

QUESTIONS AND ANSWERS

Behavioral Respite Services

1. In Question #1, what is meant by “current residential setting”?

Answer: It means the home where the individual lives, either with or without family members, including a private residence, a family home, a Supported Living home, a Residential Habilitation home, a Family Model Residential Support home, and a Medical Residential Services home. It does not include a hospital or an institutional setting (e.g., a nursing facility, an ICF/MR, a mental health hospital, a correctional facility).

2. In Question #1, what is meant by “per program year”?

Answer: “Per program year” means the 12-calendar-month period beginning with the first day of the approved waiver year. For all three of the Home and Community-Based Services (HCBS) waivers, the “program year” is currently equivalent to the calendar year. Thus, “per program year” currently means “per calendar year”, regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

3. Are there guidelines for determining the number of days of Behavioral Respite Services that would be needed to resolve the behavioral crisis as required by Question #3?

Answer: If the service recipient has had previous behavioral crises that necessitated utilization of Behavioral Respite Services, the length of time it required to stabilize the behavioral crisis and return the person back home can be used as the guideline. Otherwise, use the following guidelines:

- a. If no change in housemates is anticipated, approve an initial period of 15 days.
- b. If the incompatibility is so serious that a change in housemates is needed, approve an initial period of 30 days

4. How can one determine if the annual limit of 60 days per waiver program year has been exceeded?

Answer: The Plans Reviewer will check the cost plan to determine the number of approved days of waiver-funded Behavioral Respite Services listed in the cost plan during the current program (calendar) year and will verify the amount of waiver-funded Behavioral Respite Services that have been billed (or which may be pending) for services provided during the current program (calendar) year.

Behavior Services (by a Behavior Analyst or Behavior Specialist)

1. **Can a service recipient under age 21 years get Behavior Services (by a Behavior Analyst or Behavior Specialist) through the waiver program IF the service recipient is not currently approved for Behavior Services?**

Answer: No. Medically necessary Behavior Services must be obtained from the TennCare Managed Care Contractor (MCC).

2. **Can a service recipient under age 21 years who is already receiving Behavior Services through the waiver obtain an increase in the amount of Behavior Services currently approved through the waiver program?**

Answer: No. Medically necessary Behavior Services must be obtained from the TennCare Managed Care Contractor (MCC). An increase in services must be obtained through the MCC. DMRS will submit the request for increased services, as well as a request to transition existing services, to the MCC in accordance with the transition process described in the protocol.

3. **What is the authorization process for the behavior plan development and initial training of staff on the plan?**

Answer: Any time that a Behavior Services assessment is approved in accordance with this protocol, the corresponding behavior plan development (including the training of staff on the plan during the first 30 days following its approval) based on the assessment may also be authorized if requested, up to the maximum of six (6) hours.

4. **What is the authorization process for presentations of the service recipient's information at human rights committee meetings, behavior support committee meetings, and planning meetings?**

Answer: Any time that a Behavior Services assessment is approved in accordance with this protocol, presentation of behavior information at human rights committee meetings, behavior support committee meetings, and planning meetings may also be authorized if requested, up to the maximum of five (5) hours per year per provider.

5. **In Question A-2, how can one determine if there has been an interval of at least 12 months since the last Behavior Services assessment?**

Answer: The Plans Reviewer will check the cost plan to determine the date that the last assessment, if any, was approved and will verify whether any Behavior Services assessments have been billed (or which may be pending) for services provided during the current program (calendar) year.

6. **In Question A-5 and elsewhere, what is meant by "imminent risk of harm", "significant damage to property", and "significantly impair the service recipient's ability to live in the home and community setting or participate in normal community activities?"**

Answer:

- a. "Imminent risk of harm" means that, for practical purposes, within the last 30 days, multiple instances have occurred in which:

- (1) The service recipient's behavior resulted in physical harm to him or herself;

- (2) The service recipient's behavior would have resulted in physical harm to him or herself but for the intervention of someone else and such intervention cannot reasonably be relied upon to prevent physical harm in the future;
 - (3) The service recipient has inflicted bodily harm on someone else; or
 - (4) The service recipient has attempted or threatened to inflict bodily harm on someone else.
- b. "Significant damage to property" means damage to property that would cost more than \$200.00 to repair or replace.
- c. "Significantly impair" means that the service recipient's behavioral issues, for practical purposes, either pose an immediate and substantial danger to the health and safety of the service recipient or to others or manifest as socially unacceptable behavior that would prevent participation in normal community activities.

7. In Question #6, what is meant by "program year"?

Answer: "Program year" means the 12-calendar-month period beginning with the first day of the approved waiver year. For all three of the Home and Community-Based Services (HCBS) waivers, the "program year" is currently equivalent to the calendar year. Thus, "program year" currently means "per calendar year", regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

8. In Question #6, how can one determine if the annual limit of 2 assessments per waiver program (calendar) year has been exceeded?

Answer: The Plans Reviewer will check the cost plan to determine the number of assessments listed in the cost plan during the current program (calendar) year and will verify the number of assessments that have been billed (or which may be pending) for assessment provided during the current program (calendar) year.

9. In Question B-2.c and elsewhere, what is meant by "to achieve measurable and sustained functional gains"?

Answer: "To achieve measurable and sustained functional gains" means that the provision of Behavior Services would be reasonably expected to result in clinical improvement in the service recipient's behavior that could be objectively measured and that such clinical improvement would reasonably be expected to be sustained and that such sustained improvement can be demonstrated in normal daily activities outside the treatment setting. For example, episodes of behavioral aggression that occurred 2-3 times per week could be eliminated or reduced in frequency as a result of behavioral interventions specified in the Behavior Support Plan.

10. In Question B-2.d and elsewhere, what is meant by "reasonable and appropriate given the person's current age and health status?"

Answer: It means that the goals are feasible for the service recipient based on the age and medical conditions of the service recipient. For example, it may not be realistic to implement interventions to influence the behavior of an elderly individual who has developed dementia and cannot remember events from day to day or hour to hour.

11. In Question B-3 and elsewhere, are there guidelines for determining whether requested Behavior Services are "consistent with and not in excess of" the amount required to meet the service recipient's needs?

Answer: "Consistent with and not in excess of" means that the requested Behavior Services, based on an assessment of the service recipient's needs, will be sufficient, but not in excess of the amount

necessary, to meet those needs and to accomplish specific measurable therapeutic goals and objectives that are feasible given the service recipient's age, health status, and behavioral issues. When there is a question regarding whether the requested services are appropriate, the Plans Reviewer should consult with the Behavior Analyst in the Regional Office.

12. In Question B-3 and elsewhere, how will concurrent review dates be determined?

Answer: Guidelines for establishing initial and subsequent review dates will be provided.

13. In Question C-2.c, what is meant by “unreasonable delays by the MCC?”

Answer: An unreasonable delay would be:

- a. Failure of the MCC to act on a transition request and to make a medical necessity determination to approve or deny the service within 30 days of the date DMRS submitted the transition request to the MCC; or
- b. Failure of the MCC to identify a provider for an approved service and to arrange a date for initiation of services within 14 days of the date of approval by the MCC.

14. How are psychological evaluations and psychiatric evaluations handled under the protocol?

Answer: To the limited extent that psychological evaluations and psychiatric evaluations have previously been covered, the Behavior Services protocol is not applicable to requests for such. The protocol only applies to Behavior Services provided by a Behavior Analyst or Behavior Specialists.

ENVIRONMENTAL ACCESSIBILITY MODIFICATIONS

1. In Question #1, what is meant by “per two (2)-program year”?

Answer: “Per two (2)-program year” means the 24-calendar-month period beginning with the first day of the approved waiver year for the preceding calendar year. For all three of the Home and Community-Based Services (HCBS) waivers, the “program year” is currently equivalent to the calendar year. Thus, “per two (2)-program year” currently means “per 2 calendar years”, regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

Examples:

- a. If the service recipient was enrolled in the waiver on 3/1/2007, the two-year period began 1/1/2007 and will end 12/31/2008. At that point the 2-year cycle will start over.
- b. If the service recipient was enrolled in the waiver on 3/1/2008, the two-year period began 1/1/2008 and will end 12/31/2009. At that point the 2-year cycle will start over.
- c. If the service recipient was enrolled in the waiver on 3/1/2006, the first two-year period began 1/1/2006 and ended 12/31/2007. The second 2-year cycle began on 1/1/2008 and will end 12/31/2009. At that point another 2-year cycle will start.

2. How can one determine if the \$15,000 waiver service limit has been exceeded?

Answer: The Plans Reviewer will check the cost plan to determine the amount of waiver-funded Environmental Accessibility Modifications approved in the cost plan during the current “2-program year” cycle and will verify the amount of waiver-funded Environmental Accessibility Modifications that has been billed (or which may be pending) for services provided during the current 2-year cycle.

3. In Question #3, how can one determine what is the least costly alternative?

Answer: The Plans Reviewer will review the reasonableness of the proposed modification and the supporting documentation. The intent is for coverage to be provided for basic modifications sufficient to appropriately meet the needs of the service recipient.

Examples:

- a. While basic wood or metal hand rails for exterior stairs or steps could be covered, wrought iron hand rails would not be covered.
- b. A site-built wheelchair ramp would not be covered if a less expensive manufactured wheelchair ramp which could safely and appropriately meet the service recipient’s needs could be installed.

INDIVIDUAL TRANSPORTATION SERVICES

1. **In Question #1, what is required to document that there are no others who are “willing to provide” transportation?**

Answer: The ISC or case manager must state in the ISP that the service recipient does not have immediate family members, close friends who are involved in providing supports, or available sources of public transportation to provide the needed transportation without charge.

2. **In Question #2, what is required to document that the transportation is not being provided for an excluded reason?**

Answer: The ISC or case manager must state in the ISP the purpose for the Individual Transportation Services.

3. **In Question #4, are there guidelines for determining whether requested Individual Transportation Services are “consistent with and not in excess of” the amount required to meet the service recipient’s needs?**

Answer: “Consistent with and not in excess of” means that the requested Individual Transportation Services, based on an assessment of the service recipient’s needs, will be sufficient, but not in excess of the amount necessary, to access approved activities specified in the Individual Support Plan (and not otherwise excluded by the waiver definition).

Family Model Residential Support

1. **In Question A-1 and elsewhere, what is required to document that the service is not provided in the home of the service recipient's family of origin?**

Answer: The Family Model Residential Support provider must provide the ISC with a statement (to be submitted with the ISP) that the Family Model Residential Support home will not be the home of a family member where the service recipient resides with the family member.

2. **In Question A-2.c(2), how can one determine what is more cost-effective?**

Answer: Compare the cost of Family Model Residential Support with the current cost of Personal Assistance, Respite, and Individual Transportation Services that would be required to meet the needs of the service recipient in the service recipient's home or in a home with family members or other caregivers.

Vehicle Accessibility Modifications

1. **In Question # 1, what is required to document that the service is not being provided for one of the specified exclusions?**

Answer: The ISC or case manager must describe the proposed Vehicle Accessibility Modification in the ISP.

2. **What is meant by “per five (5)-program year”?**

Answer: The initial “per five (5)-program year” means the 60-calendar-month period beginning 1/1/2005 or the first day of the approved waiver year in which the service recipient was enrolled in the waiver, whichever is more recent. For all three of the Home and Community-Based Services (HCBS) waivers, the “program year” is currently equivalent to the calendar year. Thus, “per five (5)-program year” currently means “per 5 calendar years”, regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

Examples:

- a. If the service recipient was enrolled in the waiver on 1/1/2005, the 5-year period began 1/1/2005 and will end 12/31/2009. At that point another 5-year cycle will begin.
 - b. If the service recipient was enrolled in the waiver on 3/1/2005, the 5-year period began 1/1/2005 and will end 12/31/2009. At that point another 5-year cycle will begin.
 - c. If the service recipient was enrolled in the waiver on 3/1/2006, the 5-year period began 1/1/2006 and will end 12/31/2010. At that point another 5-year cycle will begin.
 - d. If the service recipient was enrolled in the waiver on 11/1/2007, the 5-year period began 1/1/2007 and will end 12/31/2011. At that point another 5-year cycle will begin.
3. **How can one determine if the \$20,000 waiver service limit has been exceeded?**

Answer: The Plans Reviewer will check the cost plan to determine the amount of waiver-funded Vehicle Accessibility Modifications approved in the cost plan during the current “5-program year” cycle and will verify the amount of waiver-funded Vehicle Accessibility Modifications that have been billed (or which may be pending) for services provided during the current 5-year cycle.

4. **In Question #2, what is required to document that the vehicle to be modified is owned by the service recipient?**

Answer: The ISC or case manager must submit a copy of:

- (1) A motor vehicle title showing that the vehicle is titled in the service recipient’s name (joint titles are not acceptable); or
- (2) An official bill of sale showing that the vehicle was sold to the service recipient (joint bill of sales are not acceptable).

Registration certificates are not acceptable as proof of ownership.

5. **In Question #3, what is required to document that the vehicle to be modified is owned by the conservator or guardian?**

Answer: The ISC or case manager must submit a copy of:

- (1) A motor vehicle title showing that the vehicle is titled in the name of the guardian or conservator; or
- (2) An official bill of sale showing that the vehicle was sold to the guardian or conservator.

Registration certificates are not acceptable as proof of ownership.

6. In Question #4, how can one determine what is the least costly alternative?

Answer: The Plans Reviewer will review the reasonableness of the proposed modification and the supporting documentation. The intent is for coverage to be provided for basic modifications sufficient to appropriately meet the needs of the service recipient.

Respite

1. **How can one determine if the annual limit of 30 days per waiver program year has been exceeded?**

Answer: The Plans Reviewer will check the cost plan to determine the number of approved days of waiver-funded Respite services listed in the cost plan during the current program (calendar) year and will verify the amount of waiver-funded Respite services that have been billed (or which may be pending) for services provided during the current program (calendar) year.

Transitional Case Management

1. **In Questions #2 and #3, how can one determine how long the person has been residing in an institution and whether the person will qualify for waiver services upon discharge?**

Answer: The ISC or case manager must:

- a. Specify the institution where the individual has been residing;
- b. Indicate the date of the most recent admission to the institution; and
- c. Specify the target date on which the person will be simultaneously discharged from the institution and enrolled in the waiver. (The target date must be within 60 days for persons institutionalized 180 days or more or within 14 days for persons institutionalized less than 180 days.)

Unless the person is already receiving Medicaid-funded services in an ICF/MR, the ISC or case manager must also:

- a. Provide documentation from the Department of Human Services (DHS) that the person is financially eligible for Medicaid or will be at the time of discharge from the current institutional setting; and
- b. A copy of the ICF/MR level of care Pre-Admission Evaluation (PAE) approved by the Bureau of TennCare or a letter from the Bureau of TennCare stating that the person has been determined to meet the Medicaid ICF/MR level of care criteria.

2. **In Question #4, what is meant by “will be ... enrolled in the waiver within 60 days?”**

Answer: “Will be ... enrolled in the waiver within 60 days” means that the person will be discharged from the institution and will begin receiving waiver services outside the institution immediately upon discharge. For purposes of Transitional Case Management, the date of enrollment in the waiver is the same date on which the following events simultaneously occur:

- a. The person is discharged from the institution; and
- b. The person begins receiving one or more waiver-funded services.

Specialized Medical Equipment and Supplies and Assistive Technology

1. In Question #1, what is meant by “per two (2)-program year”?

Answer: “Per two (2)-program year” means the 24-calendar-month period beginning with the first day of the approved waiver year for the preceding calendar year. For all three of the Home and Community-Based Services (HCBS) waivers, the “program year” is currently equivalent to the calendar year. Thus, “per two (2)-program year” currently means “per 2 calendar years”, regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

Examples:

- a. If the service recipient was enrolled in the waiver on 3/1/2007, the two-year period began 1/1/2007 and will end 12/31/2008. At that point the 2-year cycle will start over.
- b. If the service recipient was enrolled in the waiver on 3/1/2008, the two-year period began 1/1/2008 and will end 12/31/2009. At that point the 2-year cycle will start over.
- c. If the service recipient was enrolled in the waiver on 3/1/2006, the first two-year period began 1/1/2006 and ended 12/31/2007. The second 2-year cycle began on 1/1/2008 and will end 12/31/2009. At that point another 2-year cycle will start.

2. How can one determine if the \$10,000 waiver service limit has been exceeded?

Answer: The Plans Reviewer will check the cost plan to determine the amount of waiver-funded Specialized Medical Equipment and Supplies and Assistive Technology approved in the cost plan during the current “2-program year” cycle and will verify the amount of waiver-funded Specialized Medical Equipment and Supplies and Assistive Technology that has been billed (or which may be pending) for services provided during the current 2-year cycle.

3. In Question #3, how can one determine what is the least costly alternative?

Answer: The Plans Reviewer will review the reasonableness of the proposed Specialized Medical Equipment and Supplies and Assistive Technology and the supporting documentation. The intent is for coverage to be provided for basic items sufficient to appropriately meet the needs of the service recipient.

4. In Question #7, how will the Plans Reviewer know the outcome of the fair hearing process or whether or not there has been a denial by Medicare?

Answer: The ISC or case manager must submit documentation with the ISP that the item of Specialized Medical Equipment or Assistive Technology was denied through the TennCare MCO fair hearing process or that such a determination is pending. Documentation may include:

- a. A copy of the denial; or
- b. Verbal confirmation of the denial from the TennCare Solutions Unit. The date of denial and the contact person in the TennCare Solutions Unit must be specified.

If an item was denied or not covered by Medicare, documentation of such must be submitted with the ISP. A letter or statement of non-coverage of the item by Medicare may also be submitted as documentation.

Day Services

1. **In Question A-1.c and elsewhere, what is meant by “appropriate based on the service recipient’s needs, therapeutic goals, and objectives?”**

Answer: This means that the type of Day Services requested can provide services, based on an assessment of the service recipient’s needs, which can meet specific measurable therapeutic goals and objectives that are feasible given the service recipient’s age, health status, and behavioral issues.

2. **In Question A-1.d and elsewhere, what is meant by “without more intensive staffing than would routinely be required in the service recipient’s home?”**

Answer: This means that the service recipient would not require a higher level of staffing than would routinely be required to ensure health and safety in the service recipient’s place of residence. For example, if the service recipient routinely has 1 to 1 staffing in the home, but because of behavioral issues would require 2 to 1 staffing in order to participate in Supported Employment, a different type of Day Services not requiring more intensive staffing would be more appropriate based on the person’s behavioral needs.

3. **In Question #1, what is meant by “per program year”?**

Answer: “Per program year” means the 12-calendar-month period beginning with the first day of the approved waiver year. For all three of the Home and Community-Based Services (HCBS) waivers, the “program year” is currently equivalent to the calendar year. Thus, “per program year” currently means “per calendar year”, regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

4. **In Question A-1.d and elsewhere, how can one determine if either the annual limit of 243 days per waiver program year or the limit of 5 days per week has been exceeded?**

Answer: The Plans Reviewer will check the cost plan to determine the number of approved days of waiver-funded Day Services listed in the cost plan during the current program (calendar) year and will verify the amount of waiver-funded Day Services that have been billed (or which may be pending) for services provided during the current program (calendar) year. This will be compared to the annual limit of 243 days of Day Services per program (calendar) year. The limit of 5 days per week is a billing edit which will be enforced at the time of claims payment.

5. **In Question A-2 and elsewhere, are there guidelines for determining whether requested Day Services are “consistent with and not in excess of” the amount required to meet the service recipient’s needs?**

Answer: “Consistent with and not in excess of” means that the requested type of Day Services, based on an assessment of the service recipient’s needs, will be sufficient, but not in excess of the amount necessary, to meet the service recipient’s needs and to accomplish specific measurable therapeutic goals and objectives that are feasible given the service recipient’s age, health status, and behavioral issues.

Nursing Services

1. **Can a service recipient under age 21 years get Nursing Services through the waiver program IF the service recipient is not currently approved for Nursing Services?**

Answer: No. Medically necessary Nursing Services must be obtained from the TennCare Managed Care Organization (MCO).

2. **Can a service recipient under age 21 years who is already receiving Nursing Services through the waiver obtain an increase in the amount of Nursing Services currently approved through the waiver program?**

Answer: The answer is no if the service recipient is under age 20 years. Pending further clarification of the waiver Nursing Services definition, if a service recipient is age 20 years (but not yet age 21), transition of Nursing Services to the TennCare MCO will not be initiated. For individuals under age 20 years, medically necessary Nursing Services must be obtained from the TennCare Managed Care Organization (MCO). An increase in services must be obtained through the MCO. DMRS will submit the request for increased services, as well as a request to transition existing services, to the MCO in accordance with the transition process described in the protocol.

3. **In Question A-4 and elsewhere, will the request for Nursing Services be denied if the physician's order does not specify the specific skilled nursing functions to be performed and the frequency of such skilled nursing functions?**

Answer: Yes. Explanation of the specific skilled nursing functions to be performed and the frequency of such skilled nursing functions is required in order to determine the medical necessity of the service. Prior to denial, the Plans Reviewer should attempt to obtain such information from the prescriber and/or the ISC or case manager. However, if such information is not received in time to render a timely review and decision, such request will be denied as the medical necessity of the service cannot be established.

4. **In Question A-4 and elsewhere, are there guidelines for determining whether requested Nursing Services are "consistent with and not in excess of" the amount required to meet the service recipient's needs?**

Answer: "Consistent with and not in excess of" means that the requested Nursing Services, based on an assessment of the service recipient's needs, will be sufficient, but not in excess of the amount necessary, to meet the service recipient's needs for skilled nursing services (not otherwise excluded by the waiver service definition). Approval of Nursing Services will be based on the amount of time that is reasonably required to provide the specific skilled nursing services requested. When there is a question regarding whether the requested services are appropriate, the Plans Reviewer should consult with the Regional Nurse in the Clinical Review Unit. General guidelines outlining standard periods of time for service approval will be developed (e.g., 15 minutes for performing a fingerstick with a sliding scale insulin injection).

5. **In Question A-4 and elsewhere, how will concurrent review dates be determined?**

Answer: Guidelines for establishing initial and subsequent review dates will be provided. At the time of the annual ISP update, exemptions from the concurrent review process may be granted by the Regional Nurse on a case-by-case basis, when there is justification that the skilled nursing services will be needed long-term (e.g., for ventilator care, gastrostomy tube feedings).

6. **In Question B-4.c, what is meant by "unreasonable delays by the MCO?"**

Answer: An unreasonable delay would be:

- a. Failure of the MCO to act on a transition request and to make a medical necessity determination to approve or deny the service within 30 days of the date DMRS submitted the transition request to the MCO; or
- b. Failure of the MCO to identify a provider for an approved service and to arrange a date for initiation of services within 14 days of the date of approval by the MCO.

Supported Living

1. **In Question A-1 and elsewhere, what is required to document that the service is not provided in a home where the service recipient will live with family members who are not service recipients enrolled in the waiver?**

Answer: The Supported Living provider must provide the ISC with a statement (to be submitted with the ISP) that the Supported Living home will not be a home where the service recipient will live with family members who are not service recipients enrolled in the waiver.

2. **In Question A-2.c(2), how can one determine what is more cost-effective?**

Answer: Compare the cost of Supported Living with the current cost of Personal Assistance, Respite, and Individual Transportation Services that would be required to meet the needs of the service recipient in the service recipient's home or in a home with family members or other caregivers.

3. **In Question A-4.a(2) and elsewhere, what is meant by “serious and imminent danger of harm” and by “significant psychiatric or behavioral problems”?**

Answer:

- (1) “Serious and imminent risk of harm” means that for practical purposes, the service recipient has either inflicted physical injury on another person that required medical treatment or has attempted or threatened to inflict physical injury on another person that would likely require medical treatment and behavioral interventions to address such aggressive behaviors and minimize the risk of physical harm to others have not been successful.
- (2) “Significant psychiatric or behavioral problems” means extreme violence (e.g., murder, attempted murder); multiple physical assaults inflicting injury to others requiring medical treatment; sexual assault; or pedophilia, which would reasonably be expected to place others at extreme risk of harm.

4. **In Question A-4.a(3) and elsewhere, what is meant by “cannot be reasonably and adequately managed?”**

Answer: It means that the service recipient’s behavior toward others poses an immediate risk of physical injury, which would require medical treatment, and that such behavior cannot, for practical purposes, be reasonably controlled in a shared residential setting by behavioral supervision and intervention strategies.

5. **In Question A-6 and elsewhere, what is required to document that the size of a 2-person Supported Living home is such that it can only accommodate 2 service recipients?**

Answer: The Supported Living provider must provide the ISC with a statement (to be submitted with the ISP) that the size of the Supported Living home is such that it can only accommodate 2 service recipients and an explanation of why the home can only accommodate 2 service recipients.

6. **In Question C-7 and elsewhere, what is meant by “the current Supported Living home is adequate to meet the service recipient’s needs?”**

Answer: Adequate means that:

- a. The service recipient’s needs involving direct support services and other waiver services can be safely and appropriately met without the need for transfer to a different Supported Living home; and

- b. If the service recipient has had a change in condition affecting ambulation and mobility, the service recipient's needs involving direct support services and other waiver services can be safely and appropriately met through additional Environmental Accessibility Modifications and without the need for transfer to a different Supported Living home.

Orientation and Mobility Training

1. **In Question A-1, how can one determine if there has been an interval of at least 12 months since the last assessment?**

Answer: The Plans Reviewer will check the cost plan to determine the date that the last assessment, if any, was approved and will verify whether any assessments have been billed (or which may be pending) for services provided during the current program (calendar) year.

2. **In Question A-5 and elsewhere, what is meant by “program year”?**

Answer: “Program year” means the 12-calendar-month period beginning with the first day of the approved waiver year. For all three of the Home and Community-Based Services (HCBS) waivers, the “program year” is currently equivalent to the calendar year. Thus, “program year” currently means “per calendar year”, regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

3. **In Question A-5, how can one determine if the annual limit of 3 assessments per waiver program (calendar year) per provider has been exceeded?**

Answer: The Plans Reviewer will check the cost plan to determine the number of assessments listed in the cost plan during the current program (calendar) year and will verify the number of assessments that have been billed (or which may be pending) for assessment provided during the current program (calendar) year.

4. **In Question B-1.c and elsewhere, what is meant by “to result in measurable and sustained functional gains”?**

Answer: “To result in measurable and sustained functional gains” means that the provision of Orientation and Mobility Training would be reasonably expected to result in clinical improvement in the service recipient’s functional limitations in orientation and mobility related to visual impairment that could be objectively measured and that such clinical improvement would reasonably be expected to be sustained and that such sustained improvement can be demonstrated in normal daily activities outside the treatment setting.

5. **In Question B-1.d and elsewhere, what is meant by “reasonable and appropriate given the person’s current age and health status?”**

Answer: It means that the goals are feasible for the service recipient based on the age and medical conditions of the service recipient.

6. **In Question B-1 and elsewhere, how can one determine if either the annual limit of 52 hours per program (calendar) year has been exceeded?**

Answer: The Plans Reviewer will check the cost plan to determine the number of approved hours of Orientation and Mobility Training services listed in the cost plan during the current program (calendar) year and will verify the amount of Orientation and Mobility Training services that have been billed (or which may be pending) for services provided during the current program (calendar) year. This will be compared to the annual limit of 52 hours per program (calendar) year.

7. **In Question B-2 and elsewhere, are there guidelines for determining whether requested Orientation and Mobility Training services are “consistent with and not in excess of” the amount required to meet the service recipient’s needs?**

Answer: “Consistent with and not in excess of” means that the requested Orientation and Mobility Training services, based on an assessment of the service recipient’s needs, will be sufficient, but not

in excess of the amount necessary, to meet the service recipient's needs and to accomplish specific measurable therapeutic goals and objectives that are feasible given the service recipient's age, health status, and behavioral issues. When there is a question regarding whether the requested services are appropriate, the Plans Reviewer should consult with the Regional Nurse in the Clinical Review Unit.

8. In Question B-2 and elsewhere, how will concurrent review dates be determined?

Answer: Guidelines for establishing initial and subsequent review dates will be provided.

Nutrition Services

- 1. Can a service recipient under age 21 years get Nutrition Services through the waiver program IF the service recipient is not currently approved for Nutrition Services?**

Answer: No. Medically necessary Nutrition Services must be obtained from the TennCare Managed Care Organization (MCO).

- 2. Can a service recipient under age 21 years who is already receiving Nutrition Services through the waiver obtain an increase in the amount of Nutrition Services currently approved through the waiver program?**

Answer: The answer is no if the service recipient is under age 20 years. If the service recipient is age 20 years (but not yet age 21), transition of Nutrition Services to the TennCare MCO will not be initiated. For individuals under age 20 years, medically necessary Nutrition Services must be obtained from the TennCare Managed Care Organization (MCO). An increase in services must be obtained through the MCO. DMRS will submit the request for increased services, as well as a request to transition existing services, to the MCO in accordance with the transition process described in the protocol.

- 3. In Question A-2, how can one determine if there has been an interval of at least 12 months since the last Nutrition Services assessment?**

Answer: The Plans Reviewer will check the cost plan to determine the date that the last assessment, if any, was approved and will verify whether any Nutrition Services assessments have been billed (or which may be pending) for services provided during the current program (calendar) year.

- 4. In Question A-4 and elsewhere, will I have to calculate the Body Mass Index (BMI)?**

Answer: While the formulas used to calculate the BMI are included in the protocol, DMRS will also provide reference charts (based on height and weight) that are much quicker and easier to use.

- 5. In Question A-6 and elsewhere, what is meant by “a significant exacerbation of a pre-existing medical condition after having been discharged” from services?**

Answer: “Significant exacerbation of a pre-existing medical condition” means a clinically significant worsening of the medical condition or its symptoms (e.g., an increase in the instability of diabetes mellitus). When there is a question regarding this, the Plans Reviewer should consult with the Regional Nurse in the Clinical Review Unit.

- 6. In Question A-8 and elsewhere, what is meant by “program year”?**

Answer: “Program year” means the 12-calendar-month period beginning with the first day of the approved waiver year. For all three of the Home and Community-Based Services (HCBS) waivers, the “program year” is currently equivalent to the calendar year. Thus, “program year” currently means “per calendar year”, regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

- 7. In Question A-8, how can one determine if the annual limit of 3 assessments per waiver program (calendar year) per provider has been exceeded?**

Answer: The Plans Reviewer will check the cost plan to determine the number of assessments listed in the cost plan during the current program (calendar) year and will verify the number of assessments that have been billed (or which may be pending) for assessment provided during the current program (calendar) year.

8. In Question B-2.c and elsewhere, what is meant by “imminent development of serious nutrition-related medical problems?”

Answer: “Imminent development of serious nutrition-related medical problems” means that there would be an immediate, ongoing, and substantial risk of the development of clinically significant nutrition-related medical problems. When there is a question regarding this, the Plans Reviewer should consult with the Regional Nurse in the Clinical Review Unit.

9. In Question B-2.d and elsewhere, what is meant by “reasonable and appropriate given the person’s current age and health status?”

Answer: It means that the goals are feasible for the service recipient based on the age and medical conditions of the service recipient.

10. In Question B-3 and elsewhere, are there guidelines for determining whether requested Nutrition Services are “consistent with and not in excess of” the amount required to meet the service recipient’s needs?

Answer: “Consistent with and not in excess of” means that the requested Nutrition Services, based on an assessment of the service recipient’s needs, will be sufficient, but not in excess of the amount necessary, to meet the service recipient’s needs and to accomplish specific measurable therapeutic goals and objectives that are feasible given the service recipient’s age, health status, and behavioral issues. When there is a question regarding whether the requested services are appropriate, the Plans Reviewer should consult with the Regional Nurse in the Clinical Review Unit.

11. In Question B-3 and elsewhere, how will concurrent review dates be determined?

Answer: Guidelines for establishing initial and subsequent review dates will be provided.

12. In Question C-2.c, what is meant by “unreasonable delays by the MCO?”

Answer: An unreasonable delay would be:

- a. Failure of the MCO to act on a transition request and to make a medical necessity determination to approve or deny the service within 30 days of the date DMRS submitted the transition request to the MCO; or
- b. Failure of the MCO to identify a provider for an approved service and to arrange a date for initiation of services within 14 days of the date of approval by the MCO.

Medical Residential Services

1. **In Question A-1 and elsewhere, what is required to document that the service is not provided in a home where the service recipient will live with family members who are not service recipients enrolled in the waiver?**

Answer: The Medical Residential Services provider must provide the ISC with a statement (to be submitted with the ISP) that the Medical Residential Services home will not be a home where the service recipient will live with family members who are not service recipients enrolled in the waiver.

2. **In Question A-3.a and elsewhere, will the request for Medical Residential Services be denied if the physician's order does not specify the specific skilled nursing functions to be performed and the frequency of such skilled nursing functions?**

Answer: Yes. Explanation of the specific skilled nursing functions to be performed and the frequency of such skilled nursing functions is required in order to determine the medical necessity of the service. Prior to denial, the Plans Reviewer should attempt to obtain such information from the prescriber and/or the ISC or case manager. However, if such information is not received in time to render a timely review and decision, such request will be denied as the medical necessity of the service cannot be established.

3. **In Question A-3.d, how can one determine what is more cost-effective?**

Answer: Compare the cost of Medical Residential Services with:

- a. The current combined cost of Personal Assistance, Respite, Nursing Services (including waiver Nursing Services, TennCare Private Duty Nursing, and TennCare Home Health Skilled Nursing Services), and Individual Transportation Services that would be required to meet the needs of the service recipient in the service recipient's home or in a home with family members or other caregivers; or
- b. If applicable, the combined cost of Nursing Services (including waiver Nursing Services, TennCare Private Duty Nursing, and TennCare Home Health Skilled Nursing Services), and any other waiver residential service that the service recipient is receiving.

TennCare will provide average hourly and per visit nursing rates that can be used for cost-effective comparisons.

4. **In Question A-5 and elsewhere, what is meant by "serious and imminent danger of harm" and by "significant psychiatric or behavioral problems"?**

Answer:

- (1) "Serious and imminent risk of harm" means that for practical purposes, the service recipient has either inflicted physical injury on another person that required medical treatment or has attempted or threatened to inflict physical injury on another person that would likely require medical treatment and behavioral interventions to address such aggressive behaviors and minimize the risk of physical harm to others have not been successful.
- (2) "Significant psychiatric or behavioral problems" means extreme violence (e.g., murder, attempted murder); multiple physical assaults inflicting injury to others requiring medical treatment; sexual assault; or pedophilia, which would reasonably be expected to place others at extreme risk of harm.

5. **In Question A-5.a(3) and elsewhere, what is meant by "cannot be reasonably and adequately managed?"**

Answer: It means that the service recipient's behavior toward others poses an immediate risk of physical injury, which would require medical treatment, and that such behavior cannot, for practical purposes, be reasonably controlled in a shared residential setting by behavioral supervision and intervention strategies.

6. In Question A-6 and elsewhere, what is required to document that the size of a 2-person Medical Residential Services home is such that it can only accommodate 2 service recipients?

Answer: The Medical Residential Services provider must provide the ISC with a statement (to be submitted with the ISP) that the size of the Medical Residential Services home is such that it can only accommodate 2 service recipients and an explanation of why the home can only accommodate 2 service recipients.

7. In Question C-4 and elsewhere, what is meant by "Medical Residential Services in the *current* home is adequate to meet the service recipient's needs?"

Answer: Adequate means that:

- a. The service recipient's needs involving direct support services and other waiver services can be safely and appropriately met without the need for transfer to a different Medical Residential Services home; and
- b. If the service recipient has had a change in condition affecting ambulation and mobility, the service recipient's needs involving direct support services and other waiver services can be safely and appropriately met through additional Environmental Accessibility Modifications and without the need for transfer to a different Medical Residential Services home; and
- c. If the service recipient has had a change in medical condition affecting the need for skilled nursing services, the service recipient's needs involving the provision of skilled nursing services can be safely and appropriately met without the need for transfer to a different Medical Residential Services home.

Occupational Therapy

- 1. Can a service recipient under age 21 years get Occupational Therapy through the waiver program IF the service recipient is not currently approved for Occupational Therapy?**

Answer: With the exception of assessments focused specifically on determining the need for Environmental Accessibility Modifications, the answer is no. Otherwise, medically necessary Occupational Therapy must be obtained from the TennCare Managed Care Organization (MCO).

- 2. Can a service recipient under age 21 years who is already receiving Occupational Therapy through the waiver obtain an increase in the amount of Occupational Therapy currently approved through the waiver program?**

Answer: The answer is no if the service recipient is under age 20 years. If a service recipient is age 20 years (but not yet age 21), transition of Occupational Therapy to the TennCare MCO will not be initiated. For individuals under age 20 years, medically necessary Occupational Therapy must be obtained from the TennCare Managed Care Organization (MCO). An increase in services must be obtained through the MCO. DMRS will submit the request for increased services, as well as a request to transition existing services, to the MCO in accordance with the transition process described in the protocol.

- 3. In Question A-4 and elsewhere, how will the Plans Reviewer know the outcome of the fair hearing process or whether or not there has been a denial by Medicare?**

Answer: The ISC or case manager must submit documentation with the ISP that the Occupational Therapy was denied through the TennCare MCO fair hearing process or that such a determination is pending. Documentation may include:

- a. A copy of the denial; or
- b. Verbal confirmation of the denial from the TennCare Solutions Unit. The date of denial and the contact person in the TennCare Solutions Unit must be specified.

If the service was denied or not covered by Medicare, documentation of such must be submitted with the ISP. A letter or statement of non-coverage of the service by Medicare may also be submitted as documentation.

- 4. In Question A-5, how can one determine if there has been an interval of at least 12 months since the last assessment?**

Answer: The Plans Reviewer will check the cost plan to determine the date that the last assessment, if any, was approved and will verify whether any assessments have been billed (or which may be pending) for services provided during the current program (calendar) year.

- 5. In Question A-8.c and elsewhere, what is meant by “a significant exacerbation of a pre-existing medical condition after having been discharged” from services?**

Answer: “Significant exacerbation of a pre-existing medical condition” means a clinically significant worsening of the medical condition or its symptoms that justifies additional treatment (e.g., a substantial decrease in the service recipient’s ability to perform activities of daily living following an injury or illness). When there is a question regarding this, the Plans Reviewer should consult with the Regional Nurse or therapist in the Clinical Review Unit.

- 6. In Question A-11 and elsewhere, what is meant by “program year”?**

Answer: “Program year” means the 12-calendar-month period beginning with the first day of the approved waiver year. For all three of the Home and Community-Based Services (HCBS) waivers, the “program year” is currently equivalent to the calendar year. Thus, “program year” currently means “per calendar year”, regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

7. In Question A-11, how can one determine if the annual limit of 3 assessments per waiver program (calendar year) per provider has been exceeded?

Answer: The Plans Reviewer will check the cost plan to determine the number of assessments listed in the cost plan during the current program (calendar) year and will verify the number of assessments that have been billed (or which may be pending) for assessment provided during the current program (calendar) year.

8. In Question B-4.d and elsewhere, what is meant by “to achieve measurable and sustained functional gains”?

Answer: “To achieve measurable and sustained functional gains” means that the provision of Occupational Therapy would be reasonably expected to result in clinical improvement in the service recipient’s medical condition or functional deficits involving the ability to perform activities of daily living that could be objectively measured and that such clinical improvement would reasonably be expected to be sustained and that such sustained improvement can be demonstrated in normal daily activities outside the treatment setting.

9. In Question B-4.d and elsewhere, what is meant by “maintain current functional abilities that would be lost?”

Answer: This means that, but for the provision of continued Occupational Therapy, there would be a clinically significant worsening of the medical condition or its symptoms involving the ability to perform activities of daily living and that the loss of the current level of functional abilities would be clinically significant.

10. In Question B-4.d and elsewhere, what is meant by “prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems?”

Answer: This means that the service recipient has a chronic progressive condition that would reasonably be expected to result in continued loss of functional ability to perform activities of daily living or to result in an immediate and clinically significant worsening of the pre-existing medical condition, unless Occupational Therapy was provided on an ongoing basis. When there is a question regarding this, the Plans Reviewer should consult with the Regional Nurse or therapist in the Clinical Review Unit.

11. In Question B-4.e and elsewhere, what is meant by “reasonable and appropriate given the person’s current age and health status?”

Answer: It means that the goals are feasible for the service recipient based on the age and medical conditions of the service recipient.

12. In Question B-5 and elsewhere, are there guidelines for determining whether requested Occupational Therapy services are “consistent with and not in excess of” the amount required to meet the service recipient’s needs?

Answer: “Consistent with and not in excess of” means that the requested Occupational Therapy services, based on an assessment of the service recipient’s needs, will be sufficient, but not in excess of the amount necessary, to meet the service recipient’s needs and to accomplish specific measurable therapeutic goals and objectives that are feasible given the service recipient’s age,

health status, and behavioral issues. When there is a question regarding whether the requested services are appropriate, the Plans Reviewer should consult with staff in the Clinical Review Unit.

13. In Question B-5 and elsewhere, how will concurrent review dates be determined?

Answer: Guidelines for establishing initial and subsequent review dates will be provided.

14. In Question C-2.c, what is meant by “unreasonable delays by the MCO?”

Answer: An unreasonable delay would be:

- a. Failure of the MCO to act on a transition request and to make a medical necessity determination to approve or deny the service within 30 days of the date DMRS submitted the transition request to the MCO; or
- b. Failure of the MCO to identify a provider for an approved service and to arrange a date for initiation of services within 14 days of the date of approval by the MCO.

Physical Therapy

- 1. Can a service recipient under age 21 years get Physical Therapy through the waiver program IF the service recipient is not currently approved for Physical Therapy?**

Answer: With the exception of assessments focused specifically on determining the need for Environmental Accessibility Modifications, the answer is no. Otherwise, medically necessary Physical Therapy must be obtained from the TennCare Managed Care Organization (MCO).

- 2. Can a service recipient under age 21 years who is already receiving Physical Therapy through the waiver obtain an increase in the amount of Physical Therapy currently approved through the waiver program?**

Answer: The answer is no if the service recipient is under age 20 years. If a service recipient is age 20 years (but not yet age 21), transition of Physical Therapy to the TennCare MCO will not be initiated. For individuals under age 20 years, medically necessary Physical Therapy must be obtained from the TennCare Managed Care Organization (MCO). An increase in services must be obtained through the MCO. DMRS will submit the request for increased services, as well as a request to transition existing services, to the MCO in accordance with the transition process described in the protocol.

- 3. In Question A-4 and elsewhere, how will the Plans Reviewer know the outcome of the fair hearing process or whether or not there has been a denial by Medicare?**

Answer: The ISC or case manager must submit documentation with the ISP that the Physical Therapy was denied through the TennCare MCO fair hearing process or that such a determination is pending. Documentation may include:

- a. A copy of the denial; or
- b. Verbal confirmation of the denial from the TennCare Solutions Unit. The date of denial and the contact person in the TennCare Solutions Unit must be specified.

If the service was denied or not covered by Medicare, documentation of such must be submitted with the ISP. A letter or statement of non-coverage of the service by Medicare may also be submitted as documentation.

- 4. In Question A-5, how can one determine if there has been an interval of at least 12 months since the last assessment?**

Answer: The Plans Reviewer will check the cost plan to determine the date that the last assessment, if any, was approved and will verify whether any assessments have been billed (or which may be pending) for services provided during the current program (calendar) year.

- 5. In Question A-8.b and elsewhere, what is meant by “a significant exacerbation of a pre-existing medical condition”?**

Answer: “Significant exacerbation of a pre-existing medical condition” means a clinically significant worsening of the medical condition or its symptoms that justifies additional treatment (e.g., a substantial decrease in the service recipient’s capability for ambulation and mobility following an injury or illness). When there is a question regarding this, the Plans Reviewer should consult with the Regional Nurse or therapist in the Clinical Review Unit.

- 6. In Question A-11 and elsewhere, what is meant by “program year”?**

Answer: “Program year” means the 12-calendar-month period beginning with the first day of the approved waiver year. For all three of the Home and Community-Based Services (HCBS) waivers, the “program year” is currently equivalent to the calendar year. Thus, “program year” currently means “per calendar year”, regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

7. In Question A-11, how can one determine if the annual limit of 3 assessments per waiver program (calendar year) per provider has been exceeded?

Answer: The Plans Reviewer will check the cost plan to determine the number of assessments listed in the cost plan during the current program (calendar) year and will verify the number of assessments that have been billed (or which may be pending) for assessment provided during the current program (calendar) year.

8. In Question B-4.d and elsewhere, what is meant by “to achieve measurable and sustained functional gains”?

Answer: “To achieve measurable and sustained functional gains” means that the provision of Physical Therapy would be reasonably expected to result in clinical improvement in the service recipient’s medical condition or functional deficits involving ambulation and mobility that could be objectively measured and that such clinical improvement would reasonably be expected to be sustained and that such sustained improvement can be demonstrated in normal daily activities outside the treatment setting.

9. In Question B-4.d and elsewhere, what is meant by “maintain current functional abilities that would be lost?”

Answer: This means that, but for the provision of continued Physical Therapy, there would be a clinically significant worsening of the medical condition or its symptoms involving ambulation and mobility and that the loss of the current level of functional abilities would be clinically significant.

10. In Question B-4.d and elsewhere, what is meant by “prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems?”

Answer: This means that the service recipient has a chronic progressive condition that would reasonably be expected to result in continued loss of functional abilities involving ambulation and mobility or to result in an immediate and clinically significant worsening of the pre-existing medical condition, unless Physical Therapy was provided on an ongoing basis. When there is a question regarding this, the Plans Reviewer should consult with the Regional Nurse or therapist in the Clinical Review Unit.

11. In Question B-4.e and elsewhere, what is meant by “reasonable and appropriate given the person’s current age and health status?”

Answer: It means that the goals are feasible for the service recipient based on the age and medical conditions of the service recipient.

12. In Question B-5 and elsewhere, are there guidelines for determining whether requested Physical Therapy services are “consistent with and not in excess of” the amount required to meet the service recipient’s needs?

Answer: “Consistent with and not in excess of” means that the requested Physical Therapy services, based on an assessment of the service recipient’s needs, will be sufficient, but not in excess of the amount necessary, to meet the service recipient’s needs and to accomplish specific measurable therapeutic goals and objectives that are feasible given the service recipient’s age, health status, and behavioral issues. When there is a question regarding whether the requested services are appropriate, the Plans Reviewer should consult with staff in the Clinical Review Unit.

13. In Question B-5 and elsewhere, how will concurrent review dates be determined?

Answer: Guidelines for establishing initial and subsequent review dates will be provided.

14. In Question C-2.c, what is meant by “unreasonable delays by the MCO?”

Answer: An unreasonable delay would be:

- a. Failure of the MCO to act on a transition request and to make a medical necessity determination to approve or deny the service within 30 days of the date DMRS submitted the transition request to the MCO; or
- b. Failure of the MCO to identify a provider for an approved service and to arrange a date for initiation of services within 14 days of the date of approval by the MCO.

Speech, Language, and Hearing Services

- 1. Can a service recipient under age 21 years get Speech, Language, and Hearing Services through the waiver program IF the service recipient is not currently approved for Speech, Language, and Hearing Services?**

Answer: No. Medically necessary Speech, Language, and Hearing Services must be obtained from the TennCare Managed Care Organization (MCO).

- 2. Can a service recipient under age 21 years who is already receiving Speech, Language, and Hearing Services through the waiver obtain an increase in the amount of Speech, Language, and Hearing Services currently approved through the waiver program?**

Answer: The answer is no if the service recipient is under age 20 years. If a service recipient is age 20 years (but not yet age 21), transition of Speech, Language, and Hearing Services to the TennCare MCO will not be initiated. For individuals under age 20 years, medically necessary Speech, Language, and Hearing Services must be obtained from the TennCare Managed Care Organization (MCO). An increase in services must be obtained through the MCO. DMRS will submit the request for increased services, as well as a request to transition existing services, to the MCO in accordance with the transition process described in the protocol.

- 3. In Question A-3 and elsewhere, how will the Plans Reviewer know the outcome of the fair hearing process or whether or not there has been a denial by Medicare?**

Answer: The ISC or case manager must submit documentation with the ISP that the request for Speech, Language, and Hearing Services was denied through the TennCare MCO fair hearing process or that such a determination is pending. Documentation may include:

- a. A copy of the denial; or
- b. Verbal confirmation of the denial from the TennCare Solutions Unit. The date of denial and the contact person in the TennCare Solutions Unit must be specified.

If the service was denied or not covered by Medicare, documentation of such must be submitted with the ISP. A letter or statement of non-coverage of the service by Medicare may also be submitted as documentation.

- 4. In Question A-4, how can one determine if there has been an interval of at least 12 months since the last assessment?**

Answer: The Plans Reviewer will check the cost plan to determine the date that the last assessment, if any, was approved and will verify whether any assessments have been billed (or which may be pending) for services provided during the current program (calendar) year.

- 5. In Question A-7.b(2) and elsewhere, what is meant by “a significant exacerbation of a pre-existing medical condition”?**

Answer: “Significant exacerbation of a pre-existing medical condition” means a clinically significant worsening of the medical condition or its symptoms that justifies additional treatment (e.g., a substantial decrease in the service recipient’s capabilities involving speech, language, hearing, or chewing/swallowing following an injury or illness). When there is a question regarding this, the Plans Reviewer should consult with the Regional Nurse or therapist in the Clinical Review Unit.

- 6. In Question A-8 and elsewhere, what is meant by “program year”?**

Answer: “Program year” means the 12-calendar-month period beginning with the first day of the approved waiver year. For all three of the Home and Community-Based Services (HCBS) waivers, the “program year” is currently equivalent to the calendar year. Thus, “program year” currently means “per calendar year”, regardless of the date during the calendar year when the service recipient was enrolled in the waiver.

7. In Question A-8, how can one determine if the annual limit of 3 assessments per waiver program (calendar year) per provider has been exceeded?

Answer: The Plans Reviewer will check the cost plan to determine the number of assessments listed in the cost plan during the current program (calendar) year and will verify the number of assessments that have been billed (or which may be pending) for assessment provided during the current program (calendar) year.

8. In Question B-5.d and elsewhere, what is meant by “to achieve measurable and sustained functional gains”?

Answer: “To achieve measurable and sustained functional gains” means that the provision of Speech, Language, and Hearing Services would be reasonably expected to result in clinical improvement in the service recipient’s medical condition or functional deficits that could be objectively measured and that such clinical improvement would reasonably be expected to be sustained and that such sustained improvement can be demonstrated in normal daily activities outside the treatment setting.

9. In Question B-5.e and elsewhere, what is meant by “maintain current functional abilities that would be lost?”

Answer: This means that, but for the provision of continued Speech, Language, and Hearing services, there would be a clinically significant worsening of the medical condition or its symptoms involving speech, language, hearing, or chewing/swallowing and that the loss of the current level of functional abilities would be clinically significant.

10. In Question B-5.e and elsewhere, what is meant by “prevent or minimize the deterioration of a chronic condition that would result in the further loss of function or the imminent development of serious medical problems?”

Answer: This means that the service recipient has a chronic progressive condition that would reasonably be expected to result in continued loss of functional abilities involving speech, language, hearing, or chewing/swallowing or to result in an immediate and clinically significant worsening of the pre-existing medical condition, unless Speech, Language, and Hearing Services were provided on an ongoing basis. When there is a question regarding this, the Plans Reviewer should consult with the Regional Nurse or therapist in the Clinical Review Unit.

11. In Question B-5.e and elsewhere, what is meant by “reasonable and appropriate given the person’s current age and health status?”

Answer: It means that the goals are feasible for the service recipient based on the age and medical conditions of the service recipient.

12. In Question B-6 and elsewhere, are there guidelines for determining whether requested Speech, Language, and Hearing Services are “consistent with and not in excess of” the amount required to meet the service recipient’s needs?

Answer: “Consistent with and not in excess of” means that the requested Speech, Language, and Hearing services, based on an assessment of the service recipient’s needs, will be sufficient, but not in excess of the amount necessary, to meet the service recipient’s needs and to accomplish specific measurable therapeutic goals and objectives that are feasible given the service recipient’s age,

health status, and behavioral issues. When there is a question regarding whether the requested services are appropriate, the Plans Reviewer should consult with staff in the Clinical Review Unit.

13. In Question B-5 and elsewhere, how will concurrent review dates be determined?

Answer: Guidelines for establishing initial and subsequent review dates will be provided.

14. In Question C-2.c, what is meant by “unreasonable delays by the MCO?”

Answer: An unreasonable delay would be:

- a. Failure of the MCO to act on a transition request and to make a medical necessity determination to approve or deny the service within 30 days of the date DMRS submitted the transition request to the MCO; or
- b. Failure of the MCO to identify a provider for an approved service and to arrange a date for initiation of services within 14 days of the date of approval by the MCO.

Residential Habilitation

1. In Question A-1.c(2), how can one determine what is more cost-effective?

Answer: Compare the cost of Residential Habilitation with the current cost of Personal Assistance, Respite, and Individual Transportation Services that would be required to meet the needs of the service recipient in the service recipient's home or in a home with family members or other caregivers.

2. In Question A-3.b and elsewhere, what is meant by “serious and imminent danger of harm” and by “significant psychiatric or behavioral problems”?

Answer:

- (1) “Serious and imminent risk of harm” means that for practical purposes, the service recipient has either inflicted physical injury on another person that required medical treatment or has attempted or threatened to inflict physical injury on another person that would likely require medical treatment and behavioral interventions to address such aggressive behaviors and minimize the risk of physical harm to others have not been successful.
- (2) “Significant psychiatric or behavioral problems” means extreme violence (e.g., murder, attempted murder); multiple physical assaults inflicting injury to others requiring medical treatment; sexual assault; or pedophilia, which would reasonably be expected to place others at extreme risk of harm.

3. In Question A-3.c and elsewhere, what is meant by “cannot be reasonably and adequately managed?”

Answer: It means that the service recipient's behavior toward others poses an immediate risk of physical injury, which would require medical treatment, and that such behavior cannot, for practical purposes, be reasonably controlled in a shared residential setting by behavioral supervision and intervention strategies.

4. In Question A-5 and elsewhere, what is required to document that the size of a 2-person Residential Habilitation home is such that it can only accommodate 2 service recipients?

Answer: The Residential Habilitation provider must provide the ISC with a statement (to be submitted with the ISP) that the size of the Residential Habilitation home is such that it can only accommodate 2 service recipients and an explanation of why the home can only accommodate 2 service recipients.

5. In Question C-4 and elsewhere, what is meant by “the current Residential Habilitation home is adequate to meet the service recipient's needs?”

Answer: Adequate means that:

- a. The service recipient's needs involving direct support services and other waiver services can be safely and appropriately met without the need for transfer to a different Residential Habilitation home; and
- b. If the service recipient has had a change in condition affecting ambulation and mobility, the service recipient's needs involving direct support services and other waiver services can be safely and appropriately met through additional Environmental Accessibility Modifications and without the need for transfer to a different Residential Habilitation home.

Personal Assistance

1. **In Question A-2 and elsewhere, what is required to document that the service is not provided by the service recipient's parent (i.e., the parent of a minor)?**

Answer: The Personal Assistance provider must provide the ISC with a statement (to be submitted with the ISP) that Personal Assistance will not be provided by the service recipient's parent (whether the relationship is by blood, by marriage, or by adoption).

2. **In Question A-3 and elsewhere, what is required to document that the service is not provided by the spouse of the service recipient?**

Answer: The Personal Assistance provider must provide the ISC with a statement (to be submitted with the ISP) that Personal Assistance will not be provided by the service recipient's spouse.

3. **In Question A-4 and elsewhere, what is required to document that the Personal Assistance is not being provided for an excluded reason?**

Answer: The ISC or case manager must state in the ISP the specific functions or tasks the Personal Assistant is expected to perform.

4. **In Question A-5 b(2) and elsewhere, what is required to document that the primary caregiver must work outside the home to support the family?**

Answer: If the basis for the request for Personal Assistance is that the primary caregiver must work outside the home to support the family, the ISC or case manager must provide a statement indicating that the primary caregiver is employed outside the home and specifying the place of employment and the work schedule.

5. **In Question A-5 b(8) and elsewhere, what is required to document that unrelated Personal Assistance providers have been "extremely difficult to find and retain?"**

Answer: With the exception of self-directed Personal Assistance services provided through the Self-Determination Waiver, the person providing Personal Assistance may not be parent or grandparent of a service recipient (whether the relationship is by blood, by marriage, or by adoption) unless there is documentation that it has been extremely difficult to find and retain unrelated providers willing to provide the Personal Assistance services. The Personal Assistance provider must provide documentation to the ISC or case manager (to be submitted with the ISP) that, despite multiple good faith attempts, the provider has been unable to find and retain persons to provide Personal Assistance services to the service recipient. Refusal of the conservator or family members to accept services from available qualified Personal Assistants shall not constitute a basis for approval of the family member or conservator to provide the Personal Assistance services.

6. **In Question A-5.d and elsewhere, what is required to document that the Personal Assistance services will not replace uncompensated care that is the responsibility of the primary caregiver?**

Answer: The ISC or case manager must provide:

- (1) A list of the names of the primary caregivers which specifies the relationship to the service recipient, whether the caregiver works outside the home and, if so, the work schedule outside the home; and
- (2) A statement clarifying why any family member caregiver would not be able to meet the needs of the service recipient during non-working hours.

7. In Question A-5.e and elsewhere, what is required to document that there is no other caregiver available during the time that Personal Assistance is requested?

Answer: If the service recipient is requesting Personal Assistance services and the service recipient does **not** receive (and is not requesting) waiver-funded Nursing Services; TennCare Private Duty Nursing; TennCare Home Health Skilled Nursing Services; or TennCare Home Health Aide Services, the ISC or case manager must provide:

- (1) A statement that no caregivers will be available in the home during the time that Personal Assistance is requested; or
- (2) A statement why the primary caregiver and any family member caregivers who would be in the home during the time Personal Assistance is requested would not be able to meet the needs of the service recipient.

If the service recipient is requesting Personal Assistance services to be provided at the same time as either waiver-funded Nursing Services; TennCare Private Duty Nursing; TennCare Home Health Skilled Nursing Services; or TennCare Home Health Aide Services, the ISC or case manager must provide a statement specifying:

- (1) Why the primary caregiver and any family member caregivers who would be in the home during the time Personal Assistance is requested would not be able to meet the needs of the service recipient;
- (2) The total number of hours of each type of service requested (i.e., Personal Assistance; Waiver Nursing Services; or TennCare Private Duty Nursing, Home Health Skilled Nursing Services, or Home Health Aide Services);
- (3) The specific functions or tasks the Personal Assistant is expected to perform, including the frequency with which each task must be performed;
- (4) The specific skilled nursing services (if applicable) to be performed and the frequency such skilled nursing services are (or will be) provided;
- (5) The specific functions or tasks the Home Health Aide (if applicable) is expected to perform, including the frequency with which each task must be performed, and
- (6) A schedule of how such services will be coordinated that clearly demonstrates the total amount of time during which the service recipient will be receiving more than one such service at the same time.

The intent is to prevent the inappropriate duplication of services, not to preclude the provision of intermittent clinical services during scheduled Personal Assistance hours.

8. In Question A-5.e and elsewhere, how will one know the number and schedule of TennCare Private Duty Nursing or Home Health Skilled Nursing Services or Home Health Aide Services being provided to the service recipient?

Answer: It is the responsibility of the ISC or case manager to coordinate ALL of the service and support needs of the service recipient. Gathering this information is critical in the development of the ISP in order to ensure that the service recipient's needs are met and in order to determine the need for waiver services. Accordingly, the ISC or case manager must submit such information with the ISP and, if necessary, must contact the TennCare Managed Care Organization (MCO) to obtain such information. TennCare and DMRS will work with the MCO's to help facilitate timely access to this information.

9. In Question A-5.e and elsewhere, what is the process for submitting an "exceptional circumstance" request to the DMRS Central Office?

Answer: The Plans Reviewer will submit a written request to the DMRS Office of Community Services requesting a review of the “exceptional circumstance.” DMRS is developing the process for submitting such requests.

10. In Question A-6 and elsewhere, are there guidelines for determining whether requested Personal Assistance services are “consistent with and not in excess of the amount of services needed?”

Answer: “Consistent with and not in excess of” means that the requested Personal Assistance services, based on an assessment of the service recipient’s needs, will be sufficient, but not in excess of the amount necessary, to meet the service recipient’s needs and to accomplish specific measurable therapeutic goals and objectives that are feasible given the service recipient’s age, health status, and behavioral issues. Personal Assistance services shall be considered to be “consistent with and not in excess of the amount of services needed” when:

- a. There is documentation to justify the hours that the Personal Assistant must be present to provide direct assistance with activities of daily living (e.g., bathing, dressing, personal hygiene, feeding/assistance with eating, toileting and incontinence care, assistance with transfer and mobility) or instrumental activities of daily living (e.g., meal preparation, household chores, budget management, and accompaniment to medical appointments or on personal errands); and/or to provide behavioral supervision and intervention; AND
- b. There is no other caregiver available during the time that Personal Assistance is requested (See response to Question #7 above).

11. In Question A-9 and elsewhere, how will the Plans Reviewer know the outcome of the fair hearing process?

Answer: The ISC or case manager must specify in the ISP that the Personal Assistance was denied though the TennCare MCO fair hearing process.