by a mental health care professional for the purposes of determining eligibility for Specialty Services and supports, as well as the treatment needs of the child.

Behavior Management Review (Comprehensive Multidisciplinary Evaluation)

Description

A behavior management or treatment plan, when needed, is developed through the planning process and involves the child. Any behavior management or treatment plan that proposes aversive, restrictive or intrusive techniques, or includes psycho-active medications for behavior control purposes (when the target behavior is not due to an active substantiated psychotic process), must be reviewed and approved by a specially constituted body comprised of at least three individuals, one of whom shall be a fully- or limited-licensed psychologist with the formal training or experience in applied behavior analysis; and one of whom shall be a licensed physician/psychiatrist. The approved behavioral plan shall be based on a comprehensive assessment of the behavioral needs of the child. Review and approval (or disapproval) of such treatment plans shall be done in light of current research and prevailing standards of practice as found in current peer-reviewed psychological/psychiatric literature.

Acceptable behavioral treatment plans are designed to reduce maladaptive behaviors, to maximize behavioral self-control, or to restore normalized psychological functioning, reality orientation, and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships.

Service Parameters

These reviews shall be completed as expeditiously as possible and must occur prior to the parent/guardian signing or implementation of the plan.



Documentation all behavior management reviews/decisions must be maintained in the child's records.

Child Therapy

Description

Child therapy is a treatment activity designed to prevent deterioration, reduce maladaptive behaviors, maximize skills in behavioral self-control, or restore or maintain normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships. A child mental health professional may provide child therapy on an individual or group basis.

Crisis Interventions

Description

Crisis intervention is an unscheduled activity conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy. The standard for whether or not a crisis exists is a "prudent layperson" standard. That means that a prudent layperson would be able to determine from the child's symptoms that crisis services are necessary. Crisis situation means a situation, in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure himself, or another individual, either intentionally or unintentionally.
- The individual is unable to provide himself food, clothing, or shelter, or attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the mental health professional, his continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

If the beneficiary developed a crisis plan, the plan is followed with permission from the beneficiary.

Children's Crisis Residential Services

Description

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for persons experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert a psychiatric admission, or to shorten the length of an inpatient stay. Nursing services must be available through regular consultation, and must be provided on an individual basis according to the level of need of the child. Child caring institutions providing this service must have

an attestation of adherence to federal standards on the use of seclusion and restraint. Covered services include: Psychiatric supervision, therapeutic support services, medication management/stabilization and education, behavioral services, milieu therapy, and nursing services.

Service Parameters

Services must be provided under the auspices of an enrolled PIHP/CMHSP. The PIHP/CMHSP must identify the crisis residential program as part of their provider registration process with MDCH.

Treatment services must be provided under the supervision of a psychiatrist. A psychiatrist need not be present when services are delivered, but must be available by telephone at all times. The program must be under the immediate direction of a professional possessing at least a bachelor's degree in a human service field, who also has at least two years of work experience providing services to children with serious mental illness. Treatment activities may be carried out by non degreed staff who have at least one year of satisfactory work experience providing services to children with mental illness, or who have successfully completed a PIHP/MDCH approved training program for working with beneficiaries with mental illness.

Services must be provided to persons in licensed crisis residential foster care or group home settings not exceeding 16 beds in size. Homes/settings must have appropriate licensure from the Michigan Department of Consumer and Industry Services and must be approved by MDCH to provide specialized crisis residential services. Services must not be provided in a hospital or any other institutional setting. Exception: Child caring institutions are permitted and facilities licensed in this manner may exceed 16 beds, according to the terms of their license.

Family Therapy

Description

Family Therapy is therapy for a child and family member(s), or other person(s) significant to the child, for the purpose of improving the child/family function. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a mental health professional.

Health Services-Individual or Group

Description

Health Services are provided for purposes of improving the child's overall health and ability to care for health-related needs. This includes nursing services (on a per-visit basis, not on-going hourly care), dietary/nutritional services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, recognizing early symptoms of illness and teaching the family and child to seek assistance in case of emergencies. A registered nurse, nurse practitioner, or dietician must provide these services, according to their scope of practice. Health services must be

carefully coordinated with the child's health care plan so that the PIHP does not provide services that are the responsibility of the Medicaid Health Plan.

Individual/Group Therapy

Description

Individual or group therapy is treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Individual/group therapy is performed by a mental health professional.

Medication Administration

Description

Medication Administration is the process of giving a physician-prescribed oral medication, injection, intravenous (IV) or topical medication treatment to a child.

Service Parameters

This service may not be used as a separate coverage when other health services, such as Private Duty Nursing or Health Services are utilized and include these activities. A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician may perform medication administration.

Medication Review

Description

Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, psychiatric nurse, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.

Occupational Therapy-Evaluation

Description

Occupational therapy evaluation is a physician-prescribed activity provided by an occupational therapist currently registered by the State of Michigan to determine the child's need for services and to recommend a course of treatment. It is anticipated that therapy will result in a functional

improvement that is significant to the child's ability to perform daily living tasks appropriate to the child's chronological developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable).

Service Parameters

An occupational therapy assistant may not complete evaluations.



Physician's prescription is required and is valid for one year from the date of signature.
(See glossary)

Occupational Therapy-Individual or Group

Description

It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.

Therapy must be skilled (requiring the skills, knowledge, and education of a registered occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.

Services must be prescribed by a physician and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, currently registered by the State of Michigan or by an occupational therapy aide who has received on-the-job training. The occupational therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress, but on-site supervision of an assistant is not required. An aide performing an occupational therapy service must be directly supervised by a qualified occupational therapist who is on site. All documentation by an occupational therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising occupational therapist.



A physician prescription is required and is valid for one year from the date of signature.

Speech, Hearing, Language Therapy-Evaluation

Description

Speech, hearing, or language evaluation is an activity provided by a speech-language pathologist or audiologist possessing a current certificate of Clinical Competence (CCC) to determine the child's need for services and to recommend a course of treatment.

Service Parameters

A speech-language pathology assistant may not complete evaluations.

Speech, Hearing, Language Therapy-Individual or Group

Description

Speech, hearing, language therapy includes diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO).

Therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is when the treatment is required due to a recent change in the child's medical or functional status affecting speech, or the child would experience a reduction in medical or functional status were the therapy not provided.

Speech therapy must be skilled (i.e., requires the skills, knowledge, and education of a certified speech-language pathologist) to assess the child's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, registered occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.

Services may be provided by a speech-language pathologist or audiologist possessing a current CCC or by a speech pathology or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a CCC). All documentation by the candidate must be reviewed and signed by the appropriately credentialed supervising speech-language pathologist or audiologist.



A physician referral is required.

Physical Therapy-Evaluation

Description

Physical therapy is a physician-prescribed activity provided by a physical therapist currently licensed by the State of Michigan to determine the child's need for services and to recommend a course of treatment. A physical therapy assistant may not complete an evaluation.



A physician prescription is required and is valid for one year from the date of signature.

Physical Therapy-Individual

Description

It is anticipated that physical therapy will result in a functional improvement that is significant to the child's ability to perform daily living tasks appropriate to his chronological, developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Physical therapy must be skilled (it requires the skills, knowledge, and education of a licensed physical therapist).

Services must be prescribed by a physician and may be provided on an individual or group basis by a physical therapist or an assistant currently licensed by the State of Michigan, or a physical therapy aide who is receiving on-the-job training. The physical therapist must supervise and monitor the assistant's performance with continuous assessment of the child's progress. On-site supervision of an assistant is not required. An aide performing a physical therapy service must be directly supervised by a physical therapist that is on-site.

Service Parameters

Therapy to make changes in components of function that do not have an impact on the child's ability to perform age-appropriate tasks is not covered. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, registered occupational therapist, family member or caregiver) would not be considered as a Medicaid cost under this coverage.



All documentation by a physical therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising physical therapist.



A physician prescription is required and is valid for one year from the date of signature.

Treatment Planning

Description

Treatment planning activities associated with the development and periodic review of the IPOS, includes all aspects of the planning process, pre-meeting activities, and external facilitation of the PCP and FCP process. This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration); and ways to measure achievement relative to the outcome methodologies; attending planning meetings per invitation; and documentation.

Case managers perform these functions as part of the case management services; therefore they should not report this activity as "Treatment Planning." For the CWP, the attendance of all clinicians and case managers during treatment planning is included in the monthly case management fee.

Targeted Case Management (Refer to Section 8)

Description

Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders, who have multiple service needs, have a high level of vulnerability.

Service Parameters

The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the child. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the child's health and welfare needs identified in the IPOS.

Intensive Crisis Stabilization Services

Description

These services are structured treatment and support activities provided by a mental health crisis team and designed to provide a short-term alternative to inpatient psychiatric services. Services may only be used to avert a psychiatric admission or to shorten the length of an inpatient stay.

The standard for whether or not an emergency exists is a "prudent layperson" standard. That means that a prudent layperson must be able to determine from the child's symptoms that emergency services are necessary.

These services are for children who have been assessed to meet criteria for psychiatric hospital admissions, but who, with intense interventions, can be stabilized and served in their usual community environment. These services may also be provided to children leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.

Service Parameters

These services may be provided where necessary to alleviate the crisis situation, and to permit the child to remain in, or return more quickly to, his/her usual community environment.

Exceptions: Intensive/crisis stabilization services may not be provided in: Inpatient settings, jails or other settings where the child has been adjudicated, or crisis residential settings.

Medicaid State Plan Prior Authorized by the CMHSPs-Private Duty Nursing Service (Refer to Section 17)

Private duty nursing (PDN) is a Medicaid state plan benefit for children and young adults under age 21 who meet the medical criteria for coverage. If the child is enrolled in or receiving case management services from one of the following programs, the applicable program will authorize the PDN:

- Children's Special Health Care Services (CSHCS)
- Home and Community-Based Services Waiver for the Elderly and Disabled
- Children's Waiver Program (CMHSP)
- Habilitation/Support Services Waiver (CMHSP)

For a Medicaid eligible child who is not receiving services from one of the above programs, the CSHCS Program will review the request for authorization and authorize the services if the medical criteria and general eligibility requirements are met. If services are approved, the provider will receive an approval letter.

Meeting the medical criteria for PDN requires a finding that the child meets the criteria found in Section 17 and the Medicaid Provider Manual.

The PDN Decision Guide (Appendix 17-a) from the Medicaid Provider Manual is a tool used to determine the appropriate range of nursing hours that can be authorized under the PDN benefit. The amount of PDN that can be authorized for a child is based on several factors, including the child's care needs that establish medical necessity for PDN, the child's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay).

Service Parameters

This PDN benefit must be provided by a private duty nursing agency or Medicaid enrolled registered nurse (RN) or a licensed practical nurse (LPN) working under the supervision of a RN (per Michigan Public Health Code). Either a private duty nursing agency, RN, or LPN may choose to obtain the services of a billing agent to bill for services rendered. The General Information for Providers chapter of the Medicaid Provider Manual contains information on billing agents. The CMHSP's may choose to function as a billing agent when agreed by both the PDN provider and the CMHSP. Private duty nursing services are not a benefit when rendered in a hospital, nursing facility including nursing facility for mentally ill (NF/MI), ICF/MR, or licensed adult foster care facility.

PROVIDER QUALIFICATIONS FOR RESPITE AND COMMUNITY LIVING SUPPORT STAFF

Individuals who provide respite and community living supports must be:

- At least 18 years of age
- Able to prevent transmission of any communicable diseases from self to others in the environment in which they are providing support
- Able to communicate expressively and receptively in order to follow the IPOS and emergency procedures and report on activities performed
- In good standing with the law according to the MDCH/PIHP contract
- Trained in recipient rights; emergency procedures, implementation of the IPOS, as well as certification in basic First Aid
- An employee of the CMHSP or CMHSP contract agency, or an employee of the parent who is paid through the choice voucher system. Refer to Section 5 for additional requirements of the choice voucher system.
- Under very limited circumstances and on a time-limited basis, parents and step-parents who possess appropriate license/certification, special skills, documented training and are considered a qualified provider by the CMHSP, may function and be paid as a service provider for waiver services only.

The child and family may choose qualified providers of CWP services who are included in the CMHSP provider panel. In addition to the minimum qualifications noted above, the child's team should identify other staff competencies that will assure the best possible outcomes for the child.

Under very limited circumstances, parents and step-parents who possess appropriate license/certification, special skills, documented training and are considered a qualified provider by the CMHSP, may function and be paid as a service provider for waiver services only. This would require documentation that the service being provided is not personal care, the service was not provided during the time the family is responsible to provide the care and other qualified non-familial providers of these services are not available. Reimbursement for the child's care provided by the parent(s) will not exceed 248 hours in 30 consecutive days, and is not to be used more than twice within a fiscal year.

WAIVER SERVICES PROVIDER QUALIFICATIONS LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Respite Care	RN LPN Mental Health Aide	Current license under Part 172 of Michigan PA 368 of 1978 as amended		MA enrolled As specified in the Individual Plan of Services (IPOS)*
Non-Family Training	Psychologist Master's Level Social Worker QMRP	Current license under Part 18 of Michigan PA 368 of 1978, as amended	Current certification of registration under Michigan PA 352 of 1972, as amended.	MA enrolled CFR 483.430

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Specialty Service	Therapeutic Recreation Spec. Massage Therapist Music Therapist Art Therapist		Certified by the National council for Therapeutic Recreation (NCTRC) Certified by the National Certification Board for Therapeutic Massage & Bodywork (NCBTMB) Board certified (MT-BC) National Music Therapy Registry (NMTR) Board certified (ATR-BC) Credentials Board, Inc. (ATCB)	
Environmental Modifications	Licensed Builder	MCL 339.601 (1) MCL 339.601.2401 MCL 339.601.2404		MA enrolled
Specialized Medical Equipment & Supplies	CMHSP Agency			MA enrolled

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Enhanced Transportation	Public carriers, licensed individuals			Holds a valid Michigan's driver's license and has a good driving record.
Community Living Supports	Individuals, agencies or facilities CLS staff			MA enrolled. Providers must have expertise in service areas identified in the IPOS and assure needs, health and safety issues are addressed. As specified in the IPOS*

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Family Training	Psychologist Masters Level Social Worker QMRP	Current license under part 18 of Michigan PA 368 of 1978, as amended	Current certification of registration under Michigan PA 352 of 1972, as amended	MA enrolled CFR 483.430

* The qualifications/standards applicable to Mental Health Aides staffing respite care and Community Living Supports will be specified in the IPOS and will require knowledge and proficiency in at least the following: a) emergency procedures (i.e., fire, tornado and client health care emergencies); b) basic first aid; c) recipient rights; and d) IPOS implementation strategy (i.e., other providers' responsibilities and schedules, goals, etc.) and performance specifics.

SECTION 5: CHOICE VOUCHER
WILL BE FORTHCOMING

SECTION 6: PRE-SCREEN PROCESS

- If the CMHSP determines that a child is at risk and a CWP pre-screen is appropriate, that child falls within the priority population mandated for service under the Michigan Mental Health Code.
- Prior to the completion of a CWP pre-screen, the CMHSP must have reviewed the child's needs and presenting eligibility against all Mental Health Code and MDCH Contract mandated service provision requirements and be providing all services and supports indicated in the amount, duration, and scope required and exhaust all available and appropriate Medicaid state plan and MDCH covered services appropriate for the child.
- Each pre-screen must be completed in its entirety to obtain a maximum score to assure that all possible issues have been considered and thus all possible points have been assigned.
- The completed pre-screen must be sent to the CWP, and a copy must be maintained in the child's CMHSP record.
- Only the information listed on the pre-screen or in an update will be considered when scoring.
- If significant changes occur for the child or family after the initial pre-screen has been submitted, the CMHSP case manager must submit an update containing the new information to CWP for re-scoring.
- When scoring of the pre-screen is completed by MDCH, a copy of the scoring is sent to the case manager to review with the family. If the family feels the scoring is based on errors or incomplete information, a revised pre-screen can be resubmitted for MDCH review.
- Priority status to apply for a CWP is based on the score resulting from the information provided in the pre-screen.

Introduction

The CWP offers necessary services and supports beyond what is available under the Medicaid state plan to children with developmental disabilities whose intensive behavioral and medical needs have placed them at risk for health, safety and/or out-of-home placement (Refer to Section 3 for a description of eligibility requirements). Prior to considering a request for CWP services, the CMHSP must review and utilize all available and appropriate Medicaid state plan and MDCH covered services appropriate for the child. If the CMHSP determines that a child is at risk and a CWP pre-screen is appropriate, that child falls within the priority population mandated for service under the Michigan Mental Health Code.

The Michigan Mental Health Code (Code), Section 330.1100c(6) defines "priority" as "preference for and dedication of a major proportion of resources to specified populations or services. Priority does not mean servicing or funding the specified populations or services to the exclusion of other populations or services." Section 330.1208 (3) of the Code further states: "Priority shall be given to the provision of services to individuals with the most severe forms of serious mental illness, serious emotional disturbance, and developmental disability. Priority shall also be given to the provision of services to individuals with a serious mental illness, serious emotional disturbance, or developmental disability in urgent or emergency situations." Section 330.1100 (14) of the Code defines "urgent situation" as a "situation in which an individual is determined to be at risk of experiencing an emergency situation in the near future if he or she does not receive care, treatment or support services."

A child identified as "at-risk" or "priority" must have their urgent care needs met by the CMHSP to ensure health, welfare, and safety, while the child remains on the CWP Priority Weighing List. The CMHSP must assess the child's needs and develop an IPOS through the PCP and FCP process. This would apply to any child whether or not they are Medicaid eligible. For children who are not Medicaid eligible the Michigan Mental Health Code, section 330.1124, states that "community mental health services programs maintain waiting lists if all service needs are not met, and that the waiting lists include data by type of services, diagnostic groups or program categories, age, and gender, and that they specify the length of time each individual has been on the waiting list from the date of the initial request for services. The order of priority on the waiting lists shall be based on severity and urgency of need. Individuals determined to be of equal severity and urgency of need shall be served in the order in which they applied for services." For children with Medicaid in need of mental health specialty services, CMHSP cannot place them on a waiting list for CMHSP services nor is the completion of a pre-screen for the CWP and inclusion on the CWP Priority Weighing List considered to have discharged the CMHSP from its code mandated obligation to provide services.

Initiating a Pre-Screen

A request for CWP services begins with a pre-screen completed by the by CMHSP case manager and the child's parent(s). Determination of severity of need is based on program-specific criteria. The CWP Priority Weighing Criteria (Appendix 6-d) provides a consistent and objective basis on which to determine the priority status of children who may be eligible for the program.

The case manager must meet with the child's family and provide detailed information on CWP service parameters and program requirements. This includes eligibility requirements, services available, program criteria, requirements for family participation in planning and active treatment, and financial disclosure requirements. After this discussion, if the family wishes to have their child considered for the CWP, the case manager completes a pre-screen (Appendix 6-a.). The case manager then submits the form to MDCH. The pre-screen form will identify those services to be provided by the CMHSP, based on the child's priority status.

Pre-Screen Scoring Process

The case manager determines whether a child meets the eligibility criteria described in Section 3.

If the family agrees, the case manager completes the pre-screen with the family. Reviewing the Priority Weighing Criteria with the family will help identify relevant scoring information and result in the most appropriate score. Only information summarized in the pre-screen will be considered in the scoring process. Additional documents and attachments are not reviewed and should not be submitted. A parent must sign the completed pre-screen and a copy must be maintained in the child's record.

The original form must be sent to:

Children's Waiver Program
Michigan Department of Community Health
Mental Health Services to Children and Families
5th Floor, Lewis Cass Building
320 S. Walnut Street
Lansing, Michigan 48913

The pre-screen is date stamped upon arrival at MDCH. Within 14 days, two MDCH staff review the pre-screen using the nine factors in the Priority Weighing Criteria (Appendix 6-d). The reviewers assign a score for each factor based on the information submitted. The scores for each factor are then totaled. Priority status for application is based on this score.

During scoring, a cover memo and scoring form are completed for each pre-screen. Copies of both documents are mailed to the case manager to review with the family. (Appendices 6-c and 6-d).

If the cover memo contains questions about the pre-screen or indicates the availability of other potential resources, the case manager should follow up and provide updated information to MDCH. A brief memo containing requested information is sufficient, a new pre-screen is not required. Rescoring occurs when updated information is received.

If there are subsequent changes in the child or family's situation that would affect a child's score, based on the Priority Weighing Criteria, the case manager should submit a brief update letter describing relevant changes.

The Priority Weighing List contains a sequential list of all pre-screen scores. The Priority Weighing List is updated each time pre-screens are scored. When a CWP opening becomes available, all pre-screens that have been received and date stamped at MDCH are scored before a determination is made as to who will receive priority status to apply for the CWP opening. The child with the highest score is invited to proceed with the CWP application process. (Refer to Section 7).

The case manager is notified by phone as soon as a child is given priority status to apply for the CWP. Application forms are found in Section 7 and the application process can begin immediately. MDCH will also send written notification of priority status.

Inactive Priority Weighing List

A child's name and score will be placed on the Inactive Priority Weighing List for following circumstances:

- CMHSP is encouraged to submit a pre-screen to the CWP whenever a child is potentially eligible for services under the program and would benefit from waiver services. Early submission of a pre-screen preserves the date of the initial pre-screen even if the child's name is placed on the inactive status list.
- Under the following circumstances, a pre-screen for CWP services will be scored and placed on the "inactive status" list. The CMHSP will be advised of the inactive status determination as part of the scoring form. "Inactive status" is defined as a list, which includes the names of all children who have submitted a pre-screen form for CWP services, and whose needs for hourly care are met to the following extent by another resource at the time the pre-screen form is submitted:
 - 1) When hourly care is provided to the child, at the time the pre-screen form is submitted, by another state Medicaid program which is a regular State Plan coverage, the child will be deemed to have current hourly care needs met and the pre-screen will be considered to have been submitted for purposes of identifying future rather than present needs for hourly care. Examples would include current recipients of CSHCS-Private Duty Nursing, Habilitation/Support Waiver, the FIA Home Help Program, or any similar hourly care program subsequently available.
 - 2) When eight or more hours per day of hourly care are provided to the child by insurance or another resource at the time the pre-screen is submitted, the child will be deemed to have current hourly care needs met and the pre-screen will be considered to have been submitted for identifying future rather than present needs for hourly care. In order to rebut this presumption, CMHSP must make a written request that the child's name be placed on the active list and must submit with the pre-screen form the following documentation identifying the presently unmet needs:
 - a) A statement of the needs presently unmet by the insurance, trust, or other resource;
 - b) A statement by the primary physician that the child has a level of need for hourly care or other services that exceeds the hourly care or other service benefits available under the child's insurance and the physician's statement of the actual services needed; and
 - c) The steps taken by CMHSP to achieve funding of those services through the insurance coverage.
- If the supporting documentation described in a, b, and c above shows significant, present, unmet needs, the child's name will be placed on the active Priority Weighing List.
- If a child whose name is presently on the inactive Priority Weighing List experiences a change in eligibility for an existing service or is approaching exhaustion of benefits under insurance, the CMHSP is responsible for making a written request for transfer of the child's

name from the inactive to the active list not more than sixty days before the anticipated change. The written request must identify the change in resources and the anticipated effective date of those changes. Please note that under rating factor 10, number three, the change in services will affect the score of the individual for Priority Weighing List purposes.

Priority Weighing Criteria

All pre-screen forms are reviewed by MDCH on the basis of the criteria listed below. Each element of the criteria is related to the health and safety of the child, factors which impact the family's capacity to provide for the child at home, or the necessity for provision of services to maintain the child in the least restrictive alternative in which the needs of the child can be met. The following criteria are listed in order of importance from most important, factor 10, to least important, factor 1. A score is given for each factor. The highest score for each factor is a (five) 5, the lowest a (one) 1. A total score for each factor is achieved by multiplying the importance factor by the rating for each criterion. The totals for each criteria are added together to give the child a total numeric score on which rank is determined. Simultaneous ratings by two staff persons designated by MDCH are conducted.

Note: The level of detail required to obtain the most appropriate score is reviewed in Appendix 6-e to assist the CMHSP when completing a pre-screen.

Factor 10. Home Care Supports Other Than the CWP

In determining availability of other resources, the following parameters apply:

- The hours needed should reflect care needs requiring support at home during non-school hours. If any other request is being made, the specifics must be noted on the pre-screen form.
- All hours or financing resources currently used or available to the family must be listed in number 16 of the pre-screen form.
- MDCH staff may request a copy of private insurance policy for review.
- Respite care resources which are ordinarily available to children served by the CMHSP, will be counted toward the requested level of service.
- Extraordinary levels of hourly care paid for by the CMHSP to maintain the child at home where the funding for the hourly care is not Medicaid matched, will not be counted as meeting the needs of the child/family. The CMHSP case manager is asked to document the type of funding.

Score five (5) points if all of the following apply:

- The child is not eligible for hourly services under any regular State Plan Medicaid coverage.

- The child is not Medicaid eligible in his/her own right in the proposed setting AND there is no capacity to create Medicaid eligibility under TEFRA.
- The child has no insurance with home care benefits (based on a policy review by MDCH staff), or the home care benefit under the insurance plan has been exhausted.
- The child does not have trust funds available for four or more hours per day of hourly care.
- The child presently receives less than four hours of hourly care services per day from any resource.

Score four (4) points if the child currently receives four hours or more of hourly care services at home and would otherwise score "1" under this factor AND the family has received written notification that these current hourly services will terminate within 30 days.

Score three (3) points if the child currently receives four hours or more of hourly care services at home and would otherwise score "1" under this factor AND has received written notification that these current hourly services will terminate within 60 days.

Score two (2) points if the child currently receives four or more hours of hourly care at home and would otherwise score "1" under this factor AND the pre-screen identifies that the child needs specific waiver services not available through a resource other than CWP, in addition to hourly care services.

Score one (1) point if any one or more of the following apply:

- The child is or would be eligible for hourly services under any regular or optional Medicaid State Plan coverage AND the child is, or could be made, Medicaid eligible under regular or TEFRA requirements.
- The child presently receives four or more hours per day of hourly care through any other resource.
- Trust funds are available which are sufficient to provide four or more hours per day of hourly care.

The maximum possible score for this factor is fifty (50) points.

Factor 9. Health and Safety of the Child.

The child receives a score under one of the two categories, medical or behavioral, based on the primary identified needs. Where a child has both medical and behavioral concerns, any interactive burden of care will be considered in determining final score for degree of risk to health and safety. The age of the child is considered in evaluating the identified risks (e.g., a two or three year old would be expected to be ADL dependent and not have safety skills). Include dates and summarize details of hospitalizations, injuries or property destruction within the last six months, as applicable, when describing the child's medical or behavioral needs.

Medical:

Score five (5) points if the child is dependent daily on technologically sophisticated medical equipment to sustain life and requires continuous observations and judgments to maintain or improve health status. "Continuous" observations and judgments mean more than once hourly throughout a 24-hour period. Delayed interventions may result in further deterioration of the child's health status, in loss of function, or in death. Examples of care needs include: 1) ventilator dependence, 2) peritoneal dialysis, and 3) total parenteral nutrition in association with complex medical problems and extreme medical fragility.

Score four (4) points if the child is dependent daily on medical equipment to sustain life and requires frequent observations and judgments to maintain or improve health status. "Frequent" observations and judgments mean less often than once hourly and not less than once every three hours throughout the 24-hour period. Delayed interventions may result in an acceleration of the chronic condition, or in a preventable acute episode. Examples of care needs include: 1) managing unstable airway problems, in association with suctioning, oral or tracheostomy care, 2) managing nasogastric tube feedings or medications, 3) adjusting oxygen level several times a day related to documented desaturations and pulse oximeter readings.

Score three (3) points if the child has a medical condition that routinely requires hourly care or support on a daily basis in order to maintain or improve health status. Clinical observations may be intermittent. Medical interventions typically are associated with minimal risk to health status and delayed interventions usually are not associated with imminent risk to health status. Examples of care needs include a combination of: 1) chest physiotherapy, 2) special skin care, 3) ostomy care, 4) range of motion exercises, 5) cast care, 6) positioning and transferring, 7) gastrostomy tube feedings, or 8) PRN oxygen, or continuous oxygen with infrequent adjustments or documented desaturations.

Score two (2) points if the child has a medical condition and requires significant amounts of assistance or guidance on a daily basis due to dependence in activities of daily living. In addition, the child's medical condition is stable and medical interventions and observations are infrequently required. Interventions are associated with minimal or no risk to health status. Examples of care include: 1) assistance or guidance because the child is dependent in activities of daily living, including eating, toileting, bathing, grooming, dressing, mobility (ambulation and transferring), 2) assistance or guidance with physical transfer (e.g., bed to chair), 3) assistance or guidance with therapeutic positioning (physical therapy), including changing positions while in bed, 4) assistance for the primary care giver because the child is too large (over 80 pounds) for one person to move safely and the child is unable to assist the care giver.

Score one (1) point if the child requires the types of assistance described in item (d) and weighs less than 80 pounds.

Behavioral

Score five (5) points if the child demonstrates a pattern of severe self-injurious, physically aggressive or assaultive behavior or life-threatening property destruction which has occurred one or more times in the past six months. In addition, documented evidence of additional behavioral problems on a frequent basis each day would support a need for one-to-one intensive behavioral

treatment. "Severe behavior" is that behavior which poses a very significant risk of serious injury or death to self, a family member or others in the immediate environment. Examples of severe behavior include: Intentional fire setting with significant resulting property damage and/or physical assault or self-abuse resulting in injuries to self or others requiring inpatient hospital admission for treatment.

Score four (4) points if the child demonstrates a daily pattern of moderate, self-injurious, physically aggressive or assaultive behavioral when specific medical intervention or emergency room treatment (as contrasted with diagnostic testing) has been required but is not life threatening or if there is documented frequent, significant property destruction. "Moderate behavior" includes behaviors, which pose a significant risk of injury to self or others in the immediate environment. Examples of moderate behavior include: physical assault or self-abuse resulting in injuries requiring hospital emergency room treatment (not merely assessment) without hospital admission in the past year, biting that breaks the skin, hair pulling resulting in removal of clumps of hair from the scalp, multiple daily episodes of smearing feces with associated PICA, head banging resulting in documented concussion or detached retina, or a daily combination of multiple high intensity, high risk behavior. An example of "significant property destruction" would be four broken windows in three different incidents in the last three months or repeated incidences of breaking furniture and other items in the last six months.

Score three (3) points if the child demonstrates a daily pattern of medium level behaviors including self-injurious, physically aggressive or assaultive behaviors which have not resulted in hospitalization or emergency room treatment for injuries in the past year, or the child has engaged in occasional, significant property destruction which is not life-threatening. A "pattern of behavior" means that in addition to a single serious episode in the last year, significant daily behaviors are documented. "Medium behavior" includes behaviors similar to those defined in 2.B. (moderate behavior) that have not required specific medical intervention or emergency room treatment. Examples include: head banging resulting in bleeding and bruising without concussion or detached retina, hair pulling without removing hair from the scalp, smearing feces without PICA, biting without drawing blood. "Occasional significant property destruction" means property destruction that occurs with a frequency not greater than one time per week.

Score two (2) points if the child demonstrates mild self-injurious, aggressive or assaultive behavior on a daily basis or up to 4 days per week, or has engaged in intermittent or limited property destruction. Examples of "mild behavior" include: pinching, hitting, slapping, kicking, head banging and/or elopement without careful supervision when there is evidence of lack of judgment regarding danger, or an extremely high activity level requiring extensive supervision and redirection. Examples of "limited property destruction" would be tearing clothing, carpeting or tipping furniture.

Score one (1) point if the child demonstrates intermittent or infrequent mild self-injurious, aggressive or assaultive behaviors, or limited property destruction as described in 2.D. and this occurs three or fewer times a week.

The maximum possible score for this factor is forty-five (45) points.

Factor 8. At Risk of Out-of-Home Placement.

Score five (5) points if all of the following apply:

- The family has specifically requested out-of-home placement in the past three months.
- CMHSP has identified a specific placement and a date for placement is set which is within 14 days OR the child is currently in an out-of-home placement (medical hospitalization or psychiatric hospitalization does not constitute placement for this factor).
- CMHSP certifies that the planned length of placement is six months or more.
- CMHSP certifies that the family is unable to provide care due to severe medical or emotional conditions.

Score four (4) points if all of the following apply:

- The family has specifically requested out-of-home placement in the past three months.
- CMHSP has identified a specific placement and a planned date for placement has been set more than 14 days but within 30 days of date of pre-screen form.
- CMHSP certifies that the planned length of placement is six months or more.
- CMHSP certifies that the family is unable to provide care due to severe medical or emotional conditions.

Score three (3) points if all of the following apply:

- The family has specifically requested out-of-home placement in the last three months.
- CMHSP has not identified a placement at this time but plans to support the family's request by placing and is actively working to identify an out-of-home location, OR CMHSP has identified a placement and the planned date of placement is 30 days or more from the date of pre-screen form.
- CMHSP certifies that the planned length of placement is three months or more.
- CMHSP certifies that the family is unable to provide care due to severe medical or emotional conditions.

Score two (2) points if the family has not specifically requested out-of-home placement in the last three months but the worker believes that there is a realistic likelihood that the family will request placement and in fact would place the child in the next three months if a placement was identified.

Score one (1) point if any one of the following applies:

- The family has not specifically requested out-of-home placement.

- The family is requesting a short-term or respite placement of less than three months.
- The family has requested placement but CMHSP does not intend to facilitate or offer placement.
- The request for placement occurred more than three months ago and the child has been at home since the request (other than periods of time when the child was hospitalized or in respite).

The maximum possible score for this factor is forty (40) points.

Factor 7. The Number and Ages of Other Minor Children Residing in the Home.

A "child" is defined as an individual under 18 years of age, in addition to the waiver candidate, for whom the parent is legally responsible. For purposes of scoring this factor, foster children or children for whom the primary care giver is reimbursed for care (including adoption subsidy) are not considered to be "children residing in the home." Children of other adults or children residing in the home part-time are also not considered in this factor.

Score five (5) points if the total number of children in the home not including the child is either: a) four or more; or b) three or more of the children are under the age of five.

Score four (4) points if the total number of children in the home not including the child is either: a) three; or b) two children in the family are under the age of five.

Score three (3) points if the total number of children in the home not including the child is either: a) a total of two; or b) one child under the age of five resides in the home.

Score two (2) points if one other child resides in the home.

Score one (1) point if no other children reside in the home.

The maximum possible score for this factor is thirty-five (35) points.

Factor 6. Family Stress and/or Physical Health Problems.

This factor measures family-related stress of a physical or emotional nature. Include dates for any identified relevant health problems, disabilities or hospitalizations

Score five (5) points if any of the following apply:

- Two parents reside in the home and the parent who is the primary care giver is physically or emotionally disabled and unable to provide care because of the disability; or
- The family is a one-parent family and the parent who resides with the child is physically or emotionally disabled; or

- In a two-parent family, one of the two parents is either terminally ill and hospitalized or is permanently institutionalized.

Score four (4) points if any of the following apply:

- The family is experiencing acute long-term stress due to the physical or emotional condition of the parent or primary care giver living in the home and that condition is expected to last more than six (6) months; or
- The family is participating in family counseling at least three times per month; or
- The primary care giver is a single parent with no extended family support and the severity of the child's condition requires constant "eyes-on" supervision.

Score three (3) points if any of the following apply:

- The family is experiencing situational or temporary stress related to a specific event that is expected to be resolved within three (3) to six (6) months. (Examples: divorce, separation, loss of job, move, loss of extended family support, death of a child within past three months)
- One parent has a long-term disability that does not prevent the parent from providing care to the child. (Example: diagnosis of alcoholism, depression, or other mental or physical problems which may interfere with but do not prevent the parent from providing care, as distinguished from a physical disability which would prevent provision of care such as being wheelchair-bound).
- There is a referral/recommendation for intensive counseling by a psychologist/MSW and an intake is scheduled within 30 days or the family is participating in counseling two or fewer times per month.
- The primary care giver is a single parent with no extended family support and severity of the child's condition requires less than constant "eyes-on" supervision.

Score two (2) points if the family is experiencing temporary or situational stress which is expected to be resolved in one (1) to three (3) months. (Examples: recent death of a parent or automobile accident not producing severe, long-term disability).

Score one (1) point if the family is experiencing or identifying normal levels of stress associated with care giving for a child with special needs.

The maximum possible score for this factor is thirty (30) points.

Factor 5. The Family Has More Than One Child with Special Needs at Home.

For purposes of this factor, the term child or sibling refers to an individual under age 18 years, considered to be residing in the home (as defined in Factor 7). NOTE: Any disabled sibling who has been approved to apply for the CWP, or currently receives hourly care funded through CWP, state plan Private Duty Nursing, private insurance or other program does not count towards the total for this factor.

Score five (5) points if three (3) or more of the waiver candidate's siblings have long-term special needs (i.e., developmental disability, emotional or physical/health problems requiring special education or treatment) or two (2) siblings have severe/intense special needs.

Score four (4) points if two (2) siblings have long-term special needs.

Score three (3) points if one sibling has long-term special needs.

Score two (2) points if one sibling has short-term special needs, or one or more siblings have ADHD and are receiving special education services.

Score one (1) point if no sibling has special needs.

The maximum possible score for this factor is twenty-five (25) points.

Factor 4. Child Presently in a Nursing Home.

Score five (5) points if the child presently resides in a nursing home and has a plan that states the child could go home with appropriate supports; and the family has expressed interest in caring for their child at home.

Score one (1) point if the child is not presently in a nursing home.

The maximum possible score for this factor is twenty (20) points.

Factor 3. Child Presently Resides in an ICF/MR Facility.

Score five (5) points if the child presently resides in an ICF/MR facility and has a plan that states the child could go home with appropriate support; and the family is expressing an interest in caring for their child at home.

Score one (1) point if the child does not presently reside in an ICF/MR facility.

The maximum possible score for this factor is fifteen (15) points.

Factor 2. Reserved for Future Use.

Factor 1. The Child is Presently in Foster Care and Needs Support.

Score five (5) points for any child residing at home or for whom the immediate proposed placement is to return home from foster care.

Score one (1) point if the child presently resides in foster care and needs support to be maintained in that setting.

The maximum possible score for this factor is five (5) points.

The total maximum score for the nine (9) factors listed above is 265 points.

SECTION 7: APPLICATION AND RENEWAL PROCESS

- The initial waiver application is due within 30 days from the date the priority status is determined. If the application packet is not submitted by the due date, the invitation to apply expires.
- Within 45 days after the child was determined clinically eligible for CWP, the additional required documents must all be completed and submitted to MDCH.
- For financial eligibility, parental income is waived. The child's income and assets must not exceed the income and asset limits for Medicaid.
- For children who are not currently receiving Medicaid coverage the family will receive an application packet from the MDCH Medical Services Administration (MSA). The application packet will need to be completed and submitted to the local Family Independence Agency (FIA) within 14 days of receipt, and then on an annual basis.
- For children currently receiving Medicaid coverage, the family will receive a letter from the MDCH MSA and a copy of a MSA1785 Policy Decision form issued to the local FIA informing them of the CWP approval.
- Upon receipt of the child's mihealth card (Medicaid), the CMHSP case manager must fax MDCH a copy of the Medicaid recipient identification number, the date Medicaid became effective, and the start date for CWP services. Failure to submit this information will result in the rejection of all CWP Medicaid billings until the information is submitted.

Introduction

This section will describe the process of applying for the CWP once a pre-screen has been submitted to MDCH, scored, and determined to have priority status. Also included are descriptions of the clinical approval process, financial determination process, funding allocations and annual renewal process.

Initial Application Process

When a child is given priority status to apply for the CWP, a MDCH staff member notifies the responsible case manager by phone within two (2) working days, and by written notification within five (5) working days. An application packet is sent by MDCH to the case manager confirming the invitation to apply. The packet includes a Waiver Certification form (Appendix 7-a), Demographic Intake form (Appendix 7-b), the FIA-49 Medical Examination Form (Appendix 7-e) and the Budget (Appendix 18-a).

The case manager contacts the child's parent(s) by phone to confirm the following:

- The child is still in need of the CWP
- The child is currently residing within the family home or has a permanency plan in place to return home within 30 days
- The family is willing and able to assist in obtaining necessary documentation to complete the CWP application within 30 days of the date of priority status

For those children applying for the CWP, who are currently Medicaid eligible, and receiving specialty mental health/substance abuse/developmental disability services and supports under the 1915(b)(c) Managed Care Program, the case manager/supports coordinator will explain that:

- Enrollment in the CWP will exclude them from eligibility for any of the specialty services and supports program services
- The traditional mental health and developmental disability covered services will be available fee-for-service, but may not look exactly like what they had been receiving
- While there are some similar CWP services, those services included in the Specialty Managed Care Programs and additional (b)(3) services will not be available

The case manager works with the family to obtain the necessary documentation that verifies the child has a developmental disability and is in need of the services of an ICF/MR if waiver services are not provided. This may include a recent psychological report, school records and medical records.

The case manager works with the family to identify the child's most urgent need(s) and obtain assessments by the appropriate clinicians (e.g., nursing assessment for a child with medical needs and/or a behavioral assessment for a child with challenging behaviors).

Once a developmental disability is confirmed, the case manager will start the application process. The CWP initial application is due 30 days from the date the priority status was determined. If the initial application packet is not submitted by the due date, the invitation to apply expires.

The documents required within 30 days include the Waiver Certification form, Demographic Intake form, and documentation of Medicaid eligibility (if applicable).

Waiver Certification Form

In Section 1 of the Waiver Certification form, the CMHSP must complete the following numbered items:

- 1) or 2) Initial certification or annual recertification
- 3) Name of child
- 4) Medicaid number, if currently eligible

- 5) Social Security number
- 6) Child's address (please list the complete address)
- 7) Child's birth date
- 8) Name of Responsible Mental Health Authority
- 9) CMHSP provider number
- 10) Clinical service provider's number
- 11) or 12) Waiver recommendation
- 13) Qualified Mental Retardation Professional (QMRP) signature and date of signature

In Section 2 of the Waiver Certification form, the CMHSP must complete the following numbered items:

- 14 -16) Check the most appropriate box
- 17) Check box
- 18) Check waiver recommendation box
- 19a) Nursing Intensity of Care-circle one, **or**
- 19b) Category of Care - circle one
- 20a) Physician signature and date of signature
- 20b) Physician name printed
- 21) CMHSP provider's signature and date of signature

Section 3 of the Waiver Certification form includes the following statement: "I accept/reject (circle one) services as offered under the Home and Community-Based Children's Waiver". The parent or legal guardian must read and circle either accept or reject. Then the parent proceeds to:

- 22) Parent's or legal guardian's signature and date (only needed on Initial)
- 23) Check legal guardian/parent box (only needed on Initial)
- 24) Witness signature and date (only needed on Initial)

Section 4 of the Waiver Certification form is completed by MDCH.

Demographic Intake Form

The case manager works with the family to complete the Demographic Intake form (Appendix 7-b). This must be completed in its entirety.

Mihealth (Medicaid) Card

Obtain a copy of current mihealth card for the child from the family.

The case manager compiles the above-mentioned documents (the Waiver Certification form, the Demographic Intake form and the current mihealth card, if applicable) for submission to the CWP. The original and one copy of this application packet must be submitted to the CWP within 30 days from the date priority status is determined. A copy must also be maintained in the child's CMHSP record.

If the application packet is not submitted by the due date, the invitation to apply expires. If the family remains interested in receiving the CWP, a new pre-screen must be submitted.

Clinical Approval Process

The MDCH Clinical Review Team reviews the application packet, if complete, within 14 days of receipt and certifies clinical eligibility. The Clinical Review Team determines eligibility based on a review of the following:

- Waiver Certification form documenting the child has a developmental disability and meets the criteria for an ICF/MR, the CMHSP and physician are recommending waiver services, and the child's parent(s) accept or reject waiver services.
- Demographic Intake form identifies medical conditions and diagnoses that are consistent with ICF/MR eligibility requirements.

If the application packet is incomplete or inaccurate, it will be returned to the PIHP/CMHSP for completion and resubmission within the initial 30-day application period.

The Clinical Review Team will complete and sign the FIA 49-A Medical–Social Eligibility Certification form (Appendix 7-c). A MDCH staff person will contact the case manager by phone within five (5) working days to inform them of the approval date.

A MDCH staff person will send a copy of the signed Waiver Certification form and a cover memo to the case manager to inform them of the clinical approval and instruct them to assist the family in applying for Medicaid at the local FIA.

Final Application Procedures

Once the Clinical Review Team has determined clinical approval, the CMHSP may begin to provide waiver services when the IPOS has been completed. A retroactive Medicaid effective date can be issued by the local FIA, upon request, up to the date of clinical approval for the CWP. However, if services are provided prior to the Medicaid effective date or if Medicaid eligibility is denied, general fund dollars must be used for the services provided.

The IPOS must be completed within seven (7) days in compliance with the Michigan Mental Health Code, sec. 712.330.712 that states:

...the responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient. The individual plan of services shall be developed within seven (7) days of the commencement of services or if an individual is hospitalized, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan or both and establish meaningful and measurable goals with the recipient. The individual plan of services shall include assessments of the recipient's need for: food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services and recreation. The plan shall be kept current and shall be modified when indicated. The individual in charge of implementing the individual plan of services shall be designated in the plan.”

In addition to the assessments cited in the Mental Health Code, a child receiving CWP services may have identified needs requiring additional assessments (e.g., behavioral, occupational therapy, physical therapy, speech therapy, adaptive equipment and accessibility adaptations).

Once the IPOS is completed, the CWP budget must be developed, reflecting the identified services and the amount of service to be provided. Only those services identified in the IPOS should appear on the budget. If the Category of Care or Intensity of Care has changed since the submission of the original waiver application, the waiver certification form must be modified to reflect the change and resubmitted.

The following documentation must be submitted by the CMHSP to MDCH within 45 days of the approval date for children who meet criteria for Category of Care I of the Decision Guide for Publicly Supported Hourly Care (Refer to Section 10), or when a child is determined to meet the criteria for Intensity of Care-High (Refer to Section 17):

- Waiver Certification (modified, if necessary)
- Completed/signed/dated FIA-49 (original physician signature/date)
- CSHCS documentation
- SSI documentation
- Copy of mihealth (Medicaid)
- All pertinent assessments and medical records
- IPOS (Refer to Section 12)
- Budget (Refer to Section 18)

Children who meet criteria for Category of Care 2,3, and 4 or Intensity of Care-Medium or Low require:

- Waiver Certification (modified, if necessary)
- Completed/signed/dated FIA-49 (original physician signature/date)
- CSHCS documentation
- SSI documentation
- Copy of mihealth (Medicaid)
- Budget

Financial Determination Process

Once clinical approval has been granted by the Clinical Review Team, notification and a copy of the FIA-49A form is sent to Medicaid within 14 days.

If the child is currently receiving Medicaid or has an application pending, Medicaid sends a copy of the FIA-49A form and the FIA-1785 policy letter (Appendix 7-d) to the local FIA director. A copy of this letter will be sent to the family of the applicant.

If the child is not currently receiving Medicaid services, Medicaid will send the family a packet of information. Included in this packet are copies of the FIA-49A form, FIA-1785 policy letter, FIA-1171 Application for Assistance, and FIA-3243 form. (Appendix 7-e)

Upon receipt of the packet, the family must complete the application using financial information that pertains only to the child's income and assets. Income eligibility exists when the child's gross income is equal to or less than the amount designated by Medicaid. However, that is subject to change. For example, in calendar year 2002, the limit on income was \$1,635 per month and the limit on assets was \$2,000 as indicated in the Medicaid Program Eligibility Manual (PEM 400). Countable assets include, but are not limited to cash, savings, checking and credit union accounts, cars, trucks, campers, motorcycles and other vehicles, stocks and bonds, land contracts, farm or business equipment and machinery, real property (land) other than your homestead, trusts, and cash surrender value of life insurance policies. Note: An irrevocable (pre-paid) burial trust up to \$2,000 is not considered an asset.

Once the application has been completed the family must send the packet to their local FIA office. An addressed envelope will be provided. The packet must be submitted to FIA within 14 days of receipt and must include the following:

- Completed FIA-1171 application
- Documentation of child's income and assets

- FIA-1785 policy letter
- FIA-49A form
- Copy of child's private insurance card
- The FIA-3242 (if there are outstanding bills for the previous three months that would be covered by Medicaid)

FIA will review and determine financial eligibility to ensure the child meets or is below Medicaid income and asset limits when viewed as a family of one. The parent's income is waived (Appendix 7-e). This must be completed within 60 days.

The local FIA worker will assign a Medicaid recipient identification number if the child is not currently enrolled in Medicaid. Once financial eligibility is determined, FIA will send a letter of confirmation to the family followed by the Medicaid card. An updated mihealth card will be sent to the family on a monthly basis.

When the family receives the child's mihealth card a copy must be provided to the case manager (Appendix 7-e for assistance in reading a mihealth card). The case manager must fax a copy of the card to the CWP Director at (517) 241-5777.

The effective date of Medicaid may be made retroactive to the date of clinical approval. If there are outstanding bills that would be covered by Medicaid state plan (using the FIA-3243 form), the effective date can be retroactive three (3) months prior to the date the application was submitted. CWP services may not be billed prior to the clinical approval date.

Financial determination must be completed on an annual basis. The necessary forms will be sent to the family by FIA.



The required FIA forms must be submitted in a timely manner to avoid delay in the onset of services or a denial of waiver eligibility.



A copy of the child's mihealth card must be submitted to the CWP to ensure timely approvals and reimbursement.

Annual Renewal Process

By October 1st of each year, the case manager must submit to MDCH the following annual renewal documents:

- Budget for each child enrolled in the CWP. The budget must be based on the services identified in the current IPOS
- Waiver Certification form must be completed and signed within 12 months of the previous Waiver Certification. The date of the CMHSP Provider's signature is considered the renewal date. The Waiver Certification form must be submitted to the CRT within 30 days of signature to maintain eligibility.

- Copy of the Medical Examination Form (FIA-49)
- Update Demographic Intake form (highlight changes, if necessary)

The CRT will review and sign the completed Waiver Certification form. A copy of the signed form will be sent to the case manager for the child's file.

The following written documentation must be submitted by the CMHSP to MDCH within 30 days of the previous year's submission for children who meet criteria for Category of Care I of the Decision Guide for Publicly Supported Hourly Care (Refer to Section 10), or when a child is determined to meet the criteria for Intensity of Care-High (Refer to Section 17), or if the child is receiving exception hours (Refer to Section 11):

- CSHCS documentation or copy of Specialty Health Plan card
- Medical Examination form (FIA-49) (Appendix 7-e)
- Copy of current mihealth card
- Current assessments
- Copy of the current IPOS
- Updated demographic form (highlight changes, if necessary)

SECTION 8: TARGETED CASE MANAGEMENT

- A CWP case manager must meet the federal qualifications for a Qualified Mental Retardation Professional (QMRP).
- Case management services include assessments, planning, linking, coordinating, advocacy, reassessment/follow-up and monitoring to assist children and families in gaining access to needed health and dental services, financial assistance, housing, education, social services, and other services and natural supports.
- The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs of the child and family. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the child's health and welfare needs identified in the IPOS.

Introduction

Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Targeted case management includes working with the child receiving CWP services, the family and others that have been identified by the family, to develop an IPOS. Case management services include assessments, planning, linking, coordinating, advocacy, reassessment/follow-up and monitoring to assist children and families in gaining access to needed health and dental services, financial assistance, housing, education, social services, and other services and natural supports. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes. The child and family must be provided a choice of available, qualified case management staff.

Case Manager Qualifications

A case manager must meet the federal qualification for a QMRP. The federal qualifications for a QMRP (42 CFR 483.430) include a professional who:

- Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities, and
- Is a doctor of medicine or osteopathy, a registered nurse, or an individual who holds at least a bachelor's degree in a professional category specified in Paragraph (b)(5) of Section 42 CFR 483.430.

Core Requirements

The Medicaid Provider Manual identifies the following core requirements for targeted case management:

- Assuring the PCP process takes place and results in the IPOS
- Assuring the IPOS identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective
- Overseeing implementation of the IPOS, including supporting the child's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports
- Assuring the participation of the child and family on an ongoing basis in discussions of their plans, goals, and status
- Identifying and addressing gaps in service provision
- Coordinating the child's and family services and supports with all providers, making referrals, and advocating for the child and family
- Assisting the child and family to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services
- Assuring coordination with the child's and family's primary and other health care providers to assure continuity of care
- Coordinating and assisting the child and family in crisis intervention and discharge planning, including community supports after hospitalization
- Facilitating the transition (e.g., from the CWP to Habilitation Support Waiver, from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services
- Assisting child and family with crisis planning
- Identifying the process for after-hours contact

Service Parameters

Assessments: The case manager must have the capacity to perform an initial written comprehensive assessment addressing the child's and family's needs, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when a significant change occurs in the condition or circumstances of the child or family. The IPOS must also reflect such changes.

Monitoring: The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs of the child and family. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the IPOS.

Qualifications: A case manager must meet the federal qualifications for a QMRP

Training: A case manager who is responsible for certifying and re-certifying a child's Category of Care or Intensity of Care level for the CWP must first complete training on the use of the Decision Guides. This training is available from MDCH.



The child's record must contain sufficient information to document the provision of case management including the nature of the service, the date, and the location of contacts between the case manager and the child, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs, as cited in the Medicaid Provider Manual.



The case manager must review services at intervals defined in the IPOS. The plan shall be kept current and modified when indicated. The child and family may request and review the plan at any time. A formal review of the IPOS shall not occur less often than annually to review progress toward goals and objectives and to assess child's and family's satisfaction.



The record must document all case management activities that occur during the month, identify the professionals involved, and document the type of contacts that occurred.

Responsibilities for Children's Waiver Case Managers

A case manager is responsible for reviewing the needs of children and families for referral to the CWP (Refer to Section 3). When it appears the child may meet eligibility criteria, and it is determined that the CWP would meet the needs of the child and family, the case manager will meet with the family to complete the CWP Pre-screen form. (Refer to Section 6 and Appendix 6-a).

Once the pre-screen form has been completed, the case manager must submit it to the CWP. The CWP staff will score the pre-screen to determine placement on the Priority Weighing List. If priority status to apply for the CWP is determined, the case manager will complete the application process explained in Section 7.

As listed in the Medicaid Provider Manual, the case manager works with the child and family to develop an IPOS. The oversight of the IPOS may include advocacy, scheduling appointments and meetings, coordinating the planning process, monitoring the quality of the services and supports and the health and safety of the child. The case manager also documents activities related to implementation of the IPOS with the child's team. As goals are met and new needs are identified, the case manager updates the IPOS. Another important function of the case manager is to collaborate with schools and other community resources.

Service Parameters

Because the CWP is a home-based, family-centered program, case managers should arrange visits with the child and family in the family's home (as specified in the IPOS) at the family's convenience. Whenever possible, these visits should be coordinated with other team members to help minimize intrusion and ensure coordination with other team members. Additional visits with the child may be necessary in community settings, such as school, to facilitate coordination of services.

If a child is terminated from the CWP prior to the end of a fiscal year, the case manager must notify the CWP staff, as outlined in Section 14. When a child moves to another CMHSP, the case manager notifies the CWP staff. The case managers from both CMHSP's must work together with the family to facilitate the transfer (Refer to Section 14).

A child may be eligible for the CWP until their 18th birthday. At least one year prior to the child's 18th birthday, the case manager must begin working with the child's team and the CMHSP administration to develop a transitional plan and secure necessary funding.



The case manager is responsible for submitting the annual renewal documents to the CWP (Refer to Section 7).

The CWP annual budget must be submitted by October 1st of each year (Refer to Section 18).

For those children who meet the criteria for Category of Care-Level I, Intensity of Care-High, or are receiving exception hours, the case manager must submit a quarterly budget and clinical status report.

SECTION 9: TRAINING, MONITORING AND SUPERVISION OF HOURLY CARE STAFF

- Parents should share their expertise regarding their child's care needs with staff.
- Hourly care staff must be trained in the implementation of the IPOS.
- Documentation must indicate that hourly care staff have received the necessary training and can demonstrate proficiency in implementing the IPOS.

Introduction

The planning process involves family, friends and professionals as the child desires or requires. Members of the planning team work together to develop an IPOS that honors the child and family preferences and builds upon the child's capacity to engage in activities that promote community life, choices, abilities, and addresses identified needs. The role of professional staff has been expanded to provide training, monitoring, and supervision of hourly staff when determined necessary by the planning team.

The Role of the Family

The extent of involvement in the monitoring, supervision and training of hourly care staff will vary with each family. Many parents will play an active role, while others will prefer to leave the majority of these duties to other team members. Whatever the family preference, it is important to keep in mind that the needs and desires of the child and family, as identified in the IPOS, must be respected. In most cases, the parent who has the most contact with the hourly care staff will assume the day-to-day supervision. If a recipient rights issue arises or there is a persistent problem with attendance or job performance, the parents should discuss the issue with the case manager.

Parental participation in the training of hourly care staff will depend on the availability of the family. Parents should share their expertise regarding their child's care needs with staff. The planning process will identify the areas of training that will be provided by the family and the areas of training provided by other team members.



It is important that a parent clearly define the role of the staff person, parent's expectations and the house rules.



Staff turnover can be minimized when staff understand the importance of their role and receive frequent, consistent, and positive direction and feedback.

If conflict develops, parents should attempt to resolve it with the hourly care staff person directly. If resolution is not achieved by referring back to the IPOS and house rules, it should be discussed with the case manager.

Monitoring Duties of the Case Manager

The case manager works closely with the child and family to assure their satisfaction with the services provided. The case manager meets with both the child and family to assure that desires and needs are voiced and services and supports identified in the IPOS are implemented. Additionally, case management involves contacts and communication with other involved individuals to ensure the provision of services and supports. This is especially true with the recruitment; training, monitoring and supervision of the hourly care staff. It is recommended that the case manager work with the family and other team members to schedule a home visit together in order to increase team coordination and decrease the intrusion on the family. This also provides a time to observe the hourly care staff working with the child, ensure that the IPOS is being carried out appropriately and assess any training needs of the staff.



The case manager documents their activities and observations, as indicated in the IPOS.

Other Professional Staff Training and Monitoring Duties

When professional monitoring and training is identified in the IPOS, it must be provided by an appropriately licensed/certified psychologist, master's level social worker, occupational therapist, physical therapist, or speech therapist (Refer to Section 4). When the IPOS identifies specific needs or interventions that require daily support, hourly care staff will be trained by the appropriate professional staff to implement the program. The professional staff person will provide on-going training and monitoring of hourly care staff and will make recommendations for updating the IPOS as necessary.



A personnel file must be maintained for each staff person working with the CWP. The file must document the initial training (e.g., content, duration and date) and be signed by the parent or professional staff that provided the training.



The performance of services and supports provided by the hourly care staff must be evaluated by the parent, or monitoring professional, at a frequency determined in the IPOS. Documentation must reflect the parents or professionals determination that hourly care staff has demonstrated proficiency in the supports and services they provide.

SECTION 10: DECISION GUIDE FOR DETERMINING AMOUNT OF COMMUNITY LIVING SUPPORT HOURLY CARE

- The CWP Category of Care Decision Guide is a tool used to determine the amount of publicly supported CLS hourly care based on the child's identified health and behavioral needs.
- The Category of Care determination and assessment must be completed at the time of the annual waiver recertification and as needed to reflect changes in the child's care needs and family resources, as identified in the IPOS.
- Once the Category of Care has been determined, family circumstances and natural supports must be considered when establishing the range of hourly care.
- The Decision Guide to determine the maximum amount of PDN is outlined in Section 17.

Introduction

The purpose of the Decision Guide Table (Appendix 10-a) is to provide a tool to assist the child's team in determining the amount of publicly supported CLS hourly care. This tool is used to ensure consistency across the State of Michigan. This Decision Guide is used to determine the amount of CLS hourly care for children with challenging behaviors and children with medical and physical needs that do not meet the criteria for PDN. The amount of hourly care is determined by the care needs of the child and the resources available to the family as identified in the IPOS. There are four Category of Care definitions for children with challenging behaviors and there are two Categories of Care definitions for children with medical and physical needs that do not meet criteria for PDN.

Determining Category of Care for Children with Challenging Behaviors

To determine the amount of CLS services in the home, an assessment of the child's needs, the family's circumstances, and natural supports are required. In addition to identifying the family situation and the specific behaviors as described in the category definitions, the following elements contribute to the overall assessment of need:

- Type of behaviors identified
- Frequency, intensity and duration of the identified behaviors
- How recently serious behaviors occurred
- Specific effects of the behavior on persons in the family and property
- Level of family intervention required to prevent behavioral episodes
- Extent that family must alter normal routine to address the behavioral needs of the child

- Prognosis for change in the child's behavior
- Does the child function better in one setting than he does in another setting (e.g., home, school, community)
- Age, size and mobility of child

When determining which category is most appropriate to the child's care needs, the definitions below should be used to decide whether the needs support the necessity for CLS hourly care. The categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

Category IV

Demonstrates *mild* level behaviors that may interfere with the daily routine of the family.

Mild Behavior: Infrequent or intermittent behaviors including pinching, hitting, slapping, kicking, head banging, and/or elopement without careful supervision when there is evidence of lack of judgment regarding danger, or an extremely high activity level requiring extensive supervision and redirection.

Category III

Demonstrates a daily pattern of *medium* level behaviors including self-injurious, physically aggressive or assaultive behaviors that have not resulted in hospitalization or emergency room treatment for injuries in the past year, or has engaged in occasional, significant property destruction that is not life-threatening.

Pattern of Behavior: In addition to a single serious episode in the last year, significant daily behaviors are documented.

Medium Behavior: Includes behaviors defined in the Category II definition of "moderate behavior" when emergency room treatment or hospitalization have not been required for treatment of injuries resulting from the behavior. Examples include head banging, resulting in bleeding and bruising without concussion or detached retina, hair pulling without removing hair from the scalp, smearing feces without PICA, and biting without drawing blood.

Occasional Property Destruction: Property destruction that occurs with a frequency not greater than one time per week.

Category II

Demonstrates a daily pattern of *moderate* self-injurious, physically aggressive or assaultive behavior when medical intervention, or hospital emergency room treatment has been required for treatment of injuries in the past year without resulting hospitalization, or if the child has engaged in frequent, significant property destruction that is not life-threatening.

Moderate Behavior: Includes behaviors that pose a significant risk of injury to self or others in the immediate environment. Examples include physical assault or self abuse resulting in injuries requiring hospital emergency room treatment without hospital admission in the past year, biting that breaks the skin, hair pulling resulting in removal of clumps of hair from the scalp, multiple daily episodes of smearing feces with associated PICA, and head banging resulting in documented concussion or detached retina.

Category I

Demonstrates a pattern of *severe* self-injurious, physically aggressive or assaultive behavior, or life-threatening property destruction that has occurred one or more times in the past year. Documented evidence of additional behavioral problems on a frequent basis each day supports a need for one-to-one intensive behavioral treatment.

Severe Behavior: Poses a very significant risk of serious injury or death to self, a family member, or others in the immediate environment. Examples include intentional fire setting, physical assault or self-abuse resulting in injuries to self or others requiring inpatient hospital admission for treatment in the past year.

Determining Category of Care for Children with Medical and Physical Needs

When determining which category is most appropriate to the child's medical and physical care needs, the definitions below should be used to decide whether the needs support the necessity for CLS hourly care. The categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

Category IV

Category IV is for a medical condition that requires significant levels of daily assistance or guidance with ADLs. In addition, medical condition is stable and observations and interventions are required infrequently. Interventions require minimal training and are associated with minimal or no risk to health status.

Examples include levels of support that would exceed those expected for a person of the child's age in the areas of:

- Assistance and/or guidance in ADLs including eating, toileting, bathing, grooming, dressing, and mobility (e.g., ambulation and transferring)
- Assistance and/or guidance with physical transfer (e.g., bed to chair)
- Assistance and/or guidance with therapeutic positioning and physical therapy
- The child weighs 80 pounds or more and is not ambulatory and/or not mobile and unable to assist the primary caregiver

Category III

A medical condition that routinely requires daily hourly care or support in order to maintain and/or improve health status. Clinical observations and interventions may be intermittent. Medical interventions are typically associated with minimal risk to health status and delayed interventions are not associated with imminent risk to health status.

Examples include a combination of interventions such as:

- G-tube feedings with no oral suctioning needs
- PRN oxygen administration less often than daily over the past 30 days with or without pulse oximeter
- Daily oxygen administration at less than two liters without pulse oximeter and without the need for on-going judgments and observations for oxygen needs (e.g. routine nightly administration without other skilled nursing interventions)
- Catheterization fewer than five times per day
- Routine chest physiotherapy four or more times per day
- Ostomy care
- Total feeding or formal feeding program requiring more than 45 minutes per meal with need for special trunk-head positioning
- Concurrent diagnosis of severe hypertonicity, severe contractures, or severe scoliosis that requires therapeutic positioning every two hours
- Documented evidence that positioning causes apnea and cyanosis and that positioning is limited to positions with the body in less than a 45-degree angle to horizontal plane

Category of Care Decision Responsibility

The MDCH CWP Clinical Review Team will continue to review the IPOS and current assessments, and prior authorize waiver services for those children who:

- Meet the criteria for Category of Care I
- Have been approved for CLS exception hours

The responsible CMHSP, following the CWP Decision Guide in the following subsection, will review and prior authorize waiver services for those children who:

- Meet the criteria for Categories of Care II, III, or IV

Decision Guide Table (Appendix 10-a)

The determination of the amount of hourly care should result from the PCP and FCP process that considers the needs of both the child and family. The Decision Guide identifies the range of hours available to the family based on the Category of Care and family resources. After the Category of Care is determined, family resources, found in Sections I through VI on the Decision Guide Table should be identified. Children and families may qualify for services in more than one resource section (Sections I-V). In determining the total number of hours, it is acceptable to use the highest range of hours within the appropriate section. However, if the child is attending school an average of 25 hours per week Section VI maximums apply unless the maximum exceeds the range qualified for in sections I-V.

Once a child reaches the age of 6 it is expected that the child will be in a full-time school program. For children in school (25 hours or more per week), the school maximums apply. If the child's condition requires a homebound school program, approved by the school district and the child's physician (physician prescription required), the school maximum is waived. The school maximum is also waived for that time period when a child is out of school at least 5 consecutive days due to illness, surgery, or scheduled school breaks. If the child's condition does not warrant a homebound program but the family chooses to reduce their child's school hours or chooses to home school, the school maximums apply.

The determination of CLS hours is based on an average daily amount. However this does not mean that the same number of hours must be used every day. The hours are authorized as a monthly total that may be arranged and provided during the week that best meet the needs of the child and family. For example, the family may prefer to use authorized hours during the week to cover late workdays and complete errands, and then provide care for their child on weekends when they have more natural supports.

The definitions used in each section of the Decision Guide Table are as follows:Number of caregivers

- Caregiver is defined as legally responsible adult(s) living in the home or adult(s) who are not legally responsible but choose to participate in providing care for the child.
- Full-time (F/T) is defined as a person who works 30 or more hours per week for wages or a person who attends school 30 or more hours per week.

Health Status of Caregivers

- "Significant health concerns" of a caregiver is defined as one or more of the primary caregivers have a significant health or emotional condition, which prevents that caregiver from providing care for the child. An example would be a parent that recently had back surgery with full body cast or similar condition.

- "Some health concerns" of a caregiver is defined as one or more primary caregivers (as defined above) have a health or emotional condition, which interferes with but does not prevent provision of care. Examples would include: Alcoholism, depression, lupus, back pain when lifting, lifting restrictions and similar health concerns or when a primary caregiver is in therapy three or more times per month.

Additional Dependent Children

- This section applies when the child has one or more siblings or related individuals under the age of 18, who reside in the home full-time and the caregiver is not paid for providing care.

Additional Children with Special Needs

- Additional special needs are identified when the child has one or more siblings or related individuals who reside in the home and do not currently receive hourly care supports.
- Siblings with nursing needs would be children who meet the criteria for Intensity of Care-High or Intensity of Care-Medium (Refer to Section 17), whether or not those children are developmentally disabled.
- Siblings without skilled nursing needs would be children with needs as identified in Category of Care I-IV definitions.

Night Interventions

- If the child requires one or two interventions at night and the time required to complete the interventions is one hour or less, Section V-1 applies.
- If the child requires an average of three or more interventions per night, or the time required to complete the interventions is more than one hour, Section V- 2 applies.

School

- Average hours of school attendance should be used to determine the appropriate range of hours. Include transportation time if provided by the school.
- The number of hours of school attendance is based on the school year that applies to the child's educational classification. Variations in hours may be seen for children without a summer program.
- This factor limits the maximum number of hours that can be authorized for a child of any age in a center-based school program for more than 25 hours per week, or a child who has reached the age of 6 and for whom there is no medical justification for a home-bound school program.
- The school maximum is also waived for that time period when a child is out of school for at least 5 consecutive days due to illness, surgery, or scheduled school breaks.

Once the Category of Care is determined, circle the category at the top of the Decision Guide Table

(Appendix 10-a). Next, refer to the family resource section and circle each family resource that applies, based on the definitions. The highest range of hourly care circled may be used for determining the amount of hourly care. Once the range is identified, the specific amount of hourly care within that range that best meets the child and family's needs should be determined and documented in the IPOS.



Documentation must support the Category of Care determination and must be maintained in the child's record. If care needs meet criteria for Category of Care I, all supporting documentation must be sent to MDCH CWP.



Category of Care assessment and Decision Guide Table

SECTION 11: EXCEPTION PROCESS FOR COMMUNITY LIVING SUPPORTS AND PRIVATE DUTY NURSING HOURS

- All requests for exception hours must be submitted to MDCH CWP for prior authorization.
- Requests for exception hours must include the Prior Review & Approval Request (PRAR) form and all supporting documentation.
- Exceptions are time-limited. The criteria for a request is limited to situations beyond the family's control that places the child at risk of serious injury or significant deterioration of health status.
- A copy of the signed PRAR form will be returned to the case manager and must be maintained by the child's record for audit purposes.

Introduction

The determination of the amount of hourly care should result from the PCP and FCP process that considers the child and family's needs. Every child and family is unique, and as a result circumstances arise where an exception may be necessary to ensure the continued health and safety of the child. This section will describe the exception process for requesting additional CLS or PDN hours. All requests for exceptions must be prior authorized by MDCH CWP. The CMHSP is responsible for maintaining copies of all documentation in the child's record to support the need for additional hours.

Exception Process for CLS

CLS staffing hours that exceed the child's benefit limitations as established by the Decision Guide Table must be prior authorized by MDCH CRT. A Prior Review and Approval Request (PRAR) form must be completed to request additional hours (Appendix 11-a). The PRAR must document and substantiate both a current clinical (either medical or psychological) necessity for the exception and a current lack of natural supports requisite for the provision of the needed level of care. The hourly care services must be essential to the successful implementation of a plan of active treatment as defined by CMS ICF/MR rules (42CFR483.440), and any exceptions must be essential to maintain the child within their home.

Initiating and Documenting a Request for Exception

The child and his/her parent or guardian must initiate the request for an exception. The case manager is responsible for facilitating the request and documenting the necessity for an exception. Factors underlying the need for additional CLS hours must be identified in the child's IPOS and be included with the CWP PRAR form (Appendix 11-a). As applicable, the IPOS must include strategies directed toward resolving the factors necessitating the exception. Documentation must substantiate all of the following: 1) Current necessity for the exception; 2) current lack of natural supports

required for the provision of the needed level of support; 3) additional CLS services are essential to the successful implementation of the child's IPOS, and are essential to maintain the child within the home.

Prior to requesting an exception from MDCH CRT, the case manager should confirm that the maximum number of allowable hours under the present Category of Care Decision Guide Table is being utilized, including any unused hours from earlier in that month. If the maximum number of allowable hours under the present Category of Care is being utilized, then respite hours should be used to meet the identified need.

If the maximum number of allowable hours under the present Category of Care and the respite hours are not sufficient to meet the child's needs, the case manager should review the identified Category of Care for appropriateness. If the review results in a change in the Category of Care determination, a new Waiver Certification form must be submitted to MDCH CRT. If the new Category of Care determination addresses the need for additional hours, the process stops. Please note that any changes in the child's needs should result in the IPOS being updated to reflect those changes. If the child's need for additional hours does not result in a change in the Category of Care determination, the team must decide if the need meets the exception criteria.

If an exception for additional CLS hours is appropriate to address a temporary need, the PRAR form is submitted to the MDCH CWP. Supporting documentation must be submitted with the PRAR along with a copy of the IPOS and all current assessments. The supporting documentation should include an explanation why regular and respite hours are not sufficient to meet the need for additional hours. Be sure to identify the length of time the exception hours will be needed (start date and end date) on the PRAR form. The PRAR form should identify the daily amount of regular CLS hours the child receives, the average daily amount of respite approved in the IPOS, and the number of exception hours being requested per day. The total includes the daily amounts of regular CLS hours, respite hours and the requested exception hours. A copy of the PRAR form and supporting documentation must be maintained in the child's record.

Based on the submitted information, the MDCH CRT will determine if there is sufficient justification to approve the request. There are four possible outcomes of the CRT review: 1) Approved as presented; 2) approved as amended; 3) denied; or 4) no action taken (e.g., insufficient information received, situation resolved without intervention). If the request is amended or denied, a Notice of Right to an Administrative Hearing (Refer to Section 13) will be sent to the family by MDCH. A copy of the signed PRAR form will be returned to the case manager. A copy of the signed PRAR form must be maintained by the CMHSP for audit purposes.

For an emergency request for exception CLS hours, the case manager should contact MDCH for consultation. Verbal approval may be given to the CMHSP on a provisional basis, with necessary documentation (as required for all exception hour requests) to be forwarded within 10 working days. A provisional approval does not enable the CMHSP to bill for exception hours. If the supporting documentation is received within the 10-day limit and supports the need, MDCH CRT will send a copy of the approved PRAR to the CMHSP to be maintained in the child's record.

Exception Criteria for CLS staff

Consideration for an exception will be limited to situations outside the family's control that place the child in jeopardy of serious injury or significant deterioration of health status such as:

- A temporary deterioration of the child's clinical condition (e.g., an acute cyclic exacerbation of challenging behaviors)
- A temporary inability of the primary caregivers to provide the requisite level of care (e.g., an acute illness or injury)
- Health condition requires continuous implementation of high risk medically prescribed procedures requiring licensed nursing personnel that are not already addressed within the Decision Guide subsection. The procedures must be beyond the demonstrated capacity of the parents to provide (Refer to Section 17).
- Behavior treatment needs significantly exceed the recommended ranges for the assigned Category of Care and this exception is essential to prevent an otherwise inevitable (i.e., previously documented) deterioration in behavior. The enhanced staffing must be continuously active in the implementation of the behavior treatment plan.
- Natural supports are unable to provide the requisite level of care (e.g., only available care providers have a physical, mental, or emotional disability or they cannot demonstrate competence with the procedures essential to the implementation of the treatment plan). The IPOS must also address plans to rectify the condition or circumstance.

Exceptions may be granted for a specified period not to exceed 180 days. Renewal requests must substantiate the continuing clinical necessity and lack of natural supports.

Exceptions approved by MDCH/CWP can occur in one of the following ways:

- Temporary emergency basis only. Verbal approval can be given to the CMHSP with written justification to be forwarded to MDCH within 10 days; or
- In a non-emergency situation, the CMHSP provides MDCH with written documentation of the specific rationale to support the exception (i.e., physician's prescription). This would include a revised IPOS, highlighting the care needs to be provided with the additional staffing hours, and all current assessments. A response from MDCH will be sent to CMHSP within 10 working days.
- When approval of an exception is not granted through either of the two processes listed above, the family, case manager, or MDCH may request a meeting with other involved parties in order to clarify and reconsider the basis for the exception.

MDCH has the option to request a home visit to meet the child when it is necessary for an effective decision regarding an exception request.

Service Parameters

All requests for exceptions for CLS hourly care must be submitted to the MDCH CRT, with supporting documentation for prior authorization.



Prior authorization is required for an exception for CLS hourly care.



For exception requests the following items are required: 1) current necessity for the exception; 2) current lack of natural supports required for the provision of the needed level of support; 3) copy of the IPOS that identifies the additional CLS hours are essential to maintain the child within the home.



A copy of the IPOS including the amount, duration and scope of CLS exception hours must be maintained in the child's record for audit purposes.



A copy of the signed PRAR form must be maintained in the child's record for audit purposes.

Exception Process for PDN

Every child and family is unique and as a result circumstances arise where an exception may be necessary (Appendix 17-a) to ensure the child's safety and quality of care. PDN services that exceed the beneficiaries 'benefit limitations', must be prior authorized by MDCH. Limited authority to exceed the published PDN benefit limitations may be granted subject to the provisions of this exception process. Exceptions are time-limited, as detailed below.

Exception Criteria for PDN

Exceptions are time-limited and must reflect the increased identified needs of the child or primary caregiver(s). Consideration for an exception shall be limited to situations outside the child's or family's control that place the child in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

A temporary alteration in the child's care needs following a hospitalization, resulting in one or both of the following:

- A temporary increase in the intensity of required assessments, judgments, and interventions.
- A temporary need for additional training to enable the primary caregiver(s) to identify and meet the child's care needs.

The total number of additional PDN hours cannot exceed two hours per day, for a maximum of six months.

The temporary inability of the primary caregiver(s) to provide the required care, as the result of one of the following:

- An acute illness or injury of the primary caregiver(s). The total number of additional PDN hours cannot exceed two hours per day for the duration of the caregiver's inability, not to exceed six months. In the event there is only one caregiver living in the home and that caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized.
- The death of the primary caregiver(s) or an immediate family member. 'Immediate family member' is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of 7 days.
- The home environment has been determined to be unstable, as evidenced by involvement of FIA protective or preventive services. The IPOS must include strategies directed toward stabilizing service supports and/or the family situation. The maximum number of hours varies by the child's Intensity of Care level: High = maximum of 18 hours per day; Medium = maximum of 14 hours per day; Low = maximum of 10 hours per day. The maximum length of time for this exception is three months, or the time needed to stabilize service supports and/or the family situation, whichever is less. A one-time extension of up to three months may be made if there is documented progress toward achieving a stabilized home environment.

'Inability' is defined as the caregiver is unable to provide care or is prevented from providing care.

Initiating and Documenting a Request for Exception for PDN

Prior to requesting an exception from the MDCH CRT, the case manager should confirm the allowed maximum number of hours under the child's present Intensity of Care level have been used, including any unused hours from earlier in that month. If the maximum number of allowable hours under the present Intensity of Care level is being used, respite hours should then be used to meet the identified need.

If the maximum number of allowable hours under the present Intensity of Care level and the respite hours are not sufficient to meet the child's needs, the case manager should review the Intensity of Care determination for appropriateness. If the review results in a change in the Intensity of Care level, a new Waiver Certification form must be submitted to the MDCH CRT. If the new Intensity of Care level addresses the need for additional hours the process stops.

The child's primary caregiver must initiate the request for an exception. The CMHSP case manager is responsible for facilitating the request, documenting the necessity for an exception and completing the CWP PRAR form (Appendix 11-a) that is submitted to MDCH. The supporting documentation described below must be submitted with the PRAR along with a copy of the IPOS and all current assessments. Be sure to identify the length of time the exception hours will be needed (start date and end date) on the PRAR form. The PRAR form should identify the daily amount of regular hourly

care the child receives, the average daily amount of respite approved in the IPOS, and the number of daily exception hours requested. The total includes the daily amounts of regular hourly care, respite and the requested exception hours. A copy of the PRAR form and supporting documentation must be maintained in the child's record.

Based on information submitted, the MDCH CRT will determine if there is sufficient documented justification to approve the request. There are four possible outcomes of the MDCH CRT review: 1) approved as presented; 2) approved as amended; 3) denied; or 4) no action taken (e.g., insufficient information received, situation resolved without intervention). If the request is amended or denied, a Notice of Right to an Administrative Hearing (Refer to Section 13) will be sent to the family by MDCH. The signed PRAR request form will be returned to the case manager. A copy of the signed PRAR form must be maintained in the child's record for audit purposes.

For an emergency request for exception hours, the case manager should contact MDCH for consultation. Verbal approval may be given to the CMHSP on a provisional basis. Necessary documentation (as required for all exception hour requests) must be forwarded within 10 working days after verbal approval. A provisional approval does not enable the CMHSP to bill for exception hours. If the supporting documentation is received within the 10-day limit and supports the need, MDCH CRT will send the approved PRAR to the CMHSP. A copy of the signed PRAR form must be maintained in the child's record for audit purposes. Factors underlying the need for additional PDN must be identified in the child's IPOS. As applicable, the IPOS must include strategies directed toward resolving the factors necessitating the exception.



Current medical necessity for the exception



Current lack of natural supports required to provided the child's identified care needs



Additional PDN hours are essential to the successful implementation of the child's IPOS and are essential to maintain the child within their family home.



A copy of the signed PRAR form

SECTION 12: DEVELOPMENT OF AN INDIVIDUAL PLAN OF SERVICES

As cited in the Michigan Mental Health Code, Chapter 7, 330.1712 sec. 712 (1):

- The responsible mental health agency for each recipient shall ensure that a person-centered planning process is used to develop a written Individual Plan of Services in partnership with the recipient.
- A preliminary plan shall be developed within 7 days of commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release.
- The individual plan of services shall consist of a treatment plan, a support plan or both and establish meaningful and measurable goals with the recipient.
- The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation and recreation.
- The plan shall be kept current and be modified when indicated. The individual in charge of implementing the individual plan of services shall be designated in the plan.
- If a recipient is not satisfied with his or her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of services, the guardian of the recipient, or the parent of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by the appropriate governing body.
- An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.

Introduction

This section will describe planning process and the values and strategies used in development of an IPOS. The IPOS is a working document. A copy of the current plan must be maintained in the child's home and used by all caregivers. (An example of an IPOS can be found in Appendix 12-b).

Person-Centered Planning and Family Centered Practice Definition

(Refer to Appendix 12-a)

The Michigan Mental Health Code establishes the right for all individuals to have their individual plan of services developed through a person-centered planning process regardless of age, disability or residential setting. Person-centered planning is a highly individualized process designed to plan

and support the individual receiving services by building upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities. The PCP process involves families, friends, and professionals as the individual desires or requires. Health and safety needs are addressed in the IPOS with supports listed to accommodate those needs.

The MDCH has advocated and supported a family approach to service delivery for children and their families. This approach recognizes the importance of the family and the fact that supports and services impact the entire family. Therefore, in the case of minors, the child is the focus of service planning, and family members are integral to the planning process and its success. The wants and needs of the child/family are considered in the development of the IPOS.

Values and Principles Underlying Person-Centered Planning (as defined in the Person-Centered Planning Revised Practice Guideline)

Person-centered planning is a highly individualized process designed to respond to the expressed needs and desires of the individual.

- Each individual has strengths and abilities to express preferences and to make choices.
- The individual's choices and preferences shall always be considered, if not always granted.
- Each individual has gifts and contributions to offer the community and has the ability to choose how supports, services and /or treatment may help them utilize their gifts and make contributions to community life.
- Person-centered planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals and desires.
- A person's cultural background shall be recognized and valued in the decision-making process.

Elements of Person-Centered Planning

- The individual shall be given ongoing opportunities to express their needs or desired outcomes.
- Potential support and/or treatment options to meet the expressed needs of the individual are identified and discussed with the individual.
- The individual shall be given ongoing opportunities to express their preferences and to make choices.
- Parents and significant family members of minors are integral to, and shall participate in, the planning process.

Development of the Individual Plan of Services (IPOS)

It is essential that the child's IPOS be developed through a planning process while simultaneously considering and addressing the health and safety needs of the child. As cited in the PCP Revised Practice Guideline, Attachment C3.4.1.1 to the FY 03-04 Medicaid Managed Specialty Services and Supports Contract: "Potential issues of health and safety are explored and discussed. Supports to address health and safety needs are included in the PCP. While the consideration of health and safety issues are required in the development of an IPOS, it should not be used as a barrier to the achievement of a child's desired outcomes identified through the planning process. The IPOS shall identify the child's needs, measurable goals, and expected outcomes as identified by the child, family and other team members. The IPOS shall be kept current and be modified when indicated. The individual in charge of implementing the IPOS shall be designated in the plan. The IPOS must be reviewed, approved, and signed by a physician and the parent at least annually".

Prior to the development of the IPOS, assessments must be conducted by all disciplines identified by the child's team to address areas of need. For example, a behavioral assessment should include:

- Child/family background
- Summary of current behavioral status
- Functional analysis (including antecedent, behavior, and consequence analysis)
- Summary and recommendations (treatment goals and methodology)

Establishing Methodology for Implementation of the Individual Plan of Services (IPOS)

Once each goal has been determined, the methodology used to reach that goal must be written, and based on best practice principles. A step-by-step approach identifies:

- Who will complete each part of the IPOS
- The frequency and duration of intervention
- Interventions to be used and supports provided for each goal
- Who will be responsible for data collection
- Time lines for review of the IPOS
- Measurable outcomes
- The frequency of each service category (e.g., case management, PDN, CLS, OT)

A copy of the current IPOS must be maintained in the child's home for use by all caregivers.

Revising an Individual Plan of Services (IPOS)

An IPOS should be revised whenever there is a significant change. Examples of this would include:

- A change in the child's medical or behavioral needs
- A new identified need
- A change or disruption in the child's family or support system

The family or other team member can request changes to the IPOS. When a need has been identified, a team meeting is held to amend the IPOS. Once the team has agreed on the necessary revisions, the plan should be revised. Copies of the revised plan must be maintained in the child's CMHSP file, and the child's home. A copy must be sent to MDCH CWP when a child:

- Meets criteria for Category I of the CWP Decision Guide for Hourly Care
- Intensity of Care-High of the PDN Decision Guide
- When the child is receiving exception hours

For those children listed above, the case manager must submit to the CWP a quarterly clinical status report and a budget for prior authorization. The clinical status report will be reviewed for determination of the appropriateness of goals and interventions in the IPOS.

SECTION 13: APPEALS

- A legally sufficient notice of action must be sent whenever a Medicaid covered service is denied, suspended, reduced or terminated.
- CMHSPs are responsible for providing notice on actions taken locally.
- MDCH is responsible for providing notice on actions taken at the state level.
- Each CMHSP must assign a hearings coordinator.
- An administrative law judge (ALJ) will conduct hearings.

Introduction

An administrative hearing is defined as an impartial review of a decision made by MDCH or one of its contract agencies (including CMHSPs) that the appellant believes is inappropriate. An ALJ presides over the impartial review. Administrative hearings are also referred to as fair hearings. For a complete description of the administrative hearing process, please refer to MDCH website, www.michigan.gov/mdch and select "Inside Community Health", then select "Operations Administration" and finally, select "MDCH Administrative Tribunal".

Notice of the Right to an Administrative Hearing

The parent or guardian must be sent a written notice of actions affecting eligibility or amounts of Medicaid benefits or Medicaid covered services for their child. This may include a termination, suspension or reduction of Medicaid eligibility or covered services. There are two types of written notice:

Adequate Notice

An adequate notice is a written notice sent to the parent or guardian at the same time an action takes effect (i.e., not pended). A sample Adequate Notice form is found in Appendix 13-a. Adequate notice is provided in the following circumstances:

- Denial of new services not currently being provided
- Approval or denial of an application
- Increase in benefits
- An IPOS, developed through the planning process, identifies the services to be provided. Any additional services would require an addendum to the IPOS and a new notice; or
- When an IPOS is completed

Advance Notice

Advance notice is required when an action is being taken to reduce, suspend or terminate a benefit or service the child is currently receiving. The notice must be mailed at least 12 days before the intended action takes effect. The action is pending to provide the parent or guardian an opportunity to react to the proposed action. If the parent or guardian requests a hearing before the date of action, the agency may not terminate or reduce benefits or services until a decision and order is issued by the ALJ or the parent or guardian withdraws the hearing request, or the parent or guardian does not appear at a scheduled hearing. A sample Advance Notice form is found in Appendix 13-b.

Responsibility for Giving Notice

A DCH-0092 Hearing Request form (Appendix 13-c) or its equivalent shall be sent to the parent or guardian with all adequate or advance notices. Hearing Request Forms, Hearing Withdrawal Forms, and return postage paid envelopes addressed to the Administrative Tribunal may be ordered by completing an DCH-0646 Administrative Tribunal Requisition form (Appendix 13-d) and mailing it to the address listed on the form.

When an action is taken by MDCH, CWP staff will give the written notice. This may include actions regarding program eligibility, services for children qualifying for Category I of the CWP Decision Guide (Appendix 10-a), High Intensity of Care for the PDN Decision Guide (Appendix 19-c), and equipment/environmental accessibility adaptations requiring prior approval by MDCH.

Written notice for any action taken by a CMHSP or its contract agency will be given by the CMHSP. This may include decisions related to program eligibility, services for children qualifying for Categories II-IV of the CWP Decision Guide, and Medium or Low Intensity of Care of the PDN Decision Guide, and locally authorized equipment and supplies.

It is the responsibility of the CMHSP to designate a hearings coordinator who will serve as the liaison between the agency and the Administrative Tribunal. The purpose of the hearings coordinator is to serve as the single contact point for the Administrative Tribunal in order to communicate procedural aspects of any case. The hearings coordinator may also represent the CMHSP at a hearing.

Hearing Request

If a parent or guardian wants to appeal an action, the request for a hearing must be in writing and sent to the Administrative Tribunal. The hearing request should provide the name, address and telephone number of the child for whom the hearing is being requested. The name, address and telephone number of the parent or guardian requesting the hearing, if different, should be included. The benefit or program involved should be clearly identified. The hearing request should identify what decision is being challenged. All hearing requests should be mailed to:

Administrative Tribunal
Michigan Department of Community Health
P.O. Box 30195
Lansing, MI 48909

If a hearing request is received in another location within MDCH or at a CMHSP, a copy of the

request should immediately be faxed to the Tribunal at (517) 335-9180 with a follow-up telephone call to the Tribunal (1-877-833-0870) to ensure that the fax has been received. The original request should be forwarded to the Tribunal within seven (7) days.

The parent/guardian or authorized hearing representative has 90 calendar days from the date of the written notice of action to request a hearing. The written hearing request must be received by MDCH within that 90-day period.

If a Medicaid covered service is being reduced, suspended or terminated, a written notice must be mailed to the child or authorized representative at least 12 days before the intended action takes effect. If the parent or guardian requests a hearing before the date of action, the agency may not terminate or reduce benefits or services until a decision and order is issued by the ALJ, or the parent or guardian withdraws the hearing request or the parent or guardian does not appear at a scheduled hearing.

Processing Hearing Requests

Upon receipt of a hearing request, the Tribunal will assign a docket number and fax a copy of the hearing request to the CWP or the CMHSP that took the action being appealed. The hearings coordinator is responsible for receiving the hearing requests, identifying the responsible staff and forwarding a completed hearing summary to the Tribunal and the appellant within 14 days of receipt of the hearing request, but no later than seven (7) days prior to a scheduled hearing date.

Hearing Summary

The MDCH or CMHSP staff will prepare the DCH-0367 Hearing Summary form (Appendix 13-e) and present the case at the hearing. The form must be completed in its entirety. The narrative must include all of the following:

- Clear statement of the action or decision being appealed, including all programs involved in the action
- Facts which led to the action or decision
- Policy which supported the action or decision
- Correct address of the appellant or authorized hearing representative
- Copy of the documents the CWP or the CMHSP intends to offer as exhibits at the hearing
- Appellants and authorized hearing representatives (AHR) have the right to review the case record and obtain copies of all documents and materials to be used or relied upon at the hearing. Send a copy of the hearing summary, and all supporting documents to be used at the hearing, to the appellant and AHR. All parties should receive copies of the Hearing Summary and all documents at least seven (7) days before the scheduled hearing

The DCH-0367 Hearing Summary form (Appendix 13-e) may be ordered by writing to MDCH Administrative Services Division, at the address listed on the forms Requisition Request.

Hearings

Hearings are routinely scheduled for telephone conference calls. The ALJ conducts the hearing from his office. The appellant or AHR is directed to the local CMHSP or other location as indicated on the notice. The appellant or AHR may request permission of the Tribunal to appear by phone from an alternative location. The request must be made to the Tribunal at least one full business day before the hearing. The appellant or AHR may request the ALJ appear in person at the hearing. The ALJ will travel to the local office or facility.

The parties will present their positions to the ALJ who will determine whether the actions taken are correct according to fact, law, policy and procedure. Following opening statement(s), if any, the ALJ will direct MDCH or CMHSP representative to explain the agency's position. The hearing summary, or highlights of it, may be read into the record. The hearing summary may be used as a guide in presenting evidence.

Both parties must have adequate opportunity to present the case, bring witnesses, establish all pertinent facts, argue the case, refute any evidence, cross-examine adverse witnesses and cross-examine the author of a document offered in evidence.

The ALJ must ensure the record is complete and may take an active role in the questioning of witnesses and parties. The ALJ will assist either side to ensure all necessary information is presented on the record, or refuse to accept evidence the ALJ believes is unduly repetitious, immaterial, irrelevant or incompetent. Either party may state on the record its disagreement with the ALJ's decision to exclude evidence and the reason for the disagreement and object to evidence the party believes should not be part of the hearing record. When refusing to admit evidence, the ALJ must state on the record the nature of the evidence and the reason it was not admitted. The ALJ may allow written documents to be admitted in place of oral testimony if the ALJ decides this is fair to both sides.

When attending a hearing, MDCH or CMHSP staff is expected to present themselves in a professional manner and attire. No food or beverages are permitted.

Hearing Request Withdrawal

An appellant or AHR may agree to withdraw the hearing request at any time during the hearing process. The appellant or AHR should complete the DCH-0093 Hearing Request Withdrawal form (Appendix 13-f) or its equivalent and return it immediately in the postage paid envelope to the Tribunal. Hearing withdrawal forms may be ordered by writing to the same address listed above.

When any issue is still in dispute, do not suggest that the appellant or AHR withdraw the request or mail a withdrawal form to the appellant or AHR unless asked to do so by the appellant.

When all issues have been resolved the appellant or AHR may wish to withdraw the hearing request. A request may be made for a signed, written withdrawal. The withdrawal must clearly state why the appellant or AHR has decided to withdraw the request. Enter all identifying case information on the withdrawal, attach the original copy to the request and forward them to the Tribunal. File a copy of the withdrawal in the child's record.

Hearing Decisions

The ALJ's Decision and Order is the final determination of MDCH. Rehearing or reconsiderations may be requested within 30 days of the Decision and Order. The Tribunal will send the Decision and Order to the appellant or the AHR for MDCH or the CMHSP. A DCH-0107, Order Certification form (Appendix 13-g), will be sent by the Administrative Tribunal with the Decision and Order to the AHR if the Decision and Order requires implementation by MDCH or CMHSP. Since the DCH-0107 confirms the status of the Decision and Order's implementation (e.g., when the Decision and Order has or will be acted upon), it must be completed in a timely manner and returned to the Administrative Tribunal. It is the AHR's responsibility to ensure that the decision is implemented within 10 calendar days of the Decision and Order mailing date.

SECTION 14: WAIVER TRANSFERS AND TERMINATIONS

- When a family moves to another county within Michigan, the waiver is transferred to the new CMHSP.
- A notice of CWP termination should be sent to the family and MDCH 12 days prior to the termination. The notice must indicate the reason for the termination and the final date of CWP services.
- All terminations (including voluntary withdrawals) require written notification to the parent(s) regarding the right to an administrative hearing.

Introduction

The CWP serves children residing in Michigan who meet the eligibility criteria for the program. Each CMHSP is responsible for assisting the family in the application and implementation of the waiver. When a family moves to another county within Michigan, the CWP can be transferred to the CMHSP responsible for the county where the family will reside. This section will describe the process used to ensure a smooth transition to the new CMHSP.

This section will list those circumstances that may result in the transfer of CWP services. It will also outline the process necessary to terminate the CWP.

CWP Transfers

Once the family has informed the case manager they are moving to another county within Michigan, the case manager must do the following:

- Immediately contact MDCH CWP by phone and send a follow-up letter to the CWP with the expected date of transfer and destination of the transfer.
- Obtain a release of information from the family within five working days to facilitate communication and coordination with the new CMHSP.
- Prepare a packet of information to forward to the new CMHSP. This packet must contain a copy of the current POS, the Service Cost Summary (budget), current assessments, Category of Care determination, mihealth card, current Waiver Certification form and a FIA- 49. This must be completed within five working days.

Once the case manager has informed the CWP of the move, the CWP must do the following:

- Contact the new CMHSP where the family will reside to inform them of the impending transfer
- Periodically check to ensure the transfer process is proceeding

The initiating case manager will submit a letter to the CWP within five working days confirming the actual date of the family's transfer and their last date of CWP services in that county.

The case manager at the new CMHSP must do the following:

- Review the transfer packet
- Contact the family
- Identify a team through the planning process within seven days, which is consistent with the Michigan Mental Health Code
- Work with the team to determine if the current IPOS will be adopted as written, revised, or a new person-centered planning meeting will be scheduled
- Work with the team to establish the Category of Care or Intensity of Care determination
- Complete a new Waiver Certification form and obtain appropriate signatures
- Prepare a budget based on the adopted, revised, or new POS
- Complete the FIA-49 form, if necessary

Final Approval For a Transfer Waiver And Funding Allocation

The new case manager will compile the appropriate documentation as noted in the application process (Section 7), and submit the necessary documents to the CWP within 30 days of the transfer date. This packet must include a start date for CWP services, and a copy of the Medicaid card. The CWP will review the submitted documents and establish the funding allocation based on those documents. The CWP will issue a letter to the new CMHSP director with the funding allocation within 14 days of receipt of the packet. The CWP will issue an adjusted funding allocation to the CMHSP transferring the waiver.

CWP Terminations

Circumstances that may result in the termination of CWP services include:

- Family moves out of Michigan
- Child no longer meets one or more of the following criteria: has a developmental disability (as defined in the Michigan Mental Health Code), meets admission requirements for an ICF/MR placement, or maintains a GAF score of 50 or below
- Child is placed outside the family home without a permanency plan to return home within one month

- The day the child reaches the age of 18, or age 26 for those individuals who were grandfathered in prior to October 1, 1996.
- CWP services are no longer necessary or being provided to ensure health and safety issues or to prevent institutionalization
- Based on the Category of Care/Intensity of Care Decision Guides, the parent(s) is not able or willing to provide the care beyond the scope of these guidelines
- Child loses Medicaid eligibility due to a new financial status, or the family has not submitted the necessary documents to the FIA to maintain eligibility
- Failure to renew a Waiver Certification form annually based upon CMHSP provider's signature date
- Failure to submit annual FIA-49 Medical Eligibility Form
- Child has not utilized a CWP service within 30 days
- Death of the child

When a termination occurs, a letter from the case manager must be sent to the family confirming the reason and date of termination (Appendix 13-B). Additionally, a DCH-0092-Hearing Request form (Appendix 13-C) must be sent to the family 12 days prior to the termination, with notification of the family's right to an administrative hearing. If the CMHSP makes the determination, a copy of the termination letter must be sent to the CWP. If the CWP makes the determination, the CMHSP will receive a copy of the letter.

All voluntary withdrawals from the CWP require a letter to the CWP indicating date of and reason for the withdrawal. The family or the CMHSP may write this letter with a copy to parents; however it is the responsibility of the case manager to forward the letter to the CWP within 12 day of the termination. This is considered a negative action, therefore an Administrative Hearing Notice (DCH-0092 form) must be sent to the family. It will be the responsibility of the CMHSP to issue the notice for all voluntary withdrawals.

The CWP will adjust the funding allocation for the child who has been terminated from the program. Notification will be sent to the CMHSP director.



All voluntary withdrawals and terminations from the CWP require a letter to the CWP indicating the date and reason for the withdrawal or termination. A copy of the letter must be maintained in the child's CMHSP file.



All notification of Administrative Hearing rights must be maintained in the child's CMHSP file.

SECTION 15: QUALITY ASSURANCE & IMPROVEMENT

- The MDCH division of Quality Management and Planning (QMP) will conduct on-site visits to each Prepaid Inpatient Health Plan (PIHP). The QMP site visits will include reviews of a sample of individuals who are enrolled in the CWP, if CWP reviewers do not attend the site review and are not scheduled to complete a review of the CWP.
- MDCH staff working with the CWP may accompany the QMP staff to the site reviews.
- The MDCH staff working with the CWP will review the CMHSP/CWP documentation, complete a post payment review, and provide technical assistance to CMHSP staff.

Introduction

In accordance with CMS regulations and the MDCH/CMHSP Managed Specialty Supports and Services Contract, the MDCH division of QMP conducts on-site visits to each PIHP. These visits are conducted as part of the site review monitoring process of PIHPs. The purpose of the reviews is to monitor compliance with the Mental Health Code, the Medicaid Provider Manual, and the MDCH/CMHSP Contract. A site review protocol is used for all service areas, including the CWP. In addition, the staff working with the CWP may accompany the QMP staff to conduct a more detailed review of the CWP requirements, and to provide technical assistance to the CMHSP. The CWP review includes evidence of a safe and appropriate IPOS, eligibility requirements, freedom of choice, service provider qualifications and contracts, administrative procedures, and Medicaid billings.

Review Process for the PIHPs

For the QMP review a mutually acceptable date is negotiated between MDCH/QMP and the PIHP.

The Protocol to be used to review the PIHP performance is provided to the PIHP at least thirty (30) days prior to the review (Appendix 15-b).

An entrance conference is held with the PIHP administrative staff and other interested parties. The MDCH site review team will:

- Discuss the review process
- Answer any questions concerning the process
- Adjust/modify the review schedule as necessary

The Administrative Process Review will include:

- Person-centered planning
- Assurances of health and safety
- Qualifications and training of staff
- Quality assurance/quality improvement
- Other administrative policies and procedures

The Enrolled Program Review will focus on:

- Structural: Administrative policies and procedures of a provider
- Individual record: Use of the person-centered planning process and the appropriateness of care
- Consumer/family interview: Knowledge of customer services, use of person-centered planning, health and safety and consumer satisfaction

Individual Interview & Record Reviews will include:

- Customer services
- Person-centered planning
- Health and safety
- Consumer satisfaction

The Record Review will focus on:

- Person-centered planning
- Health and safety
- Specific program requirements
- Confirmation that the record reflects what is actually occurring

At the conclusion of the review, the MDCH site review team conducts an exit conference with the PIHP. The purpose of the exit interview is to allow MDCH to present the preliminary findings. Following the exit interview, MDCH generates a report identifying the findings that require follow-up action by the PIHP. The report also contains recommendations for use in developing the required remedial action plan. When the CWP site review team has completed a site review during the same time period, the QMP site review report will defer to the CWP site review summary. The PIHP may dispute any of the report findings using established dispute resolution processes.

The PIHP has thirty (30) days to provide a remedial action plan in response to the identified findings from the site review report. The MDCH, in response to a request from the PIHP, may extend this deadline. Correspondence approving the remedial action plan or requesting clarification or additional information is sent out after the MDCH site review team reviews the remedial action plan.

Review Process for the CMHSPs for CWP

MDCH staff working with the CWP may accompany the QMP staff to the site reviews. However, due to the limited scope of the CWP review, the review will typically involve a two-day review period. MDCH staff will review the CMHSP CWP documentation, complete a post payment review, and provide technical assistance to CMHSP staff.

The CWP Review Summary form (Appendix 15-a), used to review the CMHSP performance, is provided to the CMHSP at least thirty (30) days prior to the review.

The CWP site review will include a record review and interviews to assess and provide technical assistance on:

- Evidence of a safe and appropriate Individual Plan of Services
- Program eligibility and enrollment requirements
- Freedom of Choice
- Provider Qualifications and contracts
- Other Administrative Procedures
- Medicaid billings
- Home Visit

At the conclusion of the review, the MDCH/CWP site review team conducts an exit conference with the CMHSP. Because of the limited review period, as mentioned above, the exit interview may or may not coincide with the exit interview conducted by the QMP staff. The purpose of the exit interview is to allow MDCH to present the preliminary findings. Following the exit interview, MDCH generates a report within thirty (30) days identifying the findings that require follow-up action by the CMHSP. The report also contains recommendations for use in developing the required corrective action plan. The CMHSP may dispute any of the report findings using established dispute resolution processes.

The CMHSP has thirty (30) days to provide a corrective action plan in response to the identified findings from the site review report. The MDCH, in response to a request from the CMHSP, may extend this deadline. Correspondence approving the corrective action plan or requesting clarification or additional information is sent out after the MDCH site review team reviews the corrective action plan.

SECTION 16: AUTHORIZATION OF SPECIALIZED MEDICAL EQUIPMENT, SUPPLIES AND ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

- Many requests for specialized medical supplies and equipment and all requests for equipment repairs and environmental accessibility adaptations (EAA), otherwise known as home modifications, require prior authorization from MDCH.
- The CMHSP is responsible for maintaining copies of all documentation submitted to the CWP.
- “Standards of value purchasing” as defined in the Medicaid Provider Manual must be followed.
- The CMHSP must maintain documentation that all potentially available first and third party reimbursement (private insurance) have been explored and secured.
- Prior to billing Medicaid, items appropriately authorized locally (as described below) must be submitted to private insurers for possible reimbursement.
- If a family purchases or builds a home while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs. See Service Parameters under the EAA heading for further details.
- For EAAs, the most cost-effective alternative must be identified and specifications must be completed before obtaining three competitive bids.
- The EAA shall exclude costs for improvements exclusively required to meet local building codes.

Introduction

The CWP provides coverage for specialized medical equipment, equipment repairs, supplies, and EAAs that are not covered by Medicaid state plan or CSHCS. This section will describe the process for obtaining prior authorization from the CWP when required and which items can be locally authorized.

Locally Authorized Medical Equipment and Supplies

There are six HCPCS procedure codes that the CMHSPs must use to locally authorize certain medical equipment and supplies without obtaining prior approval from CWP:

- E1399-Durable Medical Equipment, misc. (Single Room Air Conditioner)
- T1999- Miscellaneous Therapeutic Items (Adaptive Toys)

- S5199 -Personal Care Items, NOS (Activities of Daily Living Aids)
- T2029- Specialized Medical Equipment, NOC (Environmental Safety and Control Devices)
- T2028-Specialized Supply, NOC (Allergy Control Supplies)
- T2039- Vehicle Modifications (Van Lifts and Wheelchair Tie-Downs)

These are items that are not covered benefits through the Medicaid state plan or CSHCS and do not require a denial from Medicaid/CSHCS/Trust Fund before being locally authorized. However, the CMHSP must first offer direct assistance to explore and secure all potentially available first and third party reimbursements. The HCPCS codes listed above must only be used if the requested equipment or supplies are within the corresponding service parameters. For all other equipment, supply and EAA requests, the CMHSP must follow the procedure for CWP prior authorization. The CMHSP is responsible for assuring that all documentation requirements have been met and documents are available for audit purposes.

Because the CWP does not pay state sales tax, the CMHSP must purchase items that have been locally authorized using a tax identification number. If a physician's prescription is required for a tax-exempt purchase, the prescription must be obtained and a copy maintained in the child's record for audit purposes.

Documentation of denial by private insurances for all locally authorized coverage:

The documentation of any first and third party responses must be maintained in the child's record for audit purposes. Documentation must be completed prior to billing Medicaid.

- If the private insurance carrier requires prior authorization to determine coverage, a request for prior authorization must be submitted to the carrier to obtain funding or a denial of coverage for the item.
- If the private insurance carrier denies the request, a written denial of coverage must be maintained in the record.
- If the private insurance carrier will not provide a written denial prior to purchase of the item, the bill should be submitted to the carrier once the item has been purchased. A copy of the Explanation of Benefits for the denial of the item must be maintained in the record.

Durable Medical Equipment, miscellaneous (Single Room Air Conditioner)

Description

This item is a one-time purchase of a window air conditioning unit for the room where the child spends the majority of his or her time (e.g. sleeping area). The child must have a documented medical diagnosis as specified below.

Service Parameters

The air conditioner must be ordered by a physician for treatment of one of the following specific medical diagnoses or conditions only: temperature regulation dysfunction due to brain injury or other medical diagnosis; severe respiratory distress secondary to asthma, permanent lung damage, or other medical conditions which are exacerbated by heat and humidity; severe dehydration resulting from a medical diagnosis (e.g., diabetes insipidus, which may result in hospitalization; severe cardiac problems which may result in hospitalization unless the environmental temperature is carefully controlled). A room air conditioner can only be purchased once every five years.

**Prescription Required**

IPOS must include medical necessity based on one of the medical diagnoses or conditions listed above and evidence that no other air conditioning units have been purchased during the previous five years.



Written correspondence from the private insurance carrier, if applicable.

Miscellaneous Therapeutic Items and Supplies (Adaptive Toys)Description

These are age-appropriate items required in the IPOS to meet the child's specific habilitative outcomes. The item must be adaptive and therapeutic in nature. For example, a child with fine motor difficulties may need a puzzle with handles on the pieces for improved grasp.

Service Parameters

Items that are typically available in a home and ordinarily provided by families, schools, etc. (e.g., crayons, coloring books, regular board games or non-adaptive toys/software) are not covered.

Local authorization for adaptive or therapeutic toys must not exceed a total cost of \$25.00 and the quantity is limited to one adaptive or therapeutic toy per quarter.



IPOS must include the adaptive or therapeutic need for the item



Written correspondence from the private insurance carrier, if applicable.

Personal Care Items, NOS (Activities of Daily Living Aids)Description

Activities of daily living (ADL) aids include equipment that enables the child to be as independent as possible in areas of self-care. The IPOS must describe the purpose and use of the ADL aid and any training that the child requires for its use.

The items listed below may be locally authorized:

- Grooming or dressing devices; food preparation aids; talking or vibrating alarm clocks
- Simple switches for increased independence or habilitation
- Communication picture boards; pocket charts
- Simple sensory processing equipment, such as brushes, therapy balls, small mats, parachutes, scooter boards, hammocks

Service Parameters

Local authorization for ADL aids must not exceed \$100.00. The quantity is limited to a maximum of five (5) ADL aids per month and the ADL aids must not be similar in function to previously purchased items.



IPOS of the need for the item to increase the child's independence in activities of daily living



Written correspondence from the private insurance carrier, if applicable

Specialized Medical Equipment, NOC (Environmental Safety & Control Devices)

Description

Environmental safety & control devices enable the child to be as independent as possible. These devices may assist in controlling the environment or assuring safety in conjunction with programs designed to teach safety awareness or skills. The IPOS must address the use of the device and include any training that the child requires for its use. The items listed below may be locally authorized:

- Environmental control unit for operating lights, electronics and kitchen appliances
- Door alarm
- Anti-scald device; stove protector; outlet plug covers; safety latches; coverings for existing ceiling fan

Service Parameters

The environmental safety control device (including installation if applicable) or "set" of like items must cost no more than \$250.00. A "set" is considered a group of like items which must be purchased in a quantity in order to meet the child's needs. For example, if a child needs outlet plug safety covers for all the outlets in their home, the "set" might include two dozen covers at an individual price of \$1.00. The CMHSP would bill for a quantity of one and a cost of \$24.00. If the cost of the item or "set" of like items exceeds \$250.00 the CMHSP must request prior approval. Quantities are limited to five environmental safety and control devices per quarter.

Environmental safety and control devices do not include items of general utility such as standard smoke detectors, fire extinguishers, home security systems and storage cabinets.



IPOS must address the adaptive or therapeutic need for the item



Written correspondence from the private insurance carrier, if applicable.

Specialized Supply, NOC (Allergy Control Supplies)

Description

Allergy Control Supplies are for the on-going management of a diagnosed severe reaction to airborne irritants and must be specified in the IPOS.

- Electrostatic air filters for furnace
- Tabletop air cleaner
- Hypoallergenic covers for mattress and pillow.

Service Parameters

These supplies must be ordered by a physician and documented in the IPOS that the item is necessary to control the child's severe reaction to airborne irritants.

Local authorization for allergy control supplies must not exceed \$100.00. The quantity is limited to five per quarter.

Household items routinely found in a home are not covered (e.g., bed linens, mattress, pillow, vacuum cleaner).



Prescription Required



IPOS must address the medical necessity for the item



Written correspondence from the private insurance carrier, if applicable

Van Lifts and Wheelchair Tie-down Systems

Description

Van Lifts and Wheelchair Tie-down Systems are modifications to a full-size van and may be locally authorized. These modifications must be necessary to ensure the accessibility of the child with mobility impairments, and the vehicle must be the child's primary means of transportation. The IPOS must specify the child's accessibility needs that will be addressed by these modifications.

Service Parameters

The full-size van must be owned or leased by the family and be the child's primary means of transportation. A lift is a one-time coverage for a lift with a minimum life expectancy of five years.

The van lift and wheelchair tie-down system must cost \$5,500.00 or less to be locally authorized. If the cost of the van lift or tie-down system for a full-size van exceeds this amount, the CMHSP must request prior authorization for specialized medical equipment. Quantity is limited to one lift in a five-year period unless prior approval is issued by the CWP for exceptions as listed below.

When purchasing new vehicles, many automobile manufacturers offer a rebate of up to \$1,000.00 to reimburse documented expenditures for modification of a vehicle for accessibility. The CMHSP should request that the family purchasing the vehicle obtain information regarding any rebate programs and apply the rebate toward the cost of the modifications.

Any other modifications to a full-size van, such as raised doors, which are necessary to meet the child's accessibility needs must be submitted for prior authorization. It is expected that the CMHSP will use prudence in considering and processing consumer requests for modifications to newly purchased vehicles (e.g., providing evidence that the child's needs were considered in purchasing a full-size van, for example, purchasing a vehicle that has a raised roof).

If the vehicle is stolen or damaged beyond repair within five years of the purchase by CWP, replacement would only be considered with prior review by the CWP. Documentation must address whether the existing lift could be transferred to a new van and whether automobile insurance will cover the replacement because the vehicle was damaged or stolen.



Prescription Required



Evidence that the cost was the lowest of three similar bids (required for any equipment exceeding \$1,000.00)



The IPOS must address the necessity of the vehicle modifications for the child who uses a wheelchair and that a van lift has not been purchased within the previous five years



Written correspondence from the private insurance carrier, if applicable.



Evidence of other resources, including manufactures rebates and community donations.

Prior Authorized Specialized Medical Equipment, Supplies, and Repairs

Description

Specialized medical equipment and supplies may include assistive technology such as devices, controls, or appliances specified in the IPOS which enable the child to increase his abilities to perform activities of daily living with a greater degree of independence than without them; or to perceive, control or communicate with the environment in which the child lives. This coverage includes adaptations to full-size vans that exceed or are not covered under the locally authorized

procedure code for van lifts and wheelchair tie-downs, as well as other items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items and durable and non-durable medical equipment not available under the Medicaid state plan. Items prior authorized by the CWP shall be in addition to any specialized medical equipment and supplies covered under private insurances and Medicaid state plan or CSHCS. Specialized medical equipment and supplies must be of direct medical or remedial benefit to the child. There must be evidence that the item is the most cost-effective alternative to meet the child's need. A physician must prescribe all items. The IPOS must specify the item is necessary to achieve the child's outcomes related to the health, welfare, safety and/or independent functioning. All items must meet applicable standards of manufacture, design and installation. The CMHSP must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase.

Repairs to specialized medical equipment that are not covered benefits through other insurances may be covered with prior authorization. There must be documentation in the IPOS that the enhanced medical equipment continues to enable the child to increase his or her ability to perform activities of daily living or to perceive, control or communicate with the environment in which the child lives.

Service Parameters

Items that are not of direct medical or remedial benefit or are considered to be experimental are not covered. Furnishings (e.g., furniture, appliances, bedding, storage cabinets) and other non-custom items that may routinely be found in a home are excluded (e.g., whirlpool tubs). Also excluded are items that would normally be available to any child and would ordinarily be provided by families, such as crayons, coloring books, games, regular toys, videotapes, CD players, cameras, film, computers and software, standard exercise equipment (e.g., treadmill, exercise bike) and standard outdoor play equipment (e.g., swing sets, playscapes, slides, trampolines, merry-go-rounds). Items that are considered family recreational choices are not covered (e.g., air conditioning for campers, swimming pools, pool decks and hot tubs). The purchase of a vehicle and any repairs or routine maintenance to the vehicle are the responsibility of the family. Educational supplies are expected to be provided by the school and are not covered by the CWP.

Coverage for van lifts and vehicle modifications include the installation of lifts, tie-down systems and raised roof or doors in a family-owned or leased full-size van. The modification must be necessary to ensure the accessibility of the child with mobility impairments and the vehicle is the child's primary means of transportation. This is a one-time coverage for those vehicle modifications with a minimum life expectancy of five years. Conversions to mini-vans are limited to the same modifications and would not include additional costs required to modify the frame (e.g., lower the floor) to accommodate a lift. Excluded are items such as automatic door openers, remote car starters, custom interiors, etc. Many automobile manufacturers offer a rebate of up to \$1,000.00 to individuals purchasing a new vehicle requiring modifications for accessibility. To obtain the rebate the family is required to submit documented expenditures of modifications to the manufacturer. The CMHSP should request that the family purchasing the vehicle obtain information regarding any rebate programs and apply the rebate toward the cost of the modifications.

Generators may be covered for a child who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power

to essential life-sustaining equipment (typically 5,000 watts) and is not intended to provide power for the entire home. The request for prior approval of a generator must include a documented history of power outages, including frequency and duration. The local power company must be notified in writing of the need to restore power on a priority basis due to the child's needs.

Repairs to specialized medical equipment that are not covered benefits through other insurances may be covered with prior approval by the CWP, regardless of how the equipment was originally purchased. All applicable warranty and insurance coverage must be sought and denied before requesting funding for repairs through the CWP. The CMHSP must demonstrate the ongoing need for the equipment to be repaired and that the repair is the most cost-effective solution when compared with replacement or purchase of a new item.



Prior authorization is required. Refer to "prior authorization process" in this section.



The CMHSP is responsible for maintaining copies of all documentation.

Environmental Accessibility Adaptations

Description

Environmental accessibility adaptations (EAAs) include those physical adaptations to the home specified in the IPOS, that are necessary to ensure the health, welfare and safety of the child or enable the child to function with greater independence in the home and without which, the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment. In the event that CWP staff determines that the home cannot be made accessible within the existing structure and all other housing options have been exhausted, additional square footage may be prior authorized following a MDCH specialized housing consultation.

Purchasing

Standards of value purchasing must be followed. The EAA must be the most reasonable alternative, based on the results from a review of all options, including a change in the use of rooms within the home or alternative housing. The case manager may contact MDCH housing specialist (refer to the Resource List in Appendix 2-a) for technical assistance. Once the most reasonable alternative has been identified and specifications have been developed, three competitive bids must be obtained to determine the most economical option.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home involved in the funded EAA (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, etc.) must be in compliance with all local codes.

The EAA must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

The EAA must demonstrate cost-effectiveness. The family must apply, with the assistance of the case manager if needed, to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the child's records. The CWP is a funding source of last resort.

EAs may be approved only once for a period equivalent to the average life of that adaptation. For example, a bathroom modification is expected to last at least 20 years. For rental property, an extended lease should be pursued to assure continued occupancy for the lifetime of an EAA.

All work must be completed while the child is enrolled in the CWP.

Service Parameters

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, and are not of direct medical or remedial benefit to the child. Examples of exclusions include, but are not limited to, carpeting, roof repair, driveways, heating, central air conditioning, home security system, raised garage doors, storage (e.g., cabinets, shelving, closets) and general home repairs. All services must be provided in accordance with applicable state or local building codes. EAs which are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a child's home. EAs shall exclude costs for improvements exclusively required to meet local building codes.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the child's family must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the CWP and MDCH are not obligated for any restoration costs.

If a family purchases or builds a home or addition, while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs (e.g., first floor bath/bedroom if the child has mobility limitations). The CWP does not cover construction costs in a new home or addition, or a home purchased after the child is enrolled in the CWP. The CWP funds may be authorized to assist with the adaptation noted above (e.g., ramps, grab bars, widening doorways) for a home recently purchased.

Fencing may be approved with documentation that it is essential to achieve the outcomes specified in the IPOS and necessary to meet a child's health and safety needs. CWP prior authorization may be obtained to fund up to 200 feet of standard chain link fence and one gate. If it is determined that chain link fencing will not meet the child's health and safety needs, a standard stockade fence may be considered.

Additional Square Footage

Additional square footage may be considered following a MDCH specialized housing consultation if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home accessible to the child, up to 250 square feet (which is the

equivalent of a bedroom and accessible bathroom addition).

The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's records.



Prior authorization is required. Refer to "Prior Authorization Process" below.



The CMHSP is responsible for maintaining copies of all documentation related to the prior approval request.

Prior Authorization Process

The following process is to be used for all prior authorization requests for specialized medical equipment, supplies and environmental accessibility adaptations.

CMHSP staff completes the Prior Review and Approval Request (PRAR) form (Appendix 16-a). This form must accompany every request for specialized equipment, supplies and environmental accessibility adaptations. The PRAR form must be signed and dated by both the case manager and financial representative.

The following documentation is submitted to the CWP, with copies maintained in the child's record for audit purposes (there are prompts on the PRAR form as a guide for the required documentation):

- Original PRAR form, filled out completely and signed.
- Original current prescription signed by a physician, licensed physician's assistant or licensed nurse practitioner under the supervision of a physician.
- Narrative justification of need by an appropriate professional. For environmental accessibility adaptations, an environmental assessment by a professional with expertise in this area is required (usually an occupational therapist).
- Documentation that the specialized medical equipment or supply is essential to the IPOS and is of direct medical or remedial benefit to the child, including a copy of habilitation programs related to the request.
- Written denial of funding from other sources, including private insurance, Medicaid state plan or CSHCS when applicable, charitable or community organizations and housing grant programs. A denial from the Trust Fund is not required for any requests through the CWP.
- If the private insurance carrier requires prior authorization to determine coverage, a request for prior authorization must be submitted to the carrier before submitting the request to MDCH.

A written denial of coverage from the private insurance carrier is required. If the insurance carrier will not provide prior authorization of coverage, the PRAR packet must document this. If the

requested item is authorized by the CWP, it will be given provisional approval to allow the purchase of the item and submission of a bill to the carrier for a final determination. Once the Explanation of Benefits is obtained, a copy must be forwarded to the CWP. If the carrier has denied the item, CWP will issue a final authorization number.

For items and services costing more than \$1,000.00, three similar bids must be submitted. For items and services costing less than \$1,000.00, only one bid is required. If less than three bids have been obtained for items and services costing more than \$1,000.00, you must submit documentation to show what efforts were made to secure the bids and explain why less than three were obtained for review by CWP.

The completed PRAR packet (PRAR form and all supporting documentation) is submitted to the following address:

Children's Waiver Program
Mental Health Services to Children and Families
Michigan Department of Community Health
Lewis Cass Building – 5th floor
320 S. Walnut
Lansing, Michigan 48913

The review process will begin within 15 calendar days of receipt at the address listed above.

The case manager may be contacted for additional information or clarification and is expected to respond within 30 days. The CWP Clinical Review Team (CRT) meets weekly. After review of a request by the CRT, a copy of the PRAR form with the CRT's decision will be returned to the case manager. If the request is approved as amended or denied, an explanation will be provided and the family will be notified in writing of their right to appeal. The approval of a PRAR certifies appropriateness of the request but does not guarantee payment (e.g., if the child becomes ineligible for waiver services before the date of service for the approved item or service).



The case manager should inform the family of the anticipated time lines necessary to gather supporting documentation and process requests, particularly for complicated or highly technical requests, like EAAs.



When requesting equipment, include brand name, model number, size and acquisition cost. The case manager may send a copy of catalog pages if appropriate.



When requesting supplies, the case manager must submit evidence that the supply item is not a covered benefit or that the quantity exceeds coverages by all other funding sources, that an exception request with supporting documentation was submitted and denied by all other funding sources, and what alternatives had been considered or tried and the outcome of those trials with alternative supplies.



The narrative justification of need should attempt to answer all of the following questions:

- What specific need identified in the IPOS will be addressed by this item?
- What are the expected functional outcomes for the child as a result of this item or modification?
- What else has been tried in the past three years to address the need and what were the results?
- Are there other cost effective alternatives to meet the need?
- Why was the particular item or modification selected over all other alternatives?



For EAA requests, have you included a diagram of the current room/home layout and the proposed changes?



Any approved equipment, supply, or EAA must be completed or delivered before the child's 18th birthday (or the 26th birthday for those who were eligible in October 1996 to remain in the CWP program) when they are no longer eligible for CWP services. Eligibility is determined on the date of service, not the date of the prior approval.

SECTION 17: PRIVATE DUTY NURSING

- The CWP authorizes PDN for children enrolled in the program.
- Prior authorization is required before PDN services are provided.
- The child must meet the medical criteria for PDN. Equipment needs alone do not support medical criteria.
- All requests for PDN services for children who meet the criteria for Intensity of Care-High must be submitted to MDCH for prior authorization.
- All requests for exception hours must be submitted to MDCH for prior authorization.
- All requests for PDN services for children who meet the criteria for Intensity of Care-Medium or Low must be prior authorized by the CMHSP.

Introduction

Private Duty Nursing is a Medicaid state plan benefit for children under age 21 who meet criteria for coverage. If the child is enrolled in one of the following programs, that program authorizes PDN services if both the medical criteria and eligibility requirements are met:

- Children's Special Health Care Services (CSHCS)
- MI Choice Waiver
- Children's Waiver Program
- Habilitation Supports Waiver

PDN must be ordered by a physician and provided by a Medicaid enrolled private duty agency, a Medicaid enrolled registered nurse (RN), a Medicaid enrolled licensed practical nurse (LPN) who is working under the supervision of an RN (per Michigan Public Health Code). It is the responsibility of the LPN to secure the RN supervision. Refer to Medicaid Provider Manual for details.

The CMHSP prior authorizes PDN for children meeting criteria for Intensity of Care-Medium or Low services. The MDCH prior authorizes the PDN, and then the CMHSP prior authorizes the PDN provider for children needing Intensity of Care-High.

Eligibility Requirements

The child must be enrolled in the CWP. The child must also meet the medical criteria for PDN as identified in the Medicaid Manual (www.Michigan.gov/mdch. Click on Medicaid Provider Manual, click on PDN and then click on medical criteria).

Medical Criteria for PDN

It is necessary for the CMHSP, medical staff, and the family, to have a clear understanding of these criteria. The criteria must be applied to the child's current medical status and care needs to determine that services are medically necessary. Documentation supporting the determination of medical criteria for PDN must be maintained in the child's records.

A child must meet the medical criteria of either I and III or II and III as listed below. For children who are currently receiving PDN services, it is important to pay attention to criteria III. Continued eligibility requires documentation that skilled nursing assessments, judgments, interventions, and evaluations are being provided to the child on a continuous basis (see definitions below). The Intensity of Care is determined by the CMHSP at least annually and more often if there is a change in the child's health status. For example, if a child is ventilator dependent and requires frequent adjustments to ventilator settings and oxygen flow with tracheal suctioning every 1 to 3 hours, they would be eligible for PDN. However, if that child's health status was stable on a consistent ventilator setting or oxygen flow and did not require tracheal suctioning every 1 to 3 hours, they would not meet medical criteria for PDN.

Definitions

I. The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

- Mechanical ventilation four or more hours per day or assisted respiration (Bi-PAP or C-PAP)
- Oral or tracheostomy suctioning 8 or more times in a 24-hour period
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility
- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility
- Continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration

II. Frequent episodes of medical instability within the past 3 to 6 months, requiring skilled nursing assessments, judgments or interventions as described in III below, due to a substantiated progressively debilitating physical disorder.

- "Frequent" means at least 12 episodes of medical instability related to a progressively debilitating physical disorder within the past 6 months, or at least 6 episodes of medical instability related to a progressively debilitating physical disorder within the past 3 months.

- “Medical instability” means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
- “Emergency medical treatment” means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services, and the services are needed to evaluate and stabilize an emergency medical condition.
- “Emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- “Progressively debilitating physical disorder” means an illness, diagnosis, or syndrome that results in increasing loss of function due to a physical disease process, and that has progressed to the point that continuous skilled nursing care (as defined in III below) is required.
- “Substantiated” means documented in the clinical/medical record, including the nursing notes.

Note: For beneficiaries described in II above, the requirement for frequent episodes of medical instability is applicable only to the initial determination of medical necessity for private duty nursing. Determination of continuing eligibility for private duty nursing for beneficiaries defined in II above, is based on the original need for skilled nursing assessments, judgments, or interventions, as described in III below.

III. The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

- “Continuous” means at least once every 3 hours throughout a 24-hour period, and/ or when delayed interventions may result in further deterioration of health status, in loss of function, death, in acceleration of the chronic condition, or in a preventable acute episode.
- Clinical needs, not equipment needs alone, support the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.

Determining Intensity of Care Levels for PDN

Once CMHSP establishes the child meets the criteria for PDN, the next step is to determine the Intensity of Care level. This is a clinical judgment and is based on the following factors: The child's medical condition; the type and frequency of needed nursing assessments; judgments and interventions; and the impact of delayed nursing interventions. Equipment needs alone do not determine Intensity of Care. Intensity of Care for PDN services is defined as high, medium or low based on the following definitions:

“Intensity of Care-High”: Includes children requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. For example, documentation should support that oxygen saturation levels are checked hourly and drop frequently, requiring an assessment of the cause and the need for an intervention such as deep suctioning or oxygen administration to stabilize the child.

“Intensity of Care-Medium”: Includes children requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care. For example, documentation should support that nursing interventions such as tracheal suctioning or care and administration of IV medication is needed at least every 1 to 3 hours throughout the day and the child is not able to communicate if in pain or choking.

“Intensity of Care-Low”: Includes children with medical needs requiring nursing assessments, judgments, and interventions by a licensed nurse (RN/LPN) at least 1 time every 3 hours for at least 12 hours per day, as well as those children who can participate in and direct their own care. For example, documentation should support that when the child is awake and active, they require a skilled intervention every 1 to 3 hours, such as oxygen administration and assessment of effectiveness to correct a drop in oxygen saturation level, or management of IV medication administration.

Determining the Number of Hours of PDN To Be Authorized

After the child's team has determined the Intensity of Care level, the information is used to identify the appropriate number of PDN hours using the Decision Guide Worksheet. The Decision Guide Worksheet can be found in the Medicaid Provider Manual and is included below.

When a child is between the ages of 6 and 16 it is expected that the child will be in a full-time school program. For children in school 25 hours or more per week, the school maximums apply. If the child's condition requires a homebound school program, approved by the school district and the child's physician (physician prescription required), the school maximum is waived. If the child's condition does not warrant a homebound program but the family chooses to reduce their child's

school schedule or chooses to home school, the school maximums apply. The school maximum does not apply when a child is out of school at least five or more consecutive days due to illness, surgery, or scheduled school breaks.

The determination of PDN hours is based on the average daily amount of hours. However, this does not mean that the same number of hours must be used every day. The hours are authorized as a monthly total that may be arranged and provided during the week in the way that best meets the child and family's needs. For example, the family may prefer to use authorized hours during the week to cover late work days, complete errands and then provide care for their child on weekends when they have more natural supports.

Decision Guide For Establishing Maximum Amount of Private Duty Nursing To Be Authorized on a Daily Basis

FAMILY SITUATION/RESOURCE CONSIDERATION		INTENSITY OF CARE		
		Average Number of Hours Per Day		
		LOW	MEDIUM	HIGH
Factor I - Availability of Care Givers Living in The Home	a. 2 or more caregiver; both work or are in school F/T or P/T	4-8	6-12	10-16
	b. 2 or more caregivers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
	c. 2 or more caregivers; neither works or is in school at least P/T	1-4	4-8	6-12
	d. 1 caregiver; works or is in school F/T or P/T	4-8	6-12	10-16
	e. 1 caregiver; does not work and is not a student	1-4	6-10	8-14
Factor II – Health Status of Caregiver(s)	a. Significant health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <= 14
	b. Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <= 13
Factor III- School *	Beneficiary attends school 25 or more hours per week, on average	Maximum of 6 hours per day	Maximum of 8 hours per day	Maximum of 12 hours per day
<p>* Factor III limits the maximum number of hours which can be authorized for a beneficiary:</p> <ul style="list-style-type: none"> a. Of any age in a center-based school program for more than 25 hours per week; or b. Age six and older for whom there is no medical justification for a homebound school program. <p>In both cases, the lesser of the maximum 'allowable' for Factors I and II, or the maximum specified for Factor III applies.</p>				

When using the Decision Guide, the following definitions apply:

'Caregiver': legally responsible person (e.g., birth parents, adoptive parents, spouses); guardian or other adults who are not legally responsible or paid to provide care, but who choose to participate in providing care.

'Full-time (F/T)': working at least 30 hours per week for wages/salary, or attending school at least 30 hours per week.

'Part-time (P/T)': working at least 15 hours per week for wages/salary, or attending school at least 15 hours per week.

'Significant' health issues: one or more primary care giver(s) has a health or emotional condition that prevents the caregiver from providing care to the beneficiary (e.g., beneficiary weighs 70 pounds and has no mobility and the primary care giver just had back surgery and is in a full-body cast).

'Some' health issues: one or more primary care giver(s) has a health or emotional condition, as documented by the care giver's treating physician, that interferes with, but does not prevent, provision of care (e.g., care giver has lupus, alcoholism, depression, back pain when lifting, lifting restrictions, etc.)

The average hours of school attendance per week is used to determine the maximum number of hours that can be authorized for the individual of school age. The average number of hours is determined by adding the number of hours in a school plus transportation time.

Note: During "planned breaks" of at least 5 consecutive school days (e.g., spring break, summer vacation) additional hours can be authorized within the parameters of Factors I and II.

As a matter of Special Education law, the Local School District (LSD) or Intermediate School District (ISD) is responsible for providing such 'health and related services' as necessary for the student to participate in his/her education program. Unless medically contraindicated, individuals of school age should attend school. Factor III applies when determining the maximum number of hours to be authorized for an individual of school age. The Medicaid PDN benefit cannot be used to replace the LSD's or ISD's responsibility for services (either during transportation to/from school or during participation in the school program)

Developing the Individual Plan of Service (Refer to Section 12)

The child's team must develop an IPOS through the planning process. The team includes the family, CMHSP case manager, RN and other team members as identified by the family. The IPOS must specify the assessments, judgments and interventions to be completed by an RN/LPN and the frequency of these nursing activities. The amount, scope, and duration of PDN services must be consistent with the identified Intensity of Care level for the child. The physician must approve and sign the IPOS. In addition, the physician must sign a prescription for the PDN services. This prescription must be maintained in the child's records and is valid up to one year. A formal review of the IPOS shall not occur less than annually to review progress towards goals and objectives and to

assess the child and family's satisfaction. The Intensity of Care determination must be reviewed and specified on the annual CWP Waiver Certification form. The CMHSP is responsible for assessing the ongoing care needs of the child. If the care needs change enough to affect the Intensity of Care level, the CMHSP must complete a new Intensity of Care assessment. A new Waiver Certification form must be completed and submitted to MDCH. If the child's team recommends an increase to Intensity of Care-High, the CMHSP must submit the following to MDCH: (1) All current assessments, including the nursing assessment, (2) Revised IPOS and (3) Revised budget. The MDCH CRT will review the documentation to determine whether it supports a change to Intensity of Care- High.

Prior Authorization for PDN Services

All PDN hours must be authorized before services are provided to the child. For children requiring Intensity of Care-Medium or Intensity of Care-Low services, CMHSP prior authorizes the PDN. For children requiring Intensity of Care-High services the request must first be submitted to MDCH CRT. The MDCH CRT will approve the budget provided by the CMHSP and will then authorize the PDN providers for the amount of hours the child is eligible to receive and as specified in the budget. The steps for prior authorization are as follows:

- 1) At the initiation of services, the CMHSP must assist the family in locating a qualified Medicaid-enrolled provider for PDN services. If the child has other insurance, any insurance requirements for providers must also be met. For example, if a child has Blue Cross through a parent's employer as well as Medicaid, the PDN provider selected must meet all the requirements for both Blue Cross and Medicaid. Medicaid is the payor of last resort and will not pay for services that another insurer would have covered if a qualified provider had performed the service.
- 2) The CMHSP must determine the Intensity of Care level and the number of hours of PDN required through the planning process. If the child needs Intensity of Care-High services, the budget must be submitted to the MDCH CRT for review and approval before services begin.
- 3) The CMHSP must designate the person responsible for entering the prior authorization requests into the State of Michigan Single-Sign On Prior Authorization database. Access to the prior authorization database requires prior authorization from the MDCH CWP for each designated person. Instructions for entering PDN hours may be found in Appendix 17-a. MDCH CWP sends a manual electronically when new designees are given access to the system.
- 4) Many CMHSPs have found it helpful to assign and receive authorization for a back-up designee for those times when the designated person is not available to enter prior authorizations.
- 5) A new prior authorization request must be entered, and a prior authorization number generated each month, for each PDN provider for each child. This means that if the child has three PDN providers in January, there would be three prior authorizations entered into the system for the month of January. If there are multiple PDN providers, the CMHSP must

specify how many hours each provider will staff that month. Adjustments may be made to the prior authorizations if a provider cannot staff all the authorized hours and another provider staffs those authorized hours. For example, the child's monthly PDN hours total 100 and his two providers are each initially authorized to provide 50 hours. During the month Provider A goes out of town and cannot provide 10 hours, Provider B covers the 10 hours. At the end of the month, the CMHSP would change the number of hours for Provider A to 40 hours and the number of hours for Provider B to 60 hours. The total number of hours of PDN for the month did not change, only the allocation between the two providers.

- 6) Prior authorized hours may not be increased beyond the allocations specified in the IPOS unless MDCH has approved an exception.
- 7) Prior authorizations must be entered into the system both before initial provision of services and at the beginning of each subsequent month that services will be provided. The CWP recommends that the CMHSP enter prior authorizations for the quarter before the beginning of each quarter. For example, January, February, and March authorizations would be entered into the system in late December. Subsequent quarter entries would be made in March, June and September.
- 8) Since the PDN provider cannot bill Medicaid without the prior authorization number generated, correctly entering the prior authorizations into the system is critical.
- 9) Respite hours are separate from PDN hours and are not to be included with the total hours entered for PDN.
- 10) If the CMHSP designee has questions about how to enter a prior authorization in the database, contact Delainie Cornwell at 517/241-5768 or by e-mail to CornwellD@michigan.gov



Physician's prescription required



A copy of the nursing assessment that supports the Intensity of Care level must be maintained in the child's record.



A copy of the IPOS including the amount, duration and scope of PDN hours must be maintained in the child's record.



Prior authorization letters from MDCH for children who meet the criteria for Intensity of Care-High must be maintained in the child's record.



The PDN provider must maintain detailed documentation of services provided (refer to Medicaid Provider Manual).



The PDN services for children who meet the criteria for Intensity of Care-Medium and Low are authorized by CMHSP.



Annual and revised CWP Waiver Certification forms are required for changes in the

Intensity of Care level. The original must be sent to MDCH for signature. A copy of the MDCH signed document must be maintained in the child's records.

Exception Process

Each child and family situation is unique and circumstances arise that may require the exception process (Appendix 17-a) to ensure the child's safety and quality of care. PDN services that exceed the child's 'benefit limitations', must be prior authorized by MDCH. Limited authority to exceed the published PDN benefit limitations may be granted subject to the provisions of this exception process. Exceptions are time-limited, as detailed below.

Exception Criteria

Exceptions are time-limited and must reflect the increased identified needs of the child or primary caregiver(s). Consideration for an exception shall be limited to situations outside the child's or family's control that place the child in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

1. A temporary alteration in the child's care needs following a hospitalization, resulting in one or both of the following:
 - a. A temporary increase in the intensity of required assessments, judgments, and interventions.
 - b. A temporary need for additional training to enable the primary caregiver(s) to identify and meet the child's care needs.

The total number of additional PDN hours cannot exceed two hours per day, for a maximum of six months.

2. The temporary inability of the primary caregiver(s) to provide the required care, as the result of one of the following:
 - a. An acute illness or injury of the primary caregiver(s). The total number of additional PDN hours cannot exceed two hours per day for the duration of the caregiver's inability, not to exceed six months. In the event there is only one caregiver living in the home and that caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized.
 - b. The death of the primary caregiver(s) or an immediate family member. 'Immediate family member' is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of 7 days.
 - c. The home environment has been determined to be unstable, as evidenced by involvement of Family Independence Agency protective or preventive services. The IPOS must include strategies directed toward stabilizing service supports and/or the

family situation. The maximum number of hours varies by the child's Intensity of

- d. Care level: High = maximum of 18 hours per day; Medium = maximum of 14 hours per day; Low = maximum of 10 hours per day. The maximum length of time for this exception is three months, or the time needed to stabilize service supports and/or the family situation, whichever is less. A one-time extension of up to three months may be made if there is documented progress toward achieving a stabilized home environment.

'Inability' is defined as the caregiver is either unable to provide care, or is prevented from providing care.

Initiating and Documenting a Request for Exception

Prior to requesting an exception from the MDCH Clinical Review Team, the case manager should confirm that the allowed maximum number of hours under the child's present Intensity of Care level have been used, including any unused hours from earlier in that month. If the maximum number of allowable hours under the present Intensity of Care level is being used, respite hours should then be used to meet the identified need.

If the maximum number of allowable hours under the present Intensity of Care level and the respite hours are not sufficient to meet the child's needs, the case manager should review the Intensity of Care determination for appropriateness. If the review results in a change in the Intensity of Care level, a new Waiver Certification form must be submitted to the MDCH Clinical Review Team. If the new Intensity of Care level addresses the need for additional hours the process stops.

The child's primary caregiver must initiate the request for an exception. The CMHSP case manager is responsible for facilitating the request, documenting the necessity for an exception and completing the CWP PRAR form (Appendix 11-a) that is submitted to MDCH. The supporting documentation described below must be submitted with the PRAR along with a copy of the IPOS and all current assessments. Be sure to identify the length of time the exception hours will be needed (start date and end date) on the PRAR form. The PRAR form should identify the daily amount of regular hourly care the child receives, the average daily amount of respite approved in the IPOS, and the number of daily exception hours requested. The total includes the daily amounts of regular hourly care, respite and the requested exception hours. A copy of the PRAR form and supporting documentation must be maintained in the child's record.

Based on information submitted, the MDCH CRT will determine if there is sufficient documented justification to approve the request. There are four possible outcomes of the MDCH Clinical Review Team review: 1) approved as presented; 2) approved as amended; 3) denied; or 4) no action taken (e.g., insufficient information received, situation resolved without intervention). If the request is amended or denied, a notice of right to fair hearing will be sent to the family by MDCH. The signed PRAR request form will be returned to the case manager. A copy of the signed PRAR form must be maintained in the child's record for audit purposes.

For an emergency request for exception hours, the case manager should contact MDCH for a consultation. Verbal approval may be given to the CMHSP on a provisional basis. Necessary

documentation (as required for all exception hour requests) must be forwarded within 10 working days after verbal approval. A provisional approval does not enable the CMHSP to bill for exception hours. If the supporting documentation is received within the 10-day limit and supports the need, MDCH CRT will send the approved PRAR to the CMHSP. A copy of the signed PRAR form must be maintained by the CMHSP for audit purposes. Factors underlying the need for additional PDN must be identified in the child's IPOS. As applicable, the IPOS must include strategies directed toward resolving the factors necessitating the exception.

Documentation must substantiate all of the following:



Current medical necessity for the exception



Current lack of natural supports required for the provision of the need level of support



Additional PDN hours are essential to the successful implementation of the child's IPOS and are essential to maintain the child within their family

SECTION 18: SERVICES COST SUMMARY

- An initial and annual CWP Service Cost Summary (budget) is required for each child served by the program (Appendix 18-a).
- Children who qualify for Category of Care-Level 1 of the CWP Decision Guide (Refer to Section 10), Intensity of Care-High for PDN, or those children receiving exception hours must submit a quarterly budget and clinical status report to MDCH to obtain prior authorization letters.
- MDCH Funding allocations are based on individual budgets and become available to the CMHSP once the budget has been submitted correctly.
- Annual budgets must be submitted prior to the beginning of a new fiscal year, October 1st.
- The IPOS is used to establish the budget. All CWP, PDN, and other mental health covered services that are identified in the IPOS must appear on the budget.
- In Part II of the budget, list only those equipment and supply items that have been identified in the IPOS and have been prior authorized by the CMHSP or MDCH.
- The case manager must sign and date the budget.
- When completing the budget it is important to complete the top section on each page (e.g., Name, Medicaid number, Category of Care Level).

Introduction

The CWP Cost Summary will be referred to as the budget in this section. It is a summary of the services and supplies identified in the child's IPOS and their associated costs. All waivers, PDN, and other mental health covered services that are identified in the IPOS must appear in Part I of the budget. Part II should list only specialized medical equipment, that has been locally (CMHSP) approved, or those specialized medical equipment, supplies and environmental accessibility adaptations that have been prior authorized by MDCH.

Preparing the Budget

For an initial CWP submission, the budget is completed and sent to MDCH once the IPOS has been completed. The budget must reflect the identified services, the staff qualifications to provide the services and the amount of services to be provided. All services identified in the IPOS must appear on the budget. All CWP, PDN, and other mental health covered services that are identified in the IPOS must appear on the budget.

Medicaid will not reimburse for services that exceed the maximum quantities established for each service procedure code or as determined by the Decision Guides, unless otherwise prior authorized by MDCH.

An annual budget is required for each child served by the CWP. Annual budgets must be submitted to MDCH prior to the beginning of a new fiscal year, October 1. For those children who meet the criteria for Category of Care level 1 of the CWP Decision Guide, Intensity of Care-High for PDN, or are receiving exception hours, the responsible CMHSP is required to submit to MDCH quarterly budgets and clinical status reports. MDCH will issue prior authorization letters to bill Medicaid based on the submitted budgets. The case manager will work with a financial staff person to prepare the budget (Appendix 18-a).

The top section of the budget must be completed on each page. List the child's full name, as it appears on his or her Medicaid card, date of birth, Medicaid number (if currently enrolled), the name of the CMHSP and the assigned supports coordinator. Check the appropriate box whether the budget is an initial, annual or quarterly budget. If the budget is an initial budget, give the month and year services are expected to begin. For an annual budget please list the current year. If the budget is a quarterly budget, please check the box indicating which quarter the budget is for and write in the appropriate year.

The budget headings are listed and described below. They should be completed in the following manner:

- **Services-** This column lists the different type of waiver and other mental health covered services, as well as PDN.
- **Providers-** This column lists the qualifications (i.e., RN, LPN, MSW, QMRP, LLP, MHA, OT) of each person who will deliver services, as identified in the IPOS.
- **Frequency in Billing Units-** Each service is listed separately with the number of billing units for each service. Refer to Services and Supports Billing (Section 19) and the Decision Guides (Section 10 & 17) for service parameters.
- **Net Billable Units This Quarter-** Add together the "frequency of billing units" for the first, second and third month. Place the total in this column.
- **Cost Billing Unit-** Identify the actual cost per unit for each service or the Medicaid screen amount, whichever is lower.
- **Total Cost This Quarter-** Multiply the net billable units this quarter by the cost per unit for each service identified in the IPOS. Place the total in this column.
- **Reimbursements From Non-MA Source-** Identify the total dollar amount of all reimbursements from non-Medicaid sources (i.e., private insurance 50%, in-kind, etc.) for each service.
- **Source-** List each source of non-Medicaid reimbursement included in the previous column.
- **Net Cost to MA This Quarter-** Subtract reimbursement from non-Medicaid sources from total cost this quarter. Place the total in this column.
- **Estimated Full Year net Cost to Medicaid-** For the annual budget, multiply the "Total Cost This Quarter" column times four. Place total in this column.

When completing Part II of the budget, be sure to complete the top section in its entirety. It is not necessary to list equipment or supplies covered by private insurance, Medicaid state plan or Children's Special Health Care (CSHCS). List only those items that have been identified in the IPOS and have been prior approved by the CMHSP or prior authorized by MDCH.

It is necessary for the case manager/QMRP to sign and date the budget.

Send the original and one copy of the budget to:

Children's Waiver Program
Mental Health Services to Children and Families
Michigan Department of Community Health
Lewis Cass Bldg., 5th Floor
320 S. Walnut Street
Lansing, Michigan 48913

SECTION 19: SERVICES AND SUPPORTS BILLINGS

- Mental Health and Waiver services provided to children served by CWP are billed fee-for-service.
- Billing for CWP does not take place until the child is enrolled in the CWP, a Medicaid identification number has been assigned, and the case manager informs the CWP administrators of the Medicaid identification number, Medicaid effective date, and start date for services.
- All billings for services must be line billed. This means all services using the same procedure code, provided on a single date of service, must be billed on a single service line. Series billing is not allowed on the professional claim forms.
- For children with private insurance, follow the requirements in the “Coordination of Benefits” chapter of the Medicaid Provider Manual.
- Prior authorization for CWP services must be obtained from MDCH CWP for children who qualify for Category I or Intensity of Care-High of the Decision Guides, or are receiving exception hours. Prior authorization is sent to CMHSP on a quarterly basis and is based on the IPOS, the quarterly status reports and the quarterly budget submissions to MDCH.
- Verify Medicaid eligibility for every date of service. Any services rendered during a period of ineligibility may not be billed to Medicaid.
- For current billing instructions refer to the Medicaid Provider Manual.
- Current Medicaid fee screens may be accessed through MDCH website at: www.michigan.gov/mdch, click on Providers, click on Information for Medicaid Providers, then click on Provider Specific Information.

Introduction

A child must be enrolled in the CWP and have clinical approval, enrollment date, a Medicaid identification number and effective date prior to billing Medicaid. Additionally, it is the responsibility of the case manager to inform the MDCH CWP staff upon receipt of this information. This information is necessary to enter the child into the CWP database.

Procedure Codes

The CWP procedure codes effective October 1, 2003 can be found in Appendix 19-b. Current Medicaid codes and screens can also be accessed at the MDCH website: www.michigan.gov/mdch, click on Providers, click on Information for Medicaid Providers, and then click on Provider Specific Information.

Note: Treatment planning and monitoring is included in the targeted case management service.

This includes, the attendance of all clinicians and case managers during treatment planning and monitoring. Targeted case management is billed once per month.

Prior Authorization Letters/Prior Approval Code

If a prior authorization letter is required from CWP, a copy of that letter must be maintained in the child's file. If a prior authorization number is necessary, the number must be placed in the appropriate area on the claim form. The letter should not be attached to the billing invoice. The following services will require a MDCH prior authorization letter or prior authorization number:

MDCH will authorize all CWP waiver services for children who qualify for Category I of the CLS Hourly Care Decision Guide. A prior authorization letter will be sent to the CMHSP case manager.

The CMHSP must provide a prior authorization letter to the Private Duty Nursing provider for PDN services. A copy of that letter must be maintained in the child's file. If the child qualifies for Intensity of Care-High, as determined by the Private Duty Decision Guide (Appendix 17-a), CMHSP must receive a prior authorization letter from MDCH.

MDCH will review all requests for prior authorization of exception service hours (refer to Section 11 for description of exception hours). The MDCH will issue prior authorization letters to CMHSP if approved.

For all medical supplies, environmental accessibility adaptations, medical equipment and repairs that require MDCH prior authorization, a prior authorization number will be issued. That number must be placed in the appropriate area on the claim.

Services/Quantity Billed

Only those services and the frequencies of services, as identified in the IPOS, can be billed to Medicaid. The total quantity of authorized services billed to MDCH must not exceed the authorization for that month. The authorization for hourly care is based on the child's Category of Care or PDN Intensity of Care Decision Guide determination.

The billing units of services (i.e., minutes, sessions, hours, daily or monthly) depend on the procedure code description being billed.



Billing Parameters and Helpful Hints

- Comprehensive Multidisciplinary Evaluations are covered up to 5 sessions per month.
- When billing for a single room air conditioner use code D1399 for Durable Medical Equipment, miscellaneous. Identify the item in the appropriate area of the claim form. This coverage is limited to one in five years.
- When billing Health Services, group services are only appropriate for services identified as "group" in the code description.

- Medication Administration is not billable when any other nursing or physician service is being provided during that time.
- EPS tardive dyskinesia testing is part of the medication review and is not payable separately.
- Adaptive toys are billed under code T1999 "Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified". Adaptive toys are limited to one toy per quarter. Justification for the toy must be identified in the IPOS. The item must be identified in the appropriate area of the billing claim.
- Occupational and/or Physical therapy sessions are covered up to a maximum of 8 sessions per month.
- Personal care items, not otherwise specified (ADL aides) must be identified in the appropriate area of the billing claim. These items are limited to 5 per quarter. Justification for the item must be identified in the IPOS.
- Vacation respite is covered up to a minimum of 14 days per year. If an RN or LPN provides both respite and PDN, the record must clearly specify time spent on each function.
- Environmental safety and control devices are limited to 5 per quarter.
- Specialty Services must be identified in the IPOS with specific goals, interventions and outcomes. They are limited to 4 sessions per month per type of specialty service.
- Allergy control supplies are limited to 5 per quarter.
- Speech and Language therapy is covered up to a maximum of 8 per month.

Other Insurance Coverage

Please refer to the "Coordination of Benefits" chapter of the Medicaid Provider Manual, for a detailed explanation of how to bill Medicaid when other insurance is involved.

Note: All rules/requirements for the primary insurance must be followed. Medicaid is the payor of last resort.

If the private insurance carrier requires prior authorization to determine coverage, a request for prior authorization must be submitted to the insurance carrier to obtain funding or a denial of coverage for the item.

If a child has reached the annual or lifetime cap under private insurance, this must be documented as required in the Medicaid Provider Manual. Please note that for an annual cap, the rejection is only current until the end of the year.

SECTION 20: GLOSSARY OF TERMS

Active Treatment: A combination and sequence of specialized, interdisciplinary treatment services that are of an extended duration and aggressively directed toward the acquisition and/or maintenance of skills and behaviors necessary for the child to function with as much self-determination as possible. A condition of participation for ICF/MR. Refer to Code of Federal Regulations (42CFR483.440)

Administrative Hearing, also called a Fair Hearing: An impartial review by an Administrative Law Judge of a decision made by the Michigan Department of Community Health (MDCH) or one of its contract agencies that the Appellant believes is inappropriate.

Ancillary Supplies: Supplies necessary to aid in the use of life supporting equipment.

Application: The Children's Waiver application is the process of applying for the waiver once a pre-screen form has been submitted to MDCH, scored and determined to have priority status. The CMHSP will receive a letter from MDCH informing them of priority status and provide instructions to proceed with the application.

Assessment: Refers to the process of identifying a child's specific strengths, developmental needs and desires for services. This should include: Identification of the child's present developmental level, health status and where possible, the cause of the disability. Areas for assessment should be determined by the expressed needs and desires of the child and his or her family; and the environmental conditions that would facilitate or impede the child's growth, development and performance.

Assistive Technology: An item or set of items that enables the individual to increase his or her ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he/she lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription or Certificate of Medical Necessity. An order is valid for one year from the date it was signed.

Behavioral Management Committee (BMC): A formal mechanism by which persons with specific knowledge, training and expertise in applied behavioral analysis review and approve (or disapprove) all service plans that include; (1) the use of aversive techniques; (2) the generalized use of token economies, if the contingent removal of tokens is a planned part of the program; and (3) the use of psychoactive medications when they are applied for behavior control purposes and where the target behavior(s) is (are) not due to an active psychotic process.

Center for Medicare and Medicaid Services (CMS): The federal agency that administers Medicaid.

Certificate of Medical Necessity (CMN): A document written by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under Michigan law that contains all of the following:

- Beneficiary's name and address
- Practitioner's signature, date of signature, and telephone number
- The supplier's name and address
- The expected start date of the order (if different from the date of signature)
- A complete description of the item or service
- The amount and length of time the item or service is needed
- Beneficiary's diagnosis
- The medical necessity of the item or service

(If required by Medicare or other insurer, a CMN may replace a prescription as an order for an item or service. If a CMN is completed, a separate prescription is not required.)

Children's Special Health Care Services (CSHCS): A program within the Michigan Department of Community Health for children and young adults under 21 years of age with special health care needs. Persons 21 and over with Cystic Fibrosis or certain blood clotting disorders may also qualify for services. The child's medical condition, not parental income, determines if a child qualifies for this program.

Children's Waiver Program (CWP): A home and community-based waiver for children with developmental disabilities under the age of 18 who require services and supports beyond regularly covered state plan Medicaid in order to remain at home with their family and who, without waiver services, would be at risk of admission to an ICF/MR.

Choice Voucher: An arrangement that gives the parent(s) of the child who is receiving services and supports from the CWP, control within specified conditions and limitations over the resources allotted for services agreed upon in the IPOS. The parent, by becoming the employer, hires the staff to work with their child. A fiscal intermediary acts as the payer of costs incurred by the child.

Clinical Review Team (CRT): MDCH staff that review new waiver applications for eligibility requirements, recertification of enrolled waiver participants and requests requiring prior approval. The CRT may also provide technical and clinical assistance to the CMHSPs. The team is comprised of a physician, registered nurse, master's level social worker, psychologist, occupational therapist and housing specialist.

Community Mental Health Services Program (CMHSP): A program operated under Chapter 2 of the Mental Health Code as a county community mental health agency, community mental health authority, or community mental health organization.

Decision Guide for Determining Amount of Community Living Support Hourly Care (Decision Guide Table): A table or grid used by CMHSP and MDCH to help determine the amount of publicly supported hourly care necessary to meet the identified CLS staffing needs of the child on the waiver.

Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis: A table or grid used to determine the amount of PDN hours to be provided under Medicaid state plan coverage.

Deinstitutionalization: The process of moving a child from an institution to a home or community-based setting.

Developmental Disability: A condition as defined by The Federal Developmental Disabilities Assistance and Bill of Rights Act (P.L. 101-496) and the Michigan Mental Health Code 330.1100a, Section 100a(20).

Direct Medical or Remedial Benefit: A prescribed specialized treatment and its associated equipment or environmental accessibility adaptations that is essential to the implementation of the IPOS. The IPOS must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented.

Enrollment Date: The date of the signature by the Children's Waiver Program Director and/or Chair of the CWP Clinical Review Team.

Enrollment Period: Begins on the effective enrollment date and typically continues for one year.

Exception for Hourly Care: The need for additional CLS or PDN staffing beyond the maximum hours allowed in the child's Category of Care or Intensity of Care level requires an exception. An exception is limited to situations outside the family's control that places the child at risk of serious injury or significant deterioration of health status and must be prior approved by DCH.

Experimental: The validity of use of the item has not been supported in one or more studies in a refereed professional journal.

Family Centered Practice (FCP): The MDCH has advocated and supported a family approach to service delivery for children and their families. This approach recognizes the importance of the family and the fact that supports and services impact the entire family. Therefore, in the case of minors, the child is the focus of service planning, and family members are integral to the planning process and its success. The wants and needs of the child/family are considered in the development of the IPOS.

Family Independence Agency (FIA): A state agency that determines Medicaid financial eligibility for the Children's Waiver Program.

Federal Financial Participation (FFP): The Federal portion of Medicaid funding.

Freedom of Choice: This is a documented assurance that a waiver candidate or participant can accept or reject waiver services instead of services provided in an ICF/MR and that the family has a choice of qualified service providers.

Funding Authorization: Initial and annual funding caps issued to the CMHSP by DCH for individual waiver participants based on the submitted budget.

Guardian: A person appointed by the court to exercise specific powers over an individual who is a minor, legally incapacitated, or developmentally disabled.

Global Assessment Functioning (GAF): This scale is identified in the DSM-IV Manual. It reports the individual's overall level of functioning on a scale from 1-100. The scale considers psychological, social and occupational functioning.

Individual Plan of Services (IPOS): This service is required by Section 712 of the Michigan Mental Health Code, and is referred to as the individual written plan of services. The responsible mental health agency for each recipient shall ensure that a person-centered planning/family centered practice process is used to develop a written IPOS in partnership with the recipient. The IPOS shall be developed within 7 days of the commencement of service or, if an individual is hospitalized, before discharge or release. The IPOS shall consist of a treatment plan, a support plan, or both, and shall establish meaningful and measurable goals with the recipient. The plan shall be kept current and shall be modified when indicated.

Intermediate Care Facility for the Mentally Retarded (ICF/MR): Refer to Code of Federal Regulations (42CFR483, Subpart I) An institution (or distinct part of an institution) that:

- Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions, and
- Provides active treatment, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his/her greatest ability

Lease/Rental Agreement: A document signed by the landlord and the resident (and/or his or her legal representative, if applicable) of a rental unit (apartment, room, house).

Life Support: Equipment necessary to sustain an individual's life.

Medicaid: State and federal funded program created by Title XIX of the Social Security Act (SSA) that provides a method for eligible families and individuals to receive assistance for necessary medical care.

Medicaid Health Plan (MHP): In general, MHPs are responsible for outpatient mental health in the following situations: The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments; or the beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.

Medical Necessity: Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care.

Michigan Department of Community Health (MDCH): The state department that administers the Children's Waiver Program.

Negative Action: A termination, suspension or reduction of Medicaid eligibility or covered services.

Parent/Agency Agreement: A written document that specifies individual objectives and timelines related to achieving a permanent family relationship.

Person-Centered Planning (PCP): The Michigan Mental Health Code establishes the right for all individuals to have their individual plan of services developed through a person-centered planning process regardless of age, disability or residential setting. Person-centered planning is a highly individualized process designed to plan and support the individual receiving services by building upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities. The PCP process involves families, friends, and professionals as the individual desires or requires. Health and safety needs are addressed in the IPOS with supports listed to accommodate those needs.

Physician (M.D. or D.O.): An individual who possesses a current license to practice medicine in the State of Michigan, a Michigan Controlled Substances license, and a Drug Enforcement Agency (DEA) registration.

Pre-Screen: A document submitted by the CMHSP to DCH, which outlines the pertinent information regarding a Children's Waiver Program candidate. The information in this document is used to determine priority for assigning waiver when there is an opening.

Prescription: A written order for a service or item by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under Michigan law that contains all of the following:

- Prescription
- Beneficiary's name
- Prescribing practitioner's name, address and telephone number
- Prescribing practitioner's signature (a stamped signature is not acceptable)
- The date the prescription was written
- The specific service or item being prescribed
- The expected start date of the order (if different from the prescription date)
- The amount and length of time that the service or item is needed

Prior Authorization for Equipment and Supplies: Written authorization obtained from Michigan Department of Community Health to purchase and bill for a Medicaid state plan-covered item or service.

Prior Authorization Letter: Monthly authorization letters issued either by CMHSP or DCH, that identify types and frequencies of waiver services for a waiver participant.

Prior Review and Approval (PRAR) for Equipment/Home Modifications: Written authorization obtained from the Michigan Department of Community Health prior to the purchase of enhanced medical equipment, supplies and home modifications. This prior approval must be obtained in order to bill for a Children's Waiver covered item or service.

Prior Review and Approval (PRAR) for Exception Hours: Written prior authorization obtained from the MDCH to use additional Community Living Support or Private Duty Nursing hours above the maximums established by the Decision Guides.

Priority Status: This occurs when a child on the Children's Waiver Program Priority Weighing List has the highest score at the time that a waiver opening occurs. That child receives the opportunity to proceed with the waiver application process.

Priority Weighing Criteria: Procedures for decision-making by MDCH to determine the priority status for application to the Children's Waiver Program.

Priority Weighing List: A list updated weekly, includes the names of all children who have had pre-screen forms submitted and scored by MDCH, but have not yet received priority status to apply for the Children's Waiver Program. The list also includes the child's age, pre-screen score, and the date of completion of the original pre-screen. The score is revised with all updated pre-screen applications.

Qualified Mental Retardation Professional (QMRP): Meets federal qualifications and participates in certifying and re-certifying a child's eligibility for the Children's Waiver Program. The federal qualifications for a QMRP (42 CFR 483.430) include a professional who:

1. Has at least one year of experience working directly with persons with mental retardation or other developmental disabilities, and
2. Is a doctor of medicine or osteopathy, a registered nurse, or an individual who holds at least a bachelor's degree in a professional category specified in Paragraph (b)(5) of Section 483.430

Quality Management and Planning (QMP): A division of the Michigan Department of Community Health that reviews CMHSP compliance with Medicaid program standards.

Recipient Rights: In addition to the rights, benefits and privileges guaranteed by other provisions of law, a recipient of mental health services shall have their rights guaranteed by the Michigan Mental Health Code, unless otherwise restricted by law.

Related Condition: (42 CFR 435.1009) A severe, chronic disability that meets all of the following conditions:

1. It is attributable to:
 - a. Cerebral palsy or epilepsy, or
 - b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior, similar to that of mentally retarded, and requires treatment or services similar to those required for these persons.
3. It is manifested before the person reaches the age of 22
4. It is likely to continue indefinitely
5. Results in substantial functional limitations in three or more of the following areas of major life activities:
 - a. Self care
 - b. Understanding and use of language
 - c. Learning
 - d. Mobility
 - e. Self-direction
 - f. Capacity for independent living

Responsible Mental Health Agency (RMHA): The hospital, center, or community mental health services program that has primary responsibility for the recipient's care or for the delivery of services or supports to that recipient.

Responsible Relative: Parent or legal guardian of a minor child (under 18 years of age), who, under most circumstances, may not be paid for the provision of Children's Waiver services to that individual.

Scope of Service: The parameters within which the service will be provided, including:

1. Who (e.g., professional, paraprofessional, aide supervised by a professional)
2. How (e.g., face-to-face, telephone, taxi or bus, group or individual)
3. Where (e.g., community setting, office, beneficiary's home).

Spend-Down: Medicaid beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local FIA worker to qualify for Medicaid.

Support Plan: A written plan that specifies the personal support services or any other supports that is to be developed with and provided for a recipient.

Targeted Case Management: Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Termination: Status of a waiver participant who has exited the waiver.

Third Party Liability: A payment resource available from both private and public insurance and other liable third parties that can be applied toward the beneficiary's health care expense.

Transfer: Movement of a waiver participant from one CMHSP to another.

Treatment Plan: A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services that are to be developed with and provided for a recipient.